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MANITOBA RENAL PROGRAM

SUBJECT	SECTION	60.20 Documentation Standards - Hemodialysis
▪ Hemodialysis Treatment Record Standard (For Fresenius 5008 Delivery System)	CODE	60.20.01A
AUTHORIZATION ▪ Professional Advisory Committee, Manitoba Renal Program ▪ Check with Linda for SBH group	EFFECTIVE DATE	January 2003
	REVISION DATE	June 2010 February 2013 October 2014 March 2017

PURPOSE:

To provide standards for the completion of the Hemodialysis Treatment Record Form # 1592 (60.20.01Aa Appendix A).

OBJECTIVE:

1. To provide information to assist the Nurse in completing a patient assessment by:

   i. Reviewing the dialysis/ward chart prior to initiation of hemodialysis.
   ii. Trending patient responses to nursing interventions during treatments.
   iii. Develop a complete patient treatment profile prior to initiation of treatment.

2. To provide information about the delivery system and patient station used during a specific treatment in relation to:

   i. Infection control.
   ii. Preventative and ongoing maintenance.

3. To provide the multidisciplinary team a complete evaluation of a patients' hemodialysis treatment by:

   i. Providing a thorough recording of interdialytic vital signs and dialysis parameters for hemodialysis treatments.
   ii. Trending the patient's response to treatment and relating such responses to changes in prescription.
   iii. Develop a complete and permanent record of a patient's treatments.

STANDARDS:

1. The nurse responsible for the treatment will be responsible for ensuring that the information on the Hemodialysis Treatment Record is correct.

2. The Hemodialysis Treatment Record will be maintained for a period of 3 months, and then will be saved in medical records.

3. All pertinent and/or unusual patient related findings must be documented in the Progress Note in the patient's health record.

4. Nurses who place their initials on this document will then place their signature on the Renal Signature Sheet.

5. The Hemodialysis Treatment Record will be kept in the “Treatment Record” section of the patient’s health record.

6. The Treatment Record is double sided. The first side utilized as a guide for patient’s assessment and treatment regime. The other side to record patient response to treatment, e.g. vital signs, etc. Each treatment is recorded on a separate treatment record.

PROCESS:

SIDE ONE:

Date:	The day, month and year will be written out (e.g. 01/Jan/2012).
Advanced Care Planning (ACP) Goals of Care:	The nurse will transcribe the ACP goal of care from the ACP Goals of Care record. If the facility does not use such a form, “No Code” or “Full Code” can be used. If the ACP Goals of Care Record has not been completed, leave the corresponding line blank.
In Patient:	The nurse will indicate which unit the patient is admitted to, including Emergency or Observation.
Out Patient:	The nurse will indicate with a check mark if the patient is an out-patient for the treatment.
On: Initial:	The nurse will indicate the actual time the patient treatment was established, and initial.
Off: Initial:	The nurse will indicate the time the patient is due to finish the hemodialysis treatment. If this time is changed during the treatment, the initial time will be crossed off and the revised time will be written in. The nurse discontinuing the treatment will initial the corresponding line.
Allergies:	The nurse will indicate the patient’s known allergies. If no allergies, NKA will be written.
Isolation Precautions:	The nurse will indicate the specific isolation precautions necessary for the treatment.
Nurse Assigned to the Patient:	The nurse assigned to the patient will print his/her name. If a second nurse takes over care, he/she will add their name on the line.
Physician Orders Checked:	The nurse will indicate with a check in the *yes* box once the chart has been checked for new orders prior to establishing treatment.
Patient reminded re: Appointments	The nurse will indicate with a check in the *yes* box once the chart has been checked and the patient reminded re: appointments.

A. DIALYSIS PRESCRIPTION/PARAMATERS:

Dialyzer:	The nurse will transcribe the dialyzer as ordered or used for the treatment.
Prescribed UF time	The nurse will transcribe the hours of treatment as ordered by the Nephrologist.
ISO UF time.	The nurse will transcribe the time of ISO UF ordered by the Nephrologist or determined by the nurse.
Dialysate K+ and Ca++:	The nurse will transcribe the potassium and calcium content of the dialysate as ordered by the Nephrologist.

PROCESS:

Glucose:	The nurse will transcribe the glucose content of the dialysate as ordered by the Nephrologist.
HCO_3	The nurse will transcribe the bicarbonate level of the dialysate as ordered by the Nephrologist.
Conc.#	The nurse will indicate the dialysate concentration number (e.g. A1225) that corresponds with the prescribed potassium, calcium and glucose.
Prescribed Na+	The nurse will indicate the prescribed Na+ level as ordered by the physician.
Flow	The nurse will indicate the dialysate flow rate as ordered by physician.
Temperature	The nurse will indicate the temperature ordered by the physician for dialysis treatment.
Na+ Profile	The nurse will indicate which Na+ profile (e.g. #1, #2, #3, or none) is to run during the treatment.
Start Na+	The nurse will indicate the starting sodium level of the Na+ profile.
UF profile	The nurse will indicate which UF profile will be used for this treatment (indicate using a "#").
UF control	The nurse will indicate with "*yes*" or "*no*" if UF control function to be used for the treatment.
Critical RBV%	The nurse will indicate the critical RBV specific to the patient.
Maximum UFR	The nurse will indicate the patient specific maximum recommended UFR if applicable.
V (urea)	The nurse will indicate the current urea distribution volume for the patient.
Target Kt/V:	The nurse will indicate the target Kt/V for the patient.

