Patients info label here

Peritoneal Dialysis

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Deficient knowledge *Related factors:* New Diagnosis Treatment regimen *Symptoms / Risk factors:* Multiple questions Verbalization of the problem *Outcome / Goal:* Patient verbalize understanding of disease and procedure		**Teaching: Disease Process** Acknowledge patient's knowledge about condition Assess knowledge of the disease and treatment Outline normally expected limitations, if any, on ADLs Explain home care measures:intake and output and BP measurement Emphasize need for long-term follow up and periodic reevaluation. Identify appropriate community resources Explain need for follow-up care **Teaching: Procedure/Treatment** Explain the purpose of the procedure/treatment Include the family/significant others, as appropriate Explain the use of peritoneal catheter (placed on the abdominal wall) Explain how it removes excess fluid and waste products from the body Explain the various types of dialysis: IPD, CAPD and CCPD	
	Risk for imbalanced fluid volume *Related factors:* Renal insufficiency Increased peritoneal permeability *Symptoms / Risk factors:* Acute weight gain Elevated BP Peripheral edema *Outcome / Goal:* Patient's fluid volume excess is reduced Normal vital signs Normal weight No edema		**Peritoneal Dialysis Therapy** Optain baseline weight when peritoneal cavity is empty, then every day Measure inflow and outflow (outflow should be greater than or equal to inflow) Monitor vital sign (BP and pulse) Assess patency of catheter, noting difficulty in draining Check tubing for kinks; note placement of bags. Change position frequently. Head of bed 45 deg. Turn side ot side Monitor abdominal distention associated with decreased bowel sounds. Monitor breathing sounds and change in effort of breathing Instruct fluid restrictions as appropriate Elevate edematous extremities Assess for headache, muscle cramps, mental confusion, and disorientation. Monitor lab results (sodium) Note reports of dizziness, nausea, and increasing thirst.	
	Risk for trauma *Related factors:* Catheter insertion *Symptoms / Risk factors:* Pain and bleeding Weakness *Outcome / Goal:* Experience no injury to bowel or bladder.		**Peritoneal Dialysis Therapy** Assess patency of catheter, noting difficulty in draining Check tubing for kinks; note placement of bags. Have client empty bladder before peritoneal catheter insertion Note presence of fecal material in dialysate effluent Monitor report of pain and or bleeding from catheter insertion area Note reports of intense urge to void or large urine (when start of dialysis)	
	Acute pain *Related factors:* catheter irritation Actual infusion of dialyse Inflamed bowel Bladder distention Insertion of catheter *Symptoms / Risk factors:* Abdominal distention Verbal or coded report Bleeding *Outcome / Goal:* Patient appears relaxed and comfortable		**Pain Management** Asses cause of pain Assess reports of abdominal cramping or pain Explain reasons for inflow pain Change the patient's position Instruct patient to relax and rest Investigate changes in characteristics of pain. Make sure the dialyse fluids are warm Slow infusion rate, as indicated. Administer medication as prescribet Obs. pain (effectivnes of medication) Obs vital signs_____ **Analgesic Administration** Administer medication as prescribet Obs. pain (effectivnes of medication)	

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Peritoneal Dialysis

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for infection *Related factors:* Indwelling catheter (contamination) *Symptoms / Risk factors:* Body temp. higer than_____ Stasis of body fluids *Outcome / Goal:* Norma body temperature Be free of signs of infection		**Infection Protection** Monitor client's vital signs and signs of possible hemorrhage and perforation Obs laboratory values (e.g., white blood cell count, protein and albumin) Observe and report signs of infection such as redness, Promote good hand washing by staff and client. Use proper hand washing techniques before and after giving care to client Use strict aseptic technique, IV, Tubes, drains and catheters	
	Ineffective breathing pattern *Related factors:* Abdominal pressure Restricted diaphragmatic excursion *Symptoms / Risk factors:* Decreased minute ventilation Dyspnea *Outcome / Goal:* Maintain adequate ventilation		**Respiratory Monitoring** Monitor rate, rhythm, depth, and effort of respirations Monitor for increased restlessness, anxiety, and air hunger Asses O2 saturation and arterial blood gases Elevate head and encourage frequent position changes obs. changes in O2 saturation and breathing sounds_____ Obs. lab results of electrolytes (Na(136-146),K(3,6-4,9) Administer analgesics, as indicated.	

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