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** | **Issue date: August 2018 Review date: August 2021** |
|---|---|---|---|
| _____ 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<br>• Explain reason for isolation to the child/family, involve play therapist.<br>• 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;***<br>• neurological observations (**report:** lip smacking, irritability, confusion etc)temperature, heart rate, blood pressure, respiratory rate, oxygen saturations<br>• Continuous ECG monitoring<br>• continuous assessment of fluid balance (hydration/dehydration/fluid overload)Assess Urine output<0.5ml/kg/hr if oliguric - or anuric<br>***Record and report any deterioration immediately to medical team***<br>• Perform and document 6 hourly blood sugars (observing for necrotising pancreatitis)<br>• 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<br>• Observe any bruising and degree of pallor<br>***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<br>• Check urinalysis for blood and protein on admission and daily thereafter<br>• Send urine to laboratory for microscopy C&S, Electrolytes, Urinary Albumin, Urinary Creatinine Ratio as indicated<br>• 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)<br>• Follow up on blood results promptly, reporting deviations to team<br>• Maintain blood flow sheet (front of chart) | |
| | **4.** | **Hydration (refer to care plan 19)** | |
| | . | • Strict assessment/recording of Intake and Output and Fluid Balance<br>• Fluid restriction:<br>--Assess daily, as indicated by medical staff<br>--Include 24 hour insensible losses and **ALL** output (ex. Urine, loose stools, vomit). Include all colloid in intake allowance. | |

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| | | • Administer intravenous fluids as prescribed (as per care plan 9)<br>• Record BD weight initially, then daily/as required<br>• 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)<br>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.<br>• Liaise closely with renal dietician<br>• Ensure a high calorie, controlled protein, low salt diet and supplements as indicated<br>• If receiving NG feeding, refer to care plan 19<br>• Check amylase daily/as indicated: If elevated, enteral feeding contra-indicated and TPN may be commenced<br>• Administer anti-emetic and proton pump inhibitors as prescribed<br>• Re-introduce diet slowly when the child has no further diarrhoea and vomiting | |
| | **6.** | **Dialysis** | |
| | . | • Administer dialysis as prescribed (continuous dialysis may be required)<br>• If urea is elevated, aim for gradual reduction of urea<br>• Increased fill volumes may be required to increase electrolyte clearance & aid fluid removal<br>• If on continuous dialysis, may need to lengthen dwell time, as excessive removal of fluid/potassium or rapid reduction of urea likely<br>• Observe dialysis fluid (during a drain) for colour/clarity and presence of fibrin<br>• Observe exit site regularly for leakage /excessive bleeding<br>• Document and report all findings<br>• Exit site care as per local protocol | |
| | **7.** | **Intravenous access (refer to care plan 9)** | |
| | . | • Administer intravenous fluids, blood products and medications as prescribed<br>• Care of all intravenous lines as per OLCHC Guidelines | |
| | **8.** | **Pain** | |
| | | • Assess and document pain, according to OLCHC Guidelines.<br>• Use non-pharmacological and pharmacological means for pain relief.<br>• Never administer Non-Steroidal Anti-inflammatory medication | |
| | **9.** | **Education/Discharge** | |
| | | • Involve the child/parents/family, give verbal and written information (HUS Discharge Advice Sheet)<br>• Ensure prescription given for an Iron Supplement and folic acid (up to 3 months)<br>• Inform the IPCT<br>• Ensure follow up appointments are arranged (BP check, FBC and U&E at 1-2 weeks locally and nephrology OPD)<br>• A yearly blood pressure check and urinalysis are advised.<br>• Early contact with community personnel<br>Liaise with CNSp | |



Patient Name:……..

HCR No:……..

Ward……