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MANITOBA RENAL PROGRAM

SUBJECT ▪ Renal Health/Hemodialysis/Peritoneal Dialysis Nursing Kardex Standard	**SECTION**	60.10 Standards - Kardexes
	CODE	60.10.01
AUTHORIZATION ▪ Professional Advisory Committee, Manitoba Renal Program	**EFFECTIVE DATE**	January 2003
	REVISION DATE	June 2010 November 2014 March 2017 October 2018

OBJECTIVE:

To outline the current care plan for standard and individual care requirements for the Renal Health and Hemodialysis patient.

The Nurse and Unit Clerk will document and maintain pertinent information on the Kardex using the standards set by the Manitoba Renal Program. The Kardex will become a mobile document used by the renal care team at the patient's home unit or clinic as well as any dialysis unit within the provincial program receiving the patient either temporarily or permanently.

STANDARDS:

1. The Renal Patient Kardex (60.10.01a *Appendix A form #W00195A*) is initiated when the patient begins appointment visits in the Renal Health clinics (CKD 4 & 5). This will follow the patients as they transition through the different treatment modalities.

2. The Hemodialysis Patient Kardex (60.10.01b *Appendix B form #W-00195B*) is initiated when a hemodialysis patient is deemed chronic.

3. The Peritoneal Dialysis Patient Kardex (60.10.01c Appendix C form #*W-00195c*) is initiated when a patient starts on peritoneal dialysis. Page 2 is completed if a patient is part of the Peritoneal Dialysis Community Care (PDCC) Program.

4. The addressographed Kardex is kept in front of the patient's dialysis chart or in designated binder as per unit policy.

5. The Kardex is to be reviewed by the Nurse assigned to the patient for that treatment or visit and used to transcribe orders to the hemodialysis treatment record, diagnostic requisitions, consults etc.

6. The Kardex will be updated as necessary.

7. All sections of the Kardex will be completed in pencil unless otherwise indicated.

8. The information on the Kardex will be reviewed by the nurse every 3 months or whenever a transfer or change of modality occurs.

9. For MRP sites with electronic Kidney Health Record (eKHR), the Patient Demographic Report will replace

certain sections of the Renal Patient Kardex. The report should be re-printed each time the information is updated and placed in front of the Kardex.

PROCESS:

PART I: RENAL PATIENT KARDEX (Appendix A)

A. Addressograph Space:

1. The Nurse/Unit Clerk will addressograph the Kardex for all Renal Health patients and place in front of the chart.

B. Patient Information:

1. The Nurse/Unit Clerk will indicate with a check the Advance Care Plan Status and the date of the assessment.

2. The Nurse/Unit Clerk will indicate the patient's allergies.

3. The Nurse/Unit Clerk will indicate with a check "yes" or "no" whether the patient is on isolation technique and write the indication.

4. The Nurse/Unit Clerk will write the date and results of the most recent MRSA and VRE swabs. If any other microbiology testing results requiring isolation are available they should be written next to "Other".

5. The Nurse/Unit Clerk will write in the time and date of the patient's next Renal Health, Peritoneal Dialysis (PD) or Home Hemodialysis clinic appointment if applicable.

6. The primary language interpreter will be filled in by the Nurse/Unit Clerk/Social Worker if applicable.

7. The treaty status will be filled in by the Nurse/Unit Clerk/Social Worker if applicable.

8. The Employment Income Assistance program number will be filled in by the Nurse/Unit Clerk/Social Worker if applicable.

9. Home Care services will be indicated by a "yes" or "no" check along with the name and phone number of the case coordinator or nurse.

C. Chronic Kidney Disease (CKD) History:

1. The Nurse/Unit Clerk will write in pen the site and date of the patient's first appointment or treatment in Renal Clinic, Hemodialysis and Peritoneal Dialysis as applicable.

