

RENALINK

NKF
National Kidney
Foundation®
Making Lives Better

A QUARTERLY PUBLICATION OF THE COUNCIL OF NEPHROLOGY NURSES AND TECHNICIANS,
THE COUNCIL OF NEPHROLOGY SOCIAL WORKERS AND THE COUNCIL ON RENAL NUTRITION

WINTER 2000

VOLUME 1 / NUMBER 4

Documentation in the Dialysis Unit

Janice Magnuson, RN, CNN, Jan Dudley, MA, RD, LMNT and Wendy Funk Schrag, LMSW, ACSW

Documentation is not only the single most important part of any chart, it is the most difficult to achieve. The old adage "if it's not charted, it's not done" is absolutely correct. Many aspects of a chart are critical to meeting regulatory guidelines. Although there are differences in each state and with each surveyor, all are united by the need to incorporate documentation into their procedures.

According to the guidelines of the Health Care Financing Administration (HCFA), "A member of the facility's staff is designated to serve as supervisor of medical records services, and ensure that all records are properly documented, completed, and preserved." The medical records are to be readily available, and systematically organized to facilitate the compilation and retrieval of information (Subpart U, Section 405.2139).

Each patient's medical record must contain appropriate and sufficient information to identify the patient clearly, to justify the diagnosis and treatment and to document the results accurately. Please refer to the chart on page 17 to view the general categories contained in the medical records.

I. A Nurse's Perspective

Organizations may have varying procedures for meeting documentation goals, such as use of the SOAP, PIE or nursing processes. Regardless of the method, the primary goals are to identify the problem, perform the assessment, intervene at the individual's level of expertise, and contact the appropriate person for further direc-



Accurate documentation is key to good patient care.

tion if necessary. The nurse's responsibility extends beyond these steps to include

evaluating care and providing education regarding further treatment options and prevention issues. Keeping these steps in mind will help nursing staff to meet federal regulations required for documentation and contribute to positive outcomes. As an example, vital signs need to be charted per unit policy. When blood flows are altered or the dialysis time changes without documentation, unnecessary physician orders may be written (e.g., "decrease of BFR, decrease of time, changed URR by lowering it"). If the above changes were documented, different orders would have been written.

(Continued on page 17)

LESLIE'S GIFT

BY CAROLYN L. ATKINS, RN, BS, CCTC

Leslie, one of two daughters of Clyde and Lou Geer of McKinney, Texas, was an attorney in Dallas. She was a responsible young woman with a positive attitude who saw life as an adventure. When anyone asked Leslie how she was or how her day had gone, her response was always "My sky is so blue." This saying described her outlook on life and her interactions with other people.



Leslie Geer

Leslie was very close to her sister Ashley, her parents and her dog, Oprah. She treated everyone as an equal and went out of her way to help others. She would often remind her co-workers, as well as her family, "to look at the big picture" when it appeared that the focus of a project or discussion had become fuzzy.

Leslie had a history of severe asthma. One day while driving in her car, she had a serious attack. Not able to make it to a nearby hospital, she called 911 on her cell phone and provided her location before she passed out. Sadly, Leslie was unable to survive this attack and she died at the age of 30. The impact she had on other people attested for the nearly one thousand people who attended her funeral service.

(Continued on page 3)

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	Time and date health care provider was called or notified and the time of response
Initial and ongoing assessments by each health care provider	Prescribed treatments	Patient's response to treatment and medications	Treatments
Patient's response to illness	Lab work ordered	Plan for further care	Patient transfers
Vital signs	PRN Orders	Change in condition	Therapy completion
	Consents	Infection	IV therapy
	Patient education	Refusal to cooperate or follow care plan	Medication administration
	Discharge instructions		Vital signs and changes
	Consultations		Patient response to treatment
	Exercise prescription		Events affecting the patient's care or response to treatment

Another area to carefully examine is patient education, which must be reviewed and charted as necessary in the dialysis population. Aspects of patient education requiring documentation include evacuation/disaster plans, access care, fluid intake, blood pressure control and dietary needs, to name a few.

Finally, creative approaches should be used to help ensure staff compliance. One way to attain this is to have every staff member participate in chart audits. In this way, frequent errors can be identified and habits corrected.

II. A Dietitian's Perspective

The role of the renal dietitian has expanded in many areas within the last ten years. Kinetic modeling (Kt/V), continuous quality improvement, anemia management, renal osteodystrophy protocols, physical assessments and subjective global assessment (SGA) are all examples of areas where dietitians are involved in patient care. Finding specific, detailed guidelines for documentation in the outpatient dialysis unit may be challenging. The "new" renal dietitian may be asking, "Where do I start?" While the dietitian with an overwhelming "dietitian-to-patient" ratio may be asking, "What do I have to complete in order to be free of violation from federal regulations?" There are several publications available to the dietitian to help answer these questions.

The Code of Federal Regulations, published by (HCFA) describes minimum requirements for patient care in the outpatient dialysis facility. The first area

described by HCFA is the patient long term program and patient care plan. "There is a written patient care plan for each patient in the ESRD facility (including home dialysis patients under the supervision of the ESRD facility), based on the nature of the patients illness, the treatment prescribed, and an assessment of the patient's needs."¹ This regulation outlines the requirements of the Patient Care Plan and provides other valuable information regarding patient classification. The long-term care plan must be renewed every year and the patient care plan every six months. If the patient is unstable, then it must be reviewed monthly.

HCFA also outlines responsibilities of the dietitian at an outpatient dialysis facility. "Each patient is evaluated as to his or her nutritional needs by the attending physician and by a qualified dietitian. The dietitian is responsible for assessing the nutrition and dietetic needs of each patient, recommending diets, counseling patients and their families on prescribed diets, and monitoring adherence and response to diets."¹

Another publication helpful in discerning proper documentation and expectations of the dietitian is the "Suggested Guidelines for Nutrition Care of Renal Patients." This is a compilation of minimum patient care standards as reviewed by the Renal Practice Group (RPG) of the American Dietetic Association and NKF-CRN. This publication gives a specific time frame for when the assessment and initial plan of care should be completed. "Within one month of the initiation of

dialysis, admission to the facility, or 13 dialysis treatments, the renal dietitian will document in the patient's chart an assessment of nutritional status. The plan of care for nutritional management should be developed within one month of initiation of the dialysis process."²

The most recent reference for the adult dialysis patient is the Kidney Disease Outcomes Quality Initiative (K/DOQI). According to the K/DOQI Clinical Practice Guidelines for Nutrition in Chronic Renal Failure, "this plan of care should be modified every 3-4 months based upon the patient's medical and social situation. It is suggested that counseling sessions be intensive initially. Thereafter, counseling sessions should be provided (and documented) every one to two months. Obviously, these sessions should be conducted more frequently if deterioration in nutritional status occurs. Other recommendations include monthly assessment of albumin, nPNA for HD patients, and percent usual body weight; quarterly assessment of percent standard body weight and nPNA for PD patients; and bi annual assessment of dietary interviews/diaries and SGA"³

The above information provides the "basics" for what should be completed and documented by the dietitian in the dialysis unit. Obviously, the regular chart note should include the basic nutrition assessment and lab review items. For peritoneal dialysis patients, documentation of dialysate solution and estimation of calories absorbed is appropriate. There

(Continued on page 18)

are many other areas in which the dietitian is crucial in communicating or documenting information to other health professionals. A few examples of these areas would be Kt/V, PNA, iron status and supplementation, renal osteodystrophy, physical assessment findings and SGA.

No matter what method is used for documentation, the health care team must review recommendations in a timely manner. This may mean placing a copy of recommendations in the doctor or nurse manager's mailbox, or better yet, personally contacting the appropriate person. The dietitian has always provided unique and valuable perspective when assessing and making recommendations for the dialysis patient.

One final thought: The collective interpretation of the three publications mentioned above might be variable. It would be wise to establish specific policies and procedures regarding documentation for your particular unit and adhere to them.

III. A Social Worker's Perspective

Documentation for nephrology social workers in the dialysis clinic setting focuses on three major areas: initial psychosocial assessment, progress notes and care planning. The HCFA regulations can be found in the Code of Federal Regulations, Title 42, Part 405 Subpart U - Conditions for Coverage of Suppliers of End Stage Renal Disease. The regulations may be accessed at www.access.gpo.gov, under the Code of Federal Regulations, by typing "Title 42, Part 405 Subpart U" in the appropriate blanks.

Of the three major areas for social work documentation listed above, HCFA defines care planning with the most clarity, specifying time frames and persons responsible for creating and maintaining the long-term and short-term care plan. The long-term care plan is developed by the health care team and is designed to ensure that each patient is receiving the appropriate modality of care and appropriate care within that modality. As mentioned in the dietitian's perspective, it must be formally reviewed and revised in writing at least every 12 months, or more often according to the patient. The short-term care plan, also developed by the team, should be reviewed monthly for unstable patients and every six months for stable patients. The

HCFA regulations for both long-term and short-term care plans state that the patient, or where appropriate, parent or legal guardian, be involved with the health care team in the planning of care (Subpart U, Section 405.2139).

Psychosocial evaluation and progress notes are mentioned in the HCFA regulations, but no time frame for completion is defined. CNSW documentation guidelines include the completion of an initial psychosocial evaluation within 30 days of initiation of treatment and quarterly progress notes. CNSW also has recommendations for the content of an initial psychosocial evaluation. This is covered in more detail in the *CNSW Standards of Practice for Nephrology Social Work*, available from NKF.

The National Forum of ESRD Networks developed a "Medical Record Model," which was published in *Nephrology News & Issues* in 1994 and endorsed by a number of kidney organizations including the NKF. Similar to the CNSW recommendations, this model calls for the initial social work assessments to be completed within 30 days of admission to a facility with an annual update. Progress notes are recommended monthly on unstable patients and quarterly on stable patients. Care plans are to be done as specified by HCFA.⁴

HCFA specifies that ESRD facilities have written patient care policies on certain specific topics (Subpart U, Section 405.2135), which include the following:

- 1) Scope of services provided by the facility
- 2) Admission and discharge policies
- 3) Medical supervision and physician services
- 4) Patient long term programs, patient care plans and methods of implementation
- 5) Care of patients in medical and other emergencies
- 6) Pharmaceutical services
- 7) Medical records
- 8) Administrative records
- 9) Use and maintenance of the physical plant and equipment
- 10) Consultant qualifications, functions and responsibilities
- 11) Provision of home dialysis support services, if offered.

Depending on the dialysis clinic and definition of job roles, the nephrology social

worker may be responsible for providing the patient with information on these topics. Nephrology social workers should ensure that their clinics have written patient care policies on any topics for which they are responsible.

Nephrology social workers may also be involved in meeting the HCFA requirement that all patients be informed of their rights and responsibilities and the grievance mechanism, and documenting this in the medical record (Subpart U, Section 405.2138). Additionally, the Networks' model advises that a signed "receipt" of rights and responsibilities and grievance mechanism be in the record. Finally, a copy of any advance directive or documentation that the issue has been addressed, as applicable, with the patient is included in this model.⁴

Documentation requirements can be challenging to achieve but are vital components of patient care delivered by nephrology social workers.

IV. Conclusion

Each staff member must do his or her part in achieving correct and complete records. When a state surveyor enters a facility and sees that each area of the chart is complete and signed properly, it demonstrates that the facility is organized and committed to optimum patient care education.

It is necessary to review charting protocols frequently in any organization. Proper inservice education should have a significant impact on charting goals set by each unit. The key to a successful unit stems from proper and complete documentation.



RESOURCES:

1 Code of Federal Regulations, HCFA, HHS.405.2100 to 405.2163. April 1995.

2 Suggested Guidelines for Nutrition Care of Renal Patients. The American Dietetic Assoc. 2nd Ed. 1992

3 K/DOQI Clinical Practice Guidelines for Nutrition in Renal Failure. Am J Kidney Dis 35: (suppl 2), 2000.

4 Harbert, G. "A National Model for ESRD Patient Medical Records," *Nephrology News & Issues*, May 1994, pp. 40-42.