



EDUCATIONAL RESOURCES

Assessment & Detailed Documentation Promotes Improved Clinical Outcomes for Home Dialysis Patients

April McGraw, BSN, RN, CNN

 RENAL DIALYSIS



Objectives

- Describe the importance of proper documentation of home dialysis records to ensure continuity of care.
- Describe how a thorough physical examination can help you meet or exceed clinical quality benchmarks.
- Review the fundamentals of detailed documentation and how it can legally protect your employees and reduce risk to the organization.
- Learn how appropriate and accurate documentation is key to ensuring compliance with federal/state regulations.

Good Documentation is a Duty

- No one method of record keeping
- Recognized principles and standards
- A framework in maintaining accurate care records
- Good and accurate part of an interdisciplinary teams' duty of care
- A skill which needs to be performed with accuracy at all times

Basics of Good Documentation

- Ensure correct chart
- Chart as soon as possible.
- Use approved abbreviations
- Be accurate. Document what you see, hear, and do.
- Correct any errors as soon as noticed
- Ensure that findings are properly communicated, tracked, and acknowledged
- Avoid copying and pasting

Accurate Documentation Ensures

- Professional accountability
- Regulatory and observatory standards that facilitate evidence-based practices
- Nursing services are organized based on rational reasoning for clinical decisions

The Significance of Proper Documentation

- Critical in both patients' medical records and claims
- To preserve home dialysis programs
- To safeguard the lives of home dialysis patients
- To safeguard the livelihood of clinicians
- To avoid miscommunication between clinicians

Patient Records for Safety and Continuity of Care

- Must be useful and highly valuable to ensure continuity of care.
- Must be useful for planning and evaluating patient care
- Quality of nursing documentation is still a challenge between providers
- Documentation must be easy to carry out

Examples of the type of information to be included in patients' record by discipline

Master of Social Work

- Any memory or emotional and mental health concerns?
- Safe and supportive family unit?
- Financial advice or assistance available? Do they have insurance?
- Do they have an advanced directive or living will?
- Have they discussed any concerns with the healthcare team?
- Has your patient been evaluated for the kidney transplant?

Registered Dietitian

- Do you have any concerns about your patients' fluid gain or how much
- is being taken off during treatments?
- What is their nutritional status?
- Are they able to obtain medications?
- ***Any unintended weight changes?

Registered Nurse

- What is the length of time of your patients' dialysis treatment?
- Do they dialyze for the prescribed length of time?
- Is their PD catheter working properly?
- Do you have any concerns about your patients' lab results?

Registered Nurse Continued

- Are vaccinations up to date?
- Updated medication list?
- Issues with anemia?
- Complaints of fatigue?
- Smoker?

The Registered Nurse Role

- In charge of determining whether the patient need nursing care
- Responsible for the planning, implementing, and evaluating such care
- Generating effective notes
- Efficiently communicates with multiple disciplines

Case Study #1

Mr. Duck is in for his monthly clinic visit. He is currently an ADP patient that is thought to be non adherent with his treatments and currently not meeting Kt/V. What kind of documentation would you expect to see written in his notes post monthly clinic visit?

Process and Outcome Measures

- Process measures concentrate on the provider's precise actions
- Outcome measures attempt to capture the impact of care on a patient's health.
- Accurate documentation of outcome indicators, assess the health state of people with chronic diseases.

Intermediate Outcomes

- This type of metric aids in determining whether patients with chronic illnesses are being properly managed
- Their symptoms are being adequately controlled
- If not, they are far more likely to develop complications.

Clinical Benchmarking

- The process of establishing a standard of excellence
- Comparing a clinical function or activity as a whole with that standard
- Will be used increasingly by home dialysis programs
- Aim to reduce expenses
- Improve care and quality outcomes.