D. Medical/Surgical History:

1. The Nurse/Unit Clerk will write in pen the primary renal diagnosis if known.

2. The Nurse/Unit Clerk will write in pen the patient's medical and surgical history in point form with dates.

3. The Nurse/Unit Clerk will write the dates of the last chest x-ray and EKG.

E. Erythropoietic Therapy:

1. The Nurse/Unit Clerk will indicate with a check and write the date started if the patient is on erythropoietic therapy.

2. The name of the person (family member or other) administering the drug will be written on the line provided.

3. If administered by a Home Care Nurse: the name, phone number and fax number of the nurse will be written.

F. Warfarin/Clopidogel:

1. If patient is on Warfarin or Clopidogrel, the Nurse/Unit Clerk will indicate with a check

2. If patient is on Warfarin, the Nurse will indicate the INR target range, the indication and the name of the physician following the INR if someone other than a Nephrologist.

G. Contact Information:

1. The Nurse/Unit Clerk will indicate the date of each update.

2. The Nurse/Unit Clerk will write the patient's permanent address, phone number, cell number and alternate phone number if available.

3. If a temporary address exits, it will be indicated along with the temporary phone number.

4. The Nurse/Unit Clerk will write the name of a contact person, their phone number and/or cell number.

5. If applicable, the Nurse/Unit Clerk will indicate the name of the patient's family physician, Health facility, Nursing Station, Lab and Pharmacy and each of their corresponding phone numbers and fax numbers.

H. Transportation:

1. The Nurse/Unit Clerk will indicate the mode of transportation the patient uses for appointments and treatments as well as the phone number and account number if applicable.

I. Allied Health:

1. The Nurse/Unit Clerk or corresponding Allied Health Professional will indicate their name and phone number on the designated line for each discipline.

J. Vaccinations:

1. The Nurse/Unit Clerk will write the most recent results and dates of the hepatitis B antigen and antibody level.

2. The Nurse will check the yes box once the first and if necessary the second immunization series is complete. Otherwise the no box will be checked. The date of completion will also be written. If the patient is immune after the first series, the N/A box will be checked next to second dose.

3. If a Booster dose is ordered, the date given will be recorded.

4. The nurse will circle the word non-responder if applicable.

5. The date of the last two pneumococcal vaccines will be recorded if applicable.

6. The Nurse will write the results and dates of the two step Mantoux.

7. The date of the last influenza vaccine will be recorded if applicable.

K. Renal Education Summary:

1. The Renal Health Nurse will indicate with a check, the type of education provided to the patient and the dates of the education. If any specific education given that isn't listed, it may be added to the "Other Information" line.

2. If the patient begins renal replacement therapy without education, the Hemodialysis Nurses or Peritoneal Dialysis Nurses (PD) may update this information also.

L. Modality Assessment and Planning:

1. The Renal Health, Hemodialysis or Peritoneal Dialysis Nurse will indicate the type, dates and location of each modality assessment.

2. As each assessment progresses, a check is placed in the Accepted: yes, no or pending box for each modality.

M. Vascular Access Planning:

1. The Vascular Access Nurse in Renal Health clinic will indicate the date of the original consult to the Vascular Surgeon and once known, the type of access planned is checked.

2. Once the access is created, the date is recorded and the name of the surgeon.

N. Appointments/Consults:

1. The Nurse/Unit clerk will record all Renal related appointments and consults along with the date of the requisition and once known the dates of the appointment and the report received..

2. The Nurse will indicate with "yes" or "no" once the attendance can be confirmed.

3. All upcoming appointments/consults will be recorded in the remaining space. Once all rows have been filled, older appointments at the top can be erased to make room for more.

PART II: HEMODIALYSIS PATIENT KARDEX (Appendix B)

A. Addressograph Space:

1. The Unit Clerk will addressograph the Kardex for all chronic hemodialysis patients and place in front of the chart.

B. Dialysis Prescription:

The Nurse/Unit Clerk will:

1. Transcribe the treatment schedule by checking the treatment days, schedule and indicating the number of treatments per week.

