Peritoneal Dialysis
Functional Assessment

The functional assessment provides examples of basic skills that are needed to be able to perform and manage Peritonal Dialysis.

Instructions to perform the functional assessment:

1. Gather supplies and place them on a working surface.
2. Nurse to demonstrate and verbally describe basic skill (#1-8) as it is performed.
3. Have patient perform each basic skill (#1-8) following.
4. Patient to complete basic skill #9 and #10 without assistance.
5. Nurse to document observations.

Supplies required

- Transfer set with white mini cap
- Mini cap
- Red clamp
- Mask
- PD solution bag with tubing and colored pull ring attached
- 2 liter PD solution bag
- Tongue depressor
- IV pole
- Pencil/pen

Resources

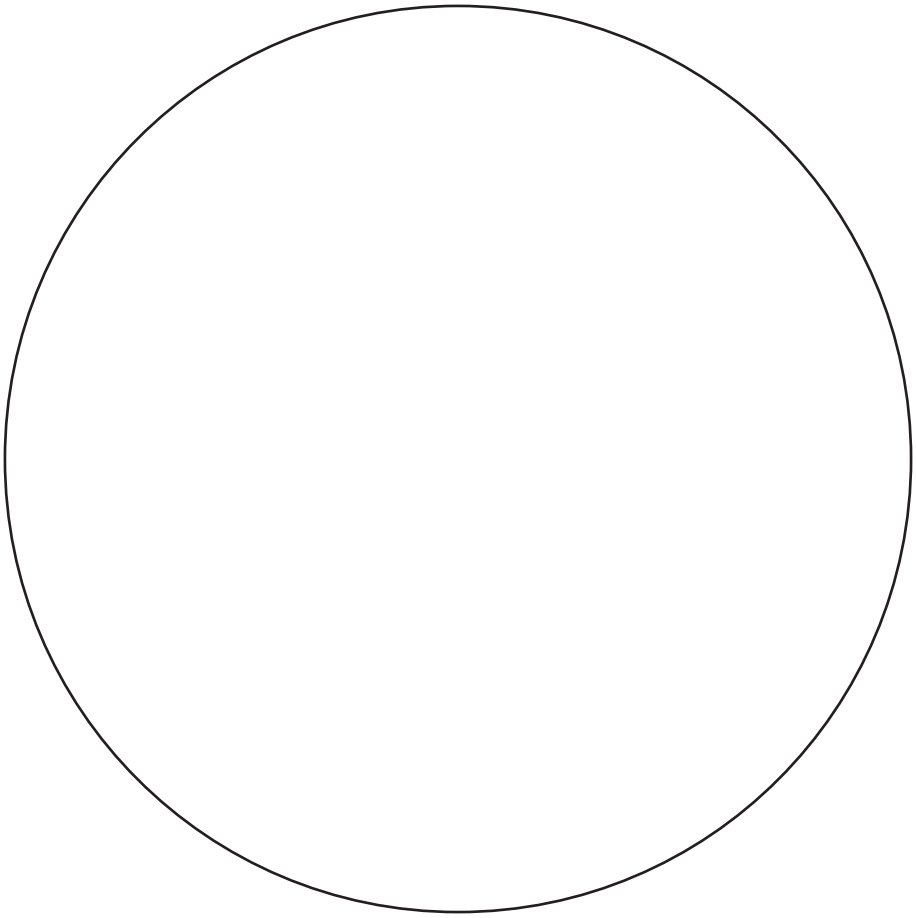
VIHA: Functional assessment. 22 June 2016 Reviewed by: Backx,T, VKCC, NKCC, CI/SI Navigators

BASIC SKILL	CAN PERFORM	CANNOT PERFORM	COMMENTS
1. Pick up the PD solution bag and hold it over head for a count of 3.			
2. Hang PD solution bag on IV pole.			
3. Hold the transfer set and twist the clamp open and closed until it clicks.			
4. Open a minicap package and place on the end of the transfer set without contamination.			
5. Remove the mini cap from the transfer set.			
6. Remove the colored ring from the PD solution bag.			
7. Attach the red clamp anywhere along the PD tubing and snap it closed. Release the clamp to open.			
8. Pick up the tongue depressor and snap it into 2 pieces.			
9. Look at the picture of the home choice cycler below and record what is seen in the display screen.			

What is displayed on the screen?

Clock Test

BASIC SKILL	CAN PERFORM	CANNOT PERFORM	COMMENTS
10. Using the circle diagram below as a clock face: 1. Put the numbers on the face of the clock. 2. Make the clock say “10 minutes after 11”.			



PD Functional Assessment- For Nursing Use Only

Patient name	
Assessment date	
Assessment completed by	

Patient completed all aspects of the assessment following visual/verbal demonstration without difficulty. ☐ Yes ☐ No
Comments:

Patient required repeated prompting to complete all aspects of the assessment following visual/verbal instructions. ☐ Yes ☐ No
Comments:

Clock test score: _____

• Score 1 point for each number in its correct eighth (1,2,4,5,7,8,10,11).
  • No points for pen marks or words instead of numbers.
• Score 1 point for short hand pointing to number 11
• Score 1 point for long hand pointing to number 2
  • No points for hands approximately the same length
  • No point if the short hand is pointing to the 2 and the long hand pointing to the 11
 	
Results:
10 or greater suggests cognitive impairment unlikely
6 - 9 indicates probable impairment
0 - 5 indicates prominent impairment

Comments:

Future Steps:

Documentation completed: ☐ Chart ☐ PROMIS