Hydrocephalus and Shunt

Care Plan

for education and care

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| To be completed by the treating health professional and parent or legal guardian.  This information is confidential and will be available only to relevant staff and emergency medical personnel. | | | |
| Name of child/young person: |  | | |
| DOB: |  | Review date: |  |
| Allergies: |  | | |
| Education or care service: |  | | |  |

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| **What is Hydrocephalus?**  Inside everyone’s brain and spinal cord there is a clear fluid called ‘cerebrospinal fluid’ also known as CSF.  CSF is made inside spaces in the brain called ventricles, and acts as a cushion to protect the brain and spinal cord.  Hydrocephalus is when there is too much CSF in the ventricles in the brain, and the ventricles get bigger. This may lead to an increase in pressure causing one or more of the signs listed on the next page. If left untreated this can result in damage to the brain.  Hydrocephalus is usually treated by a shunt insertion operation. | |  |
| **What is a shunt (or ventriculo peritoneal (VP) shunt)?** | | |
| A shunt is used to treat hydrocephalus.  It is a very fine tube that is inserted from inside one of the ventricles in the brain to a place to dump the CSF, usually the peritoneum (tummy).  It is completely internal and the child will only have a small wound behind one ear and another on the tummy.  This new pathway allows CSF to drain from the ventricles, lowering the pressure inside the head. |  | |
| **What do I need to know?**  While the shunt is working the hydrocephalus is resolved and the child or young person should be treated normally. This means that they can participate in all curriculum activities including camps and excursions. There is no need to place any restrictions on participation in activities such as swimming and aquatics. If the child is involved in an incident provide standard first aid and inform emergency contacts as per first aid training. This application of standard first aid also applies to head injuries.  Very infrequently the shunt may not work properly and the child or young person may show one or more of the signs in the tables below. If the child is exhibiting one or more of these signs inform the emergency contacts. An ambulance should be called if staff are concerned for the child’s wellbeing.  **Refer to the tables below for signs that indicate the shunt may not be working** | | |

**Signs the shunt may not be working** (may have one or more)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Signs for infant** |  | **Signs for child** |  | **FIRST AID\*** |
| Irritable, unsettled  More sleepy than usual  High pitched cry  Vomiting  Sunsetting eyes (eyes unable to look up)  Poor feeding  Head getting bigger  Fontanelle (soft spot on top of head) full and firm when sitting up and quiet  Seizures (fits)  Fever  Swelling or redness along shunt tract |  | Irritable, confused, disorientated or just not usual self  More sleepy than usual  Headache  Vomiting  Double or blurred vision  Photophobia (eyes sensitive to light)  Unsteady on feet  Difficulty doing routine tasks  Seizures (fits)  Fever  Swelling or redness along shunt tract |  | If there are any signs that the shunt may not be working contact the parent or legal guardian, or emergency contacts.  If the child has a seizure, follow Seizure First Aid (attached).  **In an emergency call**  **000 (Ambulance)**  **Ambulance**  *\*An* [**individual first aid plan**](https://www.education.sa.gov.au/sites/g/files/net691/f/individual-first-aid-plan.doc) *must be completed if the first aid response is not the standard first aid response for that condition.* |

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| **Additional information**  [Individual first aid plan](https://www.education.sa.gov.au/sites/g/files/net691/f/individual-first-aid-plan.doc) attached |

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| **AUTHORISATION AND AGREEMENT**  *(To be signed after form has been completed)* | | The following settings have been considered in the development of the health care plan and is appropriate for use in the following: | | | | |
|  | Children’s centre, preschool or school | | |  | Childcare, Out of School Hours Care | |
|  | Camps, excursions, special event, transport (incl. aquatics) | | |  | Work experience or other education placement | |
|  | Respite, accommodation | | |  | Work | |
|  | Transport | | |  | Other (specify) | |
| *Treating health professional* | | | | | | |
| *(print name & practice/hospital or stamp)* | | | Professional role | | |  |
| Email or signature | | |  |
| Telephone | | | Date | | |  |
| *Parent or legal guardian; or adult student* | | | | | | |
| * **I understand and agree with the care plan as indicated above** * **I approve the release and sharing of this information to supervising staff and emergency medical staff (if required).** * **I understand staff may seek additional information and/or advice regarding the medical information contained in the care plan from the Access Assistant Program (AAP) to inform duty of care.** | | | | | | |
| (name) | | | | | (relationship) | |
| (email or signature) | | | | | (date) | |

