# Documentation in Dialysis Unit

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# Recommended documentation categories

| Patient Assessments | Patient Interventions | Patient Outcomes | Significant Events |
|---|---|---|---|
| History and physical | Physician orders | Progress notes | Physician visits |
| Patient's condition on admission | Medication administration | All lab reports | Treatments |
| Initial and ongoing assessments by each health care provider | Prescribed treatments | Patient's response to treatment and medications | Patient transfers |
| Patient's response to illness | Lab work ordered | Plan for further care | Therapy completion |
| Vital signs | Consents | Change in condition | IV therapy |
| | Patient education | Infection | Medication administration |
| | Discharge instructions | Refusal to cooperate or follow care plan | Vital signs and changes |
| | Consultations | | Patient response to treatment |
| | Exercise prescription | | Events affecting the patient's care or response to treatment |

# Documentation in Dialysis

- Documentation It is the process of communicating in written form about essential facts for the maintenance of continuous history of events over a period of time. Reporting is communication of information to another individual. **I**mportant purpose of documentation is to communicate information among health care workers. It is an account of client's history, present health status, treatment & response to treatment.
- It helps in providing comprehensive care. Documentation protect client as well as workers, every client has right to inform & access information on chart.

“If it's not charted, it's not done"

# Documentation In dialysis centre

- Dialysis consent
- Procedures consent for eg; catheter insertion, ascitic tapping, etc
- Detailed clinical history sheet
- Vascular access history sheet
- Dialysis chart
- Lab investigations chart
- Medications chart
- Summary notes in case of any further medical investigations carried out; for eg: 2D echo, USG, etc.

# Dialysis consent

- **Written Informed consent**
- **The type, duration, frequency of dialysis.**
- **The working hours of the dialysis centre**
- **policy about the reuse of dialysers and tubings.**
- **Policy about the blood investigations and their frequencies.**
- **The consent should clearly mention that no particular patient can be allotted a particular technician for cannulation.**
- **It is vital that the consent should be signed by 3 individuals:**
  - **The patient**
  - **The relative**
  - **Dialysis staff who has explained the consent.**
- **(In case, the patient cannot sign, thumb impression can be taken. )**
- **In case the dialysis unit does not have an attached ICU, this should be featured in the consent form as this helped the patient take correct steps during emergencies.**

# Procedures consent

- Any other interventional procedure  e.g.  catheter insertion/Removal  or ascitic tapping, etc.
- This sheet should clearly mention the type of procedure to be carried out and the name of the doctor who will perform the procedure.
- This consent too should be signed by 3 individuals:
  - The patient
  - The relative
  - Dialysis staff who has explained the consent.
- (In case, the patient cannot sign, thumb impression can be taken)

# Clinical history sheet

The clinical history sheet should include all details of the patient including:

- personal details, demographic details
- medical history
- surgical history
- final diagnosis

# Vascular access history sheet

- Type Vascular access
- When?
- Info about past access and current access.
- Diagram/ image
- This sheet should include:
- the name, date and contact no of the surgeon who had constructed the fistula.
- It should also contain details of the no of failed vascular accesses.

# Dialysis chart

- Personal details – full name of the patient
- Date and timing of initiation and termination of dialysis
- Dialysis initiated by and terminated by ? (name of the Nurse/technician)
- Dialyzer details: type of dialyzer, no of reuse
- Anticoagulant details
- Access details
- Pre dialysis assessment
- Post dialysis records, i.e. weight, BP (standing and supine), pulse, UF achieved, Kt/V
- Intra dialysis assessment
- Intradialysis post dialysis Medications

# Other important charts

- Lab investigations chart
- Medications chart
- Summary notes

REMEMBER: ANY MISSED (UNREPORTED) DATA CAN PROVE TO BE FATAL TO THE PATIENT !