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MANITOBA RENAL PROGRAM

SUBJECT ▪ Hemodialysis Treatment Record Standard for Health Sciences Centre (HSC) Hemodialysis Treatment	**SECTION**	**60.20 Documentation Standards and Forms**
	CODE	60.20.01 B
AUTHORIZATION ▪ Professional Advisory Committee, Manitoba Renal Program ▪ Nursing Practice Council, Health Sciences Centre (HSC) ▪ Forms Committee, Health Sciences Centre (HSC)	**EFFECTIVE DATE**	February 2017
	REVISION DATE	April 2018

PURPOSE:

To provide standards for the completion of the Hemodialysis Treatment Record Form # W-00497 (see appendix).

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.** Patient safety
- **iii.** Preventative and ongoing maintenance.

3. To provide the multidisciplinary team a complete evaluation of a patient's 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 comprehensive and permanent record of a patient's treatments for the patient's Health Care Records (HSC Hemodialysis (HD) and in patient)

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 placed in the HD Health Care Record will be maintained for a period of 3 months, and then will be saved in medical records.

3. The HD Treatment Record placed in the Inpatient Health care record will be maintained as per HSC policy.

4. All pertinent and/or unusual patient related findings must be documented in the Integrated Progress Notes in the patient's health records

5. Nurses who place their initials on this document will then place their signature on the Renal Signature Sheet and in the Inpatient Health Care Record if applicable.

6. The Hemodialysis Treatment Record will be kept in the "Treatment Record" section of the patient's health record. For patients admitted to HSC, a photocopy of the Treatment Record will be kept in the flow sheet section of HSC inpatient Health Care Record.

7. 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, and discharge status post HD treatment, etc. Each treatment is recorded on a separate treatment record.

PROCESS:

SIDE ONE:

Addressograph	The addressograph of the patient will be stamped in the upper right hand corner
Date:	The day, month and year will be written out (e.g. 01/Jan/2016).
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.
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.
HD unit	The unit in which the patient receives HD treatment will be noted (e.g. SCDU, CDU, MICU)
In pt: _____(unit)	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.
Assigned nurse(s)	The nurse(s) 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.
HD start time/estimated end time/end time	The nurse will indicate the times as indicated and initial.
HD Chart orders Last order date	The nurse will indicate with a check in the box once the HD chart has been checked for new orders prior to establishing treatment and indicate the date the last order was written.
Last 3 tx records	The nurse will indicate with a check mark once the last three treatment records have been reviewed.
Appt. reminders	The nurse will indicate with a check in the *yes* box once the chart has been checked and the patient reminded re: appointments and indicate upcoming appts. The nurse ill check n/a if there are no upcoming appointments noted in the chart.

A. DIALYSIS PRESCRIPTION/PARAMETERS:

Dialyzer:	The nurse will transcribe the dialyzer as ordered or used for the treatment.

PROCESS:

UF time	The nurse will transcribe the hours of treatment as ordered by the Nephrologist.
ISO UF	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.
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.
Dialysate #	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 the 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 (e.g. #1, #2, #3, or none) will be used for this treatment
UFC	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.
Goal Kt/V	The nurse will indicate the target Kt/V for the patient's treatment.
Comments	The nurse will note any specific comments pertinent to the dialysis prescription or set up (e.g. additional rinse required)

DELIVERY SYSTEM:

Stn#	The nurse will indicate the patient station number the treatment occurs in.
Machine #:	The nurse will indicate the delivery system unit number as identified on the system.

PROCESS:

Chemical Residue:	The nurse will identify and initial the results of the chemical residual test(s) of the delivery system as performed according to procedure 30.10.01 *Use of the Fresenius 5008 Delivery System using Saline* or 30.10.02 *Fresenius 5008 Preparation for Hemodialysis using the ONLINEplus™ System*
T1/Level set/Dialysate flow/Shunt door/bypass/ Ven. Line in clamp	The nurse will initial after verification that these tests/procedures were performed and passed in accordance with MRP procedure 30.10.01 *Use of the Fresenius 5008 Delivery System* or 30.10.02 *Fresenius 5008 Preparation for Hemodialysis using the ONLINEplus™ System.*

HEPARIN

Heparin yes/no	The nurse will indicate with a check mark if the patient is to receive heparin during the HD treatment
Bolus/prime/Rate/Stop time	The nurse will indicate prescribed heparin bolus, rate, and stop time of heparin administration as per patient's Medication Administration Record.
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 health care record. Antibiotics to be administered will be entered on separate line as indicated on the treatment record.
BW/Labs: pre HD/post HD	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.
BG	The nurse filling out the treatment record will circle the required blood glucose tests: Pre, Mid, Post. The nurse obtaining results will record them on the space provided.
0.9% NaCl flushes/ Frequency	The nurse will put a check mark in the "*yes*" or "*no*" box indicating if 0.9 % NaCl flushes are to be given. The nurse will indicate the frequency of 0.9% NaCl flushes to be given during the treatment
Cont. 0.9% NaCl /Volume	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. The nurse will indicate the total volume in mL of0.9 % NaCl.

ACCESS

CVC: R/L Site:	The nurse will indicate the type and location of catheter; e.g. left femoral catheter, right internal jugular, etc.
Drsg change yes/no	The nurse will indicate with a check if a dressing change to the access site is required.
Instillation:	The nurse will indicate if heparin 1000u/mL is to be instilled to the catheter lumen post dialysis.
Other:	The nurse will indicate alternative anticoagulant to be instilled into each lumen if heparin not used.
Arterial___mL /Venous ___mL	The nurse will indicate the instillation volume of the arterial and venous lumens.