Clinical Benchmark Example

- To improve patient hand washing and PD catheter care practices to prevent infections.
- Use internal benchmarking to evaluate practices of each patient during clinic or home visit.
- Set goals for 100% hand hygiene compliance and PD catheter care

Thorough Physical Assessments

- Accurate, complete physical assessment identifies the scope of care needed
- Identifies additional treatment or education that the patient need
- Team assess which areas of patients' health that need immediate attention
- Goal to prevents bigger issues later on

Physical Assessment

At minimum should contain:

- Patient and family education
- Patient Assessment
- Assessment of the peritoneal dialysis catheter site
- Unexpected outcomes and additional interventions provided
- Pain assessment

Legal and Risk Implications

- Health record acts as the legal record of the care in a court of law
- Used by accrediting bodies and risk managers to assess the quality of care a patient receives
- To validate the care received, insurance firms use documentation systems
- Nursing documentation in the medical record can also be used for quality improvement programs, research, and education

The Best Defense

- The strongest defense against any malpractice or licensing board for nurses practicing in a specialized setting such as home dialysis, is accurate clinical records.
- The level of autonomy that home dialysis nurses have can open them up to legal ramifications when documentation is poor and good clinical judgement can't be ascertained.

Medical Records

- Facility must keep a well-organized medical record.
- Separately for each patient.
- Entries written, typed, or stored on electronic means
- Signed and dated by the author
- Facility must keep track missed visits
- Monthly physician progress notes required
- Reports from the lab and x-rays
- Annual history

Medical Record Inclusion

The medical record must be current and include the following information:

- Identification data (name, date of birth, gender)
- Diagnosis
- Primary care physician's name and phone number
- Responsible person or other individual to be notified in case of emergency and phone number
- Patient's address and phone number
- Date of admission

The Medical Record Inclusion Continued

- Patient was trained to perform dialysis in the home environment
- Method, frequency, and patient tolerance of dialysis sessions
- Support at least one face-to-face visit per month
- Lab results for both the current and previous month
- Annually standing orders modified. ***May vary by facility/company

On Site Documentation Retention

- One (1) year of medical records ***May vary by facility/company policy
- One (1) year of documentation of visits by a physician or other authorized healthcare provider. ***May vary by facility/company policy

Plan of Care

- The Interdisciplinary Team constructs the Individual Plan of Care
- Should guarantee optimal modality of care
- Within the first thirty (30) calendar days of care or within the first thirteen (13) treatments
- Developed based on the needs of the patient

Elements of Plan of Care

- Medical
- Psychological
- Social
- Dietary requirements
- Patient stability
- Diagnosis

Elements of Plan of Care

- Dialysis treatment type
- Patient stability (stable or unstable)
- If patient is a candidate for transplantation or home dialysis
- Dietary needs and interventions
- Psychological needs, goals, and interventions.
- The course of action to be taken
- The response and reaction to the treatment and/or services offered

Evaluation of Plan of Care

- At least once a month for unstable patients
- Once a year for stable patients
- For change in patient needs
- Document the participation
- Review and completion confirmed by the signatures and dates

Face to Face Visits

- Each billing period the provider:
- Completes the comprehensive assessment
- Creates the patient's plan of care
- Provides continuous management

Case Study #2

Mrs. Mouse is consistently above her EDW target and below her Kt/V goal. She is 29 y/o x 15 years (HHD and PD). Currently on PD x 1 yr 10 mth due to vascular access failure and is exhausted of vascular options for further HD/HHD.

- PET= HA
- APD Rx=2000x5 with a dwell time of 86 minutes + 500 LF and Midday.
- Patient states that she is “too busy during the day.”

Would you expect to see written in her plan of care?

Necessity of Documentation

- Organizes the nursing care chain
- Improves patient outcomes
- Shows that a nurse has applied nursing knowledge pursuant to Nurse Practice Act
- Nurse has applied skills, and judgment in accordance with professional nursing standards.
- Improves communication and teamwork

The Details Matter

- Clinicians may feel there aren't enough hours in the day to check every box and triple-check every detail in a home dialysis setting
- Paying close attention to detailed charting standards is never a waste of time.
- Details save lives
- Good documentation prevents nurses from having to defend their acts in court in the future.

