ONS Nursing Documentation Standards

Introduction

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

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

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

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

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

- Chemotherapy/Biotherapy
- Blood and Marrow Transplant
- Radiation
- Surgery
- Extravasation Management
- Blood Product Transfusion
- Treatment with a Central Venous Access Device

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

- "Assessment of" – documentation indicates that specific elements were assessed by a nurse (or practice-designated employee)
- "Review of" – documentation indicates that a specific elements were reviewed by a nurse (or practice-designated employee)
- "Verification of" – documentation indicates that a specific elements were verified as part of the treatment plan by a nurse (or practice-designated employee)

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

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

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References:

American Nurses Association. (2010). ANA's Principles for Nursing Documentation: Guidance for Registered Nurses. American Nurses Association: Silver Spring, MD.

American Nurses Association (2015). Inclusion of Recognized Terminologies within HERRs and other Health Information Technology Solutions. Retrieved online from http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Inclusion-of-Recognized-Terminologies-within-EHRs.html

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Chemotherapy/Biotherapy Administration Documentation Standards

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

Standard I. Work-Up

A. Physical Elements of Documentation

a. General:

i. Verification of:

1. Medical/surgical history
2. Family medical history
3. Prior cancer treatment

b. Constitutional:
    i. Assessment of:
        1. Vital signs
        2. Pain
        3. Activities of Daily Living
        4. Performance Status
        5. Height/Weight
        6. History of hypersensitivity reactions
    ii. Medication Reconciliation
    iii. Allergies
c. Neurological
    i. Assessment of:
        1. Level of Consciousness
        2. Peripheral neuropathy
d. HEENT:
    i. Assessment of:
        1. Oral exam/Mucositis/Esophagitis
        2. Dental exam
        3. Dry mouth
        4. Dysphagia
        5. Epistaxis
        6. Sinus Pain
        7. Visual impairment

8. Ototoxicity

e. Cardiovascular:

i. Assessment of:

1. Heart sounds
2. Edema
3. Palpitations
4. Cyanosis
5. Chest pain
6. Venous thromboembolism (VTE)

ii. Review of:

1. Electrocardiogram (ECG)
2. MUGA

f. Pulmonary:

i. Assessment of

1. Respiratory Sounds
2. Oxygen delivery
3. Cough
4. Sputum
5. Dyspnea
6. Shortness of Breath

ii. Review of:

1. Pulmonary Function Tests
2. Chest X-ray

g. Gastrointestinal/Nutritional:
    i. Assessment of:
        1. Altered Taste Sense
        2. Nausea/Vomiting
        3. Constipation/Diarrhea
        4. Weight Loss
        5. Dietary History
h. Genitourinary/Renal:
    i. Assessment of:
        1. Dysuria
        2. Incontinence
        3. Hematuria
        4. Color of urine
    ii. Review of:
        1. Creatinine clearance (if applicable)
i. Reproductive:
    i. Verification of:
        1. Contraception (if of childbearing potential)
        2. Breastfeeding status (if applicable)
j. Musculoskeletal:
    i. Assessment of:
        1. Gait function
k. Dermatologic:

i. Assessment of:

1. Skin condition
2. Wounds
3. Skin Breakdown
4. Rashes
5. Palmar Plantar Erythrodysesthesia (PPE)

l. Hematologic/Lymphatic:

i. Assessment of:

1. Anemia
2. Blood coagulation disorder

ii. Review of:

1. Laboratory data

m. Immune System:

i. Review of:

1. Presence or absence of known infection

n. Structural Changes:

i. Assessment of (as applicable)

1. Implanted devices
2. Stoma
3. Tubes/drains as indicated

o. Malignancy:

i. Verification of:

1. Cancer diagnosis and stage

B. Psychologic Elements of Documentation:

a. General:

i. Verification of:

1. History of psychologic disorder (depression, anxiety, bipolar, etc.)

2. Prior treatment for psychologic disorders

b. Distress and Stressors

i. Assessment of:

1. Baseline distress and current stressors

2. Caregiver support

c. Coping:

i. Assessment of:

1. Coping mechanisms

d. Anxiety

i. Assessment of:

1. Signs/symptoms of anxiety

ii. Current treatment if applicable

e. Depression

i. Assessment of

1. Signs/symptoms of depression

2. Suicide risk

ii. Current Treatment

f. Cultural/Spiritual:

i. Assessment of:

1. Cultural/spiritual beliefs and practices
2. Impact on plan of care

C. Social and Financial Elements of Documentation

a. Language:

i. Assessment of:

1. Primary language
2. Need for interpreter
3. Health literacy

b. Advance Directive:

i. Review of:

1. Advanced directives, living will, power of attorney/decision makers

c. Income concerns:

i. Assessment of:

1. Financial concerns

d. Living Arrangements:

i. Assessment of:

1. Living arrangements appropriate for functional status
2. Access to care

e. Insurance Status:

i. Assessment of:

1. Insurance coverage
2. Ability to procure drug

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

f. Substance Abuse

i. Assessment of:

1. Past/current substance abuse

2. Last use

ii. Review of:

1. Referrals made (if applicable)

g. Referrals as indicated

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

A. Physical Elements of Documentation

a. General:

i. Verification of:

1. Changes to medical/surgical history baseline

2. Prior cancer treatment

b. Constitutional:

i. Assessment of:

1. Vital signs

2. Pain

3. ADLs

4. Height/Weight

5. Fatigue

6. Performance Status

c. Neurological:

i. Assessment of:

1. Level of Consciousness
2. Orientation
3. Peripheral Neuropathy
4. Cerebellar Assessment (if applicable)

d. HEENT:

i. Assessment of:

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

e. Cardiovascular:

i. Assessment of:

1. Heart sounds
2. Edema
3. Palpitations
4. Cyanosis
5. Chest pain
6. VTE

ii. Review of:

1. ECG
2. MUGA where applicable

f. Pulmonary:

i. Assessment of:

1. Respiratory Sounds
2. Oxygen delivery
3. Cough
4. Sputum
5. Dyspnea
6. Shortness of Breath

ii. Review of: (where applicable)

1. PFTs
2. Chest X-ray

g. Gastrointestinal/Nutrition

i. Assessment of:

1. Altered taste sense
2. Nausea/vomiting
3. Constipation/diarrhea
4. Weight loss
5. Dietary intake

h. Genitourinary/Renal:

i. Assessment of:

1. Dysuria

2. Incontinence
3. Point of Care testing (ex. pH, heme) (where applicable)

ii. Review of:

1. Creatinine clearance (where applicable)

i. Reproductive:

i. Review of:

1. Contraception
2. Last Menstrual period (where applicable)
3. Sexual dysfunction/dissatisfaction
4. Beta Hcg (where applicable)

j. Musculoskeletal:

i. Assessment of:

1. Gait function
2. Muscular strength (+0-+5)

k. Dermatologic:

i. Assessment of:

1. Skin condition
2. Wounds
3. Skin breakdown
4. Rashes
5. PPE

l. EcchymosisHematologic/Lymphatic

i. Review of:

1. Laboratory data

ii. Assessment of:

1. Anemia

2. Blood Coagulation Disorder

m. Immunologic:

i. Review of:

1. Presence of/absence of known infection

n. Structural Changes

i. Assessment of: (where applicable)

1. Implanted devices

2. Stomas

3. Tubes/drains

o. Malignancy:

i. Verification of:

1. Cancer diagnosis and stage

B. Psychologic Elements of Documentation

a. Distress and Stressors

i. Assessment of:

1. Distress

2. Current stressors

ii. Anxiety:

1. Assessment of:

a. Presence of anxiety

2. Current treatment

iii. Depression

1. Assessment of:

a. SIgns/symptoms of depression

2. Current treatment

iv. Culture/Spiritual:

1. Review of:

a. Changes from baseline

C. Social and Financial Elements of Documentation

a. Language:

i. Review of:

1. Use of interpreter if applicable

b. Advance Directive:

i. Review of:

1. Changes from baseline

2. Goals of care conversations

c. Income Concerns:

i. Review of:

1. Changes from baseline

d. Living arrangements:

i. Review of:

1. Changes from baseline

e. Insurance Status:

i. Review of:

1. Changes from baseline

f. Substance Abuse:

i. Review of:

1. Changes from baseline

g. Referrals as indicated

D. Patient/Caregiver Education Elements of Documentation

a. Assessment of:

i. Preferred learning styles (ex. written, verbal etc.)

ii. Barriers to learning

iii. Person(s) being educated

iv. Patient/family comprehension of chemotherapy/biotherapy regimen prescribed

v. Ability to obtain and self-administer agents according to institutional/state/federal guidelines where applicable (ex. oral agents at home)

b. Resources provided:

i. Drug-specific resources/materials

ii. Discharge documents

c. Key Teaching points:

i. Consent process

ii. Concurrent cancer treatment and supportive care medications/measures

iii. Drug/protocol specific toxicities,

iv. Chemotherapy administration schedule

v. Risks/benefits to treatment

vi. Infertility risk and contraception requirements if indicated

vii. Alternatives to chemotherapy

viii. Return demonstrations where applicable

ix. Storage, handling, preparation and disposal of chemotherapy for those on oral chemotherapy at home

x. Plan for missed doses for those on oral chemotherapy at home

d. Response to Teaching:

i. Full understanding of teaching points

ii. Return demonstration where applicable

iii. Patient/family comprehension of goals of treatment (ex. Cure, control, disease palliation, etc.)