PROCESS:

Site Care/Assessment	The nurse will indicate access site care. The nurse will document assessment of the vascular access (CVC or AVF/AVG.
Fistula: AVF/AVG R/L	The nurse will indicate if patient has AVF or AVG and indicate location
Needles:	The nurse will indicate the type of needles used to access the fistula/graft.
Lidocaine 1%:	The nurse will indicate if this is used with a check in *yes* or *no* box.
# of Punc:	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.
Remove Post HD drsg @	The nurse will indicate what time post HD dressings should be removed.

NURSING ASSESSMENT AND PLAN

Lab result/date	The nurse will record the most recent indicated lab values and accompanying date 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.
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.
Pt. achieves goal Kt/V	The nurse completing the assessment will review previous treatment and document yes or no.
Pt. achieves assigned DW	The nurse completing the assessment will review previous treatments and record yes or no.
Pre HD:	Vital signs taken pre HD will be recorded by the nurse completing the assessment.
Inpatient: ward chart orders reviewed.	The nurse completing the assessment will review the patient's in-hospital Health Care Record for new orders and document using his/her initials.
Nursing Dx/Plan:	The nurse will document the nursing diagnosis and plan of care for the hemodialysis treatment.
Notify:	The nurse will document if notification of allied health team members needed.
Initial:	The nurse assessing the patient and developing a plan of care will provide her/his initials.

B. FLUID MANAGEMENT:

Dry Weight:	The nurse will indicate the prescribed dry weight of the patient as ordered by the Nephrologist, as found in the Kardex.

PROCESS:

Pre HD Weight:	The nurse will record the patient's pre-dialysis weight.
Target:	The nurse will record the target weight for the treatment based on a thorough nursing assessment and review of previous treatment information.
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/infusion in the corresponding lines.
Reinfusion Volume:	The nurse will calculate and record the amount of fluid (0.9% NaCl or substituate) required to initiate and to 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.
Total UF Goal:	The nurse will record the planned amount of fluid to be removed during the treatment.
Initials/calculation	The nurse will confirm calculations are correct. A second nurse will confirm the calculations within one hour of HD initiation.
Post Weight:	The nurse will record the final post weight for the treatment.

SIDE TWO:

Addressograph	The addressograph of the patient will be stamped in the upper right hand corner
Transfer of Care/Report	The nurse giving report will ensure that the nurse receiving report on the patient will document time/name/ and initials.

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

Isolation Room: Alarm Connected	The nurse will confirm that the Fresenius 5008 is connected to remote alarm panel (when available.)
Dialysate Flow at Prescribed Rate/On	The nurse will confirm that the dialysate flow is set at the prescribed rate and that dialysate flow is on.
Hemodialert	The nurse will confirm that the Hemodialert in in place as recommended. Check N/A if not being used.
Heparin Line Open/On:	The nurse will confirm that the heparin line is open and that the heparin pump is running. Check N/A if heparin free.
Na+ Profile Set	The nurse will confirm that the Na+ Profile is set as ordered. Check N/A if no profile is used.
UF timer on	The nurse will confirm that the UF timer light is on.
UF Goal set	The nurse will confirm that that UF goal has been programmed into delivery system and write the initial fluid removal goal in mL
Time:	Enter the time of each recording.

PROCESS:

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 outcome,
Heparin Bolus given	The nurse will indicate, as necessary, if heparin bolus given at initiation of treatment.
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.
TREATMENT REMINDERS:	The nurse will indicate any special instructions or reminders to be followed up during treatment (e.g. Check CBC result).

FLUSHES:

Time:	The nurse will indicate the times the 0.9% NaCl or substituate flushes are to be given.
Volume of Flushes:	The nurse will indicate the volume of the flush.
Comments	The nurse will provide comments as to the condition of the fibres in relation to clotting of the dialyzer or venous chamber. The nurse administering the flushes will initial when a flush is completed.

POST HEMODIALYSIS

PROCESS:

HD tx outcome	The nurse will write a brief statement re: outcome of treatment (e.g. stable treatment).
See IPN	The nurse will indicate with a check mark if an Integrated Progress Note was written.
Net fluid removed/ Post HD weight (kg)	The nurse will document the net fluid removal and measure post HD weight
Vital Signs	The nurse will record post HD vital signs and time VS were taken.
Final Kt/V	The nurse will record final Kt/V as measured by the Fresenius 5008.
Discharge	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 80.20.03 *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. The nurse signing release criteria will indicate with a check mark if the patient was discharged home. 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, GD4, or different facility.
Transfer of care/report	The nurse discharging the patient will initial that transfer of care report was given verbally and/or FAXED. The name of the nurse receiving report may be recorded,
Medications given and documented in MAR(s)	The nurse discharging the patient will confirm that all medications given in HD are signed for in the HD record and the inpatient record as required.
If in patient MAR not available, photocopy HD record and send wit inpatient Health Care record	In the event that a patient does not have an in-patient MAR (e.g. patient arriving from Emergency Department), the HD nurse is to photocopy HD MAR and send with patient returning to department.

REFERENCES:

Accreditation Canada (2013). Required Organizational Practices Handbook 2014. Retrieved from http://www.accreditation.ca/sites/default/files/rop-handbook-2014-en.pdf

Silver, Samuel A, et al (2015*). Development of a hemodialysis safety checklist using a structured panel process*. Canadian Journal of Kidney Health and Disease (2015) 2:5