

1 **ONS Nursing Documentation Standards**

2 **Introduction**

3 Documentation is a reflection of nursing care, and is an integral component of practice
4 (American Nurses Association [ANA], 2010; Brant and Wickham, 2013). Thorough
5 documentation has not only legal, financial, and regulatory implications but promotes
6 communication between clinicians and disciplines, facilitates research, and demonstrates
7 nursing's contributions to patient outcomes (American Nurses Association, 2010). With the
8 implications of reporting quality and outcome measures associated with the Affordable Care Act,
9 focus on standardized documentation in the health care arena has never been more critical.

10 *ONS Nursing Documentation Standards* detail requirements for nursing documentation to be
11 used consistently across practice settings. All of the recommended elements of documentation as
12 detailed by the ANA were considered when developing the *ONS Nursing Documentation*
13 *Standards*. These elements include: assessments; clinical problems; communication with other
14 health care professionals; communication with and education of the patient, family and the
15 patient's support system; medication records; order acknowledgement, implementation and
16 management; patient clinical parameters; patient responses and outcomes and plans of care that
17 reflect the social and cultural framework of the patient (ANA, 2010).

18 ONS supports the American Nurses Association (2015) in standardizing terminologies to
19 facilitate communication between systems. Terms used in the *ONS Nursing Documentation*
20 *Standards* comply with those used in the International Health Terminology Standards
21 Development Organization's (IHTSDO) Systemized Nomenclature of Medicine-Clinical Terms

22 (SNOMED-CT) and Logical Observation Identifiers Names and Codes (LOINC) in order to
23 facilitate incorporation and adaptation of ONS' documentation standards into existing electronic
24 health records systems and data sharing.

25 Incorporation of the *ONS Nursing Documentation Standards* ensures thorough documentation
26 and promotes comprehensive care for patients with cancer. What follows are nursing
27 documentation standards for patients undergoing common forms of cancer treatment and for
28 those requiring supportive care. These standards were developed for patients undergoing:

- 29 • Chemotherapy/Biotherapy
- 30 • Blood and Marrow Transplant
- 31 • Radiation
- 32 • Surgery
- 33 • Extravasation Management
- 34 • Blood Product Transfusion
- 35 • Treatment with a Central Venous Access Device

36 All of the documentation standards are divided into one of 3 categories:

- 37 • “Assessment of” – documentation indicates that specific elements were assessed by a
38 nurse (or practice-designated employee)
- 39 • “Review of” – documentation indicates that a specific elements were reviewed by a nurse
40 (or practice-designated employee)
- 41 • “Verification of” – documentation indicates that a specific elements were verified as part
42 of the treatment plan by a nurse (or practice-designated employee)

43 It should be noted that the *ONS Nursing Documentation Standards* are intended as a minimal set
44 of required elements to include in patient documentation. Patient care and documentation should
45 be individualized to meet patient needs specific to the treatment plan and the patient's tolerance
46 of such. Additional components of documentation should be incorporated into the patient records
47 based on individualized care and assessment as well as institutional policies and procedures.

48 These standards were developed through a rigorous process to ensure accuracy, thoroughness,
49 and applicability to practice. The required elements of documentation were developed through a
50 task force of volunteer members who are expert in their respective field. Documentation
51 standards were then opened to a public comment period. ONS nursing staff compiled the
52 elements into a usable format with consideration of nursing scope of practice. ONS staff then
53 conducted site visits at various cancer centers to determine feasibility of applying standards into
54 practice with existing electronic health records at the point of care. Required elements were then
55 revised based on an analysis of themes emerging from site visitations and formatted into a
56 sequential outline.

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58 *Hospital of the University of Pennsylvania in Philadelphia, PA and the Helen F. Graham Cancer*
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60 *and for their invaluable input during the development of ONS documentation standards*

61 References:

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71

DRAFT

72 **Chemotherapy/Biotherapy Administration Documentation**

73 **Standards**

74 During the administration of chemotherapy and biotherapy agents, incorporation of drug-specific
75 considerations, adherence to safe handling procedures, and vigilant assessment is of the utmost
76 importance. Equally as important, is a medical record reflective of evidence-based, thorough, and
77 accountable care. The ONS Chemotherapy/Biotherapy Administration Documentation Standards
78 detail the required elements of nursing documentation for patients undergoing treatment with
79 chemotherapy and/or biotherapy. Elements are divided into one of four categories: physical,
80 psychological; social/financial; patient/caregiver education. They were further subdivided
81 according to phase in the treatment plan (work-up, prep and start of a new regimen, ongoing
82 treatment, transition to follow-up, and follow-up) and drug administration documentation. Note
83 that certain chemotherapy/ biotherapy regimen protocols require more vigilant site-specific
84 assessment and documentation based on anticipated side effects and organ toxicity. Always
85 consider facility requirements and individualized patient care based on anticipated treatment
86 plan.

87 **Standard I. Work-Up**

88 A. Physical Elements of Documentation

89 a. General:

90 i. Verification of:

- 91 1. Medical/surgical history
- 92 2. Family medical history
- 93 3. Prior cancer treatment

- 94 b. Constitutional:
- 95 i. Assessment of:
- 96 1. Vital signs
- 97 2. Pain
- 98 3. Activities of Daily Living
- 99 4. Performance Status
- 100 5. Height/Weight
- 101 6. History of hypersensitivity reactions
- 102 ii. Medication Reconciliation
- 103 iii. Allergies
- 104 c. Neurological
- 105 i. Assessment of:
- 106 1. Level of Consciousness
- 107 2. Peripheral neuropathy
- 108 d. HEENT:
- 109 i. Assessment of:
- 110 1. Oral exam/Mucositis/Esophagitis
- 111 2. Dental exam
- 112 3. Dry mouth
- 113 4. Dysphagia
- 114 5. Epistaxis
- 115 6. Sinus Pain
- 116 7. Visual impairment

117 8. Ototoxicity

118 e. Cardiovascular:

119 i. Assessment of:

120 1. Heart sounds

121 2. Edema

122 3. Palpitations

123 4. Cyanosis

124 5. Chest pain

125 6. Venous thromboembolism (VTE)

126 ii. Review of:

127 1. Electrocardiogram (ECG)

128 2. MUGA

129 f. Pulmonary:

130 i. Assessment of

131 1. Respiratory Sounds

132 2. Oxygen delivery

133 3. Cough

134 4. Sputum

135 5. Dyspnea

136 6. Shortness of Breath

137 ii. Review of:

138 1. Pulmonary Function Tests

139 2. Chest X-ray

- 140 g. Gastrointestinal/Nutritional:
- 141 i. Assessment of:
- 142 1. Altered Taste Sense
- 143 2. Nausea/Vomiting
- 144 3. Constipation/Diarrhea
- 145 4. Weight Loss
- 146 5. Dietary History
- 147 h. Genitourinary/Renal:
- 148 i. Assessment of:
- 149 1. Dysuria
- 150 2. Incontinence
- 151 3. Hematuria
- 152 4. Color of urine
- 153 ii. Review of:
- 154 1. Creatinine clearance (if applicable)
- 155 i. Reproductive:
- 156 i. Verification of:
- 157 1. Contraception (if of childbearing potential)
- 158 2. Breastfeeding status (if applicable)
- 159 j. Musculoskeletal:
- 160 i. Assessment of:
- 161 1. Gait function
- 162 k. Dermatologic:

- 163 i. Assessment of:
- 164 1. Skin condition
- 165 2. Wounds
- 166 3. Skin Breakdown
- 167 4. Rashes
- 168 5. Palmar Plantar Erythrodysesthesia (PPE)
- 169 l. Hematologic/Lymphatic:
- 170 i. Assessment of:
- 171 1. Anemia
- 172 2. Blood coagulation disorder
- 173 ii. Review of:
- 174 1. Laboratory data
- 175 m. Immune System:
- 176 i. Review of:
- 177 1. Presence or absence of known infection
- 178 n. Structural Changes:
- 179 i. Assessment of (as applicable)
- 180 1. Implanted devices
- 181 2. Stoma
- 182 3. Tubes/drains as indicated
- 183 o. Malignancy:
- 184 i. Verification of:
- 185 1. Cancer diagnosis and stage

- 186 B. Psychologic Elements of Documentation:
- 187 a. General:
- 188 i. Verification of:
- 189 1. History of psychologic disorder (depression, anxiety, bipolar, etc.)
- 190 2. Prior treatment for psychologic disorders
- 191 b. Distress and Stressors
- 192 i. Assessment of:
- 193 1. Baseline distress and current stressors
- 194 2. Caregiver support
- 195 c. Coping:
- 196 i. Assessment of:
- 197 1. Coping mechanisms
- 198 d. Anxiety
- 199 i. Assessment of:
- 200 1. Signs/symptoms of anxiety
- 201 ii. Current treatment if applicable
- 202 e. Depression
- 203 i. Assessment of
- 204 1. Signs/symptoms of depression
- 205 2. Suicide risk
- 206 ii. Current Treatment
- 207 f. Cultural/Spiritual:
- 208 i. Assessment of:

- 209 1. Cultural/spiritual beliefs and practices
- 210 2. Impact on plan of care
- 211 C. Social and Financial Elements of Documentation
- 212 a. Language:
- 213 i. Assessment of:
- 214 1. Primary language
- 215 2. Need for interpreter
- 216 3. Health literacy
- 217 b. Advance Directive:
- 218 i. Review of:
- 219 1. Advanced directives, living will, power of attorney/decision
- 220 makers
- 221 c. Income concerns:
- 222 i. Assessment of:
- 223 1. Financial concerns
- 224 d. Living Arrangements:
- 225 i. Assessment of:
- 226 1. Living arrangements appropriate for functional status
- 227 2. Access to care
- 228 e. Insurance Status:
- 229 i. Assessment of:
- 230 1. Insurance coverage
- 231 2. Ability to procure drug

232 3. Ability to cover co-pays and out of pocket expenses

233 f. Substance Abuse

234 i. Assessment of:

235 1. Past/current substance abuse

236 2. Last use

237 ii. Review of:

238 1. Referrals made (if applicable)

239 g. Referrals as indicated

240 **Standard II. Preparation for New Regimen and Administration of First Cycle**

241 A. Physical Elements of Documentation

242 a. General:

243 i. Verification of:

244 1. Changes to medical/surgical history baseline

245 2. Prior cancer treatment

246 b. Constitutional:

247 i. Assessment of:

248 1. Vital signs

249 2. Pain

250 3. ADLs

251 4. Height/Weight

252 5. Fatigue

253 6. Performance Status

254 c. Neurological:

- 255 i. Assessment of:
- 256 1. Level of Consciousness
- 257 2. Orientation
- 258 3. Peripheral Neuropathy
- 259 4. Cerebellar Assessment (if applicable)

260 d. HEENT:

- 261 i. Assessment of:
- 262 1. Oral exam/Mucositis/Esophagitis
- 263 2. Dry mouth
- 264 3. Dysphagia
- 265 4. Epistaxis
- 266 5. Sinus pain
- 267 6. Visual impairment
- 268 7. Ototoxicity

269 e. Cardiovascular:

- 270 i. Assessment of:
- 271 1. Heart sounds
- 272 2. Edema
- 273 3. Palpitations
- 274 4. Cyanosis
- 275 5. Chest pain
- 276 6. VTE
- 277 ii. Review of:

- 278 1. ECG
279 2. MUGA where applicable

280 f. Pulmonary:

281 i. Assessment of:

- 282 1. Respiratory Sounds
283 2. Oxygen delivery
284 3. Cough
285 4. Sputum
286 5. Dyspnea
287 6. Shortness of Breath

288 ii. Review of: (where applicable)

- 289 1. PFTs
290 2. Chest X-ray

291 g. Gastrointestinal/Nutrition

292 i. Assessment of:

- 293 1. Altered taste sense
294 2. Nausea/vomiting
295 3. Constipation/diarrhea
296 4. Weight loss
297 5. Dietary intake

298 h. Genitourinary/Renal:

299 i. Assessment of:

- 300 1. Dysuria

- 301 2. Incontinence
- 302 3. Point of Care testing (ex. pH, heme) (where applicable)
- 303 ii. Review of:
- 304 1. Creatinine clearance (where applicable)
- 305 i. Reproductive:
- 306 i. Review of:
- 307 1. Contraception
- 308 2. Last Menstrual period (where applicable)
- 309 3. Sexual dysfunction/dissatisfaction
- 310 4. Beta Hcg (where applicable)
- 311 j. Musculoskeletal:
- 312 i. Assessment of:
- 313 1. Gait function
- 314 2. Muscular strength (+0-+5)
- 315 k. Dermatologic:
- 316 i. Assessment of:
- 317 1. Skin condition
- 318 2. Wounds
- 319 3. Skin breakdown
- 320 4. Rashes
- 321 5. PPE
- 322 l. EcchymosisHematologic/Lymphatic
- 323 i. Review of:

- 324 1. Laboratory data
- 325 ii. Assessment of:
- 326 1. Anemia
- 327 2. Blood Coagulation Disorder
- 328 m. Immunologic:
- 329 i. Review of:
- 330 1. Presence of/absence of known infection
- 331 n. Structural Changes
- 332 i. Assessment of: (where applicable)
- 333 1. Implanted devices
- 334 2. Stomas
- 335 3. Tubes/drains
- 336 o. Malignancy:
- 337 i. Verification of:
- 338 1. Cancer diagnosis and stage
- 339 B. Psychologic Elements of Documentation
- 340 a. Distress and Stressors
- 341 i. Assessment of:
- 342 1. Distress
- 343 2. Current stressors
- 344 ii. Anxiety:
- 345 1. Assessment of:
- 346 a. Presence of anxiety

- 347 2. Current treatment
- 348 iii. Depression
- 349 1. Assessment of:
- 350 a. Signs/symptoms of depression
- 351 2. Current treatment
- 352 iv. Culture/Spiritual:
- 353 1. Review of:
- 354 a. Changes from baseline

355 C. Social and Financial Elements of Documentation

- 356 a. Language:
- 357 i. Review of:
- 358 1. Use of interpreter if applicable
- 359 b. Advance Directive:
- 360 i. Review of:
- 361 1. Changes from baseline
- 362 2. Goals of care conversations
- 363 c. Income Concerns:
- 364 i. Review of:
- 365 1. Changes from baseline
- 366 d. Living arrangements:
- 367 i. Review of:
- 368 1. Changes from baseline
- 369 e. Insurance Status:

- 370 i. Review of:
- 371 1. Changes from baseline
- 372 f. Substance Abuse:
- 373 i. Review of:
- 374 1. Changes from baseline
- 375 g. Referrals as indicated
- 376 D. Patient/Caregiver Education Elements of Documentation
- 377 a. Assessment of:
- 378 i. Preferred learning styles (ex. written, verbal etc.)
- 379 ii. Barriers to learning
- 380 iii. Person(s) being educated
- 381 iv. Patient/family comprehension of chemotherapy/biotherapy regimen
- 382 prescribed
- 383 v. Ability to obtain and self-administer agents according to
- 384 institutional/state/federal guidelines where applicable (ex. oral agents at
- 385 home)
- 386 b. Resources provided:
- 387 i. Drug-specific resources/materials
- 388 ii. Discharge documents
- 389 c. Key Teaching points:
- 390 i. Consent process
- 391 ii. Concurrent cancer treatment and supportive care medications/measures
- 392 iii. Drug/protocol specific toxicities,

- 393 iv. Chemotherapy administration schedule
- 394 v. Risks/benefits to treatment
- 395 vi. Infertility risk and contraception requirements if indicated
- 396 vii. Alternatives to chemotherapy
- 397 viii. Return demonstrations where applicable
- 398 ix. Storage, handling, preparation and disposal of chemotherapy for those on
- 399 oral chemotherapy at home
- 400 x. Plan for missed doses for those on oral chemotherapy at home
- 401 d. Response to Teaching:
- 402 i. Full understanding of teaching points
- 403 ii. Return demonstration where applicable
- 404 iii. Patient/family comprehension of goals of treatment (ex. Cure, control,
- 405 disease palliation, etc.)

