

NURSING CARE PLAN No 31
Nursing care of a child with Haemolytic Uremic

Please use in conjunction with careplan 1

Full Name:
Address: Addressograph
HCR:.....

Care Plan No 31 Problem	Nursing care of a child with Typical Haemolytic Uremic Syndrome Goals	Issue Date: August 2018 Review Date: August 2021	
..... Has Typical HUS	<ul style="list-style-type: none">will receive safe and appropriate care. Potential complications will be detected promptly and managed appropriately. 		
No	NURSING INTERVENTION	Commencement, Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
1	Isolation		
<ul style="list-style-type: none"> Ensureis nursed in a single cubicle according to OLCHC Guideline on Isolation,2011 Explain reason for isolation to the child/family, involve play therapist. Notify the relevant area medical officer in community by fax/phone, once particulars of Vero toxin producing bacteria is isolated. 			
2	Observations		
<p>Assess and document hourly observations. until child is stable, including;</p> <ul style="list-style-type: none"> Neurological observations (report: lip smacking, irritability, confusion etc) temperature, heart rate, blood pressure, respiratory rate, oxygen saturations Continuous ECG monitoring Continuous assessment of fluid balance (hydration/dehydration/fluid overload) Assess Urine output<0.5ml/kg/hr if oliguric - or anuric <p>Record and report any deterioration immediately to medical team</p> <ul style="list-style-type: none"> Perform and document 6 hourly blood sugars (observing for necrotising pancreatitis) Assess peripheral perfusion - by difference between core & peripheral temperature, a gap >2° indicates dehydration/hypovolaemia/poor perfusion or sepsis, observe and document skin colour, temperature, capillary refill, skin colour and skin temperature Observe any bruising and degree of pallor <p>Change in frequency of assessment and documentation of observations as condition improves:</p>			
3	Investigations		
<ul style="list-style-type: none"> Send initial Stool for microscopy C&S -and before discharge to check if negative Check urinalysis for blood and protein on admission and daily thereafter Send urine to laboratory for microscopy C&S, Electrolytes, Urinary Albumin, Urinary Creatinine Ratio as indicated Assist with blood sampling: VTEC Serology, FBC, Film, Group & Hold, clotting, U&E, Amylase, LFT's, LDH, Glucose, Gas, daily or twice daily bloods may be required, (observing for acidosis, hyperkalaemia, hypocalcaemia, elevated phosphate) Follow up on blood results promptly, reporting deviations to team Maintain blood flow sheet (front of chart) 			

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4	Hydration (refer to care plan 19)	Commencement , Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
	<ul style="list-style-type: none"> • Strict assessment/recording of Intake and Output and Fluid Balance • Fluid restriction: <ul style="list-style-type: none"> ○ Assess daily, as indicated by medical staff ○ Include 24-hour insensible losses and ALL output (ex. Urine, loose stools, vomit). ○ Include all colloid in intake allowance. • Administer intravenous fluids as prescribed (as per care plan 9) • Record BD weight initially, then daily/as required • Give Red Cell Concentrate as prescribed when Haemoglobin is 7g/dl or less - cautiously, and during dialysis to avoid pulmonary oedema (as per OLCHC transfusion guidelines) • On recovery polyuria is common- ensure intake is adequate 		
5	Nutrition (refer to care plan 19)		
	<ul style="list-style-type: none"> • Ng tube should be passed in OT if having a tenckhoff catheter inserted. • Liaise closely with renal dietician • Ensure a high calorie, controlled protein, low salt diet and supplements as indicated • If receiving NG feeding, refer to care plan 19 • Check amylase daily/as indicated: If elevated, enteral feeding contra-indicated and TPN may be commenced • Administer anti-emetic and proton pump inhibitors as prescribed • Re-introduce diet slowly when the child has no further diarrhoea and vomiting 		
6	Dialysis		
	<ul style="list-style-type: none"> • Administer dialysis as prescribed (continuous dialysis may be required) • If urea is elevated, aim for gradual reduction of urea • Increased fill volumes may be required to increase electrolyte clearance & aid fluid removal • If on continuous dialysis, may need to lengthen dwell time, as excessive removal of fluid/potassium or rapid reduction of urea likely • Observe dialysis fluid (during a drain) for colour/clarity and presence of fibrin • Observe exit site regularly for leakage /excessive bleeding • Document and report all findings • Exit site care as per local protocol 		
7	Intravenous Access (refer to care plan 9)		
	<ul style="list-style-type: none"> • Administer intravenous fluids, blood products and medications as prescribed • Care of all intravenous lines as per OLCHC Guidelines 		
8	Pain		
	<ul style="list-style-type: none"> • Assess and document pain, according to OLCHC Guidelines. • Use non-pharmacological and pharmacological means for pain relief. Never administer Non-Steroidal Anti-inflammatory medication 		

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9	Education / Discharge	Commencement , Date, Signature, Time, Grade	Discontinued, Date, time, Signature, Grade
	<ul style="list-style-type: none"> • Involve the child/parents/family, give verbal and written information (HUS Discharge Advice Sheet) • Ensure prescription given for an Iron Supplement and folic acid (up to 3 months) • Inform the IPCT • Ensure follow up appointments are arranged (BP check, FBC and U&E at 1-2 weeks locally and nephrology OPD) • A yearly blood pressure check and urinalysis are advised. • Early contact with community personnel • Liaise with CNSp 		

Created by Fiona McHugh – St. Johns Ward
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