2. Transcribe the prescribed dialyzer.

3. Transcribe the number of diffusion hours and isolated ultrafiltration (ISO) time on the appropriate line.

4. Transcribe the prescribed K^+, Ca^{++}, glucose and bicarbonate levels of the dialysate.

5. The nurse will indicate the acid concentrate manufacturer code corresponding to the above acid concentrate parameters.

6. Transcribe the dialysate flow rate and temperature.

7. Transcribe the sodium profile number as #1, #2 or #3 if ordered and start sodium if ordered.

8. Transcribe the Ultrafiltration (UF) profile as #1, #2 or #3 if ordered or indicate with a check mark if UF Control is to be used

The Nurse will:

9. If applicable, record the critical relative blood volume (RBV) %, the maximum UF rate and the goal KT/V based on trended values from the Hemodialysis Flowsheet and Hemodialysis Treatment Record.

10. Record the calculated urea distribution volume (V- urea) using Watson Formula and date of calculation along with the patient's height, weight and amputations used to calculate that value. This should be reviewed annually and with any dry weight changes or amputations.

C. Anticoagulation:

1. The Nurse/Unit Clerk will indicate with a "yes" or "no" check if Heparin is given during treatment. If "no" the reason why and a date of reassessment if applicable will be indicated. The date of the order is also recorded.

2. The Nurse/Unit Clerk will transcribe the heparin prime (initial bolus), hourly infusion rate in units, and stop time in minutes.

3. If 0.9% NaCl flushes are required the Nurse will check "yes" as either "Flushes" or "Continuous infusion" and indicate the frequency and volume.

D. Fluid Management:

1. The Nurse/Unit Clerk will transcribe ordered dry weight along with the date.

2. The Nurse will record any weight deductions, i.e. shoes, wheelchairs etc.

3. The Nurse will indicate the reinfusion volume.

E. Blood Specimens:

1. The Nurse will indicate frequency of glucose monitoring if applicable by checking appropriate intervals.

2. If patient on Warfarin, the Nurse/Unit Clerk will record INR due date.

3. If other reoccurring or non-reoccurring tests ordered, indicate next to "Other", i.e. Digoxin level every 2 weeks.

F. Treatment Reminders/Patient Care Issues:

1. The nurse will indicate any special instructions or reminders to be followed up during treatment (i.e. One can Ensure during dialysis).

2. The Nurse will indicate any specific patient care issues that need follow-up.

G. Wound and Skin Management:

1. The Nurse will indicate the date of the last Braden Scale risk assessment and the date it is due according to the facility policy.

2. The nurse will record the Risk Assessment Score and the Recommendations based on that score.

3. If applicable, the nurse will record the date of the last Wound Photos and date due.

4. The nurse will record the date of the last foot assessment, the date due based on facility policy and the recommendations based on the latest assessment.

5. If applicable, the nurse will record the current Wound care instructions either as prescribed by a wound care clinician or as recommended by a nurse.

H. Recopied Date:

1. Each time a Hemodialysis Nursing Kardex Part 2 is recopied, the nurse will indicate the date the recopying was completed, sign and print their name in ink. A second nurse must double-check all information, sign and print their name in ink

I. Vascular Access:

1. The Nurse will indicate with a check if patient's has either AVF or AVG and write the location. Place a check in the appropriate box, either radio-cephalic (RC), brachio-cephalic (BC), basilic vein transposition (BVT). Other types will need to be indicated in long hand on the "other" line.

2. The Nurse/Unit Clerk will write the date fistula created, and the anticipated date of maturation based on facility policy and record surgeon's name.

3. The Nurse will indicate with a check if patient has an AVF with a buttonhole. If yes, record the date each site was initiated by the primary cannulator and the dates each site was ready for multiple cannulators.

4. Next to "Comments/Instructions" the Nurse will provide clear and concise recommendations or instructions regarding cannulation or care of the fistula.