406 **Standard III. Ongoing Chemotherapy/Biotherapy Treatment**

407 A. Physical Elements of Documentation

- 408 a. Constitutional:
- 409 i. Assessment of:
- 410 1. Vitals signs
- 411 2. Pulse oximetry
- 412 3. Pain
- 413 4. ADLs
- 414 5. Height/Weight
- 415 6. Fatigue

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7. Performance status

b. Neurological:

i. Assessment of:

1. Level of Consciousness
2. Orientation
3. Peripheral neuropathy
4. Cerebellar assessment if applicable

c. HEENT:

i. Assessment of

1. Oral exam/mucositis/Esophagitis
2. Dry mouth
3. Dysphagia
4. Epistaxis
5. Sinus pain
6. Visual impairment
7. Ototoxicity
8. Jaw Necrosis

d. Cardiovascular

i. Assessment of:

1. Heart sounds
2. Edema
3. Palpitations
4. Cyanosis

- 439 5. Chest pains
- 440 6. VTE
- 441 ii. Review of:
- 442 1. ECG where applicable
- 443 e. Pulmonary:
- 444 i. Assessment of:
- 445 1. Respiratory Sounds
- 446 2. Oxygen delivery
- 447 3. Cough
- 448 4. Sputum
- 449 5. Dyspnea
- 450 6. Shortness of breath
- 451 f. Gastrointestinal/Nutrition:
- 452 i. Assessment of:
- 453 1. Altered taste sense
- 454 2. Nausea/Vomiting
- 455 3. Constipation/Diarrhea
- 456 4. Weight loss
- 457 5. Dietary intake
- 458 g. Genitourinary/Renal
- 459 i. Assessment of:
- 460 1. Dysuria
- 461 2. Incontinence

462 3. Point of Care testing where applicable

463 h. Reproductive:

464 i. Review of:

465 1. Contraception

466 2. Last menstrual period

467 3. Sexual dysfunction/dissatisfaction

468 i. Musculoskeletal:

469 i. Assessment of :

470 1. Gait function

471 2. Muscular strength (+0-+5)

472 j. Dermatologic:

473 i. Assessment of:

474 1. Skin condition

475 2. Wounds

476 3. Skin breakdown

477 4. Rashes

478 5. PPE

479 k. Hematologic:

480 i. Review of:

481 1. Laboratory data as appropriate

482 ii. Assessment of:

483 1. Anemia

484 2. Blood coagulation disorder

- 485 1. Immunologic:
- 486 i. Review of:
- 487 1. Presence/absence of known infection

488 m. Structural Changes:

- 489 i. Assessment of: (where applicable)
- 490 1. Implanted devices
- 491 2. Stomas
- 492 3. Tubes/drains

493 B. Psychologic Elements of Documentation

494 a. Distress:

- 495 i. Assessment of:
- 496 1. Distress and stressors

497 b. Anxiety:

- 498 i. Assessment of:
- 499 1. Presence of anxiety

500 ii. Current treatment

501 c. Depression:

- 502 i. Assessment of:
- 503 1. Signs/symptoms of depression

504 ii. Current treatment

505 d. Cultural/Spiritual:

- 506 i. Assessment of:
- 507 1. Impact on plan of care

508 C. Social and Financial Elements of Documentation

509 a. Language:

- 510 i. Use of interpreter (if applicable)

511 b. Advance Directive:

512 i. Review of:

- 513 1. Changes from baseline

- 514 2. Goals of care conversations

515 c. Income Concerns

516 i. Review of:

- 517 1. Changes from baseline

518 d. Living Arrangements:

519 i. Review of:

- 520 1. Changes from baseline

521 e. Insurance Status:

522 i. Review of:

- 523 1. Changes from baseline

524 f. Substance Abuse:

525 i. Review of:

- 526 1. Changes from baseline

527 g. Referrals as indicated

528 D. Patient/Caregiver Education

529 a. Assessment of:

- 530 i. Preferred learning styles

- 531 ii. Barriers to learning
- 532 iii. Target of education
- 533 b. Resources Provides:
- 534 i. Drug-specific resources/materials
- 535 ii. Discharge documents
- 536 c. Key Teaching Requirements:
- 537 i. Consent process
- 538 ii. Drug/Protocol specific toxicities
- 539 iii. Side effect management
- 540 iv. Risks/benefits to treatment
- 541 v. Alternatives to chemotherapy
- 542 vi. Ability to safely administer agents (where applicable in self-administration
- 543 regimens)
- 544 d. Response to Teaching
- 545 i. Full understanding of chemotherapy administration schedule
- 546 ii. Return demonstrations where applicable
- 547 iii. Patient/family comprehension of goals of treatment

548 **Standard IV. Transition to Post-Treatment - (Completion of final cycle of**
549 **current regimen)**

550 A. Physical Elements of Documentation

551 a. Constitutional:

552 i. Assessment of:

- 553 1. Vital Signs
554 2. Pain
555 3. ADLs
556 4. Height/Weight
557 5. Fatigue

558 b. Neurological:

559 i. Assessment of:

- 560 1. Level of Consciousness
561 2. Orientation
562 3. Peripheral neuropathy
563 4. Cerebellar assessment if applicable

564 c. HEENT:

565 i. Assessment of:

- 566 1. Oral exam/mucositis/Esophagitis
567 2. Dry mouth
568 3. Dysphagia
569 4. Epistaxis
570 5. Sinus pain
571 6. Visual impairment
572 7. Ototoxicity
573 8. Jaw necrosis

574 d. Cardiovascular:

575 i. Assessment of:

- 576 1. Heart sounds
- 577 2. Edema
- 578 3. Palpitations
- 579 4. Cyanosis
- 580 5. Chest pain
- 581 6. VTEs
- 582 ii. Review of: (where applicable)
- 583 1. ECG
- 584 2. MUGA
- 585 e. Pulmonary:
- 586 i. Assessment of:
- 587 1. Respiratory Sounds
- 588 2. Oxygen delivery
- 589 3. Cough
- 590 4. Sputum
- 591 5. Dyspnea
- 592 6. Shortness of Breath
- 593 ii. Review of: (where applicable)
- 594 1. PFTs
- 595 2. Chest X-ray
- 596 f. Gastrointestinal/Nutrition
- 597 i. Assessment of:
- 598 1. Altered taste sense

- 599 2. Nausea/vomiting
- 600 3. Constipation/diarrhea
- 601 4. Weight loss
- 602 5. Dietary intake

603 g. Genitourinary:

604 i. Assessment of:

- 605 1. Dysuria
- 606 2. Incontinence
- 607 3. Hematuria

608 h. Reproductive:

609 i. Review of:

- 610 1. Contraception
- 611 2. Last Menstrual Period (where applicable)
- 612 3. Sexual dysfunction/dissatisfaction

613 i. Musculoskeletal:

614 i. Assessment of:

- 615 1. Gait function
- 616 2. Muscular skeletal (+0-+5)

617 j. Dermatologic:

618 i. Assessment of:

- 619 1. Skin condition
- 620 2. Wounds
- 621 3. Skin breakdown

- 622 4. Rashes
- 623 5. PPE
- 624 k. Ecchymosis Hematologic:
- 625 i. Review of:
- 626 1. Laboratory data
- 627 ii. Assessment of:
- 628 1. Anemia
- 629 2. Blood Coagulation disorder
- 630 l. Immunologic:
- 631 i. Review of:
- 632 1. Presence/absence of known infection
- 633 m. Structural Changes:
- 634 i. Assessment of: (where applicable)
- 635 1. Implanted devices
- 636 2. Stomas
- 637 3. Tubes/drains
- 638 n. Malignancy:
- 639 i. Verification of:
- 640 1. Disease and stage as appropriate
- 641 ii. Assessment of signs and symptoms of disease
- 642 B. Psychologic Elements of Documentation
- 643 a. Distress and Stressors:
- 644 i. Assessment of:

- 645 1. Distress and current stressors
- 646 b. Anxiety:
- 647 i. Assessment of:
- 648 1. Presence of anxiety
- 649 ii. Current treatment
- 650 c. Depression:
- 651 i. Assessment of:
- 652 1. Signs/symptoms of depression
- 653 ii. Current Treatment
- 654 d. Cultural/Spiritual:
- 655 i. Assessment of:
- 656 1. Impact on plan of care
- 657 C. Social and Financial Elements of Documentation
- 658 a. Language:
- 659 i. Review of:
- 660 1. Use of interpreter (where applicable)
- 661 b. Advance Directive:
- 662 i. Review of:
- 663 1. Changes from baseline
- 664 2. Goals of care conversations
- 665 c. Income Concerns:
- 666 i. Review of:
- 667 1. Changes from baseline

- 668 d. Living Arrangements:
 - 669 i. Review of:
 - 670 1. changes from baseline
- 671 e. Insurance Concerns:
 - 672 i. Review of:
 - 673 1. Changes from baseline
- 674 f. Substance Abuse
 - 675 i. Review of:
 - 676 1. Changes from baseline
- 677 g. Referrals as indicated
- 678 D. Patient/Caregiver Education:
 - 679 a. Resources Provided:
 - 680 i. Specific materials/resources
 - 681 b. Key Teaching Requirements:
 - 682 i. Expected toxicities
 - 683 ii. Organ Damage
 - 684 iii. Side Effect Management
 - 685 iv. Signs and Symptoms of recurrence
 - 686 c. Response to Teaching
 - 687 i. Assessment of understanding

688 **Standard V. Follow Up**

- 689 A. Physical Elements of Documentation
 - 690 a. General:

- 691 i. Verification of:
- 692 1. Changes in medical/surgical history
- 693 b. Constitutional:
- 694 i. Assessment of:
- 695 1. Vital Signs
- 696 2. Pain
- 697 3. ADLS
- 698 4. Height/Weight
- 699 5. Fatigue
- 700 c. Neurological:
- 701 i. Assessment of:
- 702 1. Level of Consciousness
- 703 2. Peripheral neuropathy
- 704 d. HEENT:
- 705 i. Assessment of:
- 706 1. Oral exam/mucositis
- 707 2. Dry mouth
- 708 3. Dysphagia
- 709 4. Epistaxis
- 710 5. Sinus Pain
- 711 6. Visual impairment
- 712 7. Ototoxicity
- 713 8. Osteonecrosis of the jaw

- 714 e. Cardiovascular:
- 715 i. Assessment of:
- 716 1. Heart sounds
- 717 2. Edema
- 718 3. Palpitations
- 719 4. Cyanosis
- 720 5. Chest pains
- 721 6. VTEs
- 722 f. Pulmonary:
- 723 i. Assessment of:
- 724 1. Respiratory Sounds
- 725 2. Oxygen delivery
- 726 3. Cough
- 727 4. Dyspnea
- 728 5. Shortness of Breath
- 729 g. Gastrointestinal/Nutrition
- 730 i. Assessment of:
- 731 1. Altered taste sense
- 732 2. Bowel Habits
- 733 3. Weight Loss
- 734 4. Dietary intake
- 735 h. Genitourinary:
- 736 i. Assessment of:

- 737 1. Dysuria
- 738 2. Incontinence
- 739 i. Reproductive:
- 740 i. Review of:
- 741 1. Last Menstrual Period (where applicable)
- 742 2. Sexual Dysfunction/Dissatisfaction
- 743 j. Musculoskeletal:
- 744 i. Assessment of:
- 745 1. Gait function
- 746 2. Muscular Strength (+0-+5)
- 747 k. Dermatologic:
- 748 i. Assessment of:
- 749 1. Skin condition
- 750 2. Wounds
- 751 3. Skin Breakdown
- 752 4. Rashes
- 753 5. PPE
- 754 6. Ecchymosis
- 755 l. Hematologic:
- 756 i. Review of:
- 757 1. Laboratory data as appropriate
- 758 ii. Assessment of
- 759 1. Anemia

- 760 2. Blood Coagulation disorder
- 761 m. Immunologic:
- 762 i. Review of:
- 763 1. Presence/absence of known infection
- 764 n. Structural Changes:
- 765 i. Assessment of (where applicable):
- 766 1. Implanted devices
- 767 2. Stomas
- 768 3. Tubes/Drains
- 769 o. Malignancy:
- 770 i. Verification of:
- 771 1. Disease and stage as appropriate
- 772 ii. Assessment of:
- 773 1. Signs and symptoms of disease
- 774 B. Psychologic Elements of Documentation
- 775 a. Distress and Stressors:
- 776 i. Assessment of:
- 777 1. Distress
- 778 2. Current stressors
- 779 b. Anxiety:
- 780 i. Assessment of:
- 781 1. Presence of anxiety
- 782 ii. Current treatment

- 783 c. Depression:
- 784 i. Assessment of:
- 785 1. Signs and symptoms of depression
- 786 ii. Current Treatment
- 787 d. Cultural/Spiritual:
- 788 i. Assessment of:
- 789 1. Impact on plan of care

790 C. Social and Financial Elements of Documentation

- 791 a. Language:
- 792 i. Review of:
- 793 1. Interpreter (if applicable)
- 794 b. Advance Directive:
- 795 i. Review of:
- 796 1. Changes to baseline
- 797 2. Goals of care conversations
- 798 c. Income Concerns
- 799 i. Review of:
- 800 1. Changes from baseline
- 801 d. Living Arrangements
- 802 i. Review of:
- 803 1. changes from baseline
- 804 e. Insurance Status
- 805 i. Review of:

- 806 1. Changes from baseline
- 807 f. Substance Abuse
- 808 i. Review of:
- 809 1. Changes to baseline
- 810 g. Referrals as indicated
- 811 D. Patient/Caregiver Education
- 812 a. Resources Provided:
- 813 i. Materials/Resources
- 814 ii. Key Teaching Requirements:
- 815 1. Expected delayed toxicities
- 816 2. Organ Damage
- 817 3. Side Effect Management
- 818 4. Signs and symptoms of recurrence
- 819 5. Follow Up Schedule
- 820 6. Diagnostic Exams
- 821 7. Survivorship care plan (where applicable)
- 822 iii. Response to Teaching:
- 823 1. Assessment of understanding