B. ANTICOAGULATION:

Heparin	The nurse will put a check mark in the "*yes*" or "*no*" box corresponding with the Physician's Order or the nurse's assessment.
Heparin Prime (Initial Bolus):	The nurse will transcribe the heparin prime (initial bolus) dosage to be given for this treatment.
Heparin rate/hr	The nurse will transcribe the hourly heparin pump infusion rate to be given over the treatment.
Stop time	The nurse will record the minutes that the heparin pump infusion is to be stopped prior to the end of treatment
Continuous 0.9% NaCl	The nurse will check the yes or no box if a continuous infusion of 0.9% NaCl is used instead of or in addition to intermittent flushes.
0.9% NaCl Flushes	The nurse will put a check mark in the "*yes*" or "*no*" box indicating if 0.9 % NaCl flushes are to be given.
Frequency	The nurse will indicate the frequency of 0.9% NaCl flushes to be given during the treatment.

PROCESS:

C. DELIVERY SYSTEM:

Machine Unit Number:	The nurse will indicate the delivery system unit number as identified on the system.
Station:	The nurse will indicate the patient station number the treatment occurs in.
Unit:	The nurse will indicate the unit of treatment e.g. SOH, SCDU.
Chemical Residue: Bleach	The nurse will identify and initial the results of the chemical residual test(s) of the delivery system as performed according to procedure 30.20.07 *Use of the Fresenius 5008 Delivery System.*
Prechecks:	T1 test; Dialysate Flow; Shunt Door/Bypass; Level Set; Ven. Line in Clamp. The nurse will initial after verification that these tests/procedures were performed and passed in accordance with MRP procedure 30.20.07 *Use of the Fresenius 5008 Delivery System.*

D. VASCULAR ACCESS:

Access site assessment	The nurse will record assessment of the catheter exit site or the AV fistula or AV graft site.

Fistula:

AVF/AVG:	The nurse will indicate the type and location of the fistula/graft on the corresponding line.
Needles:	The nurse will indicate the type of needles used to access the fistula/graft.
Xylocaine 1%:	The nurse will indicate if this is used with a check in *yes* or *no* box.
# of Punctures:	The nurse will indicate the number of punctures used to establish dialysis for this treatment and will document in the progress note if more than two punctures were required to establish dialysis.
Comments:	The nurse will indicate any issues, cannulation instructions, and dressing care necessary for this treatment.

Catheter:

Type:	The nurse will indicate the type and location of catheter; e.g. left femoral catheter, Right internal jugular, tunnelled vs. non-tunnelled, etc
Instillation Heparin Dose:	The nurse will indicate the dosage concentration of heparin per lumen post dialysis.
Other:	The nurse will indicate alternative anticoagulant to be instilled into each lumen if heparin not used.
Arterial/Venous:	The nurse will indicate the instillation volume of the arterial and venous lumens.
Comments:	The nurse will indicate issues and access site care.
Dressing Change:	The nurse will indicate with a check if a dressing change to the access site is required.

PROCESS:

E. MEDICATIONS

Medications:	The nurse assigned to the patient will transcribe medications ordered for this treatment after checking the Medications Administration Records and Physician's Orders in both dialysis and in-hospital charts.

F. NURSING ASSESSMENT:

Initial:	The nurse assessing the patient and developing a plan of care will provide her/his initials.
Current lab values:	The nurse will record the most recent indicated lab values available in the patient's' health record.
Assessment:	The nurse will complete a full patient assessment each treatment that is individualized according to the patient's condition. The nurse will review each system. The abnormal findings will be reported to the appropriate physician and multidisciplinary team member, e.g. Social Worker, Dietician, and Pharmacist.
Plan:	The nurse will document the plan of care for the hemodialysis treatment.
Wound and skin care:	The nurse filling out the treatment record will indicate with a check mark in the "yes" or "no" boxes if skin care or dressings are required as per the Kardex.

G. FLUID MANAGEMENT:

Pre-Weight:	The nurse or delegate will record the patient's pre-dialysis weight.
Dry Weight:	The nurse will indicate the prescribed dry weight of the patient as ordered by the Nephrologist, as found in the Kardex.
Target:	The nurse will record the target weight for the treatment based on a thorough nursing assessment and review of previous treatment information.
Post Weight:	The Nurse will record the final post weight for the treatment.
Weight Difference:	The nurse will calculate and record the difference between the target weight and the pre weight.
Fluid Intake:	The nurse will record the anticipated oral, IV intake and 0.9%NaCL flushes in the corresponding lines.
Reinfusion Volume:	The nurse will calculate and record the amount of 0.9% NaCl required to initiate and discontinue the treatment.
Subtotal:	The nurse will add weight difference, fluid intake, and reinfusion volume.
Replacement/Fluid:	The nurse will calculate the amount of fluid replacement (if applicable) anticipated during the treatment.
UF Goal:	The nurse will record the planned amount of fluid to be removed during the treatment.

H. BLOOD/SPECIMENS:

PROCESS:

Blood/Specimens:	The nurse assigned to the patient will record the bloodwork and/or specimens ordered for this treatment after reviewing the bloodwork requisitions, Physicians Orders from dialysis and in-hospital patient charts, and any other unit specific bloodwork reminder system. On completion of obtaining the specimens, the nurse will use a check mark to indicate that the specimens were obtained.
Glucose:	The nurse filling out the treatment record will circle the required tests: Pre, Mid, Post. The nurse obtaining results will record them on the space provided.

I. DISCHARGED:

Home:	The nurse signing release criteria will indicate with a check mark if the patient was discharged home.
Unit:	The nurse signing release criteria will indicate if the patient was transferred to a ward or unit post dialysis with a specific location, such as ER, 5B, or different facility.
Meets Release Criteria:	The nurse assigned to the patient at the time of discharge will document and initial that the release was based on nursing assessment and according to Manitoba Renal Program Policy 30.70.08 *Discharge Criteria for Hemodialysis Patients from the Dialysis Unit Following Treatment*. In the event that patient did not meet release criteria further documentation (e.g. Progress Note, AMA form) must be completed.
See Progress Note	The nurse will indicate with a check mark if a Progress Note was written.
Report Given:	The nurse giving report will initial and may record the name of the ward nurse receiving report.

J. NEXT TREATMENT/REMINDERS:

Next Treatment Reminders:	The nurse will place pertinent information regarding patient care that does not require a progress note but may require an assessment/reminder for the next treatment.

SIDE TWO:

Name:	The name of the patient will be written on the line provided.
Date:	The date of treatment will be recorded, with the month, day and year.

Post Checks (to be completed at time of initiation):

i. UF Goal set	The nurse will confirm and initial that that UF goal has been programmed into delivery system
ii. UF Profile Set	The nurse will confirm and initial that the UF Profile (if being used) has been programmed into delivery system. Document **n/a** if no profile is used.
iii. UF timer on	The nurse will initial and confirm that the UF timer light is on.
iv. Na+ Profile Set	The nurse will confirm and initial that the Na+ Profile is set as ordered.
v. Dialysate Flow at Prescribed Rate/On	The nurse will confirm and initial that the dialysate flow is set at the prescribed rate and that dialysate flow is on.

PROCESS:

vi. Heparin Line Open/On:	The nurse will confirm and initial that the heparin line is open and that the heparin pump is running. Document **n/a** if heparin free.
Time:	Enter the time of each recording.
BP/HR:	The vital signs will be recorded in the appropriate columns and the row corresponding to the time. If the nurse determines by assessment respirations are abnormal for that patient, respiratory rate and quality shall be recorded in the comments area.
Qb:	Blood flow rate displayed on the home screen of the delivery system (at the time vital signs are obtained) will be recorded in the appropriate column.
AP/VP:	Arterial pressure and venous pressure will reflect the AP/VP displayed on the delivery system (at the time vital signs are obtained) and will be recorded in the appropriate column.
UFR:	Ultrafiltration rate displayed on the delivery system at the time vital signs are obtained will be recorded in the appropriate column.
UF Rem'd	Total amount (in ml) of ultrafiltration removed as displayed on the home screen will be recorded in the appropriate column.
RBV:	RBV value as indicated on the Home and BVM screens will be recorded in the appropriate column.
Heparin in	The heparin amount infused as indicated on the heparin screen will be recorded in the appropriate column.
Clearance	The last available clearance value as indicated on the OCM screen will be recorded in the appropriate column.
Kt/V	The current cumulative Kt/V as indicated on the OCM screen will be recorded in the appropriate column.
Lines secure	The nurse will confirm and document that vascular access lines/needles are secured and in-situ.
Comments:	The nurse will record other pertinent assessment data, interventions, and subsequent outcomes.
Initial:	The nurse obtaining vital signs and other information on the treatment record must initial at the corresponding time care is given in the appropriate column. The nurse initialling the treatment record must assure that there is a corresponding signature on the Signature Sheet.
Initial Hgb:	The nurse will document the initial haemoglobin as displayed on the BVM screen or on the treatment history screen.
% Recirculation: #1; #2 PRN; #3 PRN	The nurse will document the % recirculation value as displayed on the BTM screen or on the home screen. Further recordings done as per MRP policy 30.30.08 *AVF/AVG Vascular Access Assessment.*

A. <u>0.9% NaCl FLUSHES:</u>

Time:	The nurse will indicate the times the 0.9% NaCl flushes are to be given.
Volume of Flushes:	The nurse will indicate the volume of 0.9%NaCl used for the flush.

PROCESS:

Comments:	The nurse will provide comments as to the condition of the fibres in relation to clotting of the dialyzer or venous chamber.
Initial:	The nurse administering the flushes will initial when a flush is completed.

B. TREATMENT/REMINDERS:

Treatment/Reminders:	The nurse will indicate any special instructions or reminders to be followed up during treatment (e.g. Check CBC result).