5. The Nurse will indicate the type and size of needles used and the type of local anaesthetic if required by the patient

6. The Nurse will record any special site care that is indicated for the patient i.e. chlorhexidine, no povidone, Mefix.

7. The Nurse will indicate the type of bandage used post treatment for haemostasis and the time required to hold if greater than 10 minutes.

8. Whenever an angioplasty of the fistula is performed, the date of the procedure will be recorded.

9. The Nurse will draw a diagram of the fistula using operative record if available and indicate flow path, identify problem areas of fistula and write any helpful comments.

10. The Nurse will record the date of insertion whenever a new hemodialysis central venous catheter (CVC) is inserted or exchanged.

11. The Nurse will indicate with a check whether the central venous catheter (CVC) is tunnelled or non-tunnelled and record the name of physician that performed the procedure. If a second central line access is present, record in comments section.

12. The Nurse will indicate the type and location of central venous catheter (CVC) and the date of the "OK for use order"

13. The Nurse will process heparin dose used for instillation in units per mL, or Na+ Citrate dose in percentage, or other anticoagulant if applicable. The volumes of each lumen will be recorded in mL and updated with each catheter exchange.

14. The Nurse will indicate the schedule for changing the central venous catheter (CVC) dressing, the type of dressing beside "site care" and any other recommendations/instructions. Indicating the product code can be helpful in identifying the correct dressing.

PART III: PERITONEAL DIALYSIS PATIENT KARDEX (Appendix C)

A. Addressograph Space:

1. The Unit Clerk will addressograph the Kardex for all chronic hemodialysis patients and place in front of the chart.

B. Peritoneal Dialysis (PD) Product Information

1. The Nurse/Unit Clerk will indicate if patient is using Baxter or Fresenius products and the patient's identification number.

2. The Nurse/Unit Clerk will document the name of patient's primary nurse.

C. Clinic Appointment

1. The Nurse/Unit Clerk will transcribe the time and date of next clinic appointment.

D. General PD Information

1. The Nurse/Unit Clerk will document date of *Peritoneal Dialysis catheter insertion.*

2. The Nurse will document date of *next transfer set change* and update as required.

3. The Nurse/Unit Clerk will document date patient initiated *Peritoneal Dialysis Community Care* (PDCC).

4. The Nurse will document and date *target weight* for patient; empty/full and update as required.

5. The Nurse will document the patient's *Backup plan*, date initiated and update as required

6. The Nurse/Unit Clerk will transcribe *Patient Safe Handling/Falls Assessment risk level* and date of assessment and any recommendations.

7. The Nurse/Unit Clerk will document patient's *Primary Care Person* and contact number.

8. The Nurse/Unit Clerk will document patient's *Backup Person* and contact number.

E. Dialysis Efficiency

1. The Nurse/Unit Clerk will document patient's *height* in centimeters (cm).

2. The Nurse/Unit Clerk will document and date the results of patient's *PET* (peritoneal equilibrium test).

3. The Nurse/Unit Clerk will document date *last KTV* done and date of *next KTV* due and update as required.

4. The Nurse/Unit Clerk will document the *rKTV* results and the *pKTV* results.

5. The Nurse/Unit Clerk will document and date the *24 hour urine volume* in milliliters (ml).

6. The Nurse/Unit Clerk will document current *KTV regime.*

F. Training information

1. The Nurse/Unit Clerk will document the name of *training nurse* patient on Continuous Ambulatory Peritoneal Dialysis (CAPD) and *date of training*.

2. The Nurse/Unit Clerk will document the name of *training nurse* patient on Continuous Cycler Peritoneal Dialysis (CAPD) and *date of training*.

