**Conclusion(s)/discussion:** Children gave a very detailed account of the good nurse's traits. Our results confirm Randall's study (2008).

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## CAN NURSES USE CONTINUOUS CENTRAL VENOUS OXYGEN SATURATION MONITORING, TO DICTATE HOW AND WHEN TO PROVIDE CARE?

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Can paediatric critical care nurses adequately evaluate the effects of routine care using traditional hemodynamic monitoring tools? Is the care and procedures beneficial or potentially harmful? How can this be assessed in "real-time"? Can newly advanced monitoring tools help determine optimal times to change inotropes, suction, bathe or reposition the child, or assess child's tolerance to weaning? Can these "real-time" monitoring tools guide nurses' clinical decision making for when and how to provide care?

Continuous monitoring central venous oxygen saturation can provide "real-time" information of the balance between oxygen delivery and consumption. Many seemingly innocuous procedures can drastically increase oxygen consumption needs, beyond oxygen delivery capabilities.

Nurses have knowledge of physiological causes and exogenous interventions that can lead to increases in oxygen consumption. While most of these interventions are necessary, continuous monitoring of central venous oxygen saturation, can help nurses at the bedside determine when the best time is to provide care, and how patient's tolerate it.

With health care costs, worldwide nursing shortage, and increasingly complex and critical diagnosis, there exists an obligation to decrease mortality and morbidity as much as possible. Advanced technology can provide an early warning in the extremely critical periods of recovery.

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## CRITICAL CARE MANAGEMENT OF FULMINANT HEPATITIS

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**Background:** Fulminant hepatitis in pediatrics is the result of acute liver failure, and it may have multiple causes. Without support therapy and/or liver transplantation, mortality may reach 70% or more. The developments of fulminant hepatitis in adults, including liver necrosis and encephalopathy within 8 wees, are different than those in pediatrics, especially if fulminant hepatitis is secondary to a metabolic or autoimmune disease.Congenital metabolic defects and infections are common in infants, whereas viral hepatitis and drug-induced liver failure are more common in older children.

**Goals:** Screening for infections and drugs is important to determine the cause of liver failure. The biochemical features evidence significant conjugated hyperbilirubinemia, high aminotransferase, high blood ammonia levels and coagulopathy.

**Methodology:** Management of acute liver failure includes:

Assessment of prognosis for liver transplantation

Prevention of complications while awaiting hepatic regeneration or liver transplantation.

Hepatic support

Many are the complications of acute liver failure. Management includes fluid restriction to 75% of maintenance using dextrose or high-calorie enteral nutrition. It is extremely important to maintain proper glucose levels. In the early stages of establishing the prognosis and requirements for liver transplantation, coagulation support is not recommended. If coagulation is severe (prothrombin time > 60'') and/or the decision for liver transplantation has been made.

**Conclusion:** Acute liver failure in pediatrics is rare but fatal disease. The development of effective supportive medical therapies and outcome of liver transplantation improve the prognosis, however also depends of the level of nursing care.