

**NATIONAL STANDARDS ON DOCUMENTATION FOR  
CARDIOTHORACIC TRANSPLANT PATIENTS**

**Published: March 2002**

**Revised: September 2009**

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## **NATIONAL STANDARDS ON DOCUMENTATION FOR CARDIOTHORACIC TRANSPLANT PATIENTS**

### **1 INTRODUCTION**

Following the recommendations of the Commission for Health Improvement (CHI) Investigation into Heart and Lung Transplantation at St George's Healthcare NHS Trust (2001) the former UK Transplant Cardiothoracic Advisory Group (UKT CTAG) was given the remit to:

“Develop a national protocol for recording the written and verbal information given to heart and lung transplant patients in patients' notes.”

This standard has been produced by CTAG. The paramount importance of maintaining accurate records is an integral part of patient care. Inadequate documentation may lead to neglect in patient care. Effective documentation is important to help prevent breakdown in communication within the multi-disciplinary approach and to ensure continuity of care. A further purpose of accurate documentation is to maintain evidence of care received by the patient and to provide an accurate, concise record of information pertaining to the condition of the patient (UKCC 1993).

The standards set out in this document are in accordance with the General Medical Council's (GMC) expectations (set out in the GMC Good Clinical Care 2001) that state the following:

“Keep clear, accurate, legible and contemporaneous patient records which report the relevant clinical findings, the decision made, the information given to the patients and any drugs or other treatment prescribed.”

This document sets out the minimal accepted standard on documentation for cardiothoracic transplant patients. Key issues must be discussed and documented in the patient's notes.

### **2 REVIEW**

This document will be reviewed every two years, or more frequently as need occurs.

### **3 DOCUMENTATION**

#### **3.1 Aim**

To ensure accurate and concise documentation of the whole process of referral, assessment, waiting list registration, transplant operation, post-operative stage, drug therapy, side effects, and follow-up care. Also, that advice on when and how to seek help is given to the patient and that this is recorded in the patient's case notes (Commission for Health Improvement 2001), thus ensuring that consistent, complete and accurate open communication is maintained with the patient and other healthcare professionals.

#### **3.2 Essential Components**

All pertinent information is given to the patient and is documented to the following standards:

Clear and concise

Unambiguous

Written legibly

Accurate in context with time and date recorded

Black ink used only

Any errors to be crossed out with a single line, with initials and dated

All entries signed with name, printed name with designation, date and time

Abbreviations not to be used.

#### **3.3 Ethical Considerations for Documentation**

Documentation should demonstrate the ethical principles on which good clinical practice is based and highlight the clinical and professional decisions made (UKCC 1993). Documentation should take into consideration confidentiality in accordance with the Caldicott Report (1997), the GMC Good Clinical Care (2001) and the NHS Strategy for Confidentiality (2001). All documentation should reflect the truth and be accurate. Informed consent for all procedures must be obtained in accordance with the DOH guidelines on consent (2001). Centres are strongly advised to ensure that all relevant documentation is completed, processed and appropriately filed in a secure manner in accordance with Caldicott principles and the Data Protection Act (1998).

### 3.4 **Legality of Documentation**

Any documentation that reflects any care of the patient may be used as evidence before a court of law or in a professional conduct hearing including the General Medical Council. It is also imperative that accurate documentation is maintained in light of increasing litigation cases.

**It is the responsibility of all healthcare professionals to ensure that accurate and updated information is documented in the patient's case notes. The following areas must be documented in the patient's case notes.**

## 4 **REFERRAL PROCESS – KEY DOCUMENTATION**

- q Referring hospital, consultant and referral letter
- q Discussion with referring hospital
- q Appointment allocated to the patient
- q Request for any results of tests and copies of medical notes to be forwarded to the transplant centre
- q Outcome of the referral including communication with the GP.

