NURSING CARE PLAN AND MANAGEMENT OF COAGULOPATHIES INCLUDING DIC AND HUS

- A coagulation disorder that prompts over stimulation of normal clotting cascade and results in simultaneous thrombosis and haemorrhage.
- Formation of micro clots affects tissue perfusion in the major organs leading to Hypoxia, Ischemia and Tissue damage.
- Essential medical management of DIC is primarily aimed at treating the underlying cause, managing complications from both primary and secondary causes, supporting organ function, stopping abnormal coagulation and controlling bleeding

NURSING DIAGNOSIS

- After assessment, a nursing diagnosis is formulated to specifically address the challenges associated with DIC basing on the nurse’s judgement and understanding of a patient’s unique health condition.

NURGING CARE PLAN AND MANAGEMENT.

- Monitoring vital signs and bleeding,
- Administration of fluids and blood products,
- Practicing bleeding precautions,
- Wound care,
- Providing respiratory support
- Administration of prescribed medications.
- Offering psychosocial support and maintaining effective communication.

NURSING PROBLEBLEM PRIORITIES

- Minimizing bleeding risks,
- Respiratory support,
- Patient education,

NURSING ASSESSMENTS

Assess for subjective and objective data

- Abnormal Breathing (rate depth and rhythm),
- Confusion
- Dyspnea
- Hypercapnia
- Hypoxemia (low oxygen levels in blood)

NURSING ASSESSMENTS CONTINUED

- Capillary refill >3 sec
- Changes in the level of consciousness
- Chest pain
- Cyanosis
- Haematuria
- Oliguria (Urine out put less than 30mls/hrs)

NURSING ASSESSMENTS CONTINUED

- Abnormal arterial blood gases (ABGs)
- Hypoxia (Low oxygen levels in tissues
- Irritability
- Restlessness
- Somnolence (a state of drowsiness)

NURSING GOALS

The patient will;

- maintain optimal gas exchange as evidenced by ABGs with in normal ranges, oxygen saturation of 90% or greater, alert, responsive mentation or no further reduction in the level of consciousness, relaxed breathing and baseline heart rate.
- maintain optimal peripheral tissue perfusion in the affected extremity, as evidenced by strong palpable pulses, reduction in and /or absence of pain, warm and dry extremities, and adequate capillary refill.
- experience reduced episodes of bleeding and hematomas.

Nursing goals continued

- The patient will experience reduced side effects of medication therapy.
- The patient will maintain therapeutic levels of coagulation laboratory profile including PT, PTT among others.
- The patient and/or significant others verbalise a basic understanding of the disease condition risk factors and treatment regimen

NURSING INTERVENTIONS AND ACTIONS

1. PROMOTING EFFECTIVE GAS EXCHANGE

- Closely monitoring respiratory parameters such as spo2, ABGS, CO2 and rates.
- Give supplemental oxygen, positioning techniques and maintain proper fluid balance
- Assess for changes in the level of consciousness.
- Assess the respiratory depth, rate and rhythm.
- Assess the breath sounds. Assess cough for signs of bloody sputum.

PROMOTING EFFECTIVE GAS EXCHANGE CONTINUED

- Assess for tachycardia, shortness of breath and use of accessory muscles.
- Monitor oxygen saturation and assess arterial blood gases
- Provide reassurance and allay anxiety, anxiety increases dyspnea
- Position the patient in sitting up position as indictated
- Maintain an oxygen administration device as needed
- Anticipate the need for early intubation and mechanical ventilation
- Change patients position every two hours

2. ENHANCING TISSUE PERFUSION

- Closely monitoring hemodynamic parameter, such as blood pressure, heart rate, and urine output.
- fluid resuscitation, administration of vasopressor medication, and targeted treatment of underlying cause.
- Assess for chest pain(noting location severity, and radiation) and shortness of breath,
- Assess the amount and color of urine

ENHANCING TISSUE PERFUSION CONTINUED

- Assess the level of consciousness,
- Assess arterial blood gases (ABGs),
- Monitor blood levels for platelet count,PT, PTT, D-Dimers, among others.
- Position the patient in semi-sitting up to sitting up position as tolerated.
- Administer oxygen therapy as necessary.
- Administer parenteral fluids as prescribed.

3.PREVENTING BLEEDING RISKS AND INJURY

- Assess for underlying causes of coagulopathies,
- Assess the heart rate and blood pressure, observe for signs of orthostatic hypotension.
- Observe for signs of internal bleeding such as pain or changes in the levels of consciousness
- Institute a neurological checklist.
- Observe for signs of external bleeding from GI and GU tracts
- Note any haemoptysis or blood obtained during suctioning.
- Examine the skin surface for signs of bleeding,

PREVENTING BLEEDING RISKS AND INJURY CONTINUED

- Institute precautionary measures,
- Provide gentle oral care, using saline and water rinses instead of toothbrush.
- Administer medication as prescribed
- Administer parenteral fluid as prescribed, Anticipate the need for fluids.
- Administer blood products as prescribed, RBCs, FFPs, cryoprecipitate, and platelets.

INITIATING HEALTH TEACHING AND PATIENT EDUCATION

- Information about the cause,risk factors, signs and symptoms of bleeding and clotting, the importance of medication adherence and strategies to minimize complications.
- Assess the patient’s knowledge of the disease.
- Carefully explain the underlying cause that precipitated DIC
- Explain the purpose of drug and transfusion therapy
- Instruct the patient or significant others to notify the nurse of any new bleeding from the IV site.

ASSESSING AND MONITORING FOR POTENCIAL COMPLICATIONS

- Monitor patients vitals signs regularly
- Monitor patients cardia rhythm and ECG regularly to identify any arrhythmias or change in the cardiac function.
- Assess patients' neurological status,
- Assess patients' respiratory status, to help identify any sign os distress or compromised gas exchange.
- Assess bleeding or clotting tendencies
- Monitor laboratory studies such as FBC, Coagulation profiles and renal and hepatic functions
- Monitor fluid balance, to ensure adequate tissue perfusion.

ASSESSING AND MONITORING FOR POTENCIAL COMPLICATIONS CONTINUED

- Assess the medication regimen and monitor potential side effects or interactions.
- Collaborate with interdisciplinary team, sharing information and collaborating on care plan enhances patients' safety and improves outcome.
- Provide information about the disease to patient and family members