G. CAPD data

1. The Nurse/Unit Clerk will document *product* (Baxter/Fresenius) and date.

2. The Nurse/Unit Clerk will document:

    a. # exchanges/ 24 hours
    b. Volume per exchange
    c. Icodextrin overnight volume (if applicable)

H. CCPD data

1. The Nurse/Unit Clerk will document *product* (Baxter/Fresenius), *cycler serial number* and date.

2. The Nurse/Unit Clerk will document:

    a. Therapy volume in ml.
    b. I-drain alarm in ml.
    c. Therapy time in hours
    d. # of cycles
    e. Fill volume in ml
    f. Average dwell time in minutes.
    g. Last fill volume in ml
    h. Weight units (kilograms (kg) or pounds (lb))
    i. Dextrose same or different
    j. Last manual drain (yes/no)

3. Additional information required for *TIDAL*

    a. Tidal volume %
    b. Total ultrafiltration (UF) in ml
    c. Full drains every (indicate how often i.e. after every 3 drains)
    d. Date tidal started.

I. Glucometer Type

1. The Nurse/Unit Clerk will document *brand of glucometer* patient uses.

J. Documentation

1. The Nurse/Unit Clerk will indicate date Kardex completed/recopied.

2. The Nurse/Unit Clerk completing/recopying kardex will provide *signature/printed name and designation.*

3. The Nurse reviewing and double checking completed/recopied kardex information will provide *signature/printed name and designation*.

K. Peritoneal Dialysis Community Care (PDCC) Information and Services

1. The Nurse/Unit Clerk will check appropriate box to indicate if PDCC or patient are responsible for:

    a. Cycler set-up
    b. Stripping of cycler
    c. Connecting to cycler
    d. Disconnecting from cycle
    e. Completing weight and blood pressure measurement.
    f. Selection of dialysate
    g. Medication administration (i.e. Eprex/heparin)
    h. Baxter ordering
    i. Garbage/recycling removal
    j. Exit site care.

i. The Nurse/Unit Clerk will indicate if exit site care is: clean technique/sterile dressing change and if antibiotic ointment is ordered.
ii. The Nurse/Unit Clerk will indicate if exit site care dressing is: mepore/gauze and mefix/gauze and paper tape. If skin protector or adhesive remover is used

2. The Nurse/Unit Clerk will indicate if patient is working towards independence (yes/no)

3. The Nurse/Unit Clerk will document patient/family teaching plan.

4. The Nurse/Unit Clerk will document frequency of planned visits.

L. <u>Equipment</u>

1. The Nurse/Unit Clerk will indicate:

    a. Number of dialysate bags per day
        I. 5000 ml bags (none, 1, 2, or 3)
        II. 3000ml bags (none, 1, 2, or 3)
        III. 2500ml bag (7.5%)
    b. Cassette 4 or 8 prong
    c. 12 foot extension easy lock (none,1 or 2)
    d. 12 foot extension (none,1 or 2)
    e. Drain manifold (none or 1)
    f. Drain bags 15L set (none or 1)

M. <u>Special orders</u>

1. The Nurse/Unit Clerk will indicate if blood sugar monitored by PDCC (yes/no)

    a. If yes, the Nurse/Unit Clerk will indicate frequency (ampc/pmpc)
    b. If yes, the Nurse/Unit Clerk will note to whom blood sugars are reported (endocrinologist/PD unit) and fax/contact number

2. The Nurse/Unit Clerk will note if Icodextrin is to be held prn (yes/no) and parameters for same
    a. Blood pressure less than
    b. Weight less than

3. The Nurse/Unit Clerk will indicate if Twin bag exchange ordered prn (yes/no)
    a. If intraperitoneal (IP) medication required:
        i. Volume of twin bag
        ii. Strength of twin bag

N. <u>Wound care</u>

1. The nurse will indicate if patient requires wound care.
    a. Documented wound care plan in space provided

O. <u>Documentation</u>

1. The Nurse/Unit Clerk will indicate date Kardex completed/recopied.

2. The Nurse/Unit Clerk completed/recopied kardex will provide signature/printed name and designation.

3. The Nurse reviewing and double checking completed/recopied information will provide signature/ printed name and designation.