Standard III. Ongoing Chemotherapy/Biotherapy Treatment

A. Physical Elements of Documentation

a. Constitutional:

i. Assessment of:

1. Vitals signs
2. Pulse oximetry
3. Pain
4. ADLs
5. Height/Weight
6. Fatigue

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

5. Chest pains
6. VTE

ii. Review of:

1. ECG where applicable

e. Pulmonary:

i. Assessment of:

1. Respiratory Sounds
2. Oxygen delivery
3. Cough
4. Sputum
5. Dyspnea
6. Shortness of breath

f. Gastrointestinal/Nutrition:

i. Assessment of:

1. Altered taste sense
2. Nausea/Vomiting
3. Constipation/Diarrhea
4. Weight loss
5. Dietary intake

g. Genitourinary/Renal

i. Assessment of:

1. Dysuria
2. Incontinence

3. Point of Care testing where applicable

h. Reproductive:

i. Review of:

1. Contraception

2. Last menstrual period

3. Sexual dysfunction/dissatisfaction

i. Musculoskeletal:

i. Assessment of :

1. Gait function

2. Muscular strength (+0-+5)

j. Dermatologic:

i. Assessment of:

1. Skin condition

2. Wounds

3. Skin breakdown

4. Rashes

5. PPE

k. Hematologic:

i. Review of:

1. Laboratory data as appropriate

ii. Assessment of:

1. Anemia

2. Blood coagulation disorder

l. Immunologic:

i. Review of:

1. Presence/absence of known infection

m. Structural Changes:

i. Assessment of: (where applicable)

1. Implanted devices

2. Stomas

3. Tubes/drains

B. Psychologic Elements of Documentation

a. Distress:

i. Assessment of:

1. Distress and stressors

b. Anxiety:

i. Assessment of:

1. Presence of anxiety

ii. Current treatment

c. Depression:

i. Assessment of:

1. Signs/symptoms of depression

ii. Current treatment

d. Cultural/Spiritual:

i. Assessment of:

1. Impact on plan of care

C. Social and Financial Elements of Documentation

a. Language:

i. Use of interpreter (if applicable)

b. Advance Directive:

i. Review of:

1. Changes from baseline

2. Goals of care conversations

c. Income Concerns

i. Review of:

1. Changes from baseline

d. Living Arrangements:

i. Review of:

1. Changes from baseline

e. Insurance Status:

i. Review of:

1. Changes from baseline

f. Substance Abuse:

i. Review of:

1. Changes from baseline

g. Referrals as indicated

D. Patient/Caregiver Education

a. Assessment of:

i. Preferred learning styles

ii. Barriers to learning

iii. Target of education

b. Resources Provides:

i. Drug-specific resources/materials

ii. Discharge documents

c. Key Teaching Requirements:

i. Consent process

ii. Drug/Protocol specific toxicities

iii. Side effect management

iv. Risks/benefits to treatment

v. Alternatives to chemotherapy

vi. Ability to safely administer agents (where applicable in self-administration regimens)

d. Response to Teaching

i. Full understanding of chemotherapy administration schedule

ii. Return demonstrations where applicable

iii. Patient/family comprehension of goals of treatment

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

A. Physical Elements of Documentation

a. Constitutional:

i. Assessment of:

1. Vital Signs
2. Pain
3. ADLs
4. Height/Weight
5. Fatigue

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
5. Chest pain
6. VTEs

ii. Review of: (where applicable)

1. ECG
2. MUGA

e. Pulmonary:

i. Assessment of:

1. Respiratory Sounds
2. Oxygen delivery
3. Cough
4. Sputum
5. Dyspnea
6. Shortness of Breath

ii. Review of: (where applicable)

1. PFTs
2. Chest X-ray

f. Gastrointestinal/Nutrition

i. Assessment of:

1. Altered taste sense

2. Nausea/vomiting
3. Constipation/diarrhea
4. Weight loss
5. Dietary intake

g. Genitourinary:

i. Assessment of:

1. Dysuria
2. Incontinence
3. Hematuria

h. Reproductive:

i. Review of:

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

i. Musculoskeletal:

i. Assessment of:

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

j. Dermatologic:

i. Assessment of:

1. Skin condition
2. Wounds
3. Skin breakdown

4. Rashes
5. PPE

k. Ecchymosis Hematologic:

i. Review of:

1. Laboratory data

ii. Assessment of:

1. Anemia
2. Blood Coagulation disorder

l. Immunologic:

i. Review of:

1. Presence/absence of known infection

m. Structural Changes:

i. Assessment of: (where applicable)

1. Implanted devices
2. Stomas
3. Tubes/drains

n. Malignancy:

i. Verification of:

1. Disease and stage as appropriate

ii. Assessment of signs and symptoms of disease

B. Psychologic Elements of Documentation

a. Distress and Stressors:

i. Assessment of:

1. Distress and current stressors

b. Anxiety:

i. Assessment of:

1. Presence of anxiety

ii. Current treatment

c. Depression:

i. Assessment of:

1. Signs/symptoms of depression

ii. Current Treatment

d. Cultural/Spiritual:

i. Assessment of:

1. Impact on plan of care

C. Social and Financial Elements of Documentation

a. Language:

i. Review of:

1. Use of interpreter (where applicable)

b. Advance Directive:

i. Review of:

1. Changes from baseline

2. Goals of care conversations

c. Income Concerns:

i. Review of:

1. Changes from baseline

d. Living Arrangements:
    i. Review of:
        1. changes from baseline
e. Insurance Concerns:
    i. Review of:
        1. Changes from baseline
f. Substance Abuse
    i. Review of:
        1. Changes from baseline
g. Referrals as indicated

D. Patient/Caregiver Education:

a. Resources Provided:
    i. Specific materials/resources
b. Key Teaching Requirements:
    i. Expected toxicities
    ii. Organ Damage
    iii. Side Effect Management
    iv. Signs and Symptoms of recurrence
c. Response to Teaching
    i. Assessment of understanding

Standard V. Follow Up

A. Physical Elements of Documentation

a. General:

i. Verification of:

1. Changes in medical/surgical history

b. Constitutional:

i. Assessment of:

1. Vital Signs
2. Pain
3. ADLS
4. Height/Weight
5. Fatigue

c. Neurological:

i. Assessment of:

1. Level of Consciousness
2. Peripheral neuropathy

d. HEENT:

i. Assessment of:

1. Oral exam/mucositis
2. Dry mouth
3. Dysphagia
4. Epistaxis
5. Sinus Pain
6. Visual impairment
7. Ototoxicity
8. Osteonecrosis of the jaw

e. Cardiovascular:
    i. Assessment of:
        1. Heart sounds
        2. Edema
        3. Palpitations
        4. Cyanosis
        5. Chest pains
        6. VTEs
f. Pulmonary:
    i. Assessment of:
        1. Respiratory Sounds
        2. Oxygen delivery
        3. Cough
        4. Dyspnea
        5. Shortness of Breath
g. Gastrointestinal/Nutrition
    i. Assessment of:
        1. Altered taste sense
        2. Bowel Habits
        3. Weight Loss
        4. Dietary intake
h. Genitourinary:
    i. Assessment of:

1. Dysuria
2. Incontinence

i. Reproductive:

i. Review of:

1. Last Menstrual Period (where applicable)
2. Sexual Dysfunction/Dissatisfaction

j. Musculoskeletal:

i. Assessment of:

1. Gait function
2. Muscular Strength (+0-+5)

k. Dermatologic:

i. Assessment of:

1. Skin condition
2. Wounds
3. Skin Breakdown
4. Rashes
5. PPE
6. Ecchymosis

l. Hematologic:

i. Review of:

1. Laboratory data as appropriate

ii. Assessment of

1. Anemia

2. Blood Coagulation disorder

m. Immunologic:

i. Review of:

1. Presence/absence of known infection

n. Structural Changes:

i. Assessment of (where applicable):

1. Implanted devices

2. Stomas

3. Tubes/Drains

o. Malignancy:

i. Verification of:

1. Disease and stage as appropriate

ii. Assessment of:

1. Signs and symptoms of disease

B. Psychologic Elements of Documentation

a. Distress and Stressors:

i. Assessment of:

1. Distress

2. Current stressors

b. Anxiety:

i. Assessment of:

1. Presence of anxiety

ii. Current treatment

c. Depression:

i. Assessment of:

1. Signs and symptoms of depression

ii. Current Treatment

d. Cultural/Spiritual:

i. Assessment of:

1. Impact on plan of care

C. Social and Financial Elements of Documentation

a. Language:

i. Review of:

1. Interpreter (if applicable)

b. Advance Directive:

i. Review of:

1. Changes to baseline

2. Goals of care conversations

c. Income Concerns

i. Review of:

1. Changes from baseline

d. Living Arrangements

i. Review of:

1. changes from baseline

e. Insurance Status

i. Review of:

1. Changes from baseline

f. Substance Abuse

i. Review of:

1. Changes to baseline

g. Referrals as indicated

D. Patient/Caregiver Education

a. Resources Provided:

i. Materials/Resources

ii. Key Teaching Requirements:

1. Expected delayed toxicities
2. Organ Damage
3. Side Effect Management
4. Signs and symptoms of recurrence
5. Follow Up Schedule
6. Diagnostic Exams
7. Survivorship care plan (where applicable)

iii. Response to Teaching:

1. Assessment of understanding

Standard VI. Chemotherapy/Biotherapy Drug Documentation

A. Drug Orders:

a. Patient's Full Name and a second identifier (eg. Medical record number, DOB)

b. Date

c. Drug name(s)

d. Diagnosis

e. Regimen Name and cycle number (if applicable)

f. Protocol Name and Number (if applicable)

g. Appropriate Criteria to treat (eg. Laboratory data etc.)

h. Allergies

i. Reference to the methodology of the dose calculation or standard practice equations

j. Height/Weight and any other variables used to calculate the dose

k. Route and rate (if applicable) of administration

l. Length of infusion (if applicable)

m. Supportive Care treatments for the regimen (ex. Premedications, hydration, growth factors, etc.

n. Sequence of dose administration (if multi-drug regimen)

o. Additional elements for oral administration

i. Dose and Quantity

ii. Frequency of administration

iii. Duration of therapy (days of rest, if applicable)

iv. Number of refills (if applicable)

B. Chemotherapy Drug Labeling:

a. Patient's full name (second patient identifier for parenteral agents)

b. Full generic drug name

c. Drug administration route

d. Total dose to be given

e. Total volume required to administer this dosage

f. Date of administration

g. Date (and time for parenteral agents) of preparation

h. Date (and time for parenteral agents) of expiration when not for immediate use

i. Special Handling instructions as appropriate

j. Administration instructions (oral agents)

k. Number of refills (for oral agents)

l. Prescriber name (for oral agents)

C. Verification of:

a. (at least two practitioners or personnel approved by the practice/institution to prepare or administer chemotherapy)

i. Confirmation with patient his/her planned treatment

ii. Two patient identifiers

iii. Drug Name

iv. Drug Dose

v. Drug Volume

vi. Calculation of dosing

vii. Drug Preparation (number of tablets/capsules) if applicable

viii. Rate of administration

ix. Route of administration

x. Expiration date/times (if applicable)

xi. Appearance and physical integrity of the drugs

xii. Rate set on infusion pump (if applicable)

xiii. Cumulative drug dose (if applicable)

xiv. Diagnostic laboratory data verification

b. Informed consent Process

i. Information regarding his/her diagnosis

ii. Goals of therapy

iii. Planned duration of chemotherapy/biotherapy drugs and schedule

iv. Information on possible short and long term adverse effects

v. Regimen or drug specific risks or symptoms that require notification and emergency contact information

vi. Plan for monitoring and follow up

c. Initial cancer stage and/or current cancer status - review of pathologic confirmation of disease

D. Drug Administration:

a. Supportive medications administered

b. Dose reductions/delays

c. Cumulative dose

d. Drug Administration

i. Nursing double checks of drug and rate

e. Treatment tolerance

f. IV access

i. Site patency during administration

ii. Line type

iii. Location

iv. Site assessment (phlebitis etc.)

v. Dressing

g. Hypersensitivity (if applicable)

h. Nursing Assessment of:

i. Clinical and or performance status

ii. Vital signs and pulse oximetry (frequency according to institutional policy based on regimen)

iii. Weight

iv. Patients adherence to oral chemotherapy and plan to address

i. Review of:

i. Laboratory profile

j. Verification of:

i. Allergies

ii. Previous reactions and treatment-related toxicities

iii. Psychosocial concerns and need for support

1. Action taken when indicated

iv. Current medications, including over the counter medication and complementary/alternative therapies

E. Treatment Discontinuation of Regimen Change

a. Rationale for regimen change

b. Oral Chemotherapy/Biotherapy Regimens

i. Patient instructions including dates to change dose, hold dose or discontinue oral chemotherapy

ii. Pharmacy alerted to oral chemotherapy regimen change or discontinuation

References

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Radiation Documentation Standards

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

Standard I. Pre-Simulation Planning

A. Treatment Planning Elements of Documentation

a. Verification of:

i. Disease type

ii. Stage (base on tumor markers, lab results, imaging, pathology, histology, cytology where applicable)

iii. Alternative treatment options

iv. Interdisciplinary communication

Prior MRI to planned radiation field

b. Review of:

i. Complicating factors based on assessment

B. Physical Elements of Documentation

a. General:

i. Verification of:

1. Medical/surgical history

2. Cancer treatment history
3. Family Medical History

b. Constitutional:
    i. Assessment of:
        1. Activity of daily living (ADLs)
        2. Sleep patters
        3. Fatigue
        4. Performance Status
    ii. Allergies
    iii. Medication Reconciliation

c. Neurological:
    i. Assessment of:
        1. Headaches
        2. Confusion/Memory loss
        3. Dizziness
        4. Altered sensation of skin

d. HEENT:
    i. Assessment of:
        1. Oral exam
        2. Dysphagia
        3. Hearing deficits
        4. Tinnitus
        5. Visual impairment

ii. Review of:

1. Use of assistive devices (ex. Glasses, hearing aids, etc.)

e. Cardiovascular:

i. Verification of:

1. Presence of pacemaker or defibrillator

f. Pulmonary:

i. Verification of:

1. Smoking history
2. Oxygen delivery

g. Gastrointestinal/Nutrition

i. Assessment of:

1. Bowel habits,
2. Acid reflux
3. Obesity
4. Dietary habits

h. Genitourinary/Renal:

i. Assessment of:

1. Incontinence
2. Urostomy
3. Bladder prolapse

i. Reproductive:

i. Verification of:

1. Pregnancy history

2. Last menstrual period
3. Menopausal state
4. Childbearing potential
5. Fertility care if applicable
6. Contraception if applicable
7. Last prostate specific antigen
8. History of sexually Transmitted Infections
9. Sexual dysfunction/dissatisfaction

j. Musculoskeletal:

i. Verification of:

1. Prostheses
2. Assistive devices (walker etc.)

k. Dermatological:

i. Assessment of:

1. Skin condition
2. Excessive sun exposure
3. Wounds

l. Endocrine:

i. Verification of:

1. Sex hormone findings

m. Hematologic/Lymphatic:

i. Verification of:

1. Lymph node removal

2. Anticoagulant use

n. Immunologic:

i. Verification of:

1. Vaccination status
2. Neutropenic episodes
3. Fevers of unknown origin
4. Presence/absence of signs and symptoms of known infection

o. Structural Devices

i. Verification of

1. External tubes
2. Stents
3. Drains
4. Implanted devices
5. Venous access devices

C. Psychologic Elements of Documentation

a. General:

i. Verification of:

1. psychologic history (depression anxiety disorders, bipolar disorder, etc.)
2. Prior treatment for psychologic disorders

b. Distress and Stressors:

i. Assessment of:

1. Baseline distress *(may consider distress assessment scale)*

2. Current stressors
3. Caregiver support

c. Coping
   i. Assessment of:
      1. Coping mechanisms

d. Anxiety
   i. Assessment of:
      1. Signs/symptoms of anxiety
   ii. Current treatment

e. Depression:
   i. Assessment of:
      1. Signs/symptoms of depression
      2. Suicide risk
   ii. Current treatment

f. Cultural/Spiritual:
   i. Assessment of:
      1. Cultural/ethnic/spiritual beliefs and practices
      2. Impact on plan of care

D. Social and Financial Elements of Documentation

a. Language:
   i. Assessment of:
      1. Primary language
      2. Health literacy

3. Need for interpreter

b. Advance Directive:

i. Verification of:

1. Advance directive, living will, power of attorney etc.

c. Income Concerns:

i. Assessment of:

1. Employment status

2. Concerns about finances

d. Living Arrangements:

i. Assessment of:

1. Living arrangement appropriate for functional status

2. Access to care

3. Transportation details

4. Access to caregiver

e. Insurance Status:

i. Verification of:

1. Insurance coverage

2. Ability to procure prescription needs

3. Preauthorization needs

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

f. Substance Abuse:

i. Assessment of:

1. Type, amount of past substance abuse

2. Past treatment if applicable
3. Need for referral
4. Impact on treatment/quality of life

g. Referrals as indicated

E. Patient/Caregiver Education Elements of Documentation:

a. Assessment of:

i. Preferred learning styles

ii. Barriers to learning

iii. Targets of education

b. Resources Provided

c. Key Teaching Elements:

i. Consent to treatment

ii. Decision making resources

iii. Tobacco use cessation if indicated

d. Response to Teaching:

i. Assessment of:

1. patient/caregiver response

Standard II. Simulation

A. Treatment Planning:

a. Review of:

i. Disease type and stage

ii. Complicating factors based on assessment

b. Verification of:

i. Informed consent

ii. Need for interdepartmental communication

iii. Multidisciplinary treatment plan

B. Physical Elements of Documentation:

a. General:

i. Verification of:

1. changes to history baseline

2. Laboratory results as appropriate

b. Constitutional:

i. Assessment of:

1. Vital Signs

2. Sleep patterns

3. ADLs

4. Weight

5. Pain

6. Fatigue

ii. Allergies

c. Neurological:

i. Assessment of:

1. Peripheral neuropathy

2. Cranial nerve function

3. Sensory function

4. Reflex test

d. HEENT:

i. Assessment of:

1. Oral/dental exam
2. Mucositis/esophagitis
3. Dysphagia
4. Xerostomia
5. Alopecia
6. Visual impairment
7. Dry eye sensation
8. Eyelashes
9. Hearing deficits
10. Tinnitus
11. Sinus pain
12. Epistaxis

e. Cardiovascular:

i. Assessment of:

1. Heart sounds
2. Edema
3. Arrhythmias
4. Palpitations
5. Chest pain
6. Claudication
7. Venous ulcers

8. Cyanosis
9. Pallor

f. Pulmonary:

i. Assessment of:

1. Respiratory sounds
2. Oxygen saturation
3. Cough
4. Sputum
5. Dyspnea on exertion
6. Exercise intolerance
7. Pain with inspiration/expiration

g. Gastrointestinal/Nutritional:

i. Assessment of:

1. Altered taste sense
2. Nausea/vomiting
3. Hematemesis
4. Diarrhea/Constipation
5. Blood in stool
6. Appetite changes
7. Weight changes
8. Acid reflux
9. Referral needs

h. Genitourinary/Renal:

i. Assessment of:

1. Dysuria
2. Incontinence
3. Flow of urine
4. Strength of urine stream
5. Hematuria
6. Urine specimen

i. Reproductive:

i. Assessment of:

1. Last menstrual period
2. Vasomotor symptoms
3. Penile changes
4. Erectile capacity
5. Vaginal discharge
6. Sexual dysfunction/satisfaction

j. Musculoskeletal:

i. Assessment of:

1. Range of motion
2. Motor Function
3. Gait Function

k. Dermatologic:

i. Assessment of:

1. Skin condition

2. Paronychia
3. Nail changes
4. Ecchymosis
5. Incisions
6. Wounds
7. Palmar plantar erythrodysesthesia (PPE)

l. Endocrine:

i. Assessment of:

1. Endocrine test findings

a. Glucose measurement

b. Thyroid panel

c. Infertility study

m. Hematologic:

i. Assessment of:

1. Leukopenia
2. Anemia
3. Thrombocytopenia

n. Immunologic:

i. Assessment of:

1. Fever/chills
2. Presence/absence of known infection

o. Structural Devices

i. Assessment of:

1. Stomas
2. External Tubes
3. Stents
4. Drains
5. Implanted devices
6. Venous access devices

C. Psychologic: Elements of Documentation

a. Distress and Stressors:

i. Assessment of:

1. Current/ongoing stressors

b. Coping:

i. Assessment of:

1. Coping mechanisms

c. Anxiety:

i. Assessment of:

1. Current/ongoing anxiety level

ii. Treatment

d. Depression:

i. Assessment of:

1. Current/ongoing signs and symptoms of depression

ii. Treatment

e. Cultural/Spiritual:

i. Assessment of

1. Impact on plan of care

D. Social and Financial Elements of Documentation

a. Language:

i. Review of:

1. Need for interpreter if applicable

b. Advance Directive:

i. Review of:

1. Goals of care

c. Income Concerns:

i. Review of:

1. Changes from baseline

d. Living Arrangements:

i. Review of:

1. Changes from baseline

e. Insurance Status:

i. Review of:

1. Changes from baseline

2. Verbalized concerns related to treatment

f. Substance Abuse:

i. Review of:

1. Changes to baseline

g. Referrals as indicated

E. Patient/Caregiver Education Elements of Documentation

a. Assessment of:
    i. Preferred learning style
    ii. Barriers to learning
    iii. Target of Education
b. Resources Provided:
    i. *Driven by institution or use of prepared materials*
c. Key Teaching Points:
    i. Consent to Treat
    ii. Treatment schedule
    iii. Regular assessment schedule
    iv. Department/staff orientation
    v. Site specific components based on treatment types
    vi. Radiation safety as applicable
    vii. Side effects
    viii. Complications
    ix. Expectations
    x. Contact information
    xi. Emergency care
d. Response to Teaching:
    i. Patient/Caregiver understanding
    ii. Additional educational needs

Standard III. Treatment

A. Treatment Planning Documentation:

a. Verification of:

i. Ongoing consent to treat

ii. Delivered radiation dose

iii. Rational for variations if applicable

iv. Interdisciplinary treatment plan for concurrent treatment and monitoring

b. Assessment of:

i. Patient tolerance

ii. Compliance issues

B. Physical Elements of Documentation

a. General:

i. Verification of:

1. Laboratory results as appropriate

b. Constitutional:

i. Assessment of:

1. Vital Signs
2. Sleep patterns
3. ADLs
4. Weight
5. Pain
6. Fatigue

ii. Allergies

c. Neurologic:

i. Assessment of:

1. Level of Consciousness
2. Orientation
3. Affect
4. Peripheral neuropathy
5. Cranial nerve
6. Sensory function
7. Reflex test

d. HEENT:

i. Assessment of:

1. Oral/Dental exam
2. Mucositis/esophagitis
3. Dysphagia
4. Xerostomia
5. Alopecia
6. Visual impairment
7. Dry eye sensation
8. Eyelashes
9. Hearing deficits
10. Tinnitus
11. Sinus pain
12. Epistaxis

e. Cardiovascular

i. Assessment of:

1. Heart sounds
2. Arrhythmias
3. Palpitations
4. Chest pain

f. Pulmonary

i. Assessment of:

1. Respiratory sounds
2. Oxygen saturation
3. Cough
4. Sputum
5. Dyspnea of exertion
6. Exercise intolerance
7. Pain with inspiration/expiration

g. Gastrointestinal/Nutritional

i. Assessment of:

1. Altered taste sense
2. Anorexia
3. Salivary duct inflammation
4. Nausea/Vomiting
5. Hematemesis
6. Diarrhea/Constipation
7. Blood in stool
8. Appetite changes

9. Weight changes
10. Acid reflux
11. Referral needs

h. Genitourinary/Renal

i. Assessment of:

1. Urine color
2. Dysuria
3. Hematuria
4. Incontinence
5. Flow of urine
6. Strength of urine stream

i. Reproductive

i. Assessment of:

1. Last menstrual period
2. Vasomotor symptoms
3. Penile changes
4. Erectile capacity
5. Vaginal discharge
6. Sexual dysfunction/satisfaction

j. Musculoskeletal

i. Assessment of:

1. Range of Motion
2. Motor function

3. Gait function

k. Dermatologic:

i. Assessment of:

1. Skin condition
2. Radiation recall
3. Radiodermatitis
4. Desquamation
5. Paronychia
6. Nail changes
7. Ecchymosis
8. PPE

l. Endocrine

i. Review of: (where applicable)

1. Glucose control
2. Thyroid studies

m. Hematologic/Lymphatic

i. Assessment of:

1. Leukopenia
2. Anemia
3. Thrombocytopenia

n. Immunologic:

i. Review of:

1. Presence/absence of known infection

o. Structural Devices:
    i. Assessment of:
        1. Stomas
        2. External tubes
        3. Stents
        4. Drains
        5. Implanted devices
        6. Venous access devices

C. Psychologic Elements of Documentation
    a. Distress/Stressors
        i. Assessment of:
            1. Current/ongoing psychological issues
    b. Coping:
        i. Assessment of:
            1. Coping mechanisms
    c. Anxiety:
        i. Assessment of:
            1. Current/ongoing anxiety level and treatment
        ii. Treatment
    d. Depression:
        i. Assessment of:
            1. Current /ongoing signs and symptoms of depression
        ii. Treatment

e. Cultural/Spiritual

i. Review of:

1. Impact on plan of care

D. Social and Financial Elements of Documentation

a. Language

i. Assessment of:

1. Need for interpreter if applicable

b. Advance Directive

i. Review of:

1. Changes from baseline

2. Goals of care

c. Income Concerns

i. Review of:

1. Changes from baseline

d. Living arrangements

i. Review of:

1. Changes from baseline

e. Insurance Status

i. Review of:

1. Changes from baseline

f. Substance Abuse

i. Review of:

1. Changes from baseline

g. Referrals as indicated

E. Patient/Caregiver Education

a. Assessment of:

i. Preferred learning style

ii. Barriers to learning

iii. Targets of Education

b. Resources Provided

i. *Driven by institution or prepared materials*

c. Key Teaching Requirements

1. Consent to treatment
2. Treatment schedule
3. Regular assessment schedule
4. Site-specific components based on treatment type
5. Radiation safety as applicable
6. Side effects
7. Complications
8. Expectations
9. Contact information
10. Emergency care

d. Response to Education

i. Ongoing patient/caregiver understanding

Standard IV. Post Treatment and Follow-Up Care

A. Treatment Planning Documentation

a. Verification of:

i. Full delivered radiation dose

ii. Rationale for dose variation

iii. Plans for coordination of care *(may be driven by survivorship care plan)*

b. Assessment of:

i. Patient tolerance

ii. Compliance issues

B. Physical Elements of Documentation:

a. General:

i. Verification of:

1. Signs and symptoms of disease

ii. Assessment of:

1. Chronic/late treatment effects

C. Psychological Elements of Documentation

a. Distress/Stressors;

i. Assessment of:

1. Current stressors

b. Coping

i. Assessment of:

1. Coping mechanisms

c. Anxiety

i. Assessment of:

1. Current/ongoing anxiety level and treatment

ii. Treatment

d. Depression

i. Assessment of:

1. Current/ongoing signs and symptoms of depression

ii. Treatment

e. Cultural/Spiritual

i. Review of:

1. Impact on plan of care

D. Social and Financial Elements of Documentation

a. Language

i. Review of:

1. Use of interpreter (if applicable)

b. Advance Directives

i. Review of:

1. Changes from baseline

c. Income Concerns

i. Review of:

1. Changes from baseline

d. Living Arrangements

i. Review of:

1. Changes from baseline

e. Insurance Status

i. Review of:

1. Changes from baseline

f. Substance Abuse

i. Review of:

1. Changes from baseline

g. Referrals as indicated

References:

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Blood and Marrow Stem Cell Transplant Documentation Standards

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

Standard I. History and Pre-Transplant Work Up

A. Physical Elements of Documentation

a. General:

i. Verification of:

1. Medical/surgical history
2. Family medical history
3. Prior cancer treatment

b. Constitutional:

i. Assessment of:

1. Vital Signs
2. Pain
3. Height/Weight

4. Fatigue
5. Performance Status
6. Activities of Daily Living

ii. Allergies

iii. Medication Reconciliation

c. Neurological:

i. Assessment of:

1. Level of Consciousness
2. Orientation
3. Peripheral Neuropathy

d. HEENT:

i. Review of:

1. Use of assistive devices (contacts, glasses, hearing aids, etc.)

ii. Assessment of:

1. Oral exam
2. Dysphagia
3. Visual impairment
4. Dry eyes
5. Tinnitus
6. Hearing Deficits

iii. Verification of:

1. Dental Exam

e. Cardiovascular:

i. Assessment of:

1. Heart sounds
2. Edema
3. Chest Pain
4. Arrhythmias
5. Palpitations
6. Cyanosis

ii. Verification of:

1. MUGA
2. ECG

f. Pulmonary:

i. Assessment of:

1. Respiratory Sounds
2. Oxygen delivery
3. Cough
4. Sputum
5. Dyspnea
6. Shortness of Breath
7. Smoking history and status

ii. Verification of:

1. Pulmonary Function Tests

g. Gastrointestinal:

i. Assessment of:

1. Nausea/vomiting
2. Diarrhea/Constipation
3. Nutrition and dietary history
4. Weight status
5. Altered Taste Sense

h. Genitourinary:

i. Assessment of:

1. Dysuria
2. Color of Urine
3. Hematuria
4. Incontinence

ii. Verification of:

1. Creatinine Clearance

i. Reproductive:

i. Review of:

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

j. Musculoskeletal:

i. Assessment of:

1. Fall history
2. Range of Motion

3. Gait Function
4. Muscle Strength (+0-+5)

k. Dermatologic:

i. Verification of:

1. Prior radiation sites

ii. Assessment of:

1. Skin condition
2. Rashes
3. Pruritis
4. Ecchymosis
5. Incisional Site
6. Nail condition

l. Hematologic:

i. Review of:

1. Blood type
2. Transfusion history
3. HLA testing
4. CBC w/differential
5. Blood work as appropriate

m. Endocrine:

i. Review of:

1. Hypo/hyperglycemia

n. Immunologic:

i. Verification of:

1. Sexually transmitted infection status

2. History of vaccination

ii. Review of:

1. Viral titer status

2. Presence or absence of known infection

o. Structural Devices/Changes

i. Assessment of:

1. Implanted devices

2. Vascular access device(s)

p. Malignancy:

i. Verification of:

1. Diagnosis and stage if applicable

2. Disease Status (via bone marrow biopsy, lumbar puncture, PET/CT, MRI, bone scan, immunoglobulins, tumor markers if applicable)

3. Tolerance of prior chemotherapy/radiotherapy regimens and prior cancer treatment

q. Transplant Specific:

i. Review of:

1. Planned stem cell source

2. Donor Type (Sibling, MUD, Cord)

B. Psychologic Elements of Documentation

a. General:
    i. Verification of:
        1. History of psychologic disorder (depression, anxiety disorder, bipolar disorder, etc.)
        2. Prior treatment for psychologic disorders
b. Distress and Stressors:
    i. Assessment of:
        1. Baseline distress
        2. Current Stressor
        3. Caregiver support
c. Coping:
    i. Assessment of:
        1. Coping mechanisms
d. Anxiety:
    i. Assessment of:
        1. Signs/symptoms of anxiety
    ii. Current treatment if applicable
e. Depression
    i. Assessment of:
        1. Signs/symptoms of depression
        2. Suicide Risk
    ii. Current treatment
f. Cultural/Spiritual:

i. Assessment of:

1. Cultural/spiritual beliefs and practices

2. Impact on plan of care

C. Social and Financial Elements of Documentation:

a. Language:

i. Assessment of:

1. Primary language

2. Need for interpreter (if applicable)

3. Health literacy

b. Advance Directive:

i. Review of:

1. Advance directives, living will, power of attorney/decision makers

c. Income Concerns

i. Assessment of:

1. Concern about finances

d. Living Arrangements:

i. Assessment of:

1. Access to care

2. Access to caregiver

e. Insurance Status:

i. Review of:

1. Insurance coverage

2. Prescription coverage

3. Preauthorization

f. Substance Abuse:

i. Assessment of:

1. Past/current substance abuse

2. Last use

g. Referrals as indicated

D. Patient/Caregiver Education Elements of Documentation

a. Assessment of:

i. Preferred learning styles (ex. Written, verbal, etc.)

ii. Barriers to learning

iii. Person(s) being educated

b. Resources Provided:

i. Driven by institution or use of prepared materials

ii. Transplant and/or research consents

c. Key Teaching Requirements:

i. Transplant treatment plan (including schedule)

ii. Alternatives to transplant

iii. Risks/benefits to transplant

d. Response to Teaching:

i. Full understanding of teaching points

ii. Return Demonstration where applicable

Standard II. Product Preparation

A. Physical Elements of Documentation:

a. Constitutional:
    i. Assessment of:
        1. Vital Signs
        2. Pain
        3. Height/Weight
        4. Performance Status
        5. ADLs
        6. Fatigue
    ii. Allergies
    iii. Medication Reconciliation
b. Neurological:
    i. Assessment of:
        1. Level of Consciousness
c. HEENT:
    i. Assessment of:
        1. Visual impairment
        2. Oral exam
        3. Dysphagia
d. Cardiovascular:
    i. Assessment of:
        1. Heart sounds
        2. Edema
        3. Chest pain

4. Arrhythmias
5. Palpitations
6. Cyanosis

e. Pulmonary:

i. Assessment of:

1. Respiratory Sounds
2. Oxygen delivery
3. Cough
4. Sputum
5. Shortness of Breath
6. Dyspnea

f. Gastrointestinal/Nutrition:

i. Assessment of:

1. Nausea/vomiting
2. Hematemesis
3. Diarrhea/constipation
4. Nutritional and weight status
5. Altered taste sense

g. Genitourinary/Renal:

i. Assessment of:

1. Dysuria
2. Color of urine
3. Hematuria

4. Incontinence

h. Reproductive:

i. Review of:

1. Last Menstrual Period (if applicable)

i. Musculoskeletal:

i. Assessment of:

1. Range of Motion

2. Gait Function

3. Muscle Strength (+0-+5)

j. Dermatologic:

i. Assessment of:

1. Skin condition

2. Rashes

3. Ecchymosis

4. Incisional sites

k. Hematologic:

i. Review of:

1. Blood work (where applicable)

l. Structural Devices/Changes:

i. Assessment of:

1. Implanted devices/vascular access devices

m. Transplant Specific:

i. Transplant Informed Consent/Research Consents if applicable

ii. Stem cell source

iii. Donor type

iv. Cells collected

B. Psychologic Elements of Documentation:

a. Distress and Stressors:

i. Distress Assessment

ii. Stressors

b. Coping:

i. Assessment of:

1. Coping Mechanisms

c. Anxiety:

i. Assessment of:

1. Presence of anxiety

ii. Current treatment

d. Depression:

i. Assessment of:

1. Signs and symptoms of depression

2. Suicide screening

ii. Current treatment

e. Cultural/Spiritual

i. Assessment of:

1. Cultural/spiritual beliefs

2. Impact on plan of care

C. Social and Financial Elements of Documentation

a. Language:

i. Review of:

1. Use of interpreter (if applicable)

b. Advanced Directive

i. Review of:

1. Changes from baseline

c. Income Concerns:

i. Assessment of:

1. Changes from baseline

d. Living Arrangements:

i. Assessment of:

1. Changes from baseline

2. Living arrangements functional for performance status

e. Substance Abuse:

i. Assessment of:

1. Changes from baseline

f. Referrals as indicated

D. Patient/Caregiver Education Elements of Documentation

a. Assessment of:

i. Changes from baseline in:

1. preferred learning styles

2. Barriers to learning

3. Target of education

b. Resources Provided:

i. *Driven by institution or use of prepared materials*

c. Key Teaching Requirements:

i. Reinforcement of transplant treatment plan/schedule

ii. *Varies based on patient needs*

d. Response to Teaching:

i. Assessment of understanding of process

Standard III. Acute Transplant: Conditioning - Day +100

A. Physical Elements of Documentation

a. Constitutional:

i. Assessment of:

1. Vital Signs
2. Pain
3. Weight
4. Performance Status
5. ADLs
6. Fatigue

ii. Medication Reconciliation

b. Neurological:

i. Assessment of:

1. Level of Consciousness
2. Orientation

3. Headaches
4. Dizziness

c. HEENT:
    i. Assessment of:
        1. Oral exam/mucositis
        2. Dysphagia
        3. Visual Impairment
        4. Dry Eyes
        5. Epistaxis
        6. Tinnitus
        7. Hearing deficits

d. Cardiovascular:
    i. Assessment of:
        1. Heart sounds
        2. Edema
        3. Chest pain
        4. Arrhythmias
        5. Palpitations
        6. Cyanosis

e. Pulmonary:
    i. Assessment of:
        1. Respiratory Sounds
        2. Oxygen delivery

3. Pulse Oximetry
4. Cough
5. Sputum
6. Shortness of breath
7. Dyspnea

f. Gastrointestinal/Nutrition

i. Assessment of:

1. Nausea/vomiting
2. Hematemesis
3. Diarrhea/constipation
4. Stool output
5. Abdominal cramping
6. Nutrition and weight status
7. Altered Taste Sense

ii. Review of:

1. Liver function tests
2. Graft Versus Host Disease (GVHD) grade and stage where applicable

g. Genitourinary/Renal:

i. Assessment of:

1. Dysuria
2. Color of Urine
3. Hematuria

4. Incontinence

h. Reproductive:

i. Assessment of:

1. Presence of/absence of menstrual period (where applicable)

i. Musculoskeletal:

i. Assessment of:

1. Range of motion
2. Gait
3. Muscular Strength (+0-+5)

j. Dermatologic:

i. Review of

1. Skin condition
2. Rashes
3. Ecchymosis
4. Papules
5. Pruritus
6. Palmar Plantar Erythrodysesthesia (PPE)
7. Nail changes

ii. Review of:

1. GVHD stage and grade (where applicable)

k. Hematologic:

i. Assessment of:

1. Blood Transfusion reactions (if applicable)

ii. Review of:

1. Blood work profile
2. Blood type

l. Immunologic:

i. Review of:

1. Presence or absence of known local or systemic infection

m. Structural:

i. Assessment of:

1. Implanted devices/vascular access devices
2. Indication for device

n. Malignancy

i. Verification of: (where applicable)

1. Disease status (via Bone marrow biopsy, lumbar puncture, PET/CT, MRI, bone scan, immunoglobulins, tumor markers if applicable

o. Transplant Specific:

i. Stem cell source

ii. Donor type

iii. Day of transplant

iv. Review of:

1. Engraftment analyses

B. Psychologic Elements of Documentation

a. Distress and Stressors

i. Assessment of:

1. Distress

2. Quality of life

3. Stressors

b. Coping:

i. Assessment of:

1. Coping mechanisms

c. Anxiety:

i. Assessment of:

1. Presence of anxiety

ii. Current treatment

d. Depression:

i. Assessment of:

1. Signs and symptoms of depression

ii. Current treatment

e. Cultural/Spiritual:

i. Review of:

1. Impact on plan of care

2. Requests for spiritual care services

C. Social and Financial Elements of Documentation:

a. Language:

i. Review of:

1. Use of interpreter (if applicable)

b. Advance Directive:
    i. Review of:
        1. Changes from baseline
        2. Goals of care discussions
c. Income Concerns:
    i. Assessment of:
        1. Changes from baseline
d. Living Arrangements:
    i. Assessment of:
        1. Changes from baseline
        2. Living arrangements functional for performance status
e. Insurance Status:
    i. Assessment of:
        1. Changes from baseline
f. Substance Abuse:
    i. Assessment of
        1. Changes from baseline
g. Referrals as indicated

D. Patient/Caregiver Education:
a. Preferred Learning styles:
    i. Assessment of changes from baseline in:
        1. Preferred learning styles
        2. Barriers to learning

3. Target of education

b. Resources Provided;

i. Driven by institution or use of prepared materials

c. Key Teaching Requirements:

i. *Varies based on patient status*

d. Response to Teaching:

i. *Varies based on patient status*

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

A. Physical Elements of Documentation

a. Constitutional:

i. Assessment of:

1. Vital Sign
2. Pain
3. Weight
4. Performance Status
5. ADLs
6. Fatigue

ii. Allergies

iii. Medication Reconciliation

b. Neurological:

i. Assessment of:

1. Level of Consciousness
2. Headaches

3. Dizziness
4. Cognitive function

c. HEENT:
   i. Assessment of:
      1. Oral exam/Mucositis
      2. Dysphagia
      3. Visual Impairment
      4. Dry Eyes
      5. Epistaxis
      6. Tinnitus
      7. Hearing deficits

d. Cardiovascular:
   i. Assessment of:
      1. Heart sounds
      2. Edema
      3. Chest pain
      4. Arrhythmias
      5. Palpitations
      6. Cyanosis

e. Pulmonary:
   i. Assessment of:
      1. Respiratory Sounds
      2. Oxygen delivery

