

Peritoneal Dialysis: Pre-Dialysis Assessment / Monitoring the patient while on dialysis / Post-Dialysis Assessment

Site Applicability

VCH

Practice Level

RN with additional education and training in peritoneal dialysis.

Background Information

A baseline assessment is necessary to guide treatment decisions.

Quick Links to

- [Pre-Dialysis Assessment](#)
- [Monitoring the patient while on Dialysis](#)
- [Post-Dialysis Assessment](#)

PRE-DIALYSIS ASSESSMENT

Problem Statement

Detailed and complete assessment and documentation are necessary for the evaluation of multidisciplinary treatment plans.

Goal

This assessment will provide a foundation for evaluation of quality of care.

Intervention

To perform multidisciplinary assessment.

Preparation

Have patient remove shoes and outdoor clothing.

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Procedure

Evaluation of:

1. Physical and Medical Status
 - a. Temperature
 - b. Pulse - rate, rhythm, quality
 - c. Blood glucose monitoring if necessary
 - d. Blood pressure lying and standing
 - e. Volume Status - weight, respirations, breath sounds, neck vein distension, presence or absence of edema, fluid intake and output, skin turgor, mucous membranes, and dizziness
 - f. Bowel status - regular bowel habits are imperative for PD fluid inflow and outflow
 - g. Laboratory and other reports such as radiology as ordered
 - h. Medications - any changes to the medication profile since previous visit
 - i. General condition - cause of renal failure, any injuries or complications or co-morbidities
 - j. Diet plan
 - k. Parenteral fluid evaluations
2. Catheter Patency – integrity of the catheter and tubing
3. Exit Site Condition:
 - a. External evaluation – evaluate for pain, swelling, drainage, color, granulation tissue, scabs, crusts, infection, swelling, trauma,
 - b. Sinus Evaluation – raise tubing gently and assess for granulation and epithelium tissue, presence of drainage
4. Willingness for self care and self concept
5. Determination of family support

Documentation

Includes:

- Type of equipment, inflow volume, dwell time, fluid removal, administration, weight adjustment, dialysate strength, medication, diet or other therapies administered, lab request.
- Information pertaining to assessment, planning and provision of care with anticipated outcomes is documented and accessible to all members of the multidisciplinary team.
- Documentation using the following:
 - Kardex, PROMIS, Nursing notes, Progress notes, medication profile, laboratory results flow sheet
 - Patient Admission assessment

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Monitoring the Patient while on Dialysis

Problem Statement

Patients are at risk of peritonitis and hyper/hypovolemia, hyperglycemia

Goal

The patient will receive a safe and effective treatment.

Procedure

1. It is important for the patient to lie flat when full of dialysis solution (DS) during the first two weeks post catheter insertion to prevent leakage or extravasation into tissues.
2. Monitor fluid status throughout the treatment. It is important to determine the adequacy of the drainage as well as the overall fluid balance. Weigh patient empty following three to four exchanges. Check blood pressure lying and standing. Ensuring complete drains also ensures that a patient does not become distended or respiratory compromised. Removal of large amounts of fluid can lead to hypovolemia and hypotension.
3. In the diabetic or pre-diabetic patient the high dextrose solutions can lead to hyperglycemia. Assess blood glucose levels closely. Intraperitoneal or subcutaneous insulin is administered as ordered.
4. Monitor exit site condition using the Exit Site Evaluation Guide. Ensure that the catheter is anchored securely to prevent trauma. Remove sutures in 7 – 10 days.
5. Assess patient for pain on inflow/outflow.
6. Assess patient for shoulder pain.
7. Assess rate of DS inflow/outflow.
8. Assess integrity of the system.
9. Assess for color and clarity of the drainage every drain. If the drainage looks cloudy a sample taken from the sample port should be sent for a Gram stain, white cell count and differential and C&S.
10. Assess drainage for fibrin.
11. Assess bloodwork for signs of hypoalbuminemia, which can be caused by protein losses in the dialysis drainage.

Documentation

Nurses notes, history, and dialysis flow sheet

Post-Dialysis Assessment

Problem Statement

Ongoing assessment is important in the prevention of complications related to peritoneal dialysis.

Goal

The assessment of the patient's response to treatment on an ongoing basis is important to the provision of care.

Procedure

1. Assess patient for signs of swelling/leakage of fluid in tissues
2. Vital signs-temperature, pulse, respirations, lying and standing blood pressure
3. Assess volume status by doing post weight
4. Ensure the dressing is dry and intact and the catheter is safely anchored to the skin
5. Ensure the cap is on the tubing securely

Documentation

Nurses notes, dialysis flow sheet

ASSOCIATED GUIDELINES / FORMS / EDUCATIONAL MATERIAL:

- [P-269 - Peritoneal Dialysis: Twin Bag Procedure\[D-00-12-30316\]](#)

References

Prowant, B., Ponferrada, L. & Satalowich, R.(2008) Peritoneal Dialysis. In Counts, C. (Ed.) Core Curriculum for Nephrology Nursing, Fifth Edition.(pp.765-851) Pitman, NJ: American Nephrology Nurses Association

UNIT(s) OF ORIGIN: Peritoneal Dialysis Unit

Approved for Posting

Director Professional Practice Nursing, Vancouver

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Alternate Search Terms

PDU

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