# Nursing Care of patients with Renal Failure



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# Goals of nursing care

The nursing goals of care of patients with renal failure are

- To correct or eliminate any reversible causes of kidney failure
- To provide support by taking accurate measurements of the intake and output of all body fluids.
- To monitor vital signs
- To maintain proper electrolyte balances

# Fluid intake and output management

Accurately record fluid intake and output

- This includes hidden fluids such as IV medications, additives and oral liquid medications.
- As well as fluid losses in urine and estimated insensible losses e.g. sweat, wound drainage, stool/diarrhoea

- A decrease in output to less than 400mls per 24hrs may indicate acute renal failure
- Therefore, monitoring input/output is necessary for determining renal function, as well as fluid replacement needs and reducing the rise of fluid overload

# Daily weighing

- Done at the same time of the day, using the same scale with the same equipment and clothing.
- This can be a useful tool in assessment of fluid status
- A weight gain of more than 0.5kg/day suggests fluid retention

# Assess for oedema

- Assess skin, face and dependant areas for oedema(hands, feet, saccral region when lying down)
- Evaluate the degree of oedema.
- Patient may have gained about 4.5kg of fluid if pitting oedema is detected.
- Peri-orbital oedema may be a presenting sign of fluid shift because these tissues distend easily even with minimal fluid
- Auscultate lung for additional breathing sounds which may be a sign of pulmonary oedema

# BP, heart rate, JVP monitoring

- Hypertension and tachycardia may occur due to failure of the kidneys to excrete urine.
- It may also occur due to excessive fluid resuscitation during efforts to manage hypovolemia and/or hypotension.
- Auscultate heart sounds for any added sounds and asses the jugulovenous pressure and pulse for assessment of heart failure.

# Assess level of consciousness

- Assess and investigate changes in mentation and restlessness.
- These may reflect acidosis, electrolyte imbalances, hypoxia, or an accumulation of toxins in the case of uremic encephalopathy

# Safety of patients

- Use appropriate safety measures i.e. raising the side rails and restraints, especially in patients with CNS involvement as they may be dizzy, confused or delirious

# Salt restricted diet

- Choose and prepare foods with less salt (sodium)
- The diet should contain less than 2300mg of sodium, or the equivalent of ¼ tablespoon per day.
- It is advised to have the food cooked fresh, avoiding fast foods, frozen and pre cooked meals. Canned vegetables should be rinsed
- Look for low sodium/sodium free foods on the labels of packaged foods
- Work with a dietician to develop a meal plan

# Additional care

- Monitor and meet blood glucose targets in patients with diabetes
- Work with your healthcare team to monitor kidney health
- Ensure patient takes medications as prescribed on time
- Make physical activity part of the patient's routine.

# Additional information

Advise the patient and/or caretakers to look out for the following and seek urgent medical attention

- Excessive nausea and vomiting
- Low blood pressure
- Shortness of breath
- Reduced/no urine output (oliguria and anuria)
- Unresponsive or sudden change in the patient's mental state

Thank you