Federal and State Expectations

- The government ties compensation to the accuracy of the medical record
- Your documentation should be in keeping with the treatment plan
- Should adhere to all applicable federal, state, and local laws
- Adhere to professional and ethical requirements
- It should also reflect the coding and billing methods that have been created

Benefits of Proper Documentation

- Research
- Qualitative assessment
- Safeguard home dialysis programs
- Safeguard your home dialysis patient
- Safeguard clinicians

Consequences of Poor Documentation

- Communication between health professionals break down
- Poor care, mistakes, and miscommunication may result
- Claims cannot be supported by the medical record
- Billing issues
- May be unable to show that facility deserves to receive/keep payment

Case Study #3

- A dialysis facility billed Medicare for multiple antibiotics allegedly provided to a Medicare beneficiary treating in the home training department of a dialysis facility.
- The home facility presented this medical record when pressed by Medicare to justify the charges.
- This medical record from several clinic visits only has complaints as abdominal pain and elevated temperature as subjective and objective data.

The Missing Pieces

- Unknown if the beneficiary had cultures drawn
- Missing organism result & sensitivity report
- Unknown if the beneficiary required antibiotics
- No evidence that the results were reviewed by a physician

This billing issue may have been avoided if better documentation practices had been used



References

- Daly P. Clinical nurses lead the charge with EHR. *Nursing*. 2015;45(10):25–
<https://doi.org/10.1097/01.NURSE.0000471426.47075.d2> PMID:26372237. [[PubMed](#)] [[Google Scholar](#)]
- Jefferies D, Johnson M, Griffiths R. A meta-study of the essentials of quality nursing documentation. *Int J Nurs Pract*. 2010;16(2):112–24. <https://doi.org/10.1111/j.1440-172X.2009.01815.x> PMID:20406. [[PubMed](#)] [[Google Scholar](#)]
- Karimi Moonaghi H, Emami Zeydi A, Mirhaghi A. Patient education among nurses: bringing evidence into clinical applicability in Iran. *Invest Educ Enferm*. 2016;34(1):137–151. <https://doi.org/10.17533/udea.iee.v34n1a16> PMID:28569983. [[PubMed](#)] [[Google Scholar](#)]
- Nakate GM, Dahl D, Petrucka P, Drake KB, Dunlap R. The Nursing Documentation Dilemma in Uganda: Neglected but Necessary. A Case Study at Mulago National Referral Hospital. *Open Journal of Nursing*. 2015;5(12):1063–1071. <https://doi.org/10.4236/ojn.2015.512113>. [[Google Scholar](#)] <https://oig.hhs.gov/newsroom/oig-podcasts/importance-documentation/>

References Continued

- O'brien A, Weaver C, Hook ML, Ivory CH. EHR documentation:the hype and the hope for improving nursing satisfaction and quality outcomes. Nursing administration quarterly. 2015;39(4):333–<https://doi.org/10.1097/NAQ.0000000000000132> PMID:26340245. [[PubMed](#)] [[Google Scholar](#)] <https://pubmed.ncbi.nlm.nih.gov/10139084/>
- Valdez-Delgado K, Barba M, Kulyen A, Colston P, Boyer S, Mann-Salinas E. Evolution Of An Evidence-based Competency Assessment Program For Specialty Nursing. J Crit Care Med. 2018;46(1):485. <https://doi.org/10.1097/01.ccm.0000529009.61144.72>. [[Google Scholar](#)]
- The quality of nursing documentation is still a challenge in the nursing profession and, thus, in the health care industry. [Open Access Maced J Med Sci](#). 2018 Aug 20; 6(8): 1527–1532. Published online 2018 Aug 19. doi: [10.3889/oamjms.2018.303](https://doi.org/10.3889/oamjms.2018.303)



EDUCATIONAL RESOURCES

Thank you

 RENAL DIALYSIS



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE

