Patient Assessment and Observation: What Should I Report to the Nurse

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Session Objectives

• Describe identifying reportable events, prior to initiating dialysis
• Describe 3 observations of uremic symptoms
• Describe how to identify potential complications and facilitate early intervention
Data Collection Process

- Interview: Questions
- Observation: Look, Listen, Feel

Report Abnormal Findings
Data Collection Process: Interview

Sample Questions:

• Did you have any problems at or since your last treatment?
• Did you fall or have medical attention since your last treatment?
• Do you have pain or tenderness over access?
• Do you have numbness, tingling, or decreased use of your extremity?
• Any bleeding or oozing from needle sites?
Data Collection Process: Interview

Report complaints voiced during social conversation

- Fatigue and flu-like symptoms
- Decreased urine output
- Poor appetite and or metallic taste
- Pain
- Dyspnea (trouble breathing)
- Sleep problems
- Sexual problems

Technicians should report these uremic symptoms to the nurse.
Data Collection Process: Observation

- Look = INSPECTION
- Listen = AUSCALTATION
- Feel = PALPATION
Observation: Inspection

- Note nonverbal and verbal behavior
- Edema (swelling) in the feet, hands, and face
- Itching
- Ammonia breath
- Dyspnea (trouble breathing)
- Yellow skin complexion
- Confusion

Technicians should report these uremic and fluid overload symptoms to the nurse.
Observation: Inspection

What do you report?

Bilateral symmetry

Aneurysm or pseudo aneurysm

S & S of infections:
- Redness
- Tenderness
- Pain
- Drainage

Hematoma
Observation: Auscultation

LISTEN to the patient’s access with a stethoscope to HEAR the bruit in access.

Normal Findings:
- Low-pitched
- Continuous “whooshing” sound
- Fistula: Loudest anastomosis
- Graft: loud throughout

Abnormal Findings:
- Whistling
- No sound

Technicians should report vascular access symptoms to the nurse.
Observation: Palpation

The THRILL is a gentle buzzing feeling

FEEL the entire access when determining the cannulation sites

Normal Findings:
- Fistula; strongest anastomosis
- Graft; constant throughout
- Soft pulse maybe ok

Abnormal Findings:
- Warm or cooler
- Bounding or weaken thrill
- Tenderness or pain
- No THRILL = DO NOT CANNULATE

Technicians should report vascular access symptoms to the nurse.
Observation: Pre-Treatment

- Vital Signs
- Interview questions
- Vascular Access
  - inspection
  - auscultation
  - palpation
Observation: Vital Signs

- **Blood pressure monitoring:**
  - Cuff size
    - too large - false low readings
    - too small - false high readings
  - Placement
    - pressures arm vs leg

- 130/80 is considered normal. See interpretive guidelines.
Observation: Pre-Treatment

Reportable events for early intervention

- Elevated BP, Temp, Pulse, Breathing issues
- Recent Falls, bruising, hematoma
- Muscle weakness
- Symptoms of purple, mottled, painful skin
- Altered LOC-such as
  - changes in alertness, confusion, stupor

DO NOT INITIATE BEFORE NURSE ASSESSES
Observation: Vital Signs

BP data collection pre, intra, and post or if symptomatic:

Hypertension S & S:
• Mild Hypertension 130/85
• Severe Hypertension 180/110
• Crisis 210/120
• Taken sitting and standing
• Nervousness
• N & V
• Headache
• Blurred vision
• Dizziness
• Seizures

Technicians should report variations of VS to the nurse
Observation: Vital Signs

BP data collection pre, intra, and post or if symptomatic:

Hypotension S & S:

- Yawning
- <100/60 blood pressure
- Feeling warm
- Urge to defecate
- Feeling anxious
- Blurred vision
- Hearing loss
- N & V
- Pallor, weakness
- Feeling faint
- Seizure or unresponsive

Technicians should report variations of VS to the nurse
Observation: Vital Signs

**Pulse** data collection pre, intra, post or if symptomatic:

**Normal Findings:**
- 60-100 beats/minute
- Regular rhythm
- Post pulse higher than pre

**Abnormal Findings:**
- < 60 is bradycardia
- >100 is tachycardia
- Irregular rhythm

Technicians should report variations of VS to the nurse
Observation: Vital Signs

Temperature data collection pre, post, and if symptomatic:

Normal findings:
• Afebrile

Abnormal findings:
• Chills or rigors
• Flushing
• Body aches

Technicians should report variations of VS to the nurse
Observation: Vital Signs

Respiration data collection pre, post, and if symptomatic:

**Normal Findings:**
- 14-20 breaths/min
- Even breathing
- Relaxed

**Abnormal Findings:**
- Rapid breathing >20 breaths/min
- Labored
- Audible wheezing
- Frequent coughing
- Confusion

Technicians should report variations of VS to the nurse.
Observation: Intra Treatment

Reportable events for early intervention:

Data collection:
- Vital Signs
- Ultrafiltration Rate
- Extracorporeal circuit
  - visible at all times
- Blood Flow Rate
  - $AP > -250 \ or \ VP > 250$
- TMP trending up

Complications:
- Level of consciousness
- Cramps
- Exsanguination
  - Death in 4-5 mins
- Hemolysis
  - $AP > -250 \ or \ VP > 250$
- TMP
  - Clotting in the circuit
Potential Complication

Clotting in the circuit

Signs/Symptoms:
• Dark blood
• Elevated VP and TMP
• Clots in extracorporeal circuit

Prevention:
• Administer correct heparin dosage
• Maintain appropriate blood flow rates
• Minimize alarm response time
• Purge air

Technicians should promptly report variations to the nurse
Observation: Post Treatment

• Normal Findings:
  • Access:
    • secure with hemostasis
    • bruit and thrill present
  • Target weight achieved
  • Stable VS

• Abnormal Findings:
  • Unexpected post Weights
    • > target weight
    • < target weight
  • VS unstable with symptoms

Technicians should promptly report variations to the nurse
Final Thoughts

Refer to the clinic Policy & Procedures Manual

Policies and Procedures

When in doubt report to the nurse