OUR LADYS CHILDREN'S HOSPITAL
NURSING CARE PLAN
Nursing care of a child with Haemolytic Uremic Syndrome
Careplan 31
(Use in conjunction with care plan 1)

Care plan 31 Problem	**Nursing care of a child with Typical Haemolytic Uremic Syndrome** **Goals**	**Issue date: June 2014** **Review date: June 2017**
_____ Has Typical HUS	_____ will receive safe and appropriate care. Potential complications will be detected promptly and managed appropriately.	

Discontinued, date, time and signature, grade.	**No.**	**Nursing Intervention**	Discontinued, date, time and signature, grade.
	1.	**Isolation**	
		• Ensure _____ is 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**	
		Assess and document hourly observations until child is stable, including; • 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 ***Record and report any deterioration immediately to medical team*** • Perform and document 6 hourly blood sugars (observing for necrotising pancreatitis) • Assess peripheral perfusion - by difference between core & peripheral temperature, a gap >2º 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 ***Change in frequency of assessment and documentation of observations as condition improves:*** _____	
	3.	**Investigations**	
		• 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, hyperkaliemia, hypocalcemia, elevated phosphate) • Follow up on blood results promptly, reporting deviations to team • Maintain blood flow sheet (front of chart)	
	4.	**Hydration (refer to care plan 19)**	
	.	• Strict assessment/recording of Intake and Output and Fluid Balance • Fluid restriction: --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.	

Patient Name:……..

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		• 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)**	
	.	• 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**	
	.	• 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)**	
	.	• Administer intravenous fluids, blood products and medications as prescribed • Care of all intravenous lines as per OLCHC CVAD Guidelines	
	8.	**Pain**	
		• Assess and document pain, according to OLCHC Guidelines. • Use non-pharmacological and pharmacological means for pain relief. • Never administer Non-Steroidal Anti-inflammatory medication	
	9.	**Education/Discharge**	
		• 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 CNS	

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