824 **Standard VI. Chemotherapy/Biotherapy Drug Documentation**

- 825 A. Drug Orders:
- 826 a. Patient's Full Name and a second identifier (eg. Medical record number, DOB)
- 827 b. Date

- 828 c. Drug name(s)
- 829 d. Diagnosis
- 830 e. Regimen Name and cycle number (if applicable)
- 831 f. Protocol Name and Number (if applicable)
- 832 g. Appropriate Criteria to treat (eg. Laboratory data etc.)
- 833 h. Allergies
- 834 i. Reference to the methodology of the dose calculation or standard practice
- 835 equations
- 836 j. Height/Weight and any other variables used to calculate the dose
- 837 k. Route and rate (if applicable) of administration
- 838 l. Length of infusion (if applicable)
- 839 m. Supportive Care treatments for the regimen (ex. Premedications, hydration,
- 840 growth factors, etc.
- 841 n. Sequence of dose administration (if multi-drug regimen)
- 842 o. Additional elements for oral administration
 - 843 i. Dose and Quantity
 - 844 ii. Frequency of administration
 - 845 iii. Duration of therapy (days of rest, if applicable)
 - 846 iv. Number of refills (if applicable)

847 B. Chemotherapy Drug Labeling:

- 848 a. Patient's full name (second patient identifier for parenteral agents)
- 849 b. Full generic drug name
- 850 c. Drug administration route

- 851 d. Total dose to be given
- 852 e. Total volume required to administer this dosage
- 853 f. Date of administration
- 854 g. Date (and time for parenteral agents) of preparation
- 855 h. Date (and time for parenteral agents) of expiration when not for immediate use
- 856 i. Special Handling instructions as appropriate
- 857 j. Administration instructions (oral agents)
- 858 k. Number of refills (for oral agents)
- 859 l. Prescriber name (for oral agents)
- 860 C. Verification of:
- 861 a. (at least two practitioners or personnel approved by the practice/institution to
- 862 prepare or administer chemotherapy)
- 863 i. Confirmation with patient his/her planned treatment
- 864 ii. Two patient identifiers
- 865 iii. Drug Name
- 866 iv. Drug Dose
- 867 v. Drug Volume
- 868 vi. Calculation of dosing
- 869 vii. Drug Preparation (number of tablets/capsules) if applicable
- 870 viii. Rate of administration
- 871 ix. Route of administration
- 872 x. Expiration date/times (if applicable)
- 873 xi. Appearance and physical integrity of the drugs

- 874 xii. Rate set on infusion pump (if applicable)
- 875 xiii. Cumulative drug dose (if applicable)
- 876 xiv. Diagnostic laboratory data verification
- 877 b. Informed consent Process
- 878 i. Information regarding his/her diagnosis
- 879 ii. Goals of therapy
- 880 iii. Planned duration of chemotherapy/biotherapy drugs and schedule
- 881 iv. Information on possible short and long term adverse effects
- 882 v. Regimen or drug specific risks or symptoms that require notification and
- 883 emergency contact information
- 884 vi. Plan for monitoring and follow up
- 885 c. Initial cancer stage and/or current cancer status - review of pathologic
- 886 confirmation of disease
- 887 D. Drug Administration:
- 888 a. Supportive medications administered
- 889 b. Dose reductions/delays
- 890 c. Cumulative dose
- 891 d. Drug Administration
- 892 i. Nursing double checks of drug and rate
- 893 e. Treatment tolerance
- 894 f. IV access
- 895 i. Site patency during administration
- 896 ii. Line type

- 897 iii. Location
- 898 iv. Site assessment (phlebitis etc.)
- 899 v. Dressing
- 900 g. Hypersensitivity (if applicable)
- 901 h. Nursing Assessment of:
- 902 i. Clinical and or performance status
- 903 ii. Vital signs and pulse oximetry (frequency according to institutional policy
- 904 based on regimen)
- 905 iii. Weight
- 906 iv. Patients adherence to oral chemotherapy and plan to address
- 907 i. Review of:
- 908 i. Laboratory profile
- 909 j. Verification of:
- 910 i. Allergies
- 911 ii. Previous reactions and treatment-related toxicities
- 912 iii. Psychosocial concerns and need for support
- 913 1. Action taken when indicated
- 914 iv. Current medications, including over the counter medication and
- 915 complementary/alternative therapies
- 916 E. Treatment Discontinuation of Regimen Change
- 917 a. Rationale for regimen change
- 918 b. Oral Chemotherapy/Biotherapy Regimens

- 919 i. Patient instructions including dates to change dose, hold dose or
920 discontinue oral chemotherapy
- 921 ii. Pharmacy alerted to oral chemotherapy regimen change or discontinuation

922 References

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930 **Radiation Documentation Standards**

931 The ONS Radiation Documentation Standards detail the elements of documentation with regard
932 to physical, psychologic, and social/financial status as well as recommended patient and
933 caregiver education. The elements are also classified according to where they fall in the radiation
934 treatment trajectory – planning and simulation, active treatment, and follow-up care. Note that
935 anticipated side effects, short and long term sequela, and assessment strategies may be dictated
936 by the planned radiation field. Institutional policies and procedures regarding site-specific
937 assessment frequency and documentation should be followed based on radiation treatment plan.

938 **Standard I. Pre-Simulation Planning**

939 A. Treatment Planning Elements of Documentation

940 a. Verification of:

- 941 i. Disease type
- 942 ii. Stage (base on tumor markers, lab results, imaging, pathology, histology,
943 cytology where applicable)
- 944 iii. Alternative treatment options
- 945 iv. Interdisciplinary communication

946 Prior MRI to planned radiation field

947 b. Review of:

- 948 i. Complicating factors based on assessment

949 B. Physical Elements of Documentation

950 a. General:

951 i. Verification of:

- 952 1. Medical/surgical history

953 2. Cancer treatment history

954 3. Family Medical History

955 b. Constitutional:

956 i. Assessment of:

957 1. Activity of daily living (ADLs)

958 2. Sleep patters

959 3. Fatigue

960 4. Performance Status

961 ii. Allergies

962 iii. Medication Reconciliation

963 c. Neurological:

964 i. Assessment of:

965 1. Headaches

966 2. Confusion/Memory loss

967 3. Dizziness

968 4. Altered sensation of skin

969 d. HEENT:

970 i. Assessment of:

971 1. Oral exam

972 2. Dysphagia

973 3. Hearing deficits

974 4. Tinnitus

975 5. Visual impairment

- 976 ii. Review of:
- 977 1. Use of assistive devices (ex. Glasses, hearing aids, etc.)
- 978 e. Cardiovascular:
- 979 i. Verification of:
- 980 1. Presence of pacemaker or defibrillator
- 981 f. Pulmonary:
- 982 i. Verification of:
- 983 1. Smoking history
- 984 2. Oxygen delivery
- 985 g. Gastrointestinal/Nutrition
- 986 i. Assessment of:
- 987 1. Bowel habits,
- 988 2. Acid reflux
- 989 3. Obesity
- 990 4. Dietary habits
- 991 h. Genitourinary/Renal:
- 992 i. Assessment of:
- 993 1. Incontinence
- 994 2. Urostomy
- 995 3. Bladder prolapse
- 996 i. Reproductive:
- 997 i. Verification of:
- 998 1. Pregnancy history

- 999 2. Last menstrual period
- 1000 3. Menopausal state
- 1001 4. Childbearing potential
- 1002 5. Fertility care if applicable
- 1003 6. Contraception if applicable
- 1004 7. Last prostate specific antigen
- 1005 8. History of sexually Transmitted Infections
- 1006 9. Sexual dysfunction/dissatisfaction

1007 j. Musculoskeletal:

1008 i. Verification of:

- 1009 1. Prostheses
- 1010 2. Assistive devices (walker etc.)

1011 k. Dermatological:

1012 i. Assessment of:

- 1013 1. Skin condition
- 1014 2. Excessive sun exposure
- 1015 3. Wounds

1016 l. Endocrine:

1017 i. Verification of:

- 1018 1. Sex hormone findings

1019 m. Hematologic/Lymphatic:

1020 i. Verification of:

- 1021 1. Lymph node removal

- 1045 2. Current stressors
- 1046 3. Caregiver support
- 1047 c. Coping
 - 1048 i. Assessment of:
 - 1049 1. Coping mechanisms
 - 1050 d. Anxiety
 - 1051 i. Assessment of:
 - 1052 1. Signs/symptoms of anxiety
 - 1053 ii. Current treatment
 - 1054 e. Depression:
 - 1055 i. Assessment of:
 - 1056 1. Signs/symptoms of depression
 - 1057 2. Suicide risk
 - 1058 ii. Current treatment
 - 1059 f. Cultural/Spiritual:
 - 1060 i. Assessment of:
 - 1061 1. Cultural/ethnic/spiritual beliefs and practices
 - 1062 2. Impact on plan of care
- 1063 D. Social and Financial Elements of Documentation
 - 1064 a. Language:
 - 1065 i. Assessment of:
 - 1066 1. Primary language
 - 1067 2. Health literacy

- 1068 3. Need for interpreter
- 1069 b. Advance Directive:
- 1070 i. Verification of:
- 1071 1. Advance directive, living will, power of attorney etc.
- 1072 c. Income Concerns:
- 1073 i. Assessment of:
- 1074 1. Employment status
- 1075 2. Concerns about finances
- 1076 d. Living Arrangements:
- 1077 i. Assessment of:
- 1078 1. Living arrangement appropriate for functional status
- 1079 2. Access to care
- 1080 3. Transportation details
- 1081 4. Access to caregiver
- 1082 e. Insurance Status:
- 1083 i. Verification of:
- 1084 1. Insurance coverage
- 1085 2. Ability to procure prescription needs
- 1086 3. Preauthorization needs
- 1087 4. Ability to cover co-pays and out of pocket expenses
- 1088 f. Substance Abuse:
- 1089 i. Assessment of:
- 1090 1. Type, amount of past substance abuse

- 1091 2. Past treatment if applicable
- 1092 3. Need for referral
- 1093 4. Impact on treatment/quality of life
- 1094 g. Referrals as indicated
- 1095 E. Patient/Caregiver Education Elements of Documentation:
- 1096 a. Assessment of:
- 1097 i. Preferred learning styles
- 1098 ii. Barriers to learning
- 1099 iii. Targets of education
- 1100 b. Resources Provided
- 1101 c. Key Teaching Elements:
- 1102 i. Consent to treatment
- 1103 ii. Decision making resources
- 1104 iii. Tobacco use cessation if indicated
- 1105 d. Response to Teaching:
- 1106 i. Assessment of:
- 1107 1. patient/caregiver response

1108 **Standard II. Simulation**

- 1109 A. Treatment Planning:
- 1110 a. Review of:
- 1111 i. Disease type and stage
- 1112 ii. Complicating factors based on assessment
- 1113 b. Verification of:

- 1114 i. Informed consent
- 1115 ii. Need for interdepartmental communication
- 1116 iii. Multidisciplinary treatment plan

1117 B. Physical Elements of Documentation:

1118 a. General:

1119 i. Verification of:

- 1120 1. changes to history baseline
- 1121 2. Laboratory results as appropriate

1122 b. Constitutional:

1123 i. Assessment of:

- 1124 1. Vital Signs
- 1125 2. Sleep patterns
- 1126 3. ADLs
- 1127 4. Weight
- 1128 5. Pain
- 1129 6. Fatigue

1130 ii. Allergies

1131 c. Neurological:

1132 i. Assessment of:

- 1133 1. Peripheral neuropathy
- 1134 2. Cranial nerve function
- 1135 3. Sensory function
- 1136 4. Reflex test

- 1137 d. HEENT:
- 1138 i. Assessment of:
- 1139 1. Oral/dental exam
- 1140 2. Mucositis/esophagitis
- 1141 3. Dysphagia
- 1142 4. Xerostomia
- 1143 5. Alopecia
- 1144 6. Visual impairment
- 1145 7. Dry eye sensation
- 1146 8. Eyelashes
- 1147 9. Hearing deficits
- 1148 10. Tinnitus
- 1149 11. Sinus pain
- 1150 12. Epistaxis
- 1151 e. Cardiovascular:
- 1152 i. Assessment of:
- 1153 1. Heart sounds
- 1154 2. Edema
- 1155 3. Arrhythmias
- 1156 4. Palpitations
- 1157 5. Chest pain
- 1158 6. Claudication
- 1159 7. Venous ulcers

- 1160 8. Cyanosis
- 1161 9. Pallor
- 1162 f. Pulmonary:
- 1163 i. Assessment of:
- 1164 1. Respiratory sounds
- 1165 2. Oxygen saturation
- 1166 3. Cough
- 1167 4. Sputum
- 1168 5. Dyspnea on exertion
- 1169 6. Exercise intolerance
- 1170 7. Pain with inspiration/expiration
- 1171 g. Gastrointestinal/Nutritional:
- 1172 i. Assessment of:
- 1173 1. Altered taste sense
- 1174 2. Nausea/vomiting
- 1175 3. Hematemesis
- 1176 4. Diarrhea/Constipation
- 1177 5. Blood in stool
- 1178 6. Appetite changes
- 1179 7. Weight changes
- 1180 8. Acid reflux
- 1181 9. Referral needs
- 1182 h. Genitourinary/Renal:

- 1183 i. Assessment of:
- 1184 1. Dysuria
- 1185 2. Incontinence
- 1186 3. Flow of urine
- 1187 4. Strength of urine stream
- 1188 5. Hematuria
- 1189 6. Urine specimen
- 1190 i. Reproductive:
- 1191 i. Assessment of:
- 1192 1. Last menstrual period
- 1193 2. Vasomotor symptoms
- 1194 3. Penile changes
- 1195 4. Erectile capacity
- 1196 5. Vaginal discharge
- 1197 6. Sexual dysfunction/satisfaction
- 1198 j. Musculoskeletal:
- 1199 i. Assessment of:
- 1200 1. Range of motion
- 1201 2. Motor Function
- 1202 3. Gait Function
- 1203 k. Dermatologic:
- 1204 i. Assessment of:
- 1205 1. Skin condition

- 1206 2. Paronychia
- 1207 3. Nail changes
- 1208 4. Ecchymosis
- 1209 5. Incisions
- 1210 6. Wounds
- 1211 7. Palmar plantar erythrodysesthesia (PPE)

1212 1. Endocrine:

1213 i. Assessment of:

1214 1. Endocrine test findings

1215 a. Glucose measurement

1216 b. Thyroid panel

1217 c. Infertility study

1218 m. Hematologic:

1219 i. Assessment of:

1220 1. Leukopenia

1221 2. Anemia

1222 3. Thrombocytopenia

1223 n. Immunologic:

1224 i. Assessment of:

1225 1. Fever/chills

1226 2. Presence/absence of known infection

1227 o. Structural Devices

1228 i. Assessment of:

- 1229 1. Stomas
- 1230 2. External Tubes
- 1231 3. Stents
- 1232 4. Drains
- 1233 5. Implanted devices
- 1234 6. Venous access devices

1235 C. Psychologic: Elements of Documentation

1236 a. Distress and Stressors:

1237 i. Assessment of:

- 1238 1. Current/ongoing stressors

1239 b. Coping:

1240 i. Assessment of:

- 1241 1. Coping mechanisms

1242 c. Anxiety:

1243 i. Assessment of:

- 1244 1. Current/ongoing anxiety level

1245 ii. Treatment

1246 d. Depression:

1247 i. Assessment of:

- 1248 1. Current/ongoing signs and symptoms of depression

1249 ii. Treatment

1250 e. Cultural/Spiritual:

1251 i. Assessment of

- 1252 1. Impact on plan of care
- 1253 D. Social and Financial Elements of Documentation
- 1254 a. Language:
- 1255 i. Review of:
- 1256 1. Need for interpreter if applicable
- 1257 b. Advance Directive:
- 1258 i. Review of:
- 1259 1. Goals of care
- 1260 c. Income Concerns:
- 1261 i. Review of:
- 1262 1. Changes from baseline
- 1263 d. Living Arrangements:
- 1264 i. Review of:
- 1265 1. Changes from baseline
- 1266 e. Insurance Status:
- 1267 i. Review of:
- 1268 1. Changes from baseline
- 1269 2. Verbalized concerns related to treatment
- 1270 f. Substance Abuse:
- 1271 i. Review of:
- 1272 1. Changes to baseline
- 1273 g. Referrals as indicated
- 1274 E. Patient/Caregiver Education Elements of Documentation

- 1275 a. Assessment of:
- 1276 i. Preferred learning style
- 1277 ii. Barriers to learning
- 1278 iii. Target of Education
- 1279 b. Resources Provided:
- 1280 i. *Driven by institution or use of prepared materials*
- 1281 c. Key Teaching Points:
- 1282 i. Consent to Treat
- 1283 ii. Treatment schedule
- 1284 iii. Regular assessment schedule
- 1285 iv. Department/staff orientation
- 1286 v. Site specific components based on treatment types
- 1287 vi. Radiation safety as applicable
- 1288 vii. Side effects
- 1289 viii. Complications
- 1290 ix. Expectations
- 1291 x. Contact information
- 1292 xi. Emergency care
- 1293 d. Response to Teaching:
- 1294 i. Patient/Caregiver understanding
- 1295 ii. Additional educational needs

1296 **Standard III. Treatment**

- 1297 A. Treatment Planning Documentation:

- 1298 a. Verification of:
- 1299 i. Ongoing consent to treat
- 1300 ii. Delivered radiation dose
- 1301 iii. Rational for variations if applicable
- 1302 iv. Interdisciplinary treatment plan for concurrent treatment and monitoring
- 1303 b. Assessment of:
- 1304 i. Patient tolerance
- 1305 ii. Compliance issues
- 1306 B. Physical Elements of Documentation
- 1307 a. General:
- 1308 i. Verification of:
- 1309 1. Laboratory results as appropriate
- 1310 b. Constitutional:
- 1311 i. Assessment of:
- 1312 1. Vital Signs
- 1313 2. Sleep patterns
- 1314 3. ADLs
- 1315 4. Weight
- 1316 5. Pain
- 1317 6. Fatigue
- 1318 ii. Allergies
- 1319 c. Neurologic:
- 1320 i. Assessment of:

- 1321 1. Level of Consciousness
- 1322 2. Orientation
- 1323 3. Affect
- 1324 4. Peripheral neuropathy
- 1325 5. Cranial nerve
- 1326 6. Sensory function
- 1327 7. Reflex test

1328 d. HEENT:

1329 i. Assessment of:

- 1330 1. Oral/Dental exam
- 1331 2. Mucositis/esophagitis
- 1332 3. Dysphagia
- 1333 4. Xerostomia
- 1334 5. Alopecia
- 1335 6. Visual impairment
- 1336 7. Dry eye sensation
- 1337 8. Eyelashes
- 1338 9. Hearing deficits
- 1339 10. Tinnitus
- 1340 11. Sinus pain
- 1341 12. Epistaxis

1342 e. Cardiovascular

1343 i. Assessment of:

- 1344 1. Heart sounds
- 1345 2. Arrhythmias
- 1346 3. Palpitations
- 1347 4. Chest pain
- 1348 f. Pulmonary
- 1349 i. Assessment of:
- 1350 1. Respiratory sounds
- 1351 2. Oxygen saturation
- 1352 3. Cough
- 1353 4. Sputum
- 1354 5. Dyspnea of exertion
- 1355 6. Exercise intolerance
- 1356 7. Pain with inspiration/expiration
- 1357 g. Gastrointestinal/Nutritional
- 1358 i. Assessment of:
- 1359 1. Altered taste sense
- 1360 2. Anorexia
- 1361 3. Salivary duct inflammation
- 1362 4. Nausea/Vomiting
- 1363 5. Hematemesis
- 1364 6. Diarrhea/Constipation
- 1365 7. Blood in stool
- 1366 8. Appetite changes

- 1367 9. Weight changes
- 1368 10. Acid reflux
- 1369 11. Referral needs
- 1370 h. Genitourinary/Renal
- 1371 i. Assessment of:
- 1372 1. Urine color
- 1373 2. Dysuria
- 1374 3. Hematuria
- 1375 4. Incontinence
- 1376 5. Flow of urine
- 1377 6. Strength of urine stream
- 1378 i. Reproductive
- 1379 i. Assessment of:
- 1380 1. Last menstrual period
- 1381 2. Vasomotor symptoms
- 1382 3. Penile changes
- 1383 4. Erectile capacity
- 1384 5. Vaginal discharge
- 1385 6. Sexual dysfunction/satisfaction
- 1386 j. Musculoskeletal
- 1387 i. Assessment of:
- 1388 1. Range of Motion
- 1389 2. Motor function

- 1390 3. Gait function
- 1391 k. Dermatologic:
- 1392 i. Assessment of:
- 1393 1. Skin condition
- 1394 2. Radiation recall
- 1395 3. Radiodermatitis
- 1396 4. Desquamation
- 1397 5. Paronychia
- 1398 6. Nail changes
- 1399 7. Ecchymosis
- 1400 8. PPE
- 1401 l. Endocrine
- 1402 i. Review of: (where applicable)
- 1403 1. Glucose control
- 1404 2. Thyroid studies
- 1405 m. Hematologic/Lymphatic
- 1406 i. Assessment of:
- 1407 1. Leukopenia
- 1408 2. Anemia
- 1409 3. Thrombocytopenia
- 1410 n. Immunologic:
- 1411 i. Review of:
- 1412 1. Presence/absence of known infection

- 1413 o. Structural Devices:
- 1414 i. Assessment of:
- 1415 1. Stomas
- 1416 2. External tubes
- 1417 3. Stents
- 1418 4. Drains
- 1419 5. Implanted devices
- 1420 6. Venous access devices
- 1421 C. Psychologic Elements of Documentation
- 1422 a. Distress/Stressors
- 1423 i. Assessment of:
- 1424 1. Current/ongoing psychological issues
- 1425 b. Coping:
- 1426 i. Assessment of:
- 1427 1. Coping mechanisms
- 1428 c. Anxiety:
- 1429 i. Assessment of:
- 1430 1. Current/ongoing anxiety level and treatment
- 1431 ii. Treatment
- 1432 d. Depression:
- 1433 i. Assessment of:
- 1434 1. Current /ongoing signs and symptoms of depression
- 1435 ii. Treatment

- 1436 e. Cultural/Spiritual
- 1437 i. Review of:
- 1438 1. Impact on plan of care
- 1439 D. Social and Financial Elements of Documentation
- 1440 a. Language
- 1441 i. Assessment of:
- 1442 1. Need for interpreter if applicable
- 1443 b. Advance Directive
- 1444 i. Review of:
- 1445 1. Changes from baseline
- 1446 2. Goals of care
- 1447 c. Income Concerns
- 1448 i. Review of:
- 1449 1. Changes from baseline
- 1450 d. Living arrangements
- 1451 i. Review of:
- 1452 1. Changes from baseline
- 1453 e. Insurance Status
- 1454 i. Review of:
- 1455 1. Changes from baseline
- 1456 f. Substance Abuse
- 1457 i. Review of:
- 1458 1. Changes from baseline

- 1459 g. Referrals as indicated
- 1460 E. Patient/Caregiver Education
- 1461 a. Assessment of:
 - 1462 i. Preferred learning style
 - 1463 ii. Barriers to learning
 - 1464 iii. Targets of Education
- 1465 b. Resources Provided
 - 1466 i. *Driven by institution or prepared materials*
- 1467 c. Key Teaching Requirements
 - 1468 1. Consent to treatment
 - 1469 2. Treatment schedule
 - 1470 3. Regular assessment schedule
 - 1471 4. Site-specific components based on treatment type
 - 1472 5. Radiation safety as applicable
 - 1473 6. Side effects
 - 1474 7. Complications
 - 1475 8. Expectations
 - 1476 9. Contact information
 - 1477 10. Emergency care
- 1478 d. Response to Education
 - 1479 i. Ongoing patient/caregiver understanding

1480 **Standard IV. Post Treatment and Follow-Up Care**

- 1481 A. Treatment Planning Documentation

- 1482 a. Verification of:
- 1483 i. Full delivered radiation dose
- 1484 ii. Rationale for dose variation
- 1485 iii. Plans for coordination of care (*may be driven by survivorship care plan*)
- 1486 b. Assessment of:
- 1487 i. Patient tolerance
- 1488 ii. Compliance issues
- 1489 B. Physical Elements of Documentation:
- 1490 a. General:
- 1491 i. Verification of:
- 1492 1. Signs and symptoms of disease
- 1493 ii. Assessment of:
- 1494 1. Chronic/late treatment effects
- 1495 C. Psychological Elements of Documentation
- 1496 a. Distress/Stressors;
- 1497 i. Assessment of:
- 1498 1. Current stressors
- 1499 b. Coping
- 1500 i. Assessment of:
- 1501 1. Coping mechanisms
- 1502 c. Anxiety
- 1503 i. Assessment of:
- 1504 1. Current/ongoing anxiety level and treatment

- 1505 ii. Treatment
- 1506 d. Depression
- 1507 i. Assessment of:
- 1508 1. Current/ongoing signs and symptoms of depression
- 1509 ii. Treatment
- 1510 e. Cultural/Spiritual
- 1511 i. Review of:
- 1512 1. Impact on plan of care
- 1513 D. Social and Financial Elements of Documentation
- 1514 a. Language
- 1515 i. Review of:
- 1516 1. Use of interpreter (if applicable)
- 1517 b. Advance Directives
- 1518 i. Review of:
- 1519 1. Changes from baseline
- 1520 c. Income Concerns
- 1521 i. Review of:
- 1522 1. Changes from baseline
- 1523 d. Living Arrangements
- 1524 i. Review of:
- 1525 1. Changes from baseline
- 1526 e. Insurance Status
- 1527 i. Review of:

1528 1. Changes from baseline

1529 f. Substance Abuse

1530 i. Review of:

1531 1. Changes from baseline

1532 g. Referrals as indicated

1533 References:

1534 Iwamoto, R., Haas, M., Gosselin, T. (Eds.). (2012) *Oncology Nursing Society Manual for*

1535 *Radiation Oncology Nursing Practice and Education (4th ed)*. Oncology Nursing Society:

1536 Pittsburgh, PA.

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1538 **Blood and Marrow Stem Cell Transplant Documentation Standards**

1539 Blood and marrow stem cell transplant is a complex medical procedure and one that requires
1540 strong interdepartmental communication and collaboration. The patient's physical and mental
1541 status is likely to change dramatically multiple times throughout the transplant course. So too are
1542 their coping mechanisms and resources needed to promote the highest quality of life, restoring
1543 them to their highest level of functioning. Documenting these changes provides a transparent
1544 picture of the transplant course to all disciplines involved. Below are the ONS standards of
1545 documentation for patients undergoing a blood and marrow stem cell transplant. Elements are
1546 divided into one of four categories: physical, psychological; social/financial; patient/caregiver
1547 education. They were further subdivided according to phase in the treatment plan (history, pre-
1548 transplant work-up, product preparation, acute transplant phase, and chronic transplant phase).

1549 **Standard I. History and Pre-Transplant Work Up**

1550 A. Physical Elements of Documentation

1551 a. General:

1552 i. Verification of:

- 1553 1. Medical/surgical history
- 1554 2. Family medical history
- 1555 3. Prior cancer treatment

1556 b. Constitutional:

1557 i. Assessment of:

- 1558 1. Vital Signs
- 1559 2. Pain
- 1560 3. Height/Weight

- 1561 4. Fatigue
- 1562 5. Performance Status
- 1563 6. Activities of Daily Living
- 1564 ii. Allergies
- 1565 iii. Medication Reconciliation
- 1566 c. Neurological:
- 1567 i. Assessment of:
- 1568 1. Level of Consciousness
- 1569 2. Orientation
- 1570 3. Peripheral Neuropathy
- 1571 d. HEENT:
- 1572 i. Review of:
- 1573 1. Use of assistive devices (contacts, glasses, hearing aids, etc.)
- 1574 ii. Assessment of:
- 1575 1. Oral exam
- 1576 2. Dysphagia
- 1577 3. Visual impairment
- 1578 4. Dry eyes
- 1579 5. Tinnitus
- 1580 6. Hearing Deficits
- 1581 iii. Verification of:
- 1582 1. Dental Exam
- 1583 e. Cardiovascular:

- 1584 i. Assessment of:
- 1585 1. Heart sounds
- 1586 2. Edema
- 1587 3. Chest Pain
- 1588 4. Arrhythmias
- 1589 5. Palpitations
- 1590 6. Cyanosis
- 1591 ii. Verification of:
- 1592 1. MUGA
- 1593 2. ECG
- 1594 f. Pulmonary:
- 1595 i. Assessment of:
- 1596 1. Respiratory Sounds
- 1597 2. Oxygen delivery
- 1598 3. Cough
- 1599 4. Sputum
- 1600 5. Dyspnea
- 1601 6. Shortness of Breath
- 1602 7. Smoking history and status
- 1603 ii. Verification of:
- 1604 1. Pulmonary Function Tests
- 1605 g. Gastrointestinal:
- 1606 i. Assessment of:

- 1607 1. Nausea/vomiting
1608 2. Diarrhea/Constipation
1609 3. Nutrition and dietary history
1610 4. Weight status
1611 5. Altered Taste Sense

1612 h. Genitourinary:

1613 i. Assessment of:

- 1614 1. Dysuria
1615 2. Color of Urine
1616 3. Hematuria
1617 4. Incontinence

1618 ii. Verification of:

- 1619 1. Creatinine Clearance

1620 i. Reproductive:

1621 i. Review of:

- 1622 1. Last menstrual period (if applicable)
1623 2. Birth control method/not of childbearing potential
1624 3. Beta Hcg (if applicable)
1625 4. Fertility preservation methods (if applicable)

1626 j. Musculoskeletal:

1627 i. Assessment of:

- 1628 1. Fall history
1629 2. Range of Motion

- 1630 3. Gait Function
- 1631 4. Muscle Strength (+0-+5)
- 1632 k. Dermatologic:
- 1633 i. Verification of:
- 1634 1. Prior radiation sites
- 1635 ii. Assessment of:
- 1636 1. Skin condition
- 1637 2. Rashes
- 1638 3. Pruritis
- 1639 4. Ecchymosis
- 1640 5. Incisional Site
- 1641 6. Nail condition
- 1642 l. Hematologic:
- 1643 i. Review of:
- 1644 1. Blood type
- 1645 2. Transfusion history
- 1646 3. HLA testing
- 1647 4. CBC w/differential
- 1648 5. Blood work as appropriate
- 1649 m. Endocrine:
- 1650 i. Review of:
- 1651 1. Hypo/hyperglycemia
- 1652 n. Immunologic:

- 1653 i. Verification of:
- 1654 1. Sexually transmitted infection status
- 1655 2. History of vaccination
- 1656 ii. Review of:
- 1657 1. Viral titer status
- 1658 2. Presence or absence of known infection
- 1659 o. Structural Devices/Changes
- 1660 i. Assessment of:
- 1661 1. Implanted devices
- 1662 2. Vascular access device(s)
- 1663 p. Malignancy:
- 1664 i. Verification of:
- 1665 1. Diagnosis and stage if applicable
- 1666 2. Disease Status (via bone marrow biopsy, lumbar puncture,
- 1667 PET/CT, MRI, bone scan, immunoglobulins, tumor markers if
- 1668 applicable)
- 1669 3. Tolerance of prior chemotherapy/radiotherapy regimens and prior
- 1670 cancer treatment
- 1671 q. Transplant Specific:
- 1672 i. Review of:
- 1673 1. Planned stem cell source
- 1674 2. Donor Type (Sibling, MUD, Cord)
- 1675 B. Psychologic Elements of Documentation

- 1676 a. General:
- 1677 i. Verification of:
- 1678 1. History of psychologic disorder (depression, anxiety disorder,
1679 bipolar disorder, etc.)
- 1680 2. Prior treatment for psychologic disorders
- 1681 b. Distress and Stressors:
- 1682 i. Assessment of:
- 1683 1. Baseline distress
- 1684 2. Current Stressor
- 1685 3. Caregiver support
- 1686 c. Coping:
- 1687 i. Assessment of:
- 1688 1. Coping mechanisms
- 1689 d. Anxiety:
- 1690 i. Assessment of:
- 1691 1. Signs/symptoms of anxiety
- 1692 ii. Current treatment if applicable
- 1693 e. Depression
- 1694 i. Assessment of:
- 1695 1. Signs/symptoms of depression
- 1696 2. Suicide Risk
- 1697 ii. Current treatment
- 1698 f. Cultural/Spiritual:

- 1699 i. Assessment of:
- 1700 1. Cultural/spiritual beliefs and practices
- 1701 2. Impact on plan of care
- 1702 C. Social and Financial Elements of Documentation:
- 1703 a. Language:
- 1704 i. Assessment of:
- 1705 1. Primary language
- 1706 2. Need for interpreter (if applicable)
- 1707 3. Health literacy
- 1708 b. Advance Directive:
- 1709 i. Review of:
- 1710 1. Advance directives, living will, power of attorney/decision makers
- 1711 c. Income Concerns
- 1712 i. Assessment of:
- 1713 1. Concern about finances
- 1714 d. Living Arrangements:
- 1715 i. Assessment of:
- 1716 1. Access to care
- 1717 2. Access to caregiver
- 1718 e. Insurance Status:
- 1719 i. Review of:
- 1720 1. Insurance coverage
- 1721 2. Prescription coverage

- 1722 3. Preauthorization
- 1723 f. Substance Abuse:
- 1724 i. Assessment of:
- 1725 1. Past/current substance abuse
- 1726 2. Last use
- 1727 g. Referrals as indicated
- 1728 D. Patient/Caregiver Education Elements of Documentation
- 1729 a. Assessment of:
- 1730 i. Preferred learning styles (ex. Written, verbal, etc.)
- 1731 ii. Barriers to learning
- 1732 iii. Person(s) being educated
- 1733 b. Resources Provided:
- 1734 i. Driven by institution or use of prepared materials
- 1735 ii. Transplant and/or research consents
- 1736 c. Key Teaching Requirements:
- 1737 i. Transplant treatment plan (including schedule)
- 1738 ii. Alternatives to transplant
- 1739 iii. Risks/benefits to transplant
- 1740 d. Response to Teaching:
- 1741 i. Full understanding of teaching points
- 1742 ii. Return Demonstration where applicable

1743 **Standard II. Product Preparation**

- 1744 A. Physical Elements of Documentation:

- 1745 a. Constitutional:
- 1746 i. Assessment of:
- 1747 1. Vital Signs
- 1748 2. Pain
- 1749 3. Height/Weight
- 1750 4. Performance Status
- 1751 5. ADLs
- 1752 6. Fatigue
- 1753 ii. Allergies
- 1754 iii. Medication Reconciliation
- 1755 b. Neurological:
- 1756 i. Assessment of:
- 1757 1. Level of Consciousness
- 1758 c. HEENT:
- 1759 i. Assessment of:
- 1760 1. Visual impairment
- 1761 2. Oral exam
- 1762 3. Dysphagia
- 1763 d. Cardiovascular:
- 1764 i. Assessment of:
- 1765 1. Heart sounds
- 1766 2. Edema
- 1767 3. Chest pain

1768 4. Arrhythmias

1769 5. Palpitations

1770 6. Cyanosis

1771 e. Pulmonary:

1772 i. Assessment of:

1773 1. Respiratory Sounds

1774 2. Oxygen delivery

1775 3. Cough

1776 4. Sputum

1777 5. Shortness of Breath

1778 6. Dyspnea

1779 f. Gastrointestinal/Nutrition:

1780 i. Assessment of:

1781 1. Nausea/vomiting

1782 2. Hematemesis

1783 3. Diarrhea/constipation

1784 4. Nutritional and weight status

1785 5. Altered taste sense

1786 g. Genitourinary/Renal:

1787 i. Assessment of:

1788 1. Dysuria

1789 2. Color of urine

1790 3. Hematuria

- 1791 4. Incontinence
- 1792 h. Reproductive:
- 1793 i. Review of:
- 1794 1. Last Menstrual Period (if applicable)
- 1795 i. Musculoskeletal:
- 1796 i. Assessment of:
- 1797 1. Range of Motion
- 1798 2. Gait Function
- 1799 3. Muscle Strength (+0-+5)
- 1800 j. Dermatologic:
- 1801 i. Assessment of:
- 1802 1. Skin condition
- 1803 2. Rashes
- 1804 3. Ecchymosis
- 1805 4. Incisional sites
- 1806 k. Hematologic:
- 1807 i. Review of:
- 1808 1. Blood work (where applicable)
- 1809 l. Structural Devices/Changes:
- 1810 i. Assessment of:
- 1811 1. Implanted devices/vascular access devices
- 1812 m. Transplant Specific:
- 1813 i. Transplant Informed Consent/Research Consents if applicable

1814 ii. Stem cell source

1815 iii. Donor type

1816 iv. Cells collected

1817 B. Psychologic Elements of Documentation:

1818 a. Distress and Stressors:

1819 i. Distress Assessment

1820 ii. Stressors

1821 b. Coping:

1822 i. Assessment of:

1823 1. Coping Mechanisms

1824 c. Anxiety:

1825 i. Assessment of:

1826 1. Presence of anxiety

1827 ii. Current treatment

1828 d. Depression:

1829 i. Assessment of:

1830 1. Signs and symptoms of depression

1831 2. Suicide screening

1832 ii. Current treatment

1833 e. Cultural/Spiritual

1834 i. Assessment of:

1835 1. Cultural/spiritual beliefs

1836 2. Impact on plan of care

- 1837 C. Social and Financial Elements of Documentation
- 1838 a. Language:
- 1839 i. Review of:
- 1840 1. Use of interpreter (if applicable)
- 1841 b. Advanced Directive
- 1842 i. Review of:
- 1843 1. Changes from baseline
- 1844 c. Income Concerns:
- 1845 i. Assessment of:
- 1846 1. Changes from baseline
- 1847 d. Living Arrangements:
- 1848 i. Assessment of:
- 1849 1. Changes from baseline
- 1850 2. Living arrangements functional for performance status
- 1851 e. Substance Abuse:
- 1852 i. Assessment of:
- 1853 1. Changes from baseline
- 1854 f. Referrals as indicated
- 1855 D. Patient/Caregiver Education Elements of Documentation
- 1856 a. Assessment of:
- 1857 i. Changes from baseline in:
- 1858 1. preferred learning styles
- 1859 2. Barriers to learning

- 1860 3. Target of education
- 1861 b. Resources Provided:
 - 1862 i. *Driven by institution or use of prepared materials*
- 1863 c. Key Teaching Requirements:
 - 1864 i. Reinforcement of transplant treatment plan/schedule
 - 1865 ii. *Varies based on patient needs*
- 1866 d. Response to Teaching:
 - 1867 i. Assessment of understanding of process

1868 **Standard III. Acute Transplant: Conditioning - Day +100**

1869 A. Physical Elements of Documentation

- 1870 a. Constitutional:
 - 1871 i. Assessment of:
 - 1872 1. Vital Signs
 - 1873 2. Pain
 - 1874 3. Weight
 - 1875 4. Performance Status
 - 1876 5. ADLs
 - 1877 6. Fatigue
 - 1878 ii. Medication Reconciliation
- 1879 b. Neurological:
 - 1880 i. Assessment of:
 - 1881 1. Level of Consciousness
 - 1882 2. Orientation

- 1883 3. Headaches
- 1884 4. Dizziness
- 1885 c. HEENT:
- 1886 i. Assessment of:
- 1887 1. Oral exam/mucositis
- 1888 2. Dysphagia
- 1889 3. Visual Impairment
- 1890 4. Dry Eyes
- 1891 5. Epistaxis
- 1892 6. Tinnitus
- 1893 7. Hearing deficits
- 1894 d. Cardiovascular:
- 1895 i. Assessment of:
- 1896 1. Heart sounds
- 1897 2. Edema
- 1898 3. Chest pain
- 1899 4. Arrhythmias
- 1900 5. Palpitations
- 1901 6. Cyanosis
- 1902 e. Pulmonary:
- 1903 i. Assessment of:
- 1904 1. Respiratory Sounds
- 1905 2. Oxygen delivery

- 1906 3. Pulse Oximetry
- 1907 4. Cough
- 1908 5. Sputum
- 1909 6. Shortness of breath
- 1910 7. Dyspnea
- 1911 f. Gastrointestinal/Nutrition
- 1912 i. Assessment of:
- 1913 1. Nausea/vomiting
- 1914 2. Hematemesis
- 1915 3. Diarrhea/constipation
- 1916 4. Stool output
- 1917 5. Abdominal cramping
- 1918 6. Nutrition and weight status
- 1919 7. Altered Taste Sense
- 1920 ii. Review of:
- 1921 1. Liver function tests
- 1922 2. Graft Versus Host Disease (GVHD) grade and stage where
- 1923 applicable
- 1924 g. Genitourinary/Renal:
- 1925 i. Assessment of:
- 1926 1. Dysuria
- 1927 2. Color of Urine
- 1928 3. Hematuria

- 1929 4. Incontinence
- 1930 h. Reproductive:
- 1931 i. Assessment of:
- 1932 1. Presence of/absence of menstrual period (where applicable)
- 1933 i. Musculoskeletal:
- 1934 i. Assessment of:
- 1935 1. Range of motion
- 1936 2. Gait
- 1937 3. Muscular Strength (+0-+5)
- 1938 j. Dermatologic:
- 1939 i. Review of
- 1940 1. Skin condition
- 1941 2. Rashes
- 1942 3. Ecchymosis
- 1943 4. Papules
- 1944 5. Pruritus
- 1945 6. Palmar Plantar Erythrodysesthesia (PPE)
- 1946 7. Nail changes
- 1947 ii. Review of:
- 1948 1. GVHD stage and grade (where applicable)
- 1949 k. Hematologic:
- 1950 i. Assessment of:
- 1951 1. Blood Transfusion reactions (if applicable)

- 1952 ii. Review of:
- 1953 1. Blood work profile
- 1954 2. Blood type
- 1955 l. Immunologic:
- 1956 i. Review of:
- 1957 1. Presence or absence of known local or systemic infection
- 1958 m. Structural:
- 1959 i. Assessment of:
- 1960 1. Implanted devices/vascular access devices
- 1961 2. Indication for device
- 1962 n. Malignancy
- 1963 i. Verification of: (where applicable)
- 1964 1. Disease status (via Bone marrow biopsy, lumbar puncture,
- 1965 PET/CT, MRI, bone scan, immunoglobulins, tumor markers if
- 1966 applicable
- 1967 o. Transplant Specific:
- 1968 i. Stem cell source
- 1969 ii. Donor type
- 1970 iii. Day of transplant
- 1971 iv. Review of:
- 1972 1. Engraftment analyses
- 1973 B. Psychologic Elements of Documentation
- 1974 a. Distress and Stressors

- 1975 i. Assessment of:
- 1976 1. Distress
- 1977 2. Quality of life
- 1978 3. Stressors
- 1979 b. Coping:
- 1980 i. Assessment of:
- 1981 1. Coping mechanisms
- 1982 c. Anxiety:
- 1983 i. Assessment of:
- 1984 1. Presence of anxiety
- 1985 ii. Current treatment
- 1986 d. Depression:
- 1987 i. Assessment of:
- 1988 1. Signs and symptoms of depression
- 1989 ii. Current treatment
- 1990 e. Cultural/Spiritual:
- 1991 i. Review of:
- 1992 1. Impact on plan of care
- 1993 2. Requests for spiritual care services
- 1994 C. Social and Financial Elements of Documentation:
- 1995 a. Language:
- 1996 i. Review of:
- 1997 1. Use of interpreter (if applicable)

- 1998 b. Advance Directive:
- 1999 i. Review of:
- 2000 1. Changes from baseline
- 2001 2. Goals of care discussions
- 2002 c. Income Concerns:
- 2003 i. Assessment of:
- 2004 1. Changes from baseline
- 2005 d. Living Arrangements:
- 2006 i. Assessment of:
- 2007 1. Changes from baseline
- 2008 2. Living arrangements functional for performance status
- 2009 e. Insurance Status:
- 2010 i. Assessment of:
- 2011 1. Changes from baseline
- 2012 f. Substance Abuse:
- 2013 i. Assessment of
- 2014 1. Changes from baseline
- 2015 g. Referrals as indicated
- 2016 D. Patient/Caregiver Education:
- 2017 a. Preferred Learning styles:
- 2018 i. Assessment of changes from baseline in:
- 2019 1. Preferred learning styles
- 2020 2. Barriers to learning

- 2021 3. Target of education
- 2022 b. Resources Provided;
- 2023 i. Driven by institution or use of prepared materials
- 2024 c. Key Teaching Requirements:
- 2025 i. *Varies based on patient status*
- 2026 d. Response to Teaching:
- 2027 i. *Varies based on patient status*

2028 **Standard IV. Chronic Transplant Phase - (Day +101 post-transplant through recovery)**

2029 A. Physical Elements of Documentation

- 2030 a. Constitutional:
- 2031 i. Assessment of:
- 2032 1. Vital Sign
- 2033 2. Pain
- 2034 3. Weight
- 2035 4. Performance Status
- 2036 5. ADLs
- 2037 6. Fatigue
- 2038 ii. Allergies
- 2039 iii. Medication Reconciliation
- 2040 b. Neurological:
- 2041 i. Assessment of:
- 2042 1. Level of Consciousness
- 2043 2. Headaches

- 2044 3. Dizziness
- 2045 4. Cognitive function

2046 c. HEENT:

- 2047 i. Assessment of:
- 2048 1. Oral exam/Mucositis
- 2049 2. Dysphagia
- 2050 3. Visual Impairment
- 2051 4. Dry Eyes
- 2052 5. Epistaxis
- 2053 6. Tinnitus
- 2054 7. Hearing deficits

2055 d. Cardiovascular:

- 2056 i. Assessment of:
- 2057 1. Heart sounds
- 2058 2. Edema
- 2059 3. Chest pain
- 2060 4. Arrhythmias
- 2061 5. Palpitations
- 2062 6. Cyanosis

2063 e. Pulmonary:

- 2064 i. Assessment of:
- 2065 1. Respiratory Sounds
- 2066 2. Oxygen delivery

- 2067 3. Pulse oximetry
- 2068 4. Cough
- 2069 5. Sputum
- 2070 6. SOB
- 2071 7. Dyspnea

2072 f. Gastrointestinal/Nutritional:

2073 i. Assessment of:

- 2074 1. Nausea/vomiting
- 2075 2. Hematemesis
- 2076 3. Diarrhea/constipation
- 2077 4. Stool output
- 2078 5. Abdominal cramping
- 2079 6. Nutritional/weight status
- 2080 7. Taste changes

2081 ii. Review of:

- 2082 1. Liver function testes
- 2083 2. GVHD grade/stage

2084 g. Genitourinary/Renal:

2085 i. Assessment of:

- 2086 1. Dysuria
- 2087 2. Urine Color
- 2088 3. Hematuria
- 2089 4. Incontinence

- 2090 h. Reproductive:
- 2091 i. Review of:
- 2092 1. Presence of sexual dysfunction/dissatisfaction
- 2093 i. Musculoskeletal:
- 2094 i. Assessment of:
- 2095 1. Range of Motion
- 2096 2. Gait
- 2097 3. Presence of steroid-induced myopathy
- 2098 j. Dermatologic:
- 2099 i. Assessment of:
- 2100 1. Skin breakdown
- 2101 2. Rashes
- 2102 3. Papules
- 2103 4. Dryness
- 2104 5. Pruritus
- 2105 6. PPE
- 2106 7. Nail changes
- 2107 ii. Review of:
- 2108 1. GVHD stage/grade
- 2109 k. Hematologic:
- 2110 i. Assessment of:
- 2111 1. Transfusion reactions
- 2112 ii. Review of:

- 2113 1. Blood work profile
- 2114 2. Blood type
- 2115 3. Engraftment analysis
- 2116 1. Immunologic:
 - 2117 i. Review of:
 - 2118 1. Presence/absence of local or systemic infection
 - 2119 2. Engraftment analysis
 - 2120 m. Structural Devices/Changes:
 - 2121 i. Assessment of:
 - 2122 1. Implanted devices/vascular access devices
 - 2123 2. Indications for devices
 - 2124 n. Malignancy:
 - 2125 i. Verification of (where applicable):
 - 2126 1. Disease status (via bone marrow biopsy, lumbar puncture,
 - 2127 PET/CT, MRI, bone scan, immunoglobulins, tumor markers)
 - 2128 o. Transplant Specific:
 - 2129 i. Stem cell source
 - 2130 ii. Donor type
 - 2131 iii. Day of transplant
- 2132 B. Psychologic Elements of Documentation:
 - 2133 a. Distress and Stressors:
 - 2134 i. Assessment of:
 - 2135 1. Distress scale

- 2136 2. Quality of life
- 2137 3. Stressors
- 2138 b. Coping:
- 2139 i. Assessment of:
- 2140 1. Coping mechanisms
- 2141 c. Anxiety:
- 2142 i. Assessment of:
- 2143 1. Presence of anxiety
- 2144 2. Current treatment
- 2145 d. Depression:
- 2146 i. Assessment of:
- 2147 1. Signs and symptoms of depression
- 2148 2. Current treatment
- 2149 e. Cultural/Spiritual:
- 2150 i. Review of:
- 2151 1. Impact on plan of care
- 2152 C. Social and Financial Elements of Documentation:
- 2153 a. Language:
- 2154 i. Review of:
- 2155 1. Use of interpreter if applicable
- 2156 b. Advance Directive:
- 2157 i. Assessment of:
- 2158 1. Changes to baseline

- 2159 2. Goals of care discussions
 - 2160 c. Income Concerns:
 - 2161 i. Assessment of:
 - 2162 1. Changes to baseline
 - 2163 d. Living Arrangements:
 - 2164 i. Assessment of:
 - 2165 1. Changes to baseline
 - 2166 2. Living arrangements functional for performance status
 - 2167 e. Insurance Status:
 - 2168 i. Assessment of:
 - 2169 1. Changes to baseline
 - 2170 f. Substance Abuse:
 - 2171 i. Assessment of:
 - 2172 1. Changes to baseline
 - 2173 g. Referrals as indicated
- 2174 D. Patient/Caregiver Education
- 2175 a. Assessment of changes from baseline in:
 - 2176 i. Preferred learning styles
 - 2177 ii. Barriers to leaning
 - 2178 iii. Target of education
 - 2179 b. Resources Provided:
 - 2180 i. Driven by institution or use of prepared materials
 - 2181 c. Key Teaching Points:

2182 i. *Varies based on patient status*

2183 d. Response to Teaching:

2184 i. *Varies based on patient status*

2185 References:

2186 Ezzone, S.A. (2013). *Hematopoietic Stem Cell Transplantation: A Manual for Nursing Practice.*

2187 Oncology Nursing Society: Pittsburgh, PA.

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2189 **Surgical Documentation Standards**

2190 Surgical intervention serves various integral purposes in cancer management. Surgical
2191 intervention can be used to diagnose, stage, prevent, treat, or palliate cancer. Additionally, it may
2192 be used therapeutically to reconstruct tissue or insert therapeutic and supportive devices.
2193 Regardless of indication for surgical intervention, surgery involves complex nursing care and
2194 thorough documentation inclusive of physical, psychologic, social and financial and patient/
2195 caregiver education elements to ensure comprehensiveness of care. ONS documentation
2196 standards for surgical intervention detail the required elements of documentation during the work
2197 up phase, preoperative period, immediate post anesthesia period, and follow-up care. Additional
2198 assessment and interventions may be required in certain domains and body systems based on
2199 surgical plan and intervention. Frequency of assessment /documentation in the immediate post
2200 anesthesia and post-operative periods should be performed per institutional policies and
2201 procedures. Intraoperative documentation standards are beyond the scope of this documentation
2202 standard. Institution-specific documentation policies and procedures should always be followed.

2203 **Standard I. Patient History Documentation Standards**

2204 A. Physical Elements of Documentation

2205 a. General:

2206 i. Verification of:

2207 1. Medical/Surgical history

2208 a. Relevant to cancer site/surgical plan

2209 2. Prior Cancer Treatment

2210 3. Family Medical History

2211 4. Surgical consent

- 2212 5. Clinical trial work-up and consent if applicable
- 2213 ii. Review of:
- 2214 1. Preoperative imaging as appropriate
- 2215 2. Preoperative laboratory values as appropriate
- 2216 b. Constitutional:
- 2217 i. Assessment of:
- 2218 1. Vital Signs
- 2219 2. Height/Weight/Body Surface Area
- 2220 3. Performance Status
- 2221 4. Pain
- 2222 5. Use of Assistive devices (ex. Cane, walker)
- 2223 6. Sleep/wake patterns
- 2224 ii. Medication Reconciliation
- 2225 iii. Allergies
- 2226 c. Neurologic:
- 2227 i. Assessment of:
- 2228 1. Level of consciousness
- 2229 2. Orientation
- 2230 3. Sensory/motor function
- 2231 4. Cranial nerve function
- 2232 5. Central or peripheral neurologic symptoms
- 2233 d. HEENT:
- 2234 i. Assessment of:

- 2235 1. Use of assistive devices (ex. glasses/contacts, hearing aids)
- 2236 e. Cardiovascular:
- 2237 i. Review of:
- 2238 1. ECG
- 2239 2. Echo if applicable
- 2240 3. Stress test
- 2241 4. Doppler studies
- 2242 5. Chest x-ray
- 2243 f. Pulmonary:
- 2244 i. Verification of:
- 2245 1. Smoking history
- 2246 2. Exposure to second hand smoke/inhalants
- 2247 3. History of pleural effusions
- 2248 4. History of pneumonia
- 2249 ii. Review of:
- 2250 1. Pulmonary function tests
- 2251 2. Staph aureus nasal screen
- 2252 3. Initiation of mupirocin if positive staph screen
- 2253 g. Gastrointestinal/Nutritional
- 2254 i. Assessment of:
- 2255 1. Risk for nausea and vomiting
- 2256 2. Nutritional status
- 2257 3. Bowel function

- 2258 h. Genitourinary/Renal:
- 2259 i. Review of:
- 2260 1. Urinalysis
- 2261 2. Bladder function
- 2262 i. Musculoskeletal:
- 2263 i. Assessment of:
- 2264 1. Mobility
- 2265 2. Assistive devices
- 2266 3. Functional status
- 2267 4. ADLs
- 2268 5. Fall Risk
- 2269 j. Dermatologic:
- 2270 i. Assessment of:
- 2271 1. Risk for impaired wound healing
- 2272 2. Stomas
- 2273 k. Hematologic/Lymphatic:
- 2274 i. Assessment of:
- 2275 1. Edema
- 2276 l. Immunologic:
- 2277 i. Assessment of:
- 2278 1. Risk for infection
- 2279 2. Presence/absence of known infection
- 2280 m. Structural Devices/Changes

- 2281 i. Assessment of:
- 2282 1. External tubes
- 2283 2. Stents
- 2284 3. Drains
- 2285 4. Implanted devices
- 2286 5. Venous access device
- 2287 n. Malignancy
- 2288 i. Verification of:
- 2289 1. Cancer type and stage (if known at time of surgical intervention)
- 2290 2. Pathology reports if applicable
- 2291
- 2292 B. Psychological Elements of Documentation
- 2293 a. General:
- 2294 i. Verification of:
- 2295 1. Psychological history (anxiety disorders, depression, bipolar
- 2296 disorder, etc.)
- 2297 2. Prior treatment for psychologic disorders
- 2298 b. Distress and Stressors:
- 2299 i. Assessment of:
- 2300 1. Distress (may use distress assessment scale)
- 2301 2. Current Stressors
- 2302 3. Caregiver Support
- 2303 c. Coping

- 2304 i. Assessment of:
- 2305 1. Coping mechanisms
- 2306 d. Anxiety:
- 2307 i. Assessment of:
- 2308 1. Symptoms of anxiety
- 2309 ii. Current treatment
- 2310 e. Depression:
- 2311 i. Assessment of:
- 2312 1. Signs/symptoms of depression
- 2313 2. Suicide Risk
- 2314 ii. Current treatment
- 2315 f. Cultural/Spiritual:
- 2316 i. Assessment of:
- 2317 1. Cultural preferences and beliefs
- 2318 2. Impact on plan of care
- 2319 C. Social and Financial Elements of Documentation
- 2320 a. Language
- 2321 i. Assessment of:
- 2322 1. Primary Language
- 2323 2. Need for interpreter
- 2324 3. Health literacy
- 2325 b. Advance Directive
- 2326 i. Verification of:

- 2327 1. Presence of advance directives, durable power of attorney, decision
2328 makers
- 2329 2. DNR status
- 2330 c. Income Concerns
- 2331 i. Assessment of:
- 2332 1. Potential interruption or loss of income
- 2333 d. Living Arrangements
- 2334 i. Assessment of:
- 2335 1. Living arrangements appropriate for post-operative care/functional
2336 status
- 2337 e. Insurance Status:
- 2338 i. Verification of:
- 2339 1. Insurance coverage
- 2340 f. Substance Abuse
- 2341 i. Assessment of:
- 2342 1. Past/current substance abuse
2343 2. Last use
2344 3. Effect on future pain management
- 2345 g. Referrals as indicated
- 2346 D. Patient/Caregiver Education Elements of Documentation
- 2347 a. Assessment of:
- 2348 i. Preferred learning styles
2349 ii. Barriers to learning

- 2350 iii. Targets of education
- 2351 iv. Ability of patient/caregiver to follow pre and post operative instructions
- 2352 b. Resources Provided – driven by institutional materials/policies and type of
- 2353 surgical intervention
- 2354 c. Key Teaching Elements – driven by type of surgical intervention
- 2355 i. Expected surgical procedure
- 2356 ii. Pre-operative care
- 2357 iii. Post-operative care
- 2358 d. Response to Teaching:
- 2359 i. Accurate verbalization and/or teach back demonstration
- 2360 ii. Appropriate questions/caregiver involvement
- 2361 E. Coordination of Care:
- 2362 a. Hand off communication if applicable

2363 **Standard II. Pre-Operative Assessment Documentation Standards**

- 2364 A. Physical Elements of Documentation
- 2365 a. General:
- 2366 i. Surgical consent
- 2367 ii. Assessment of:
- 2368 1. Changes from baseline assessment
- 2369 2. Preoperative laboratory values
- 2370 iii. Verification of:
- 2371 1. Preoperative imaging if applicable
- 2372 b. Constitutional:

- 2373 i. Assessment of:
- 2374 1. Vital Signs
- 2375 2. Pain Assessment
- 2376 3. Changes from baseline
- 2377 c. Neurological:
- 2378 i. Assessment of:
- 2379 1. Changes from baseline assessment
- 2380 2. Findings that may delay or alter surgery
- 2381 d. HEENT:
- 2382 i. Assessment of:
- 2383 1. Oral exam
- 2384 2. Dry mouth
- 2385 3. Dysphagia
- 2386 4. Epistaxis
- 2387 5. Sinus Pain
- 2388 6. Visual Impairment
- 2389 7. Ototoxicity
- 2390 8. Changes to baseline
- 2391 9. Findings that may delay or alter surgery
- 2392 e. Cardiovascular:
- 2393 i. Assessment of:
- 2394 1. Heart sounds
- 2395 2. Edema

- 2396 3. Arrhythmias
- 2397 4. Palpitations
- 2398 5. Chest Pain
- 2399 6. Claudication
- 2400 7. Venous ulcers
- 2401 8. Cyanosis/pallor
- 2402 9. Changes from baseline
- 2403 10. Findings that may delay or alter surgery

2404 f. Pulmonary:

2405 i. Verification of:

- 2406 1. Staph aureus nasal screen

2407 ii. Assessment of:

- 2408 1. Respiratory sounds

- 2409 2. Oxygen delivery

- 2410 3. Dyspnea

- 2411 4. Cough

- 2412 5. Pulse oximetry

- 2413 6. Hemoptysis

- 2414 7. Use of oxygen

- 2415 8. Smoking status

- 2416 9. Changes from baseline

- 2417 10. Findings that may delay or alter surgery

2418 g. Gastrointestinal/Nutritional:

- 2419 i. Assessment of:
- 2420 1. Changes to baseline
- 2421 2. Findings that may delay or alter surgery
- 2422 h. Genitourinary/Renal:
- 2423 i. Assessment of:
- 2424 1. Changes from baseline
- 2425 2. Findings that may delay or alter surgery
- 2426 i. Musculoskeletal:
- 2427 i. Assessment of:
- 2428 1. Changes from baseline
- 2429 2. Findings that may delay or alter surgery
- 2430 j. Dermatologic:
- 2431 i. Assessment of:
- 2432 1. Changes from baseline
- 2433 2. Findings that may delay or alter surgery
- 2434 k. Endocrine:
- 2435 i. Assessment of:
- 2436 1. Changes from baseline
- 2437 2. Glycemic control if applicable
- 2438 l. Hematologic/Lymphatic:
- 2439 i. Assessment of:
- 2440 1. Changes from baseline
- 2441 2. Findings that may delay or alter surgery

- 2442 m. Immunologic:
- 2443 i. Assessment of:
- 2444 1. Changes from baseline
- 2445 2. Findings that may delay or alter surgery

2446 n. Structural Devices/Changes

- 2447 i. Assessment of:
- 2448 1. Changes from baseline
- 2449 2. Findings that may delay or alter surgery

2450 B. Psychologic Elements of Documentation

2451 a. Distress and Stressors

- 2452 i. Changes from baseline assessment
- 2453 ii. Distress assessment
- 2454 iii. Clarification of concerns

2455 b. Coping:

- 2456 i. Changes from baseline assessment
- 2457 ii. Effectiveness of coping mechanisms

2458 c. Anxiety:

- 2459 i. Changes from baseline assessment

2460 d. Depression:

- 2461 i. Changes from baseline assessment

2462 e. Cultural/Spiritual:

- 2463 i. Changes from baseline assessment
- 2464 ii. Influences on plan of care

- 2465 C. Social and Financial Elements of Documentation
- 2466 a. Language:
- 2467 i. Need for Interpreter
- 2468 b. Advance Directives
- 2469 i. Changes from baseline assessment
- 2470 ii. Immediate concerns
- 2471 iii. Availability of documents
- 2472 c. Income Concerns:
- 2473 i. Immediate concerns
- 2474 d. Living Arrangements:
- 2475 i. Immediate concerns
- 2476 e. Insurance Status:
- 2477 i. Immediate concerns
- 2478 f. Substance Abuse:
- 2479 i. Immediate concerns
- 2480 ii. Potential for post-operative withdrawal
- 2481 iii. Potential for alterations in pain management
- 2482 g. Referrals as indicated
- 2483 D. Patient/Caregiver Education
- 2484 a. Assessment of:
- 2485 i. Preferred learning style
- 2486 ii. Barriers to learning
- 2487 iii. Target of education

2488 b. Resources Provided- driven by institutional policies/materials and surgical plan

2489 c. Key Teaching Requirements:

2490 i. Expected procedure

2491 ii. Risks and benefits of procedure

2492 iii. Short and long term outcomes expected

2493 iv. Anticipated side effects of anesthesia/surgery

2494 v. Logistics on day of surgery

2495 vi. Pain management planning

2496 vii. Post-operative care and management

2497 viii. Nutritional support planning

2498 d. Response to Teaching

2499 i. Concerns raised by patient/family

2500 ii. Immediate concerns

2501 iii. Understanding/teach back demonstration if appropriate

2502 E. Coordination of Care

2503 a. Hand-off communication if applicable

2504 **Standard III. Immediate Post-Anesthesia Documentation Standards**

2505 A. Physical Elements of Documentation

2506 a. Constitutional:

2507 i. Medication administration

2508 ii. Assessment of:

2509 1. Vital signs and pain level every 5 minutes x 15 minutes; then every

2510 15 minutes until discharge

- 2511 2. Pain
- 2512 3. Response to medication or symptom management intervention
- 2513 b. Neurological:
- 2514 i. Assessment of:
- 2515 1. Level of consciousness
- 2516 2. Orientation
- 2517 3. Sensory/motor function
- 2518 4. Cranial nerve function
- 2519 c. HEENT:
- 2520 i. Change in baseline assessment
- 2521 d. Cardiovascular:
- 2522 i. Assessment of:
- 2523 1. Airway, breathing & circulation
- 2524 2. Circulatory and cardiac function
- 2525 e. Pulmonary:
- 2526 i. Assessment of:
- 2527 1. Pulmonary function
- 2528 2. Oxygen delivery
- 2529 3. Respiratory sounds
- 2530 4. Pulse oximetry
- 2531 f. Gastrointestinal/Nutritional:
- 2532 i. Assessment of:
- 2533 1. Bowel function

- 2534 2. Bowel sounds
- 2535 ii. NPO status
- 2536 iii. Nasogastric tube if applicable
- 2537 g. Genitourinary/Renal:
- 2538 i. Assessment of:
- 2539 1. Renal function
- 2540 2. Urinary output
- 2541 3. Urine color
- 2542 h. Musculoskeletal:
- 2543 i. Assessment of:
- 2544 1. Musculoskeletal function (*If assessment appropriate based on*
- 2545 *surgical intervention and post-operative plan*)
- 2546 i. Dermatologic:
- 2547 i. Assessment of:
- 2548 1. Surgical site
- 2549 a. Incision/drain location and appearance
- 2550 j. Endocrine:
- 2551 i. Assessment of:
- 2552 1. Glycemic control if indicated
- 2553 k. Hematologic/Lymphatic:
- 2554 i. Assessment of:
- 2555 1. Coagulation status
- 2556 2. Edema

- 2557 3. Thromboembolic stocking/sequential compression devices in use
- 2558 1. Structural Devices/Changes
- 2559 i. Assessment of:
- 2560 1. Tubes/drains
- 2561 2. Stents
- 2562 3. Implanted Devices
- 2563 4. Venous access devices
- 2564 B. Psychologic Elements of Documentation
- 2565 a. Distress and Stressors
- 2566 i. Immediate concerns
- 2567 ii. Referrals as needed
- 2568 b. Coping
- 2569 i. Immediate concerns
- 2570 ii. Referrals as needed
- 2571 c. Anxiety
- 2572 i. Immediate concerns
- 2573 ii. Referrals as needed
- 2574 d. Depression
- 2575 i. Immediate concerns
- 2576 ii. Referrals as needed
- 2577 e. Cultural/Spiritual
- 2578 i. Immediate concerns
- 2579 ii. Referrals as needed

- 2580 C. Social and Financial Elements of Documentation
- 2581 a. Language:
- 2582 i. Need for interpreter
- 2583 b. Advanced Directive:
- 2584 i. Assessment of
- 2585 1. Status changes
- 2586 2. Immediate concerns
- 2587 c. Referrals as indicated
- 2588 D. Patient/Caregiver Education Elements of Documentation
- 2589 a. Assessment of:
- 2590 i. Barriers to learning
- 2591 ii. targets of education
- 2592 b. Key Teaching Requirements:
- 2593 i. Immediate post-operative care
- 2594 ii. short and long term outcomes
- 2595 iii. Management of side effects
- 2596 iv. Care of incision/drains
- 2597 v. Pain management plan
- 2598 vi. medication schedule
- 2599 vii. Contact information for questions
- 2600 viii. Nutritional plan initiation
- 2601 ix. follow up appointment schedule
- 2602 c. Resources provided – driven by institutional materials

- 2603 d. Response to Teaching:
- 2604 i. Concerns of patient/caregiver
- 2605 ii. Accurate verbalization and/or teach back demonstration
- 2606 iii. Appropriate questions/caregiver involvement

2607 E. Coordination of Care:

- 2608 a. Hand-off communication

2609 **Standard IV. Post-Operative Follow-Up**

2610 A. Physical Elements of Documentation

2611 a. General:

- 2612 i. Changes from baseline assessment/medical history

2613 b. Constitutional:

2614 i. Assessment of:

- 2615 1. Return to functional baseline

- 2616 2. Pain

2617 ii. Medications

- 2618 iii. Response to medication or symptom management intervention

2619 c. Neurological:

2620 i. Assessment of:

- 2621 1. Return to functional baseline

2622 d. HEENT:

2623 i. Assessment of:

- 2624 1. Return to functional baseline

2625 e. Cardiovascular:

- 2626 i. Assessment of:
- 2627 1. Return to functional baseline
- 2628 2. Circulatory and cardiac function
- 2629 f. Pulmonary:
- 2630 i. Assessment of:
- 2631 1. Return to functional baseline
- 2632 2. Pulmonary function
- 2633 3. Smoking status
- 2634 4. Cessation strategies if applicable
- 2635 g. Gastrointestinal/Nutritional:
- 2636 i. Assessment of:
- 2637 1. Return to functional baseline
- 2638 h. Genitourinary/Renal:
- 2639 i. Assessment of:
- 2640 1. Return to functional baseline
- 2641 i. Musculoskeletal:
- 2642 i. Assessment of:
- 2643 1. Return to functional baseline
- 2644 j. Dermatologic:
- 2645 i. Assessment of:
- 2646 1. surgical incision/wound
- 2647 ii. Removal of drains/tubes if applicable
- 2648 k. Endocrine:

- 2649 i. Assessment of:
- 2650 1. Return to functional baseline
- 2651 l. Hematologic/Lymphatic:
- 2652 i. Assessment of:
- 2653 1. Return to functional baseline
- 2654 m. Immunologic:
- 2655 i. Absence/presence of known infection
- 2656 n. Structural Changes/Devices:
- 2657 i. Assessment of:
- 2658 1. Tubes/drains
- 2659 2. Stents
- 2660 3. Implanted devices
- 2661 4. Venous access devices
- 2662 o. Malignancy:
- 2663 i. Verification of:
- 2664 1. Cancer type and stage if known
- 2665 2. Pathology reports if applicable
- 2666 B. Psychological Elements of Documentation
- 2667 a. Distress and Stressors
- 2668 i. Assessment of:
- 2669 1. Changes from baseline
- 2670 2. Distress scale
- 2671 3. Current stressors

- 2672 b. Coping
- 2673 i. Assessment of:
- 2674 1. Effectiveness of coping mechanisms
- 2675 c. Anxiety
- 2676 i. Assessment of:
- 2677 1. Changes from baseline
- 2678 2. Current signs and symptoms of anxiety
- 2679 d. Depression
- 2680 i. Assessment of:
- 2681 1. Changes from baseline
- 2682 2. Current signs and symptoms of depression
- 2683 e. Cultural/Spiritual
- 2684 i. Assessment of:
- 2685 1. Changes from baseline
- 2686 C. Social and Financial Elements of Documentation
- 2687 a. Language
- 2688 i. Need for interpreter if applicable
- 2689 b. Advance Directive
- 2690 i. Changes in advance directive status
- 2691 ii. Goals of Care conversations
- 2692 c. Income Concerns

- 2693 i. Change from baseline assessment
- 2694 d. Living Arrangements
- 2695 i. change from baseline assessment
- 2696 ii. Need for long-term use of appliances or durable medical equipment
- 2697 iii. Need for PT/OT
- 2698 e. Insurance Status
- 2699 i. Changes from baseline assessment
- 2700 f. Substance Abuse
- 2701 i. New or current abuse
- 2702 ii. Presence of withdrawal symptoms
- 2703 iii. Alterations in pain management plan
- 2704 g. Referrals as indicated
- 2705 D. Patient/Caregiver Education
- 2706 a. Assessment of:
- 2707 i. Preferred learning style
- 2708 ii. Barriers to learning
- 2709 iii. Targets of education
- 2710 b. Key Teaching Requirements:

- 2711 i. Surveillance recommendations
- 2712 ii. Anticipated early and late effects
- 2713 iii. Follow-up schedule
- 2714 iv. Side effect and/or pain medication management
- 2715 v. Nutrition management plan
- 2716 vi. Specific concerns of patient/caregiver

2717 c. Response to Teaching:

- 2718 i. Accurate verbalization and/or teach back demonstration
- 2719 ii. Appropriate questions/caregiver involvement

2720 E. Coordination of Care:

- 2721 a. Hand off communication if applicable

2722 References:

2723 Davidson, G.W., Lester, J.L., & Routt, M. (2014). *Surgical Oncology Nursing*. Pittsburgh, PA:
2724 Oncology Nursing Society.

2725

2726 **Venous Access Device Documentation Standards**

2727 Successful antineoplastic treatment relies on sufficient venous access for the administration of
2728 medications, supportive care, blood product transfusions, and fluid resuscitation, as well as
2729 accommodation of frequent laboratory analysis. ONS documentation standards regarding venous
2730 access devices detail elements of documentation regarding assessments, insertion, line
2731 utilization, maintenance care, and patient/caregiver education, in the stages prior to and during
2732 insertion, during the life of the venous access device, and post removal. Frequency of assessment
2733 and documentation should be performed according to institutional policy and procedures.