3. Pulse oximetry
4. Cough
5. Sputum
6. SOB
7. Dyspnea

f. Gastrointestinal/Nutritional:

i. Assessment of:

1. Nausea/vomiting
2. Hematemesis
3. Diarrhea/constipation
4. Stool output
5. Abdominal cramping
6. Nutritional/weight status
7. Taste changes

ii. Review of:

1. Liver function testes
2. GVHD grade/stage

g. Genitourinary/Renal:

i. Assessment of:

1. Dysuria
2. Urine Color
3. Hematuria
4. Incontinence

h. Reproductive:

i. Review of:

1. Presence of sexual dysfunction/dissatisfaction

i. Musculoskeletal:

i. Assessment of:

1. Range of Motion
2. Gait
3. Presence of steroid-induced myopathy

j. Dermatologic:

i. Assessment of:

1. Skin breakdown
2. Rashes
3. Papules
4. Dryness
5. Pruritus
6. PPE
7. Nail changes

ii. Review of:

1. GVHD stage/grade

k. Hematologic:

i. Assessment of:

1. Transfusion reactions

ii. Review of:

1. Blood work profile
2. Blood type
3. Engraftment analysis

l. Immunologic:

i. Review of:

1. Presence/absence of local or systemic infection
2. Engraftment analysis

m. Structural Devices/Changes:

i. Assessment of:

1. Implanted devices/vascular access devices
2. Indications for devices

n. Malignancy:

i. Verification of (where applicable):

1. Disease status (via bone marrow biopsy, lumbar puncture, PET/CT, MRI, bone scan, immunoglobulins, tumor markers)

o. Transplant Specific:

i. Stem cell source

ii. Donor type

iii. Day of transplant

B. Psychologic Elements of Documentation:

a. Distress and Stressors:

i. Assessment of:

1. Distress scale

2. Quality of life
3. Stressors

b. Coping:

i. Assessment of:

1. Coping mechanisms

c. Anxiety:

i. Assessment of:

1. Presence of anxiety
2. Current treatment

d. Depression:

i. Assessment of:

1. Signs and symptoms of depression
2. Current treatment

e. Cultural/Spiritual:

i. Review of:

1. Impact on plan of care

C. Social and Financial Elements of Documentation:

a. Language:

i. Review of:

1. Use of interpreter if applicable

b. Advance Directive:

i. Assessment of:

1. Changes to baseline

2. Goals of care discussions

c. Income Concerns:

i. Assessment of:

1. Changes to baseline

d. Living Arrangements:

i. Assessment of:

1. Changes to baseline

2. Living arrangements functional for performance status

e. Insurance Status:

i. Assessment of:

1. Changes to baseline

f. Substance Abuse:

i. Assessment of:

1. Changes to baseline

g. Referrals as indicated

D. Patient/Caregiver Education

a. Assessment of changes from baseline in:

i. Preferred learning styles

ii. Barriers to leaning

iii. Target of education

b. Resources Provided:

i. Driven by institution or use of prepared materials

c. Key Teaching Points:

i. *Varies based on patient status*

d. Response to Teaching:

i. *Varies based on patient status*

References:

Ezzone, S.A. (2013). *Hematopoietic Stem Cell Transplantation: A Manual for Nursing Practice.* Oncology Nursing Society: Pittsburgh, PA.

Surgical Documentation Standards

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

Standard I. Patient History Documentation Standards

A. Physical Elements of Documentation

a. General:

i. Verification of:

1. Medical/Surgical history

a. Relevant to cancer site/surgical plan

2. Prior Cancer Treatment

3. Family Medical History

4. Surgical consent

5. Clinical trial work-up and consent if applicable

ii. Review of:

1. Preoperative imaging as appropriate

2. Preoperative laboratory values as appropriate

b. Constitutional:

i. Assessment of:

1. Vital Signs

2. Height/Weight/Body Surface Area

3. Performance Status

4. Pain

5. Use of Assistive devices (ex. Cane, walker)

6. Sleep/wake patterns

ii. Medication Reconciliation

iii. Allergies

c. Neurologic:

i. Assessment of:

1. Level of consciousness

2. Orientation

3. Sensory/motor function

4. Cranial nerve function

5. Central or peripheral neurologic symptoms

d. HEENT:

i. Assessment of:

1. Use of assistive devices (ex. glasses/contacts, hearing aids)

e. Cardiovascular:

i. Review of:

1. ECG
2. Echo if applicable
3. Stress test
4. Doppler studies
5. Chest x-ray

f. Pulmonary:

i. Verification of:

1. Smoking history
2. Exposure to second had smoke/inhalants
3. History of pleural effusions
4. History of pneumonia

ii. Review of:

1. Pulmonary function tests
2. Staph aureus nasal screen
3. Initiation of mupirocin if positive staph screen

g. Gastrointestinal/Nutritional

i. Assessment of:

1. Risk for nausea and vomiting
2. Nutritional status
3. Bowel function

h. Genitourinary/Renal:
    i. Review of:
        1. Urinalysis
        2. Bladder function
i. Musculoskeletal:
    i. Assessment of:
        1. Mobility
        2. Assistive devices
        3. Functional status
        4. ADLs
        5. Fall Risk
j. Dermatologic:
    i. Assessment of:
        1. Risk for impaired wound healing
        2. Stomas
k. Hematologic/Lymphatic:
    i. Assessment of:
        1. Edema
l. Immunologic:
    i. Assessment of:
        1. Risk for infection
        2. Presence/absence of known infection
m. Structural Devices/Changes

i. Assessment of:

1. External tubes
2. Stents
3. Drains
4. Implanted devices
5. Venous access device

n. Malignancy

i. Verification of:

1. Cancer type and stage (if known at time of surgical intervention)
2. Pathology reports if applicable

B. Psychological Elements of Documentation

a. General:

i. Verification of:

1. Psychological history (anxiety disorders, depression, bipolar disorder, etc.)
2. Prior treatment for psychologic disorders

b. Distress and Stressors:

i. Assessment of:

1. Distress (may use distress assessment scale)
2. Current Stressors
3. Caregiver Support

c. Coping

i. Assessment of:

1. Coping mechanisms

d. Anxiety:

i. Assessment of:

1. Symptoms of anxiety

ii. Current treatment

e. Depression:

i. Assessment of:

1. Signs/symptoms of depression

2. Suicide Risk

ii. Current treatment

f. Cultural/Spiritual:

i. Assessment of:

1. Cultural preferences and beliefs

2. Impact on plan of care

C. Social and Financial Elements of Documentation

a. Language

i. Assessment of:

1. Primary Language

2. Need for interpreter

3. Health literacy

b. Advance Directive

i. Verification of:

1. Presence of advance directives, durable power of attorney, decision makers
2. DNR status

c. Income Concerns

i. Assessment of:

1. Potential interruption or loss of income

d. Living Arrangements

i. Assessment of:

1. Living arrangements appropriate for post-operative care/functional status

e. Insurance Status:

i. Verification of:

1. Insurance coverage

f. Substance Abuse

i. Assessment of:

1. Past/current substance abuse
2. Last use
3. Effect on future pain management

g. Referrals as indicated

D. Patient/Caregiver Education Elements of Documentation

a. Assessment of:

i. Preferred learning styles

ii. Barriers to learning

iii. Targets of education

iv. Ability of patient/caregiver to follow pre and post operative instructions

b. Resources Provided – driven by institutional materials/policies and type of surgical intervention

c. Key Teaching Elements – driven by type of surgical intervention

i. Expected surgical procedure

ii. Pre-operative care

iii. Post-operative care

d. Response to Teaching:

i. Accurate verbalization and/or teach back demonstration

ii. Appropriate questions/caregiver involvement

E. Coordination of Care:

a. Hand off communication if applicable

Standard II. Pre-Operative Assessment Documentation Standards

A. Physical Elements of Documentation

a. General:

i. Surgical consent

ii. Assessment of:

1. Changes from baseline assessment

2. Preoperative laboratory values

iii. Verification of:

1. Preoperative imaging if applicable

b. Constitutional:

i. Assessment of:

1. Vital Signs
2. Pain Assessment
3. Changes from baseline

c. Neurological:

i. Assessment of:

1. Changes from baseline assessment
2. Findings that may delay or alter surgery

d. HEENT:

i. Assessment of:

1. Oral exam
2. Dry mouth
3. Dysphagia
4. Epistaxis
5. Sinus Pain
6. Visual Impairment
7. Ototoxicity
8. Changes to baseline
9. Findings that may delay or alter surgery

e. Cardiovascular:

i. Assessment of:

1. Heart sounds
2. Edema

3. Arrhythmias
4. Palpitations
5. Chest Pain
6. Claudication
7. Venous ulcers
8. Cyanosis/pallor
9. Changes from baseline
10. Findings that may delay or alter surgery

f. Pulmonary:

i. Verification of:

1. Staph aureus nasal screen

ii. Assessment of:

1. Respiratory sounds
2. Oxygen delivery
3. Dyspnea
4. Cough
5. Pulse oximetry
6. Hemoptysis
7. Use of oxygen
8. Smoking status
9. Changes from baseline
10. Findings that may delay or alter surgery

g. Gastrointestinal/Nutritional:

i. Assessment of:

1. Changes to baseline

2. Findings that may delay or alter surgery

h. Genitourinary/Renal:

i. Assessment of:

1. Changes from baseline

2. Findings that may delay or alter surgery

i. Musculoskeletal:

i. Assessment of:

1. Changes from baseline

2. Findings that may delay or alter surgery

j. Dermatologic:

i. Assessment of:

1. Changes from baseline

2. Findings that may delay or alter surgery

k. Endocrine:

i. Assessment of:

1. Changes from baseline

2. Glycemic control if applicable

l. Hematologic/Lymphatic:

i. Assessment of:

1. Changes from baseline

2. Findings that may delay or alter surgery

m. Immunologic:

i. Assessment of:

1. Changes from baseline

2. Findings that may delay or alter surgery

n. Structural Devices/Changes

i. Assessment of:

1. Changes from baseline

2. Findings that may delay or alter surgery

B. Psychologic Elements of Documentation

a. Distress and Stressors

i. Changes from baseline assessment

ii. Distress assessment

iii. Clarification of concerns

b. Coping:

i. Changes from baseline assessment

ii. Effectiveness of coping mechanisms

c. Anxiety:

i. Changes from baseline assessment

d. Depression:

i. Changes from baseline assessment

e. Cultural/Spiritual:

i. Changes from baseline assessment

ii. Influences on plan of care

C. Social and Financial Elements of Documentation

a. Language:

i. Need for Interpreter

b. Advance Directives

i. Changes from baseline assessment

ii. Immediate concerns

iii. Availability of documents

c. Income Concerns:

i. Immediate concerns

d. Living Arrangements:

i. Immediate concerns

e. Insurance Status:

i. Immediate concerns

f. Substance Abuse:

i. Immediate concerns

ii. Potential for post-operative withdrawal

iii. Potential for alterations in pain management

g. Referrals as indicated

D. Patient/Caregiver Education

a. Assessment of:

i. Preferred learning style

ii. Barriers to learning

iii. Target of education

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

c. Key Teaching Requirements:

i. Expected procedure

ii. Risks and benefits of procedure

iii. Short and long term outcomes expected

iv. Anticipated side effects of anesthesia/surgery

v. Logistics on day of surgery

vi. Pain management planning

vii. Post-operative care and management

viii. Nutritional support planning

d. Response to Teaching

i. Concerns raised by patient/family

ii. Immediate concerns

iii. Understanding/teach back demonstration if appropriate

E. Coordination of Care

a. Hand-off communication if applicable

Standard III. Immediate Post-Anesthesia Documentation Standards

A. Physical Elements of Documentation

a. Constitutional:

i. Medication administration

ii. Assessment of:

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

2. Pain
3. Response to medication or symptom management intervention

b. Neurological:
    i. Assessment of:
        1. Level of consciousness
        2. Orientation
        3. Sensory/motor function
        4. Cranial nerve function

c. HEENT:
    i. Change in baseline assessment

d. Cardiovascular:
    i. Assessment of:
        1. Airway, breathing & circulation
        2. Circulatory and cardiac function

e. Pulmonary:
    i. Assessment of:
        1. Pulmonary function
        2. Oxygen delivery
        3. Respiratory sounds
        4. Pulse oximetry

f. Gastrointestinal/Nutritional:
    i. Assessment of:
        1. Bowel function

2. Bowel sounds

ii. NPO status

iii. Nasogastric tube if applicable

g. Genitourinary/Renal:

i. Assessment of:

1. Renal function

2. Urinary output

3. Urine color

h. Musculoskeletal:

i. Assessment of:

1. Musculoskeletal function *(If assessment appropriate based on surgical intervention and post-operative plan*)

i. Dermatologic:

i. Assessment of:

1. Surgical site

a. Incision/drain location and appearance

j. Endocrine:

i. Assessment of:

1. Glycemic control if indicated

k. Hematologic/Lymphatic:

i. Assessment of:

1. Coagulation status

2. Edema

3. Thromboembolic stocking/sequential compression devices in use

l. Structural Devices/Changes

i. Assessment of:

1. Tubes/drains

2. Stents

3. Implanted Devices

4. Venous access devices

B. Psychologic Elements of Documentation

a. Distress and Stressors

i. Immediate concerns

ii. Referrals as needed

b. Coping

i. Immediate concerns

ii. Referrals as needed

c. Anxiety

i. Immediate concerns

ii. Referrals as needed

d. Depression

i. Immediate concerns

ii. Referrals as needed

e. Cultural/Spiritual

i. Immediate concerns

ii. Referrals as needed

C. Social and Financial Elements of Documentation

a. Language:

i. Need for interpreter

b. Advanced Directive:

i. Assessment of

1. Status changes

2. Immediate concerns

c. Referrals as indicated

D. Patient/Caregiver Education Elements of Documentation

a. Assessment of:

i. Barriers to learning

ii. targets of education

b. Key Teaching Requirements:

i. Immediate post-operative care

ii. short and long term outcomes

iii. Management of side effects

iv. Care of incision/drains

v. Pain management plan

vi. medication schedule

vii. Contact information for questions

viii. Nutritional plan initiation

ix. follow up appointment schedule

c. Resources provided – driven by institutional materials

d. Response to Teaching:

i. Concerns of patient/caregiver

ii. Accurate verbalization and/or teach back demonstration

iii. Appropriate questions/caregiver involvement

E. Coordination of Care:

a. Hand-off communication

Standard IV. Post-Operative Follow-Up

A. Physical Elements of Documentation

a. General:

i. Changes from baseline assessment/medical history

b. Constitutional:

i. Assessment of:

1. Return to functional baseline

2. Pain

ii. Medications

iii. Response to medication or symptom management intervention

c. Neurological:

i. Assessment of:

1. Return to functional baseline

d. HEENT:

i. Assessment of:

1. Return to functional baseline

e. Cardiovascular:

i. Assessment of:

1. Return to functional baseline

2. Circulatory and cardiac function

f. Pulmonary:

i. Assessment of:

1. Return to functional baseline

2. Pulmonary function

3. Smoking status

4. Cessation strategies if applicable

g. Gastrointestinal/Nutritional:

i. Assessment of:

1. Return to functional baseline

h. Genitourinary/Renal:

i. Assessment of:

1. Return to functional baseline

i. Musculoskeletal:

i. Assessment of:

1. Return to functional baseline

j. Dermatologic:

i. Assessment of:

1. surgical incision/wound

ii. Removal of drains/tubes if applicable

k. Endocrine:

i. Assessment of:

1. Return to functional baseline

l. Hematologic/Lymphatic:

i. Assessment of:

1. Return to functional baseline

m. Immunologic:

i. Absence/presence of known infection

n. Structural Changes/Devices:

i. Assessment of:

1. Tubes/drains

2. Stents

3. Implanted devices

4. Venous access devices

o. Malignancy:

i. Verification of:

1. Cancer type and stage if known

2. Pathology reports if applicable

B. Psychological Elements of Documentation

a. Distress and Stressors

i. Assessment of:

1. Changes from baseline

2. Distress scale

3. Current stressors

b. Coping

i. Assessment of:

1. Effectiveness of coping mechanisms

c. Anxiety

i. Assessment of:

1. Changes from baseline

2. Current signs and symptoms of anxiety

d. Depression

i. Assessment of:

1. Changes from baseline

2. Current signs and symptoms of depression

e. Cultural/Spiritual

i. Assessment of:

1. Changes from baseline

C. Social and Financial Elements of Documentation

a. Language

i. Need for interpreter if applicable

b. Advance Directive

i. Changes in advance directive status

ii. Goals of Care conversations

c. Income Concerns

i. Change from baseline assessment

d. Living Arrangements

i. change from baseline assessment

ii. Need for long-tern use of appliances or durable medical equipment

iii. Need for PT/OT

e. Insurance Status

i. Changes from baseline assessment

f. Substance Abuse

i. New or current abuse

ii. Presence of withdrawal symptoms

iii. Alterations in pain management plan

g. Referrals as indicated

D. Patient/Caregiver Education

a. Assessment of:

i. Preferred learning style

ii. Barriers to learning

iii. Targets of education

b. Key Teaching Requirements:

i. Surveillance recommendations

ii. Anticipated early and late effects

iii. Follow-up schedule

iv. Side effect and/or pain medication management

v. Nutrition management plan

vi. Specific concerns of patient/caregiver

c. Response to Teaching:

i. Accurate verbalization and/or teach back demonstration

ii. Appropriate questions/caregiver involvement

E. Coordination of Care:

a. Hand off communication if applicable

References:

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

Venous Access Device Documentation Standards

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

Standard I. Prior to Insertion Elements for Documentation

A. Process/Verification of Informed consent (if applicable)

B. Assessment of:

    a. Indication for Device

    b. Anticipated duration of therapy

    c. Any prior central access device history or problems

    d. Pertinent laboratory results prior to insertion (if applicable)

C. Patient/Caregiver Education

    a. Assessment of preferred learning styles (written, verbal etc.)

    b. Barriers to learning

    c. Target of education (patient/caregiver)

    d. Resources Provided

        i. Driven by institutional-specific materials

    e. Key Teaching Points:

        i. Rationale for venous access device placement

ii. Risks/benefits

f. Patient/Caregiver response to teaching

i. Verbalization of understanding

Standard II. Venous Access Device Insertion Elements for Documentation

A. Date, time and setting of insertion

B. Specific site preparation to prevent complication and infection

C. Location of insertion site (specify vein) and ability to flush

D. Type, Length, and gauge/size of venous access device inserted as appropriate

E. Manufacturer lot/serial number as appropriate

F. Number of attempts

G. Identification of insertion site by anatomical descriptors, laterality, landmarks, or drawing (if indicated)

H. Insertion assistance methodology (ie. Visualization and guidance technology) if indicated

I. Complications during insertion procedure

J. Methods used to secure devices; type of dressing used

K. Confirmation of catheter placement/anatomic location if appropriate prior to use (ex. Chest X-ray)

L. For Midlines and PICCS: external catheter length and effective length of catheter inserted

M. Name and credentials of clinician performing insertion

Standard III. Venous Access Device Utilization

A. Use of Venous Access Device Elements for Documentation

a. Method to evaluate proper function of device prior to use

b. Date and time of therapy initiation

c. Solution being infused (ex. Medication, intravenous fluid type etc.)

d. Drug name and dose

e. Infusion rate

f. Complications noted with use (signs/symptoms of extravasation, phlebitis, infiltration)

g. Name of provider notified of complication if indicated

h. Strategies to manage complications if indicated

B. Assessment of Venous Access Device Elements for Documentation

a. Date and time of assessment

b. Catheter insertion and exit site appearance/condition of site

c. Presence of drainage

d. Condition of device (ex. Intact, cracked, leaking etc.)

e. Presence of a antimicrobial patch if indicated

f. Type of stabilization (ex. Sutures, Stat-lock etc.)

i. If joint stabilization is required – periodical removal for assessment of circulatory status, range of motion and skin integrity

g. Condition and type of dressing

h. Assessment of indication for device

i. Subjective patient data (discomfort, pain, changes, pruritus, etc.)

C. Care and Maintenance of Venous Access Device Elements for Documentation

a. Dressing change

i. type of dressing applied

ii. procedure used

b. Flushing procedure

i. type(s) of flush solution used,

ii. Volume of flush

iii. Difficulty/ease of flushing

c. Cap change

i. Type of cap

ii. Abnormalities in cap appearance

iii. Function of cap

d. Blood withdrawal

i. procedures used

ii. devices used

iii. volume withdrawn

e. Use of clamps on the device or extension tubing if indicated

D. Patient/Caregiver Education Elements of Documentation

a. Preferred learning styles

b. Barriers to learning

c. Targets of education

d. Resources provided – driven by institutional-specific materials

e. Key Teaching Points:

i. Continued rationale for device

ii. Signs and symptoms of complications to report

iii. Procedures for line care maintenance if applicable

f. Response to Teaching

i. Verbalization of understanding

ii. Demonstration of care and maintenance of device if applicable

iii. Barriers to patient/caregiver education

Standard IV. Venous Access Device Removal

A. Indication for Removal

B. Date and time of device removal

C. Type of Device removed

D. Procedure used for removal and observations of complications during removal

E. Condition of device after removal (ex. Intact vs, cracked)

F. Length of device after removal (if indicated)

G. Condition of site post-removal

H. Dressing applied to site

I. Cultures obtained from site

J. Patient/Caregiver Education

a. Preferred learning style

b. Barriers to learning

c. Target of Education

d. Resources Provided – driven by institution-specific materials

e. Key Teaching Points

i. Rationale for removal

ii. Post removal complications

iii. Signs and symptoms to report to provider

f. Response to Teaching

i. Verbalization of Understanding

ii. Barriers to patient/caregiver education

References

Camp-Sorrell, D. (2012). Access Device Guidelines: Recommendations for Nursing Practice and Education (3rd ed). Oncology Nursing Society: Pittsburgh, PA

Infusion Nurses Society. (2016). Infusion Therapy Standards of Practice. *Journal of Infusion Nursing*, *39*(1S)

Blood Product Transfusion Documentation Standards

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

Standard I. Prior to Transfusion

A. Documentation of confirmation of informed consent

B. Validation of active type and cross

C. Blood Product Transfusion Details

   a. Confirmation of clinical data/patient symptoms necessitating transfusion

   b. Confirmation of product compatibility with patient blood type with a second competent practitioner

D. Tolerance of Blood Product Transfusion

   a. Administration of premedications as ordered

   b. Baseline vital signs with pulse oximetry

   c. Factors known to increase risk for transfusion reactions: antibodies, frequent transfusions, autoimmune disorder(s) etc.

E. Infusion Site

   a. Type of IV access device

b. Location of IV access device

c. Size/gauge of IV access device

F. Patient/Caregiver Education

a. Assessment of learning preferences (ex. Verbal, written etc.)

b. Barriers to Learning

c. Target of education (ex. Patient/caregiver etc.)

d. Resources Provided (Driven by institutional materials, patient preference)

e. Key Teaching Points:

i. Indication for transfusion

ii. Signs and Symptoms of transfusion reaction to report

f. Response to Teaching

Standard II. During Blood Product Transfusion

A. Blood Product Transfusion Details

a. Product and number of units being transfused

b. Date of transfusion

c. Start time of transfusion

d. Rate of product transfusion

e. Use of filtered tubing

f. Need for use of blood warmer or special filters or electronic infusion device

B. Tolerance of Blood Product Transfusion*

a. Vital signs with pulse oximetry

b. Assessment of Pulmonary System: (respiratory sounds, shortness of breath, tachypnea, dyspnea and other signs and symptoms as appropriate)

c. Assessment of Cardiovascular System: (chest pain, tachycardia and other signs/symptoms as appropriate

d. Assessment of Urologic/Renal System: (flank pain, hematuria and other signs/symptoms as appropriate

e. Assessment of Dermatologic System: (pruritus, rash, urticaria, and other signs/symptoms as appropriate

f. Assessment of presence of chills and/or rigors

g. Name of provider notified of intolerance of transfusion

C. Infusion Site

a. Assessment of signs and symptoms of infiltration*

b. Infusion site, clean dry and intact*

D. Patient/Caregiver Education

a. Key Teaching Points

i. Reinforcement of signs and Symptoms of transfusion reaction

b. Patient/Caregiver response to teaching

Standard III. Post Blood Product Transfusion

A. Blood Product Transfusion Details

a. Date of product stopped/completed

b. Time of product stopped/completed

c. Volume of blood product infused

d. Estimated amount of product returned to blood bank (if applicable)

B. Tolerance of Blood Product Transfusion

a. Vital signs with pulse oximetry *

b. Assessment of Pulmonary System: (respiratory sounds, shortness of breath, tachypnea, dyspnea and other signs and symptoms as appropriate)

c. Assessment of Cardiovascular System: (chest pain, tachycardia and other signs/symptoms as appropriate

d. Assessment of Urologic/Renal System: (flank pain, hematuria and other signs/symptoms as appropriate

e. Assessment of Dermatologic System: (pruritus, rash, urticaria, and other signs/symptoms as appropriate

f. Assessment of presence of chills and/or rigors

g. Name of provider notified of intolerance of transfusion

C. Patient/Caregiver Education

a. Key Teaching Points

i. Reinforcement of signs and symptoms of transfusion reaction

ii. Clinical data/signs that indicate efficacy of transfusion

b. Patient/Caregiver response to teaching

*Frequency of documentation during transfusion per institutional policy

References

Infusion Nurses Society. (2016). Infusion Therapy Standards of Practice. *Journal of Infusion Nursing*, *39*(1S).

The Joint Commission. (2011). Implementation Guide for The Joint Commission Patient Blood Management Performance Measures.

Extravasation Management Documentation Standards

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

Standard I. Time of Extravasation

A. Drug Administration

   a. Date and Time of Drug Initiation

   b. Drug Name

   c. Dilution/Concentration of extravasated agent

   d. Infusion Method (IV Piggyback, IV Push, etc.)

   e. Amount of drug administered prior to extravasation

   f. Blood Return present at start of infusion (or other confirmation of line patency)

   g. Process and frequency of line patency confirmation throughout drug administration

B. Venous Access Device and Insertion Site Assessment

a. Date and time extravasation noted

b. Type, size, gauge of intravenous device

c. Number of attempts for IV placement (If applicable)

d. Appearance of Insertion site

e. Presence/absence of blood return after extravasation

C. Interventions

a. Time infusion was stopped

b. Name of provider notified

c. Attempt to aspirate drug remaining in IV catheter

d. Removal of and appearance of IV cannula/port needle (if applicable)

e. Vital Signs

f. Pain medication administered

g. Topical Treatment applied (ex. Heat/ice)

h. Time topical treatment applied

i. Time topical treatment removed

j. Name and time of antidote administered (if applicable)

k. Consultations provided (plastic surgery, surgery, physical therapy etc.)

l. Attachment of photograph *(date and time photo taken in the photo field)*

m. Consent for site photography

n. Plan for Follow up/Return Appointments

D. Affected Limb/Skin Assessment

a. Vein affected

b. Color of affected limb/skin

c. Circumference measurement of affected limb (if applicable)
d. Pain at Rest (0-10 scale)
e. Range of Motion of affected limb
f. Pain with Range of Motion (0-10)
g. Patient-reported symptoms (burning, pain etc)
h. Presence of edema, induration, erythema, blisters/ulceration
i. Presence of necrosis
j. Measurement of affected area(s)
k. Appearance of wound bed if applicable (color, granulation, odor etc.

E. Patient/Caregiver Education
a. Patient/caregiver preferred learning style (written, verbal etc.)
b. Targets of Education (patient, caregiver(s) etc)
c. Resources Provided:
    i. Driven by institutional materials
d. Required Teaching Points
    i. Signs and symptoms of necrosis
    ii. ROM exercise to perform
    iii. Monitor temperature
    iv. Note blistering and sloughing of skin in affected area
    v. Signs and symptoms of which to alert provider
    vi. Topical care
    vii. Protect from sunlight
e. Response to Teaching

i. Patient/caregiver education

ii. Appropriate questions verbalized

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

A. Drug Documentation

a. Name of drug extravasated

b. Estimated amount of drug extravasated

B. Venous Access Device and Insertion Site Assessment

a. Function of catheter (if applicable)

C. Interventions

a. Consultations provided (plastic surgery, surgery, physical therapy, etc)

b. Vital Signs

c. Attachment of photograph if applicable *(date and time photo taken in the photo field)*

d. Consent for photography

e. Plan for Follow-up Return Appointments

D. Affected Limb/Skin Assessment

a. Vein in which drug was infused

b. Pain at rest (0-10)

c. Range of Motion of affected limb

d. Pain with Range of Motion (0-10)

e. Color of affected limb/skin

f. Circumference measurement if applicable

g. Patient-reported symptoms (burning, pain, etc.)

h. Presence of edema, induration, erythema, blisters/ulceration

i. Presence of necrosis

j. Measurement of affected areas

k. Appearance of wound bed if applicable (color, granulation, odor, etc)

l. Presence of sensory loss in affected area(s)

E. Patient/Caregiver Education

a. Targets of Education (patient, caregiver(s) etc.)

b. Resources Provided

i. Driven by institutional materials

c. Key Teaching Requirements

i. Signs and symptoms of necrosis

ii. ROM exercise to perform

iii. Monitor temperature

iv. Note blistering and sloughing of skin in affected area

v. Signs and symptoms of which to alert provider

vi. Topical care

vii. Protect from sunlight

d. Response to Teaching

i. Patient/Caregiver understanding

ii. Appropriate questions verbalized

References:

Camp-Sorrell, (2011). *Access Device Guidelines: Recommendations for Nursing Practice and Education (3rd ed).* Oncology Nursing Society: Pittsburgh, PA.

Gonzales, T. (2013). Chemotherapy Extravasations: Prevention, Identification, Management, and Documentation. *Clinical Journal of Oncology Nursing*, 17(1), 61-66.

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Polovich et al. (2014). *Chemotherapy and Biotherapy Guidelines and Recommendations for Practice* (4th ed). Oncology Nursing Society. Pittsburgh: PA

Sauerland, C. et al., (2006). Vesicant Extravasation Part 1: Mechanisms, Pathogenesis, and Nursing Care to Reduce Risk. *Oncology Nursing Forum*, 33(6), 1134-1141.