## 5 **ASSESSMENT PROCESS – KEY DOCUMENTATION**

- q Past medical/surgical history
- q Details of medication taken regularly, or recently
- q Results of investigations
- q Informed consent for procedures
- q Investigations performed
- q Details of written and verbal information given to the patient, including prognosis of patient
- q Letters to GP and referring clinicians, as appropriate.

## 6 **THE WAITING LIST – KEY DOCUMENTATION**

- q The patient's long-term expectations and commitment regarding transplantation
- q The decision to add the patient to the National Transplant Waiting List by registration with NHS Blood & Transplant
- q The importance of open communication with the transplant centre regarding any changes in the patient's physical or social circumstances
- q The patient's responsibility to be available for transplantation 24 hours a day
- q No guarantee that a transplant will proceed even if the patient is called into the hospital

- q The sequence of events when a donor is notified to the transplant centre and how organs are allocated
- q What to do when called for transplantation
- q What to expect when attending the transplant centre for potential transplant
- q Explanation of immediate post-operative care including the intensive care and the post-operative ward.

## **7 PATIENT EDUCATION – KEY DOCUMENTATION**

- q The patient's knowledge base and attitudes to transplantation should be identified and an individual educational programme instigated and documented
- q Side effects of drug therapy and the emphasis on compliance with treatment
- q Details of drug therapy including purpose, side effects, time schedule and dosage
- q Post-operative care, procedures and long-term follow-up
- q Discussions on rejection, graft loss and the possibility of death
- q Increased risk of infection
- q Monitoring the patient's progress with the education.

## **8 THE OPERATION – KEY DOCUMENTATION**

- q All risks involved with the operation including mortality and morbidity
- q Prognosis without a transplant
- q Informed consent.

## **9 POST OPERATIVE PERIOD – KEY DOCUMENTATION**

- q All NHS Blood & Transplant documentation should be fully completed and processed
- q Intra-operative anaesthetic chart
- q Operation procedure
- q Any intra- and post-operative complications
- q Intensive care chart
- q Ward charts
- q Other conditions
- q Clinical information
- q Blood results
- q Immunosuppression and other drug therapy
- q Any investigations
- q Condition of the patient.

## **10 DISCHARGE – KEY DOCUMENTATION**

- q Review of knowledge base post-education and teaching
- q Independent in the management of his/her drugs with a good basic understanding of drug actions and side effects
- q Aware of the implications of diet and exercise
- q Aware of the signs and symptoms of rejection, the appropriate action to take and the rejection therapy required
- q Aware of the risk of infection and the need to report infection episodes to the hospital promptly. He/she should understand the basic principles of infection prophylaxis
- q Sex and contraception
- q Holidays
- q Temperature recording
- q Hygiene
- q Mixing with the general public
- q Vaccinations
- q The importance of the post-transplant outpatient clinics and the procedure for contacting the transplant centre
- q Rehabilitation.

## **11 FOLLOW-UP – KEY DOCUMENTATION**

- q Routine outpatient tests
- q Drug dosage
- q General progress of patient
- q Any actions or changes in management
- q Other conditions

## **12 SUMMARY OF STANDARD DOCUMENTATION FOR CARDIOTHORACIC PATIENTS**

- q The documentation in the patient's case notes should reflect the chronological proceedings that have occurred with the patient including the referral, assessment, waiting list, education, transplant operation and follow-up care that is received
- q The documentation must be presented in a clear and unambiguous manner
- q The documentation should provide an effective open communication between healthcare professionals and support continuity of patient care
- q The documentation demonstrates that the healthcare professionals' duty to care has been fulfilled (UKCC 1993).

## REFERENCES

Commission for Health Improvement (2001) Investigation into heart and lung transplantation at St George's Healthcare NHS Trust

Data Protection Act (1998) London. Her Majesty's Stationery Office

Department of Health (2001) Good practice in consent implementation guide: consent to examination or treatment

Department of Health (1997) Caldicott Report

General Medical Council (2001) Good Clinical Care

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1993) Standards for Records and Record Keeping