2734 **Standard I. Prior to Insertion Elements for Documentation**

- 2735 A. Process/Verification of Informed consent (if applicable)
- 2736 B. Assessment of:
- 2737 a. Indication for Device
 - 2738 b. Anticipated duration of therapy
 - 2739 c. Any prior central access device history or problems
 - 2740 d. Pertinent laboratory results prior to insertion (if applicable)
- 2741 C. Patient/Caregiver Education
- 2742 a. Assessment of preferred learning styles (written, verbal etc.)
 - 2743 b. Barriers to learning
 - 2744 c. Target of education (patient/caregiver)
 - 2745 d. Resources Provided
 - 2746 i. Driven by institutional-specific materials
 - 2747 e. Key Teaching Points:
 - 2748 i. Rationale for venous access device placement

- 2749 ii. Risks/benefits
- 2750 f. Patient/Caregiver response to teaching
- 2751 i. Verbalization of understanding

2752 **Standard II. Venous Access Device Insertion Elements for Documentation**

- 2753 A. Date, time and setting of insertion
- 2754 B. Specific site preparation to prevent complication and infection
- 2755 C. Location of insertion site (specify vein) and ability to flush
- 2756 D. Type, Length, and gauge/size of venous access device inserted as appropriate
- 2757 E. Manufacturer lot/serial number as appropriate
- 2758 F. Number of attempts
- 2759 G. Identification of insertion site by anatomical descriptors, laterality, landmarks, or drawing
- 2760 (if indicated)
- 2761 H. Insertion assistance methodology (ie. Visualization and guidance technology) if indicated
- 2762 I. Complications during insertion procedure
- 2763 J. Methods used to secure devices; type of dressing used
- 2764 K. Confirmation of catheter placement/anatomic location if appropriate prior to use (ex.
- 2765 Chest X-ray)
- 2766 L. For Midlines and PICCS: external catheter length and effective length of catheter inserted
- 2767 M. Name and credentials of clinician performing insertion

2768 **Standard III. Venous Access Device Utilization**

- 2769 A. Use of Venous Access Device Elements for Documentation
- 2770 a. Method to evaluate proper function of device prior to use
- 2771 b. Date and time of therapy initiation

- 2772 c. Solution being infused (ex. Medication, intravenous fluid type etc.)
- 2773 d. Drug name and dose
- 2774 e. Infusion rate
- 2775 f. Complications noted with use (signs/symptoms of extravasation, phlebitis,
- 2776 infiltration)
- 2777 g. Name of provider notified of complication if indicated
- 2778 h. Strategies to manage complications if indicated
- 2779 B. Assessment of Venous Access Device Elements for Documentation
- 2780 a. Date and time of assessment
- 2781 b. Catheter insertion and exit site appearance/condition of site
- 2782 c. Presence of drainage
- 2783 d. Condition of device (ex. Intact, cracked, leaking etc.)
- 2784 e. Presence of a antimicrobial patch if indicated
- 2785 f. Type of stabilization (ex. Sutures, Stat-lock etc.)
- 2786 i. If joint stabilization is required – periodical removal for assessment of
- 2787 circulatory status, range of motion and skin integrity
- 2788 g. Condition and type of dressing
- 2789 h. Assessment of indication for device
- 2790 i. Subjective patient data (discomfort, pain, changes, pruritus, etc.)
- 2791 C. Care and Maintenance of Venous Access Device Elements for Documentation
- 2792 a. Dressing change
- 2793 i. type of dressing applied
- 2794 ii. procedure used

- 2795 b. Flushing procedure
- 2796 i. type(s) of flush solution used,
- 2797 ii. Volume of flush
- 2798 iii. Difficulty/ease of flushing
- 2799 c. Cap change
- 2800 i. Type of cap
- 2801 ii. Abnormalities in cap appearance
- 2802 iii. Function of cap
- 2803 d. Blood withdrawal
- 2804 i. procedures used
- 2805 ii. devices used
- 2806 iii. volume withdrawn
- 2807 e. Use of clamps on the device or extension tubing if indicated
- 2808 D. Patient/Caregiver Education Elements of Documentation
- 2809 a. Preferred learning styles
- 2810 b. Barriers to learning
- 2811 c. Targets of education
- 2812 d. Resources provided – driven by institutional-specific materials
- 2813 e. Key Teaching Points:
- 2814 i. Continued rationale for device
- 2815 ii. Signs and symptoms of complications to report
- 2816 iii. Procedures for line care maintenance if applicable
- 2817 f. Response to Teaching

- 2818 i. Verbalization of understanding
- 2819 ii. Demonstration of care and maintenance of device if applicable
- 2820 iii. Barriers to patient/caregiver education

2821 **Standard IV. Venous Access Device Removal**

- 2822 A. Indication for Removal
- 2823 B. Date and time of device removal
- 2824 C. Type of Device removed
- 2825 D. Procedure used for removal and observations of complications during removal
- 2826 E. Condition of device after removal (ex. Intact vs, cracked)
- 2827 F. Length of device after removal (if indicated)
- 2828 G. Condition of site post-removal
- 2829 H. Dressing applied to site
- 2830 I. Cultures obtained from site
- 2831 J. Patient/Caregiver Education
 - 2832 a. Preferred learning style
 - 2833 b. Barriers to learning
 - 2834 c. Target of Education
 - 2835 d. Resources Provided – driven by institution-specific materials
 - 2836 e. Key Teaching Points
 - 2837 i. Rationale for removal
 - 2838 ii. Post removal complications
 - 2839 iii. Signs and symptoms to report to provider
 - 2840 f. Response to Teaching

2841 i. Verbalization of Understanding

2842 ii. Barriers to patient/caregiver education

2843 References

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2845 Education (3rd ed). Oncology Nursing Society: Pittsburgh, PA

2846 Infusion Nurses Society. (2016). Infusion Therapy Standards of Practice. *Journal of Infusion*

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2849 **Blood Product Transfusion Documentation Standards**

2850 Anemia, thrombocytopenia, neutropenia, and coagulopathies are an unfortunate, but often
2851 inevitable result of cancer itself or antineoplastic treatment. Blood product transfusions are in
2852 many cases the standard of care for these conditions, but require vigilant assessment, adherence
2853 to protocol, and thorough documentation. Nursing documentation standards of blood product
2854 transfusion detail the required documentation elements surrounding blood product transfusion
2855 with regard to product details, tolerance of transfusion, infusion site, and patient/caregiver
2856 education. Institutional policies and procedures should be followed with regarding to timing and
2857 frequency of assessment and documentation during and after all blood product transfusions.

2858 **Standard I. Prior to Transfusion**

- 2859 A. Documentation of confirmation of informed consent
- 2860 B. Validation of active type and cross
- 2861 C. Blood Product Transfusion Details
 - 2862 a. Confirmation of clinical data/patient symptoms necessitating transfusion
 - 2863 b. Confirmation of product compatibility with patient blood type with a second
 - 2864 competent practitioner
- 2865 D. Tolerance of Blood Product Transfusion
 - 2866 a. Administration of premedications as ordered
 - 2867 b. Baseline vital signs with pulse oximetry
 - 2868 c. Factors known to increase risk for transfusion reactions: antibodies, frequent
 - 2869 transfusions, autoimmune disorder(s) etc.
- 2870 E. Infusion Site
 - 2871 a. Type of IV access device

- 2872 b. Location of IV access device
- 2873 c. Size/gauge of IV access device
- 2874 F. Patient/Caregiver Education
- 2875 a. Assessment of learning preferences (ex. Verbal, written etc.)
- 2876 b. Barriers to Learning
- 2877 c. Target of education (ex. Patient/caregiver etc.)
- 2878 d. Resources Provided (Driven by institutional materials, patient preference)
- 2879 e. Key Teaching Points:
- 2880 i. Indication for transfusion
- 2881 ii. Signs and Symptoms of transfusion reaction to report
- 2882 f. Response to Teaching

2883 **Standard II. During Blood Product Transfusion**

- 2884 A. Blood Product Transfusion Details
- 2885 a. Product and number of units being transfused
- 2886 b. Date of transfusion
- 2887 c. Start time of transfusion
- 2888 d. Rate of product transfusion
- 2889 e. Use of filtered tubing
- 2890 f. Need for use of blood warmer or special filters or electronic infusion device
- 2891 B. Tolerance of Blood Product Transfusion*
- 2892 a. Vital signs with pulse oximetry
- 2893 b. Assessment of Pulmonary System: (respiratory sounds, shortness of breath,
- 2894 tachypnea, dyspnea and other signs and symptoms as appropriate)

- 2895 c. Assessment of Cardiovascular System: (chest pain, tachycardia and other
2896 signs/symptoms as appropriate
- 2897 d. Assessment of Urologic/Renal System: (flank pain, hematuria and other
2898 signs/symptoms as appropriate
- 2899 e. Assessment of Dermatologic System: (pruritus, rash, urticaria, and other
2900 signs/symptoms as appropriate
- 2901 f. Assessment of presence of chills and/or rigors
- 2902 g. Name of provider notified of intolerance of transfusion
- 2903 C. Infusion Site
- 2904 a. Assessment of signs and symptoms of infiltration*
- 2905 b. Infusion site, clean dry and intact*
- 2906 D. Patient/Caregiver Education
- 2907 a. Key Teaching Points
- 2908 i. Reinforcement of signs and Symptoms of transfusion reaction
- 2909 b. Patient/Caregiver response to teaching

2910 **Standard III. Post Blood Product Transfusion**

- 2911 A. Blood Product Transfusion Details
- 2912 a. Date of product stopped/completed
- 2913 b. Time of product stopped/completed
- 2914 c. Volume of blood product infused
- 2915 d. Estimated amount of product returned to blood bank (if applicable)
- 2916 B. Tolerance of Blood Product Transfusion

- 2917 a. Vital signs with pulse oximetry *
- 2918 b. Assessment of Pulmonary System: (respiratory sounds, shortness of breath,
- 2919 tachypnea, dyspnea and other signs and symptoms as appropriate)
- 2920 c. Assessment of Cardiovascular System: (chest pain, tachycardia and other
- 2921 signs/symptoms as appropriate)
- 2922 d. Assessment of Urologic/Renal System: (flank pain, hematuria and other
- 2923 signs/symptoms as appropriate)
- 2924 e. Assessment of Dermatologic System: (pruritus, rash, urticaria, and other
- 2925 signs/symptoms as appropriate)
- 2926 f. Assessment of presence of chills and/or rigors
- 2927 g. Name of provider notified of intolerance of transfusion

2928 C. Patient/Caregiver Education

- 2929 a. Key Teaching Points
- 2930 i. Reinforcement of signs and symptoms of transfusion reaction
- 2931 ii. Clinical data/signs that indicate efficacy of transfusion
- 2932 b. Patient/Caregiver response to teaching

2933 *Frequency of documentation during transfusion per institutional policy

2934 References

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2938 Management Performance Measures.

2939 **Extravasation Management Documentation Standards**

2940 Vesicant extravasation involves the leakage or escape of a drug or fluid into the tissue, the results
2941 of which can be anything from minimal erythema to catastrophic tissue necrosis and loss of limb
2942 (Polovich, Olsen, & LeFebvre, 2014). In the event of a vesicant extravasation, thorough
2943 documentation is vital from the patient safety and clinical outcome perspective, but also has legal
2944 implications. The ONS Extravasation Management Documentation Standards detail the elements
2945 of documentation from the time extravasation occurs and is first noticed as well as during the
2946 care provided following extravasation. It is important to note that these standards should be
2947 followed up until resolution of injury or transfer of care to a specialty to manage extravasation
2948 sequelae. ONS does not provide the frequency with which assessments and documentation
2949 should be made in the follow up period. Rather, institutional policies and provider orders should
2950 be followed.

2951 **Standard I. Time of Extravasation**

2952 A. Drug Administration

- 2953 a. Date and Time of Drug Initiation
- 2954 b. Drug Name
- 2955 c. Dilution/Concentration of extravasated agent
- 2956 d. Infusion Method (IV Piggyback, IV Push, etc.)
- 2957 e. Amount of drug administered prior to extravasation
- 2958 f. Blood Return present at start of infusion (or other confirmation of line patency)
- 2959 g. Process and frequency of line patency confirmation throughout drug
2960 administration

2961 B. Venous Access Device and Insertion Site Assessment

- 2962 a. Date and time extravasation noted
- 2963 b. Type, size, gauge of intravenous device
- 2964 c. Number of attempts for IV placement (If applicable)
- 2965 d. Appearance of Insertion site
- 2966 e. Presence/absence of blood return after extravasation
- 2967 C. Interventions
- 2968 a. Time infusion was stopped
- 2969 b. Name of provider notified
- 2970 c. Attempt to aspirate drug remaining in IV catheter
- 2971 d. Removal of and appearance of IV cannula/port needle (if applicable)
- 2972 e. Vital Signs
- 2973 f. Pain medication administered
- 2974 g. Topical Treatment applied (ex. Heat/ice)
- 2975 h. Time topical treatment applied
- 2976 i. Time topical treatment removed
- 2977 j. Name and time of antidote administered (if applicable)
- 2978 k. Consultations provided (plastic surgery, surgery, physical therapy etc.)
- 2979 l. Attachment of photograph (*date and time photo taken in the photo field*)
- 2980 m. Consent for site photography
- 2981 n. Plan for Follow up/Return Appointments
- 2982 D. Affected Limb/Skin Assessment
- 2983 a. Vein affected
- 2984 b. Color of affected limb/skin

- 2985 c. Circumference measurement of affected limb (if applicable)
- 2986 d. Pain at Rest (0-10 scale)
- 2987 e. Range of Motion of affected limb
- 2988 f. Pain with Range of Motion (0-10)
- 2989 g. Patient-reported symptoms (burning, pain etc)
- 2990 h. Presence of edema, induration, erythema, blisters/ulceration
- 2991 i. Presence of necrosis
- 2992 j. Measurement of affected area(s)
- 2993 k. Appearance of wound bed if applicable (color, granulation, odor etc.
- 2994 E. Patient/Caregiver Education
- 2995 a. Patient/caregiver preferred learning style (written, verbal etc.)
- 2996 b. Targets of Education (patient, caregiver(s) etc)
- 2997 c. Resources Provided:
- 2998 i. Driven by institutional materials
- 2999 d. Required Teaching Points
- 3000 i. Signs and symptoms of necrosis
- 3001 ii. ROM exercise to perform
- 3002 iii. Monitor temperature
- 3003 iv. Note blistering and sloughing of skin in affected area
- 3004 v. Signs and symptoms of which to alert provider
- 3005 vi. Topical care
- 3006 vii. Protect from sunlight
- 3007 e. Response to Teaching

- 3008 i. Patient/caregiver education
- 3009 ii. Appropriate questions verbalized

3010 **Standard II. Post Extravasation Care (at intervals as determined by**
3011 **institutional policy until resolution/referral to specialty care)**

3012 A. Drug Documentation

- 3013 a. Name of drug extravasated
- 3014 b. Estimated amount of drug extravasated

3015 B. Venous Access Device and Insertion Site Assessment

- 3016 a. Function of catheter (if applicable)

3017 C. Interventions

- 3018 a. Consultations provided (plastic surgery, surgery, physical therapy, etc)
- 3019 b. Vital Signs
- 3020 c. Attachment of photograph if applicable (*date and time photo taken in the photo*
3021 *field*)
- 3022 d. Consent for photography
- 3023 e. Plan for Follow-up Return Appointments

3024 D. Affected Limb/Skin Assessment

- 3025 a. Vein in which drug was infused
- 3026 b. Pain at rest (0-10)
- 3027 c. Range of Motion of affected limb
- 3028 d. Pain with Range of Motion (0-10)
- 3029 e. Color of affected limb/skin

- 3030 f. Circumference measurement if applicable
- 3031 g. Patient-reported symptoms (burning, pain, etc.)
- 3032 h. Presence of edema, induration, erythema, blisters/ulceration
- 3033 i. Presence of necrosis
- 3034 j. Measurement of affected areas
- 3035 k. Appearance of wound bed if applicable (color, granulation, odor, etc)
- 3036 l. Presence of sensory loss in affected area(s)
- 3037 E. Patient/Caregiver Education
- 3038 a. Targets of Education (patient, caregiver(s) etc.)
- 3039 b. Resources Provided
- 3040 i. Driven by institutional materials
- 3041 c. Key Teaching Requirements
- 3042 i. Signs and symptoms of necrosis
- 3043 ii. ROM exercise to perform
- 3044 iii. Monitor temperature
- 3045 iv. Note blistering and sloughing of skin in affected area
- 3046 v. Signs and symptoms of which to alert provider
- 3047 vi. Topical care
- 3048 vii. Protect from sunlight
- 3049 d. Response to Teaching
- 3050 i. Patient/Caregiver understanding
- 3051 ii. Appropriate questions verbalized
- 3052 References:

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