HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
DATE OF BIRTH	M.O.

HOSPITAL / WARD:

HNEMR144

Facility: _____

NEPHROLOGY SERVICES
HAEMODIALYSIS TREATMENT CHART

HNE024300

Print Patient Name and Check label Correct:

Date of Treatment:		**WEIGHT & VOLUME CALCULATIONS**	
Treatment Start Time:		Pre-dialysis Weight	
Treatment Completion Time:		Ideal body Weight (IBW)	
Machine ID/ Chair No:		Today's goal weight	
Heat Disinfect:	☐ Yes	Loss (-) / Gain (+)	
Bleach test clear:	☐ Yes ☐ N/A	Wash on/off Allowance	
Prescription Date:		Oral Intake	
*Alteration:	☐ Yes ☐ No	Others & Flushes	
Comments:		**TOTAL UF VOLUME:**	
Ultrafiltration (UF) and Machine Check - Nurse initials:	Nurse 1 / Nurse 2	**Other Instructions:**	

OBSERVATIONS	Time	BP Sit	BP Stand	HR	RR / Temp	O2 Sat	BGL*	Vurea
Pre Dialysis								

Time	BP	HR	AP	VP	TMP	UF Rate	Accumulate UF Vol	Flushes/ Bolus	Heparin rate/syringe Vol	comments

Notes:
1. This form is to be used in conjunction with the Haemodialysis Prescription and BVM record chart
2. All changes of treatment during dialysis should be documented in the patient's progress notes
3. *Denotes if required

211211

BINDING MARGIN – DO NOT WRITE

NEPHROLOGY SERVICES – HAEMODIALYSIS TREATMENT CHART

Nursing Notes

HUNTER NEW ENGLAND LOCAL HEALTH DISTRICT

Facility: _____

NEPHROLOGY SERVICES
HAEMODIALYSIS TREATMENT CHART

PLEASE USE GUMMED LABEL IF AVAILABLE

SURNAME	UNIT NUMBER
OTHER NAMES	
ADDRESS	
DATE OF BIRTH	M.O.

HOSPITAL / WARD:

VASCULAR ACCESS

Fistulas/Grafts	**Assessments**	**Interventions**
Site: ☐ tick if not applicable	☐ Able to feel pulse ☐ Able to feel thrill ☐ Able to hear bruit ☐ Signs of infection ☐ Signs of Aneurysm ☐ Painful access site ☐ _____ % Recirculation ☐ Need regular monitor for needles dislodgement ☐ Access is visible and against a pale background	e.g. Ultrasound, referrals, swab, blood cultures etc. Name / Designation: Signature:
Permcath/Vascath	☐ Exit site clean and dry ☐ Signs of infection ☐ Dressing dry and intact ☐ Dressing wet/missing/not intact ☐ Problems with blood flows ☐ Locks removed ☐ Cuffs to exit site _____cm	e.g. alteplase, referrals, re-suture, swab, B/C, reverse required during dialysis etc. Name / Designation:
Site: ☐ tick if not applicable	☐ Access is visible and against a pale background	Signature:
Dressing	Dressing attended ☐ Yes ☐ No Dressing Instructions:	
☐ tick if not applicable	Name / Designation:	Signature:

MEDICATION

This section is used to counter sign medications that have been ordered on the HNE Dialysis Prescription form that has been completed by a Medical Officer or Nurse Practitioner for dialysis treatment related medications as per the HNE Renal Guidelines and Procedures.
NOTE: Hospital inpatients undergoing dialysis must have all drugs documented on their inpatient medication chart

Name	Interventions	Nurses Signature	
Anticoagulant	☐ Load / ☐ Infusion	Nurse 1	Nurse 2
	☐ Locks	Nurse 1	Nurse 2
Local Anaesthetic	☐ Subcutaneous	Nurse 1	Nurse 2
sodium chloride 0.9% (Normal Saline)	☐ Prime dialysis circuit & flushes	Nurse 1	Nurse 2
	☐ Infusion ml (total)	Nurse 1	Nurse 2

OBSERVATION POST DIALYSIS	Time	Weight	BP Sit	BP Stand	HR	RR / Temp

Substitution Volume	Kt/V	BGL*	BVM*	Access Check
				☐ AVF/ AVG stopped bleeding and dressing insitu or ☐ Catheter clamps and caps secured

☐ Second Observation required *

Time	BP Sit	BP Stand	HR	RR / Temp	O2 Sat

Discharge Destination:		**Discharge Transport:**	
Name / Designation		**Signature**	

BINDING MARGIN – DO NOT WRITE

211211