RACHEL FERGUSON

COPY ALTNAGELVIN HOSPITAL NOTES

PAGES 1-69

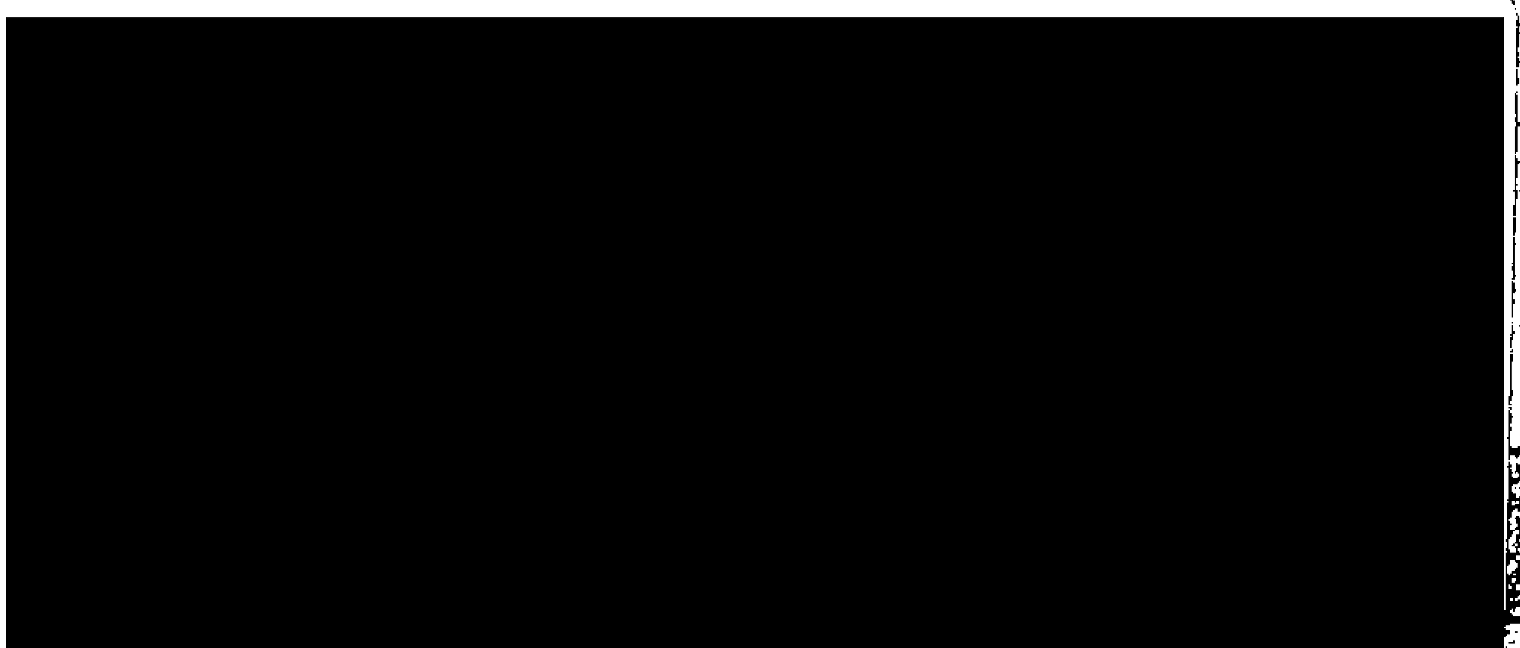
CONFIDENTIAL

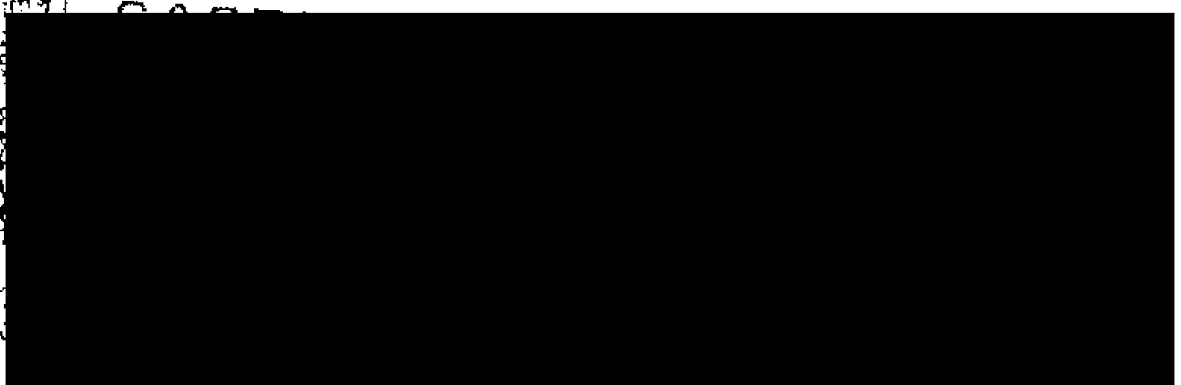
313854

313854

1992

AFFIX LABEL OR ENTER





ADVERSE DRUG REACTIONS	
DRUG	DATE

RF - CORONER

PLEASE ARRANGE A FOLLOW-UP APPOINTMENT FOR THIS PATIENT

TO BE SEEN BY ....

AT THE .... CLINIC

IN .... WEEKS

Altnagelvin Area Hospital
ADMISSION RECORD

Casenote number: AH 313854

Surname: FERGUSON

Forenames: RACHAEL

Date of Birth: 04/02/1992

Age: 9Y

Sex: FEMALE

Title: MISS

Phone: 71267734

Address:

Post Code:

Prev. Name:

Temp. Address

Post Code:

Phone Number:

FAMILY DOCTOR

Name: DR ASHENHURST

Address: WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY

Post Code: BT47 1AU

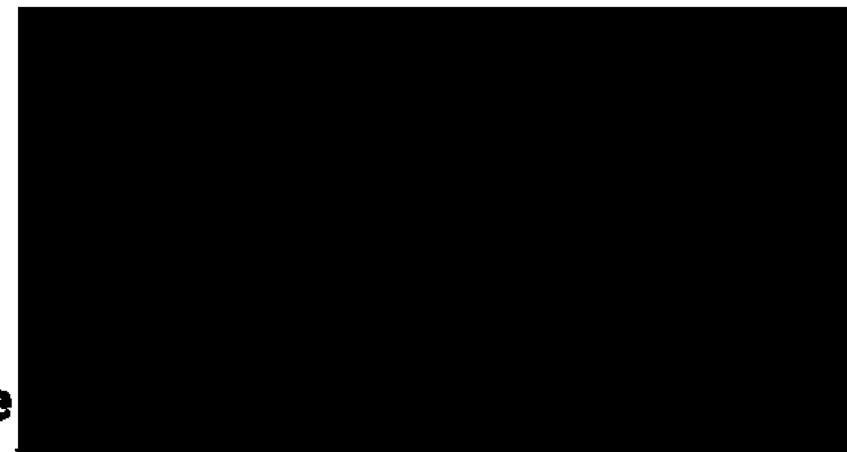
Phone Number: 01504 320100

NEXT OF KIN

Name: MARIE

Relationship: MOTHER

Address:



Post Code:

Phone (Home):

(Work):

EPISODIC DOCTOR
(if different from usual G.P.)

Name: DR E.M. ASHENHURST

Address: WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY

Post Code: BT47 1AU

Phone Number: 01504 320100

ADMISSION DETAILS

Consultant: MR GILLILAND

Specialty: GENERAL SURGERY

Referred by: Accident

Admission Reason:

Operation/Procedures:

Theatre time (mins):

Expected length of stay:

Method of Admission: EMERGENCY-VIA A&E

Accidents: Non Trauma

Source of Adm: USUAL RESIDENCE

Transf. from:

Intended Management: NORMAL ADMISSION

Category: HEALTH SERVICE PTNT

PERSONAL DETAILS

Religion:

Marital Status:

Place of Birth:

CSA Number:

Occupation or School:

Occupation (HOH):

Benefits:

Admission Date: 07/06/01

Time: 09:41 PM

Ward: CHW

Admitted By: JB1

012-002-022.

RF – CORONER

PERSONAL DATA SHEET

MH 313854

SURNAME: Mr./Mrs./Miss

FIRST NAMES

DATE OF BIRTH

HOSPITAL NUMBER 313854

ADDRESS

OCCUPATION

RELIGION RC

SPECIAL INFORMATION
EG. SENSITIVITIES

PATIENT'S BLOOD GROUP

GR. H.R.

ENTERED BY:-

GENERAL PRACTITIONERS NAME & ADDRESS:-

Ashenhurst

NEAREST RELATIVE OR FRIEND:-

NAME Marie (mother)

ADDRESS

Tel. No. to be used in emergency 71267734

IN THE EVENT OF DEATH:-

DATE AND TIME

CAUSE OF DEATH:-

(i) (A)

DUE TO (B)

DUE TO (C)

(ii)

IN-PATIENT TREATMENT

	DATE ADMITTED	WARD	DATE DISCHARGED	DIAGNOSIS	OPERATION/TREATMENT
1	7/6/01	CHW			
2					
3					
4					

RF - CORONER

012-002-023

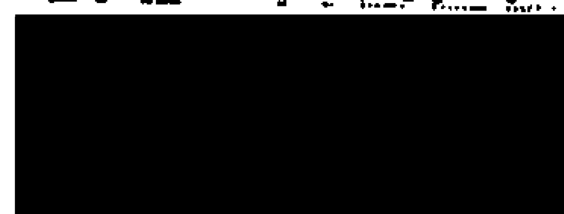
AFFIX LAB

SURNAME

FIRST NAME(S)

DATE OF BIRTH

HOSPITAL NO.



BODY FEMALE Rachel.

~~MC MULLAN~~ Ferguson 04/02/92

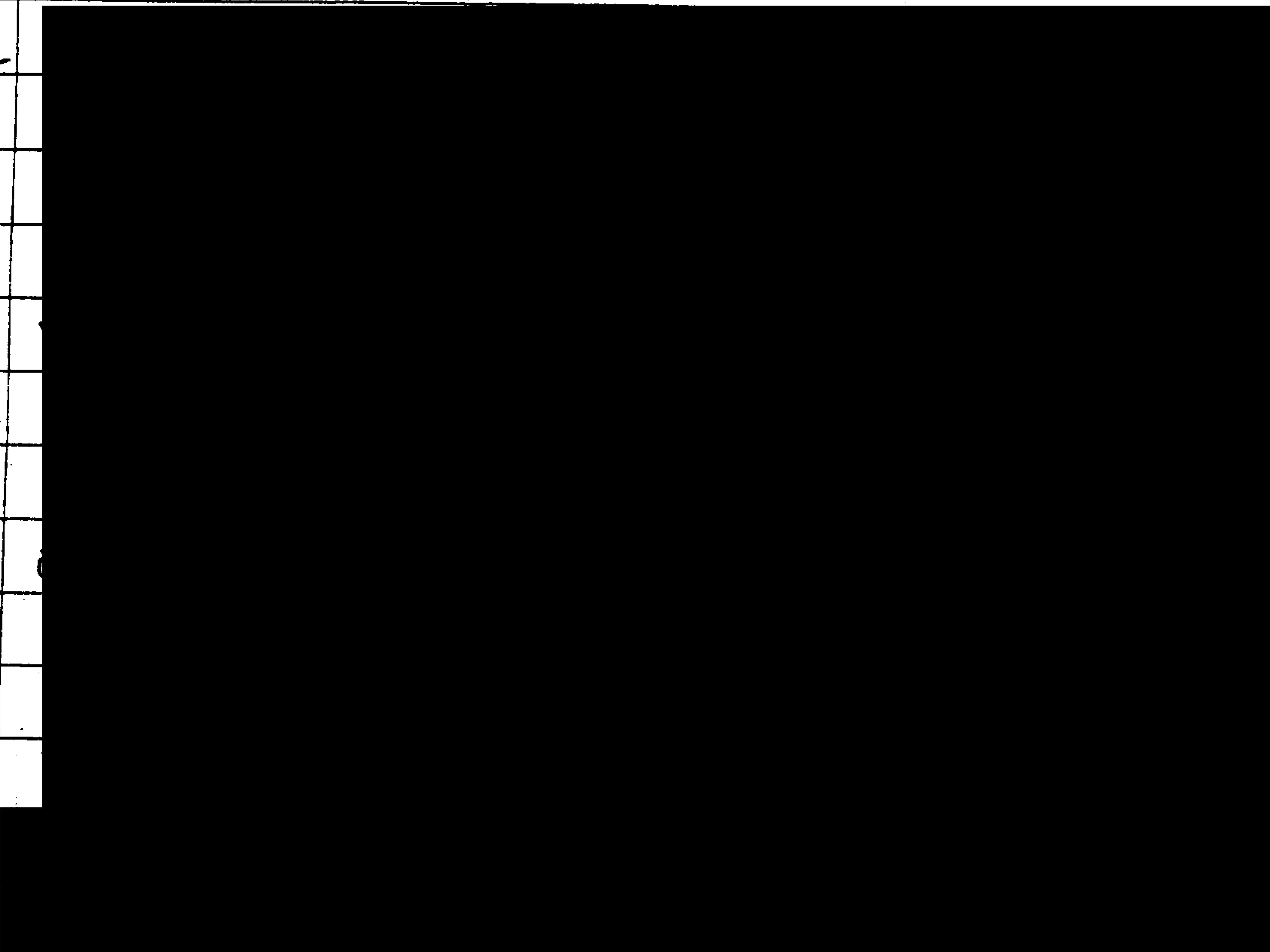
WD/OP CONSULTANT

WESTERN HEALTH and SOCIAL SERVICES BOARD

ALTNAGELVIN GROUP OF HOSPITALS

PAEDIATRIC

CLINICAL NOTES

DATE	
23/3/92	
27/4/92	

CS 9

012-002-024

RF – CORONER

WESTERN HEALTH AND SOCIAL SERVICES BOARD
LONDONDERRY, LIMAVADY AND STRABANE UNIT OF MANAGEMENT

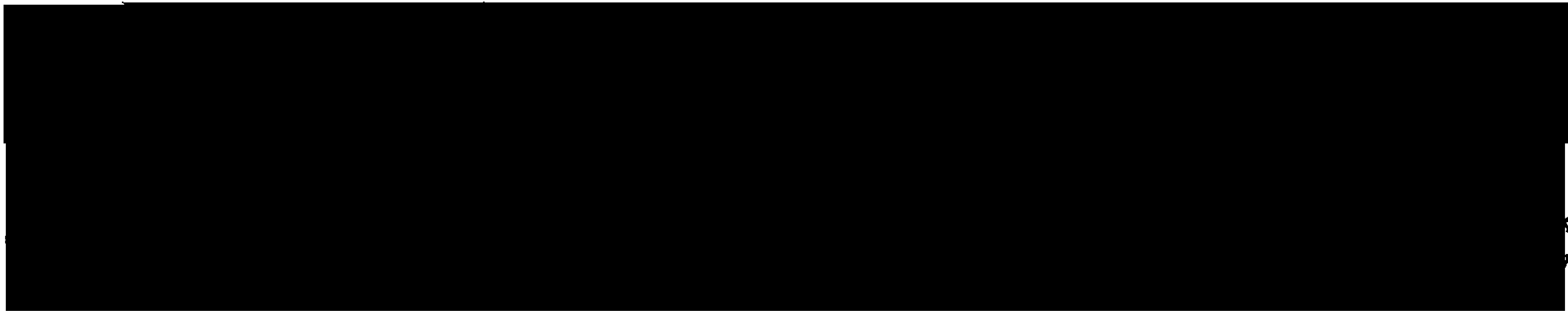
ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB Telephone

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

23 March 1992

Dear Dr Ashenhurst



Your sincerely

Dr J O'Donnell
SHO in Paeds

sr

RF – CORONER

012-002-025.

WESTERN HEALTH & SOCIAL SERVICES BOARD

ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB

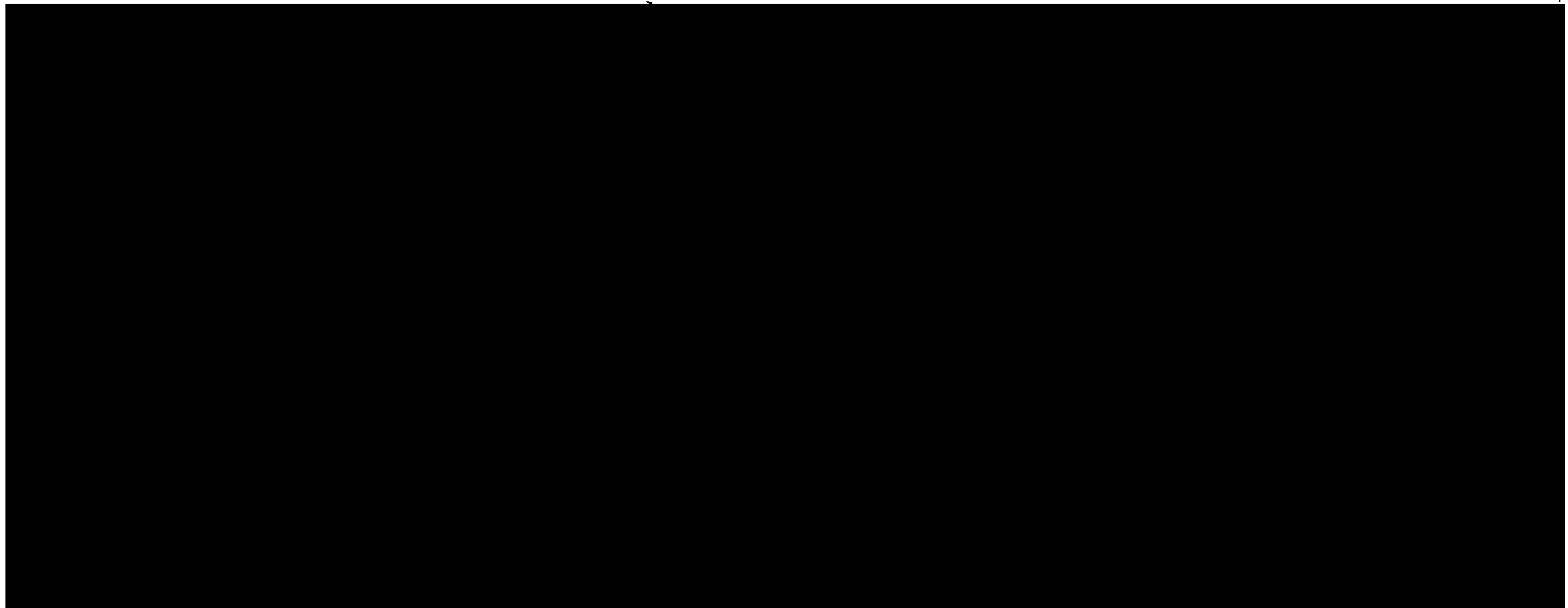
TELEPHONE- LONDONDERRY

DATE:

IN CONFIDENCE

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

PATIENTS NAME: Rachel Ferguson



Dr A Kinney
SHO in Paeds

sr

012-002-026

RF - CORONER

ALTNAGELVIN AREA HOSPITAL

LABOUR WARD BABY OBSERVATION CHART

NAME ________ DATE 4.2.'92

SEX ________

D.O.B. & TIME 4-2-92

HOSPITAL NO. ________

OBSERVATIONS - 1/2 hourly x 2 hours   Hours x 3-12 hours

TIME	TEMP.	COLOUR	RESPS.	APEX RATE	URINE	MEC.	FEEDING & AMOUNT	COMMENTS

RF – CORONER

WESTERN AREA HEALTH AND
SOCIAL SERVICES BOARD
ALTNAGELVIN GROUP OF HOSPITALS

BABY'S WEIGHT CHART

BW.67

Affix label or enter

Date	4·2·92	5th	6th	7th											
Days	0/A	1	2	3	4	5	6	7	8	9	10	11	12	13	14

WEIGHT Grms.

GAIN ↑

LOSS ↓

Colour															
Stools															
Urine															
Eyes															
Skin															
Cord															
Feeding															

RF - CORONER

012-002-028

Date of birth 4.2.92 at

Type of delivery

Period of gestation

Membranes ruptured

Apgar score

Resusicitation

Birth weight .... grams.

Length .... cms.

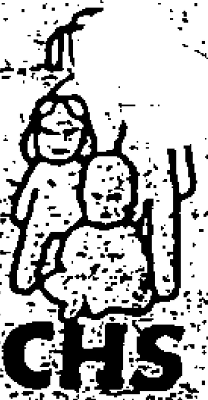
Head circumference .... cms.

Temperature ....

Ortolanni test ....

Guthrie test ....

012-002-029
CStewart



CHS

Northern Ireland Child Health System

Maternal / Neonatal Discharge Form

CHS 3
(Revised Jan. 1991)

RF – CORONER

012-002-030.

IF P[illegible]ENT ADMITTED OR REFERRED TO OUT PATIENTS, THIS COPY TO PATIENT'S CASENOTES.
[illegible]ENT NOT ADMITTED OR REFERRED: DESTROY THIS COPY.

Altnagelvin Area Hospital
Accident & Emergency

TRIAGE CODE: 3
DATE/TIME: 7/6/01 20:01
CHI NO.:
A&E NO.: 01/19050
INCIDENT: Unwell.
SOURCE:
SURNAME:
SEX:
NEXT OF KIN:
FORENAMES:
AED NO AH 01AE19050
04/02/92
G.P.: DR Ashenhurst
HOSP NO. AH 313854
11261134
STATUS:

COMPUTER CODES: TRIAGE / DOCTOR / NURSE / ADMIN.

TEMP.: 36°C
PULSE:
B.P.: 126/76
RESP.:

TRIAGE NOTES: Abdominal pain Sudden onset.

NURSE: McGonagle TIME: 8.05 PM

CONSULTANT: McKinney/Steele
SEEN BY DR.: Shelly TIME: 8.05pm

HISTORY/EXAMINATION & DIAGNOSIS/TREATMENT

Wt approx 26 kg.

C/O sudden onset of abd Pain ~4.30pm.
↑ed severity since
Nauseated
ō vomiting

Pain on urination

DHx ō Allergies

PMHx Nil of note.

O/E
→ Tender
Rebound +
Guarding +
Tender over McBurney Pt.

HAEMATOL. / BIOCHEM / BACTERIOL / X-RAY / ECG / [illegible]ER

X-RAY REQUEST:

LMP:
IGNORE A POSSIBLE PREGNANCY? YES NO
TO EXCLUDE:
RADIOGRAPHER:
X-RAY INTERPRETATION:

DIAGNOSIS: Appendicitis? Surgeons

TREATMENT:

TETANUS TOXOID: COURSE / BOOSTER

DR'S SIGNATURE & TIME: Shelly

FINAL PLACEMENT:
DISCHARGE
REFER TO GP
REFER OP
REVIEW A&E
ADMIT WD: 6
DNW/CTA

DRUG TREATMENT DISPENSED	ROUTE	DOSAGE	TIME/FREQ.	PRESCRIBED BY	DISPENSED BY
Cyclizine [illegible]	IV	25mg	1 min	[illegible]	2020

NURSING ADVICE ETC GIVEN: Admit Ward 6

NURSE SIGNATURE & TIME:

012-002-031

RF – CORONER

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME RACH?.
FIRST NAME(S) Ferguson.
DATE OF BIRTH 4/02/92
HOSPITAL NO.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

SURGICAL

CLINICAL NOTES

DATE	
	surgical SHO [illegible]
7/6/01	Periumbilical pain started at [illegible] PM
	pain is constant, shifted mainly to the
	Rt iliac fossa.
	no vomiting
	She had her dinner at 5.10 pm.
	no apetite & eat at the moment.
	last Bowel motion the PM – normal.
	no urinary symptoms.
PMH	no asthma, no heart problems, no epilepsy
	no operations
Med.	– nil
Allergy	no known drug allergy
Soc	lives with parent
F.H	no History of anaesthetic problem
	Heart disease in the family
Syst	no sore throat
	no chest symptoms

RF – CORONER

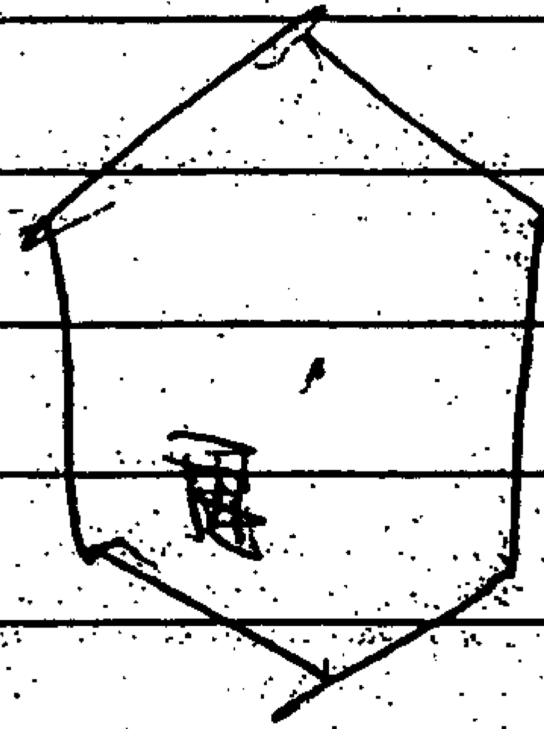
012-002-032.

DATE

o Ex. Appyrexia
p. 100 / — BP 126/76

chest → clear
Heart → WNL
C.N.S → Grossly intact
throat → not congested
slight enlarged tonsils

Abdomen →
positive pain over
McBurney's point



Tender Right iliac fossa
+ Guarding
mild rebound
mildly tender on percussion

?/6/01
Na - 137
K - 3.6
Cl - 107
? - 22
? - 4.8
Gluc - 7.2
creatinine - 47
? - 69

? - 11.7
? - 9.06
? - 339.

Bowel sounds → normal

opinion → acute appendicitis / obstructed appendix

plan → Fasting
IV fluids
consent for done
Appendectomy

[signature]

RF – CORONER

SURNAME
FIRST NAME(S)
DATE OF BIRTH
HOSPITAL NO.

DATE

CLINICAL NOTES

8/6/01 Post appendicectomy [illegible]
Bed of [illegible] [illegible]
Continue [illegible]
J

9.6.01 J Johnston 0315
Called to see regarding fit.
Day 1 postop appendicectomy.
Unresponsive for 5-10mins c contraction +
flexion of upper limbs
Not classical tonic-clonic
Assoc urinary incontinence
Unresponsive to 5mg diazepam pr.
Given Diazemuls 10mg

o/e Apyrexic 36.
Still unresponsive due to diazepam.
P 80bpm regular rhythm normal character +
volume. JVP ⊖ hs I+II+ nil
Chest clear good ae. vesicular BS.

nb No known history of epilepsy
Fit postop complication
? 2° vomiting + electrolyte abnormality.

DW PRHO urgent check EP, Ca^{2+}, Mg^{2+}, FBP ☐
ECG ☐
N By reg/consultant Jeremy Johnston JEREMY JOHNSTON SHO

42

DATE

9. [illegible]

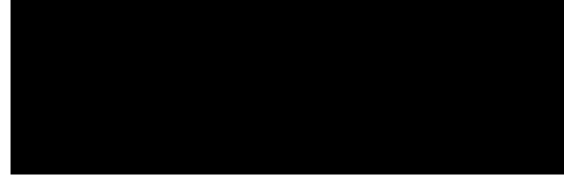
Called to see patient
- H/O Appendicectomy Headache vomiting
- Had fit ? sec to electrolyte imbalance ? Meningitis.
- Pt is on intubation, being monitored. Rash over upper half.
P/A - soft   Pupils dilated & fixed
- Hypotension
Resuscitation being carried out
- NGT
- Catheter
- Repeat urea & Electrolytes

Imp.
Fit sec. to Electrolyte imbalance / Meningitis
urgent CT scan is organised.

RF - CORONER

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM



MEDICAL OR DENTAL INVESTIGATION, TRE[redacted]ATION

Patient's Surname ......Ferguson......

Other Names ......RAChal......

Date of Birth .... Hospital Number .... Sex : (*please tick*) Male ☐ Female ☐

DOCTORS OR DENTISTS (*This part to be completed by doctor or dentist. See notes on the reverse).*

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate.

......Appendectomy......

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ......R Makar...... Date : ...7/6/01...

Name of doctor or dentist ......R Makar......

PATIENT/PARENT/GUARDIAN

1. **PLEASE READ THIS FORM AND THE NOTES OVERLEAF VERY CAREFULLY**

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient / parent / guardian (*delete as necessary*)

I agree
- to what is proposed which has been explained to me by the doctor/dentist named on this form.
- to the use of the type of anaesthetic that I have been told about.

I understand
- that the procedure may not be done by the doctor/dentist who has been treating me so far.
- that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told
- the doctor or dentist about the procedures listed below I would **not** wish to be carried out without my having the opportunity to consider them first.

....

....

LPC 04/98/008

Signature......M FERGUSON......

Name...

Address...
(*if not the patient)*

Date.......... ......

RF – CORONER

012-002-036.

Anaesthetic Record

DATE 7/06/01
Dr. GUND / Dr. Jamison.

Procedure Appendicectomy.

Primary Technique

- Inhalational / IV ☑
- Spinal ☐
- Epidural ☐
- Local ☐
- Sedation ☐

TECHNIQUE

* Retrospective note dated 13/6/01.
Patient only received 200mls of noted fluids below when in theatre.
Litre bag removed prior to leaving theatre
C Jamison (SHO).
witnessed by [signature]

Monitors

- ECG ☑
- BP ☑
- O2 analyser ☑
- Agent analyser ☑
- Steth pre/ oes ☐
- Capnograph ☑
- Pulse Oximeter ☑
- N-M blockade ☐
- Temp. ______ ☐
- CVP ______ ☐
- Art ______ ☐
- PA catheter ☐
- urinary catheter ☐
- other ______
- Warming blanket
- Fluid warmer

Airway O N
Laryngeal Mask
Intubation (O) N T
Size # 6.0

- No ETT/Airway ☐
- ET ☑
- blind ☐
- fibreoptic ☐
- awake ☐
- rapid sequence ☐

(Easy) / Mod / Diff

- Bain ☐
- Circle ☑
- Humidifier ☐
- O2 supplement ☐

RR 16 x TV 250
Paw 13.

Fluids total
Hartman's 1L.

Blood Loss

IV Cannula
#22G
Position

Signed: [signature]

Drug	Dose		
ONDENSETRON	2mg.		
Fentanyl	25 + 25mg.		
PROPOFOL	100mg.		
Scoline	30mg.		
CYCLIMORPH 10	1/2 ml.		
MIVACURIUM	2mg.		1mg.
Metrogyl	250mg.		

TIME 11.30 12

BP – V ^
HR – ●

SAO2	98 97 97	
ETCO2	43. 45 44	

RF - CORONER

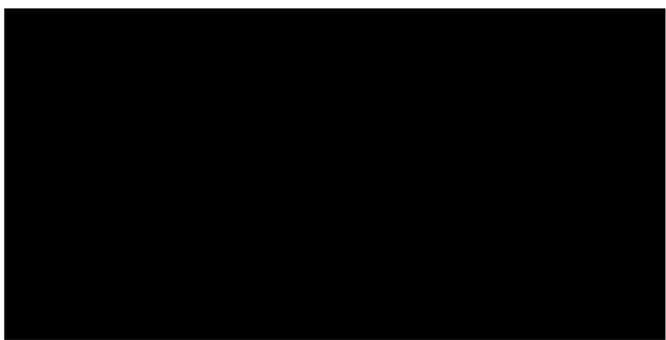
LPC 3/94/...

012 - 002 - 037.

ANAESTHE[TIST] Dr. GUND.

SURGEON

AH 313854
MISS RACHAEL
FERGUSON



F

04/02/93
OPSW245
WD/OPD: __________
CONSULTANT: _____

WEIGHT 25kg	HEIGHT	BSA
BP	HR	TEMP.
AGE	PREMEDICATION	
SEX: M ☐ F ☐		

PREANAESTHETIC EVALUATION: Parent Not available at the moment. Info from pt. herself. had dinner at 5.10 P.M. (solids). No significant Past history in her knowledge.

Talked to mother in OT area. negative past history Consented for Paracetamol suppository.

CVS: NAD.

RS: NAD.

CNS: Conscious oriented.

METABOLIC:

MOUTH / AIRWAY: Loose Canine (Lower Rt.) MP-I.

ASA Status: 1 2 3 4 5 E

HAEMATOLGY: WNL

BIOCHEMISTRY

URINANALYSIS

ECG

CXR

DRUG USE:

SMOKING: ☐ NO ☐ YES ________

DRUG ALLERGY: ? NIL

Pt. to be taken after 11:00 p.m.

PLAN FOR ANAESTHESIA: GA c̄ intubation. Paracetamol suppository 500 mg. Parents to be informed about.

signature: [signature] date: 7/6/01

PERIOPERATIVE EVENTS: Prolonged Sedation due to opioids.

POST OP. RECOVERY: Routine Obs. Analgesics as prescribed

signature: [signature] date: 8/6/01

RF – CORONER

012-002 — 038

AH 313854
FERGUSON

ION

F

O.F. 49

SURGEON'S REPORT

SURGEON Mr. Makar

ASST.

ANAESTHETIST Drs. Jamison, Gund

Surname

First name

Hospital

Consultant

WARD:

CONSULTANT:

OPERATION PERFORMED

Appendectomy

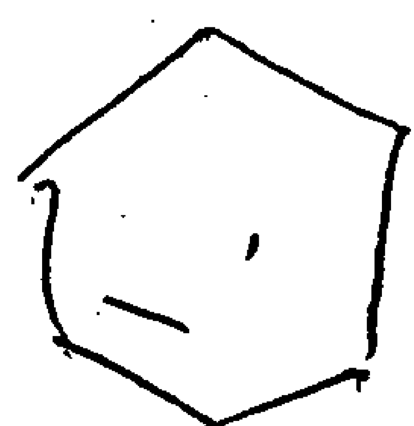
FINDINGS

Mildly congested appendix.
Feocalith intraluminal
peritoneal clean fluid reaction
no Meckel diverticulum at [illegible] ± 3 feet of small Bowel

DESCRIPTION OF PROCEDURE

Grid iron incision
muscle splitting
ligation of meso appendix
ligation of Appendicular base 2/0 vicryl
purse string using 2/0 vicryl
peritoneal suction
Wound closed in layers using 2/0 vicryl
skin closed with 3/0 vicryl Rapid

local anaesthetic
5 ml of Marcain 0.25%



Flagyl. 500 mg Tid i.v today then PO/or supp

NAME OF NURSE TAKING CASE	S/N V. Ayton
SIGNATURE:	Yvonne Ayton
NAME OF NURSE CHECKING SWABS	S/N McGeath

SPECIMEN FOR HISTOLOGY: YES (circled) NO

DELETE THAT WHICH DOES NOT APPLY

COMPLETED BY SURGEON

SIGNATURE R Makar

DATE 7/6/01

LPC 8/85/041

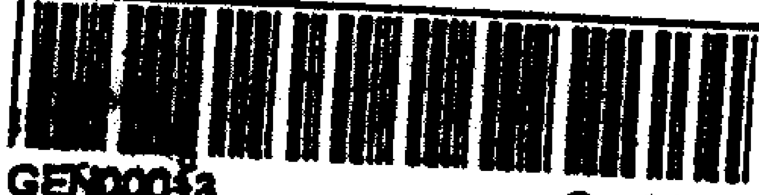
RF - CORONER

012-002-039.

GEN00013
C : 60

Altnagelvin H & S S Trust
Glenshane Rd. L'Derry BT47 6SB

STERILE



31/05/2001

GEN00013 C : 60

31/05/2002

GENERAL CUTTING SET NO. 8
GENERAL THEATRE

HEALTHEDGE
01454 322777

Packed	Checked	Pre-Op	Post-Op
07			

Single Use: Do Not Use If Packing Damaged
Store In A Clean, Dry, Dust Free Environment

RF - CORONER

Theatre Nursing Care Plan

AH 313854
MISS RACHAEL
[redacted]ON
F
04/02/92
GP:N245
WD/OP:________
CONSULTANT:_____

Date: 7-6-07.
Time: 11-20pm
Procedure(s) Appendicectomy.

Allergies
None Known ☑
Yes (specify) ☐

Mobility Impairment
None ☑
Yes (specify) ☐

Special Needs
Hearing ....
Sight ....
Language ....
Prosthesis ....
None ☑

Skin Integrity
Healthy ....✓....
Reddness ....
Raised Temp ....
Discoloured ....
Broken areas ....

Level of Response
Alert ☑
Drowsy ☐
Asleep ☐

Premedicated
Yes ☐
No ☑

Throat Pack
Yes ☐ No ☑
Time In..........
Time Out ....

Risk Score ....

Comments :

	Yes	No	Comment
Identity band present	✓		
Consent form signed	✓		
Operation site marked		✓	
Crowns/ loose teeth	✓		Bottom right
Dentures/ plate removed	N/	A	
Drains/ catheters insitu		✓	
Blood grouped			} see notes'
Blood crossmatched			

Venupuncture site.....Right arm..........
IV infusion site ......"   "......
Arterial line ......——......
C.V.P. site ....

	Yes	No
Cricoid Pressure	☑	☐
ECG Monitor	☑	☐
Oxygen Monitor	☑	☐
Co2 Monitor	☑	☐

Flexoplate Applied Bipolar Yes ☑ No ☐
Site ......Right thigh......

Anesthetist ; Drs Jamison
Grund

Type of Anaesthetic (please specify)

1 Local ☐
....

2 General ☑
oral tube 33 6.0

3 Regional ☐
....

Controlled Drugs Used :
Fentanyl } I.V. @ induction
Cyclimorph

Signature/Title : MMcGrath

RF – CORONER

012-002-041

Intra – Operative Nursing Care

Time into Theatre /

Patient Position:
Supine ....✓....
Prone ....
Lateral ....
Lithotomy ....
Other ....

Arms

Right	Left
☐	☑ At side
☑	☐ Armboard
☐	☐ Other

Tourniquet:
Yes ☐ No ☑
Site ....
Pressure ....
Time On ....
Time Off ....

Pressure Relieving Aids:
None ....
Type ....
Site ....

Moving Aids:
Easy Glide ☐
Multiglide 2 way ☐
Multiglide 1 way ☐
Other ☐

Warming Blanket:
Yes ☐ No ☑
Temp. Setting ......ºC

Comments: Voltarol supp 12.5mg. } @ 11.40pm. Paracetamol " 500mg } Marcain 0.25% 5ml to wound.

Surgeon:	**Assistant:**	**Scrub Nurse:**	**Checking Nurse:**
Mr. Makar		S/N V. Ayton	S/N M McGrath

Swab/ Instrument Counts:

	Taken before incision Yes	Taken before incision No		Correct at closure Yes	Correct at closure No
Raytex Swabs	✓			✓	
Packs	✓			✓	
Tonsil Swabs					
Needles	✓			✓	
Scalpel blades	✓			✓	
Instruments	✓			✓	
Tapes/ sloops					
Other					

Surgeon Informed
Yes ☑
No ☐

Wound Closure:
Clips ☐ Sutures ☑

Packs Left Insitu:
(specify) —

Drainage: —

Prosthesis/ Implants:
Type:
Site: —

Signature/ Title: ......M McGrath..........................

RF – CORONER

012-002-042

Recovery Area Care

Post Operative Recovery Position:

	Yes	No	Comment
Airway Control	✓		
Suction Applied	✓		
I.V. Infusion Chkd.	[illegible]		To be recommenced on ward.
Catheter Drain Chkd.	N/A		
Drains (other) Chkd.	N/A		
P.V. Loss	N/A		
Wound Chkd.	✓		
...st Chkd.	N/A		

Skin Integrity:

Healthy	✓
Redness	
Raised Temp	
Discoloured	
Broken Areas	

Oxygen Administration:

Prescription — Method

initially in recovery.

Analgesia:

Drug Given: Route: Time:

Comments

OBSERVATIONS

Time	12.45 am	12.55 pm	1.05 am	1.15 am	1.30 am
Level of Conciousness	asleep	asleep	asleep	awake	awake
Response to Stimulii	yes	yes	yes	yes	yes
Breathing Spontaneously	yes	yes	yes	yes	yes
Airway	ET tube	ET tube	clear	clear	clear
Oxygen Saturation	99%	99%	99%	99%	99%
Respiratory Rate		24	18	20	18
Blood Pressure	117/65	102/72	105/57	116/66	
Pulse	116	109	108	111	117
Peripheral Circulation	good	good	good	good	good
Pain	—	—	—	—	—
P.C.A./ Epidural Commenced	—	—	—	—	—

Recovery Nurse Signature MMC Grath **Ward Nurses Signature**

RF – CORONER

SURNAME AH 313854
FIRST MISS RAYCHEL FERGUSON F
DATE OF
HOSPITAL

DATE

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

PAEDIATRIC

CLINICAL NOTES

9/6/01 written 0620 — Paeds 2nd term SHO

9yr ♀ Surgical pt.
Post appendicectomy D1
Vomiting today — U+E (N) 7/6/01
No diarrhoea No temp.

Fairly stable until ~ 03⁰⁰
— tonic seizure + bed wet
HR ↑
given 5mg PR diazepam
10mg IV "
lasted ~ 15 mins

Called to see patient ~ 04¹⁰

O/E. Looks very unwell
Unresponsive
Pupils dilated + unresponsive
Apyrexic BM = 9
Face flushed + widespread red macular rash
Petechiae neck + upper chest
↳ probably 2° vomiting
HR 160 min
Sats 97% 100% mask

PCS 9

RF – CORONER

012-002-044

Sounds rattly — ? aspirated
Chest – transmitted sounds
Abdo soft
Not ~~hyper~~ hypertonic
c limbs flaccid
Plantars ↓↓

Imp ? seizure 2° electrolyte problem
? cerebral lesion

Na^+ reported as 118 — Mg = 0.59
K = 3 — Calcium normal

→ FBP / U+E / Ca / Mg / Gas / BC already taken
face mask O_2 + placed on side
Dr McCord contacted to come in
Transferred to Treatment room

initially sats 99% on 8l O_2
sats then ↓ to 80's + poor resp effort
→ Anaesthetist fast bleeped
Bag + mask ventn + then intubated
by anaesthetist – Size 6 ETT

⇒ PCR / meningo. ab taken ✓
100mg/kg IV Cefotaxime
50mg/kg IV benzylpen
Catheterised size 10 foley
(5ml water)
0.9% NaCl c 4.13 maint. 1 = 40ml/hr
1ml IM Magnesium sulphate 50%
Urgent CT brain

[signature]

RF – CORONER

AH 313854
MISS RACHAEL F
FERGUSON
[REDACTED]
04/02/92
WESTERN HEALTH and
SOCIAL SERVICES BOARD
Altnagelvin Group of Hospitals

PAEDIATRIC

CLINICAL NOTES

DATE	
09/06/01	Retrospective note
06:15	Recalled to see
	9 yr old – post-op appendicectomy
	– vomiting [illegible] tonic posturing – ? decerebrate
	→ needed PR + IV Diazepam
	– looked cowed / collapsed + apnoeic
	→ dilated fixed pupils
	– [illegible] → IPPV
	– [illegible]
	Urgent CT brain [illegible]
	[illegible]
	[illegible] 40ml / hr ([illegible])
	For ICU. [illegible] / electrolyte correct.
	[signature]
0430 9/6/01	Na 118 Mg 0.59
	K 3
	Urea 2.1 Calcium 2.19
	creat 43 alb 41
	gluc 11
	Hb 12.1
	WCC 17 — N 15
	Plat 319 [signature]

5651
DV
14.5
R. Ferguson
0 °C
467
3.0
41
HCO3 16.1
TCO2 16.8
BE 4.8
SBC 21.3
BEecf 7.8
O2Sat 99.4
UNITS
Gas mHg
B.P. mHg
Hb
0430 9/6/01

RF – CORONER

012-002-046.

9th June 01. Emergency CT. of Head.

There is evidence of a SUB-ARACHNOID haemorrhage with raised intracranial pressure.

No focal abnormality demonstrated.

[signature] Cons. Dr C. Morrison

8.30AM Re-scanned at the request of N.S.U., R.V.H.

To exclude a subdural empyema?

CT. of Head.

An enhanced scan was performed. No evidence of a subdural empyema.

[signature] Cons.

RF - CORONER

LPC 10/85/020

012-002-047.

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST

SHEET NUMBER FC.89

FEED CHART

AFFIX LABEL OR ENTER (in Block Letters)

Surname: Raoke Ferguson

First Name(s)

Hospital No. 313854

FEED: Cows Milk (Normal diet

DATE	TIME	FOOD	AMOUNT REQUIRED IN 24 HOURS	AMOUNT REQUIRED EACH FEED	AMOUNT TAKEN	VOMIT	STOOL
8/6/01	10 25am					LARGE VOMIT	

RF – CORONER

012-002-048

WESTERN AREA HEALTH & SOCIAL SERVICES BOARD

ALTNAGELVIN GROUP OF HOSPITALS

4 HOURLY T.P.R. CHART

Month June

Affix Label or Enter in Block Letters Full Name Hospital No. Ward Consultant

Rachel Ferguson
D.OB 4/2/92
Hosp No 313854

SHEET No. T.P.R. 1.

DAY	7	8th						DAY
DAY OF DISEASE	A.M. P.M.	A.M. P.M.	A.M. P.M.	A.M. P.M.	A.M. P.M.	A.M. P.M.	A.M. P.M.	DAY OF DISEASE
	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	2 6 10 2 6 10	

TEMPERATURE: F° 107° 106° 105° 104° 103° 102° 101° 100° 99° 98° 97° 96° 95° — C° 41° 40° 39° 38° 37° 36° 35°

PULSE: 150 140 130 120 110 100 90 80 70 60 — 103 — 61

RESPIRATION: 50 45 40 35 30 25 20 15 10 5

WEIGHT	25 Kgs	WT.
STOOLS		B.O.
AMOUNT OF URINE		AMT OF URINE
VOMITING		VOMIT
INSTRUATION		

RF - CORONER

012-002-049

Patient Name and Details

Rachel Ferguson.

PAEDIATRIC UNIT
ALTNAGELVIN AREA HOSPITAL

Date:

DATE	TIME	TEMP.	PULSE	B/P	RESP. RATE	Pain Rating Score	Analgesia given	Signature	COMMENTS
9pm	9.50pm	36.6	93	103/61	24	0–1.		D Patterson.	C/o slight central abdominal pain on admission. Colour pale.
	1.55am	36.4	100	96/49	24	0	—	D Patterson.	Sleeping but easily roused and returned to ward. Wound site satisfactory.
	2.15	36.8	96	94/48	24	0	—	D Patterson	Sleeping. Wound site satisfactory. Colour pink.
	2.35am		90.	85/45	20.	0	—	A Noble	Asleep @ present. Colour pink W/site satisfactory.
	3am	37.	84.	78/41.	20	0	—	A Noble	W/site ✓. Child asleep. Colour ✓.
	3.30am		88.	83/47.	20	0	—	A Noble.	well settled W/site Satis ✓ IVI ✓.
	4am		82	83/57	20	0	—	AN.	W/site satisfactory. n/c pain IVI ✓
	5am	37.2.	103	93/45.	20	—	—	AN	n/c pain Colour good W/site ✓ IVI ✓.
	7am	36.2	89	94/49	22	—		J Hewitt	Asleep ✓ colour good. Wound site satisfactory IVI ✓
	9am	36.9	100		24	—	—	M Rice.	No c/o pain. colour good
	1pm	36.6	90		22			AR.	No ooze from wound site. Not c/o pain
	6pm	36.9	92		20			DR	Asleep.
	21.15	35.9	101		21			S Gilchrist.	Colour flushed → pale. Vomiting ++. c/o headache

7/6/01

RF – CORONER

012-002-050

26.01.

ID:.
340

23:19

CLAR
COLO
GLU
KET
SG
pH 8.0
PRO* 2+
NIT NEGATIVE
BLJ NEGATIVE
LEU NEGATIVE

012-002-051

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

OBSERVATION SHEET

O.S.24

Date	Time	Pulse	B.P.	Observations
7.6.01.	8pm		126/76.	c/o abdominal pain. onset
		36°C.		approx 6pm. Tender ++.
				c/o pain on urination. no
				vomiting. Colour Pale o/A.
				bloods ✓
	2020	88	109/74.	Cyclimorph. 2mg IV.
		SpO2	100%.	

Rachael Ferguson

ARITY:
LOR: LT. YELLOW
U* 3+
T* TRACE
1.025
6.0
D* 1+
T NEGATIVE
D NEGATIVE
U NEGATIVE

RF - CORONER

AED NO AH 01AE19050
MISS RACHAEL
FERGUSON

Pat

04/02/92

Ho

USP NO. AH 313854

012-002-052

WESTERN HEALTH and SOCIAL SERVICES BOARD

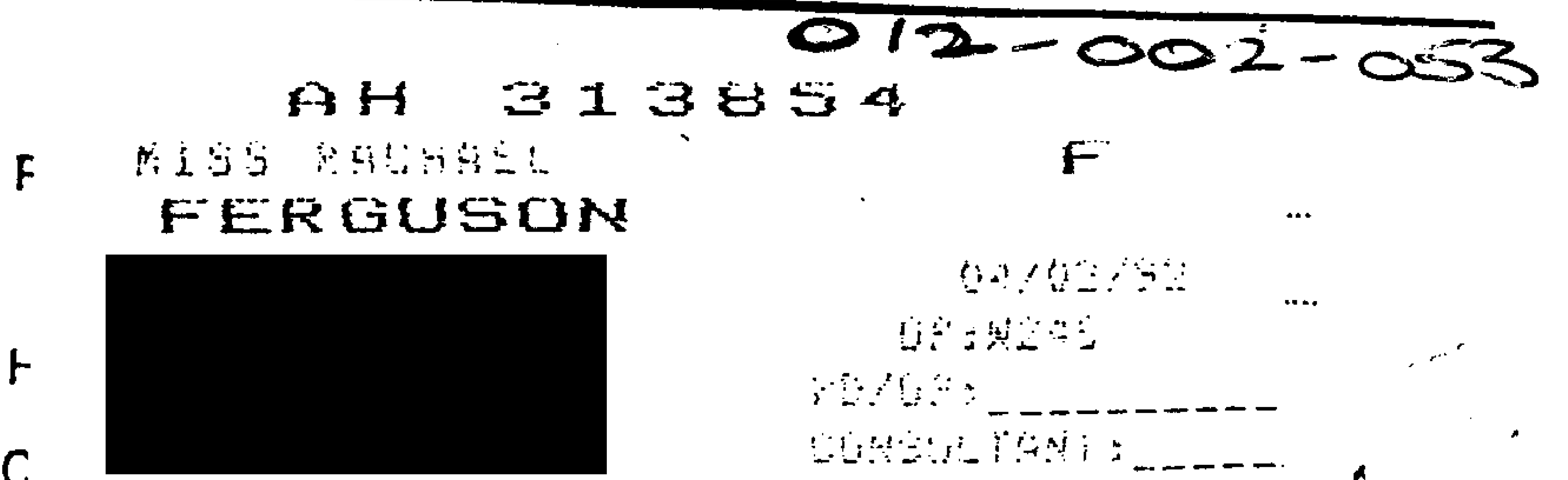
Altnagelvin Group of Hospitals

OBSERVATION SHEET

O.S.24

Date	Time	Pulse	B.P.	Observations
9/6/01.	3.05am			Child found on side having
		HR 76	T 37[2]	been incontinent. Appeared
				agitated and face & neck
				flushed – Hands tightly clenched
				& teeth. O_2 @ 15l/min & unresponsive
				5mgs Diazepam given pr.
				– still fitting – 10mgs diazepam
				given IV. – Lasted approx
	3.15am		SaO_2 99%	15 minutes
	3.30am	T 36[6]		Cool to touch. Still agitated.
				EP, Calcium & Magnesium taken
				& 'ewcine. O_2 continued via
				face mask.
	4.10am	124	104/73	
	4.30am			BM 9.7 mmols.

RF – CORONER


012-002-053

AH 313854

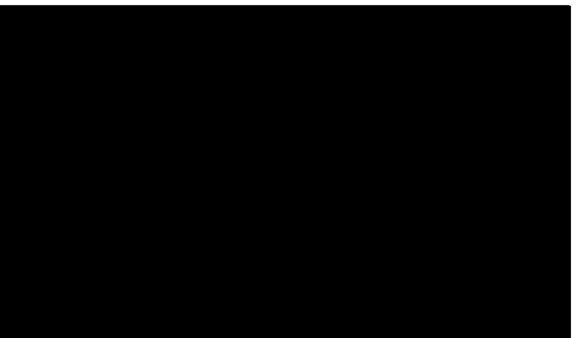
MISS RACHAEL F

FERGUSON

04/02/92

CONSULTANT: Mr Gilliland

HH 313854
MISS RACHAEL F
FERGUSON



04/02/92
GP:N245
WD/OP:__________
CONSULTANT:_____

DRUG TREATMENT SHEET

DRUG ALLERGY / CORTICOSTEROIDS / PREVIOUS RELEVANT THERAPY

Date Admitted	Discharged/Transferred	Age	Sex	Weight (Kg)
7/6/01		9yrs	F	25Kgs

	Date Treatment Started	Approved Name of Drug (Block Letters)	Dose		Special Instructions	8.00	14.00	22.00	Signature of Prescriber	Cancelled	Initials
1	7/6/01	DICLOFENAC	12.5	PR	8 hrly				[illegible]		
2	7/6/01	PARACETAMOL	800mg	PR	8 hrly				[illegible]		
3	7/6/01	Flagyl	500mg	PR	TID				[illegible]		
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											

Unit No.	Surname	Christian Name(s)	Consultant
313854	Ferguson	Rachel	

012-002-054

RF - CORONER

RF – CORONER

SPECIAL RECORDING SECTION FOR PREMEDICATION DRUGS GIVEN

Date	Premedication Prescribed	Dose	[illegible]	Signature of Prescriber	Signature of Nurse Administering

ONCE ONLY DRUGS

Date	Approved Name of Drugs (Block Letters)	Dose	[illegible]	Special Instructions	Signature of Prescriber	Time Given	Given By (Full Signature Please)
7/6/01	9. MORPHINE 1mg/ml upto 5mg.			in RECOVERY	Vijay [illegible]		
7/6/01	ZOFRAN ~~2mg~~	2mg		9/ Reqd.	Vijay [illegible]		
7/6/01	~~IV~~ DICLOFENAC.	12.5mg		in Theatre	Vijay [illegible]		
7/6/01	PARACETAMOL	500mg		in Theatre	Vijay [illegible]	11.40pm	M McGrath
~~8.6.1~~	~~Valoid~~	~~25mg~~		STAT	[illegible]	11.40pm	M McGrath
9.6.1	Valoid	25mg		STAT	M[illegible]	~~[illegible]~~	~~[illegible]~~
9.6.01	DIAZEPAM	10mg		STAT	M[illegible]	10-15pm	M[illegible]
9.6.01	DIAZEPAM	5mg		STAT	J Johnston	0315	J Johnston
9/6/01	Magnesium sulphate 50%	1ml	[illegible]	(= 2mmol)	J Johnston	3.05	J Johnston
9.6.01	CEFOTAXIME	2.5g			[illegible]	0520	[illegible]
9.6.01	BENZYLPENICILLIN	1.2g			J Johnston	} given at 0520 by Dr Johnston	

012-002-055

PARENTERAL DRUGS

	Date	Approved Name of Drug (Block Letters)	Dose	Route	Special Instructions	8.00	14.00	22.00	Signature of Prescriber	Cancelled	Initials
A	7/6/01	CYCLIMORPH. '10'	1/4 ml CJ		6 hrly PRN.				Vijay [signature]		
B	7/6/01	Metronidazole (Flagyl) (crossed out)	200mg		8 hrly 8 doses				[signature]		
C	7/6/01	Zofran	2mg						[signature]		7/6/01
D	8.6.01	CEFOTAXIME (crossed out)	2.5g						[signature]		
E	8.6.01	BENZYLPENICILLIN (crossed out)	1.2g						J Johnston		
F									J Johnston		
G	9/6/01	Cefotaxime	1.2g	IV	50mg/kg 8 hrly		✓	✓	[signature]		
H	9/6/01	Benzylpenicillin	1.2g	IV	50mg/kg 8 hrly		✓	✓	[signature]		
I											
J											
K											
L											
M											
N											
O											
P											
Q											
R											
S											
T											
U											

C Kalamazoo 15½ x 11½ 150922

Unit No.	Surname	Christian Name(s)	Consultant
313854	Ferguson	Raichel	

012-002-056

RF - CORONER

DRUG ADMINISTRATION RECORD (Continuation)

Date	For Review	RECORD FOR REGULAR PRESCRIPTION DRUGS AND "AS REQUIRED" DRUGS GIVEN AT STANDARD TIMES: 6	8	12	14	18	22	24		RECORD FOR "VARIABLE DOSE" DRUGS AND AS "REQUIRED DRUGS" GIVEN AT NON-STANDARD TIMES — Enter Reference Letter/Number, Time Dose (if variable) and initial your entry					EXCEPTIONS TO PRESCRIBED ORDERS REASON
[illegible]/6/01				3 [illegible]			3 [illegible]			1+3 at 8.05 8.20	2C 9.30PM AH				

NOTES ON PRESCRIBING AND ADMINISTRATION

PRESCRIBING

1. Please use approved names BLOCK LETTERS Metric Dosage.
2. Please ensure that the correct section is used for each prescription.
3. Place a tick in the appropriate time columns when treatment is to be given at these times.
4. Please sign your name against each prescription.
5. When changing prescriptions make sure that you cancel with a single straight line those drugs which are to be discontinued, and complete the cancelled section with date and initials.

ADMINISTRATION

1. The senior nurse must ensure that a record is made on the patients Drug Administration Record every time a drug is administered, by entering the initials of the nurse giving the dose, in the appropriate box.
2. Nurse must check carefully to see that all drugs prescribed for a certain time are administered.
3. If a drug is refused enter reference number/letter and circle it e.g. ② or Ⓐ
4. If a patient is absent enter reference number/letter and draw a diagonal line through it. e.g. 2 or M
5. If drug not given for reasons other than 3 and 4 above enter reference number/letter and draw a cross through it e.g. X or M
6. **N.B.** Always enter reason for **Non** Administration of a Drug in the "Exceptions to Prescribed Orders" Column.

GENERAL

1. External preparations should be prescribed on this record in the relevant section. The Nurse should make a record of applying or administering external preparations by the same method as internal preparations.
2. **Antibiotic prescriptions are valid for seven days only unless otherwise specified.** Therapy should be reviewed after seven days unless otherwise specified.

Unit No.	Surname	Christian Name(s)	Consultant
313854	Ferguson	Rachel	

150923 8 1/4 x 11 1/2

RF – CORONER

012-002-057.

ALTNAGELVIN HOSPITAL NEO NATAL INTENSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDS

Name: Rachel Ferguson. Date: 3/6/01 Wt.: .... Age: 9yrs.

FB. 49

	INPUT		INTRAVENOUS						ORAL				OUTPUT										
SPECIFY FLUID	No 11 c 30mls/hr.												ASPIRATE	VOMIT	URINE		STOOLS	LAB SUGAR	HAEMOCUE	Signature	I.V. SITE	Comments	Signa
	1		2		3		4		5		6												
TIME	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Amt.	Amt.	Total	Total						
08.00	150	80																					
09.00	150	160												vomit						[illegible]			
10.00	150	240																					
11.00	150	320												large vomit	PU.								
12.00	150	400																		VMR			
13.00	150	480																		VMR			
14.00	150	560												vomited ++						VMR			
15.00	150	640																		LAB			
16.00	150	720												vomited ++						[illegible]	✓		
17.00	150	800																		VMR			
18.00	150																			VMR			
19.00	150	960																		[illegible]			
20.00	150	1040																					
21.00	150	1120																		VMR			
22.00	150	1200												vomiting coffee grounds ++						NM	✓		
23.00	150	1280												vomited small amount x3						[illegible]	✓		
24.00	150.	1360												small coffee ground vomit						[illegible]	✓		
01.00	150	1440																		[illegible]	✓		
02.00	150	1520																		[illegible]			
03.00	150	1600																		[illegible]	✓		
04.00	150	1680																		[illegible]	✓		
05.00																							
06.00																							
07.00																							

Intravenous Total	
Oral Total	
TOTAL INTAKE	

Urine Total	
Other Total	
TOTAL OUTPUT	

RF - CORONER

012-002-058.

213 maint = 40 ml/hr

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	1000	Sol 18.		80	IMED 960	11445	[signature]	212003	HRice S/N 12.10pm
2	1000ml	0.9% NaCl		40			[signature]	01C19BB	A Hill S/N
3									
4									
5									
6									
7									
8									
9									
10									

LPC 01/85/064

RF – CORONER

012-002-059

ALTNAGELVIN HOSPITAL NEO NATAL INTENSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDS

Name: Rachel Ferguson Date: 7/6/01 Wt. .... Age: 8 years

FB. 491

SPECIFY FLUID	INPUT – INTRAVENOUS								INPUT – ORAL				OUTPUT											
	1		2		3		4		5		6		ASPIRATE	VOMIT	URINE		STOOLS	LAB SUGAR	HAEMOCUE	Signature	I.V. SITE	Comments	Signature
TIME	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Amt.	Amt.	Total	Total						
08.00																							
09.00																							
10.00																							
11.00																							
12.00																							
13.00																							
14.00																							
15.00																							
16.00																							
17.00																							
18.00																							
19.00																							
20.00	No 18 [illegible]																						
21.00	80ml/hr																						
22.00	180	—																					
23.00	150	60																					
24.00	At Theatre																			RP			
01.00																				[signature]	—		
02.00	150	140							Fasting														
03.00	150	220							↓														
04.00	150	300							↓														
05.00	150	380							↓											[signature]			
06.00	150	466							↓											[signature]			
07.00	150	540																		[signature]			
																				[signature]	—		
																				[signature]	—		

Intravenous Total	
Oral Total	
TOTAL INTAKE	

Urine Total	
Other Total	
TOTAL OUTPUT	

RF – CORONER

012-002-060

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	~~1 litre~~ 80ml/Hour	No 18	—	80ml/Hr	1-100	11445	R Mah	07C19BB. 2/2000	10.15am Dr... / I. Bey...
2									
3	~~80ml/h [illegible]~~								
4									
5									
6									
7									
8									
9									
10									

LPC 01/85/064

RF - CORONER

012-002-061.

Surname FERGUSON Hosp. No. AH 313854
Forename RACHAEL Ward ALTNAGELVIN AED
Year of Birth 04/02/1992 Sex F Consultant MR L A MCKINNEY

Profile FBC Department Haematology

1/1 7/6/2001 Acc no : 349

Hgb	Hct	RBC	MCV	MCH	MCHC	RDW	PLT
11.7	.335	3.96	84.6	29.5	34.9	12.4	339

WBC	LY	MO	NE	EO	BA
9.06	3.18	0.53	4.84	0.48	0.04

<CR> to Quit / <P>revious / <N>ext / <L>atest

sortres Inquiry Press <PF1><PF3> For Help

ALTNAGELVIN HOSPITAL
LABORATORY

Lab Number : 5380
Doctor : MR K J S PANESAR

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALTNAGELVIN WARD 6
Address :
Hosp No. : AH 313854
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 119	mmol/L	(135 - 145)
Potassium	* 3.4	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	22	mmol/L	(22 - 28)
Urea	2.5	mmol/L	(2.5 - 6.5)
Glucose	* 7.1	mmol/L	(3.9 - 6.7)
Creat	* 22	umol/L	(53 - 106)
T Protein	68	g/L	(63 - 79)
Total Bilirubin	* 20	umol/L	(1 - 17)
Alk Phosphatase	* 152	U/L	(20 - 90)
AST	* 59	U/L	(13 - 42)
ALT	22	U/L	(10 - 55)
GGT	12	U/L	(1 - 50)
Calcium	2.36	mmol/L	(2.10 - 2.6)
Phosphate	0.97	mmol/L	(0.60 - 1.50)
Albumin	40	g/L	(36 - 51)
Magnesium	0.83	mmol/L	(0.75 - 1.25)

[illegible]

RF - CORONER

012-002-063.

ALTNAGELVIN HOSPITAL
LABORATORY [redacted]

Lab Number : 1747
Doctor : MR K J S PANESAR

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALTNAGELVIN WARD 6**
Address : [redacted]
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST		RESULT	UNITS	(Range)
Sodium	*	118	mmol/L	(135 - 145)
Potassium	*	3.0	mmol/L	(3.5 - 5.1)
Chloride	*	90	mmol/L	(96 - 108)
CO2	*	15	mmol/L	(22 - 28)
Urea	*	2.1	mmol/L	(2.5 - 6.5)
Glucose	*	11.0	mmol/L	(3.9 - 6.7)
Creat	*	43	umol/L	(53 - 106)
T Protein		72	g/L	(63 - 79)

[illegible] CHEMISTRY [illegible] SAMPLE TIME [illegible] SAMPLE DATE [illegible]
REPORT DATE [illegible]
REPRINT DATE [illegible]

RF – CORONER

ALTNAGELVIN HOSPITAL
LABORATORY

Lab Number : 1742
Doctor : MR K J S PANESAR

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALTNAGELVIN WARD 6**
Address :
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 119	mmol/L	(135 - 145)
Potassium	* 3.0	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	* 16	mmol/L	(22 - 28)
Urea	* 2.3	mmol/L	(2.5 - 6.5)
Glucose	* 9.9	mmol/L	(3.9 - 6.7)
Creat	* 44	umol/L	(53 - 106)
T Protein	71	g/L	(63 - 79)
Alk Phosphatase	* 158	U/L	(20 - 90)
Calcium	2.19	mmol/L	(2.10 - 2.6)
Phosphate	1.22	mmol/L	(0.60 - 1.50)
Albumin	41	g/L	(36 - 51)
Magnesium	* 0.59	mmol/L	(0.75 - 1.25)

RF - CORONER

012-002-065

ALTNAGELVIN HOSPITAL
LABORATORY

Lab Number : 1633
Doctor : MR L A MCKINNEY
AH 01AE19050

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALTNAGELVIN AED
Address :
Hosp No. : AH 313854
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	137	mmol/L	(135 - 145)
Potassium	3.6	mmol/L	(3.5 - 5.1)
Chloride	107	mmol/L	(96 - 108)
CO2	22	mmol/L	(22 - 28)
Urea	4.8	mmol/L	(2.5 - 6.5)
Glucose	* 7.2	mmol/L	(3.9 - 6.7)
Creat	* 47	umol/L	(53 - 106)
T Protein	69	g/L	(63 - 79)

[illegible] SAMPLE TIME [illegible] SAMPLE DATE: [illegible]
CLINICAL SIGNATURE [illegible] REPORT DATE: [illegible]
REPRINT DATE: [illegible]

RF - CORONER

012-002-066.

ALTNAGELVIN HOSPITAL
LABORATORY

Lab Number : 5424
Doctor : MR K J S PANESAR

Name : FERGUSON
Forename : RACHAEL
Clinic/Ward : ALT - INTENSIVE CARE UNIT
Address :
Hosp No. : AH 313854
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Urine Sodium	90	mmol/L	(-)
Urine Potassium	27	mmol/L	(-)
Urine Chloride	73	mmol/L	(-)
Urine Urea	58	mmol/L	(-)
Urine Phosphate	-	mmol/L	(-)
Urine Magnesium	-	mmol/L	(-)
Urine Creatinine	* 0.86	mmol/L	(3 - 18)

RF - CORONER

012-002-067.

ALTNAGELVIN HOSPITAL

Received : 08/06/2001
Lab.Ref : 0105206

Copy to :

Name : FERGUSON,RACHAEL
Sex : F
D.O.B. : 04/02/1992
Hosp.No : AH 313854
Source Loc : ALTNAGELVIN HOSPITAL
Ward/Clinic: WARD 6
Cons/GP : MR R GILLILAND

Specimen : APPENDIX

Secretary :- COK

CLINICAL HISTORY:

Ri t sided abdominal pain of 6 hour duration and tenderness anu guarding.
Peritoneal fluid reaction.

PATHOLOGIST'S REPORT:

Received a 6 cm long appendix which grossly appears normal. On section, there is a faecolith 1 cm from the proximal margin. (4 BL NTR).

'istology of the entire appendix confirms the presence of a faecolith and Gram Stains show Gram Positive Cocci within the faecal material. There is no mucosal ulceration in the sections examined and there is no acute inflammation within the mucosa. In a few sections, there are occasional eosinophils and an occasional polymorph within the muscle layer but no plasma cells are seen. The serosal surfae shows no acute inflammation.

D' GNOSIS:

APPENDIX : FAECOLITH

BS

Signed: JCrosbie Pathologist:DR J CROSBIE (Altnagelvin Hospita

Date : 19/06/2001 Histopathology Report WHSSB Dept. of Pathology

RF - CORONER

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME Feguson
FIRST NAME(S) Rachael
DATE OF BIRTH
HOSPITAL NO. AH 313854.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

INTENSIVE CARE

CLINICAL NOTES

DATE	
9/6/01 8.30	A. Date (Anaesth.)
	fast bleeped to Wd 6 @
	♀ F/8yr. had appendicectomy ↓ GA the night before.
	- Had been vomiting during the day suddenly started twitching → had a convulsions → Airway & sats maintained but suddenly SaO_2 ↓ to 80s & stopped breathing
	On my arrival → pt was cyanosed SaO_2 ≃ 70% Apnoeic.
	IPPV c̄ bag & mask SaO_2 improved to ≃ 80%
	but vomiting +
	∴ Intubated c̄ No 6.0 cuffed tube → cuff +
	Copious dirty secretions → sucked out
* ↓ Na. ↓ Mg	Rest of Mx → as per paed notes oro gastric tube +
	C.T. scan → ? Subarachnoid haemorrhage.

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Neurosurgeons informed → want a contrast C.T. scan to rule out

PC 3/97/128

012-002 - 069.

DATE

abscess in the brain

Taken back to the C.T scan for contrast C.T scan

no new findings.

Neurosurgeon contacted →

Nothing surgical seen on the scan

- ~~Not for to~~

- But for transfer to RBHSC when bed available.

May contact Dr Hanna for advise as ~~as he is~~ on call for paed neurology at RBHSC.

Back to ICU

On ~~Drager Ventilator~~ Servo 300 ventilat

200 X 8 FiO_2 50%

SpO_2 100% Chest clear

HR → 93/- BP 105/62 S_1S_2 ✓

U O/P → 100-400 ml/hr

Na ↓

Plan:- for transfer to RBHSC when bed available

- ↑ Na gradually over 24 hrs.
- Cefotaxime & Ben Pen given
- IVF → 1000 ml (N) saline + 40 mmol KCl } 40 ml/hr.

[signature]

RF - CORONER

EVALUATION SHEET

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
			Ventilated — fluids changed to 0.9% NACL			
			sod to 40mls HR.			
			IM MGSO4			
			2.4mg IV Cefotaxime. } 5am.			
			1.2mg IV Benzylpenicillin given }			
			Catherized size 10 foley (5ml water).			
			CT Scan ordered			
			(Initially sub-achnoid haemor found			
			c̄ evidence ↑ ICP. — Transferred to			
			ICU 7am Ventilation commenced via			
			Servo.			
			Repeat CT Scan. — taken 9am.			
			Obs. (see chart) stable.			
			GCS 3. — Unresponsive Pupils			
			large fixed + dilated.			
			Bed available in Sick Children's RVH.			
			Racheal fully attended / Family informed			
			Aware of condition — RVH by ambulance			
			+ police escort 11.10am.			
			Un-eventful journey to Belfast Arrived 12.20pm	S/N [signature]		
			Neg balance 1L Obs satisfactory			
			Hypothermic. T 33.5 on departure to RVH.			
			FBP COAG EP Bone Profile MgSO4 sent.			
			Results given to staff in Sick Childrens.			

Name:

Hospital Number:

Ward:

RF - CORONER

151847 HC5

012-002-071

EVALUATION SHEET

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
9/6/01.	10.10pm		New patient age 9yrs rel/R/C. from WD6			
	unattended		at 7am with history as follows.			
			– admitted to WD6 on 7/6/01 c abdominal			
			pain. No past medical history. Δ Appendicitis.			
			Appendix removed Thursday night – mildly			
			inflamed – No problems during of			
			on 8/6/01 – no concerns – Vomited x 6-7 times			
			during day – was able to walk. No temps /			
			diarrhoea.			
			Check by nurses 3am – incont urine			
			– unresponsive – tonic seizure HR ↑ 160.			
			Recieved 5mg Diazepam P.R.			
			10mg IV diazemuls. – Seizure lasted 15mins			
			Bloods FBP / U+E / Ca / Mg / Cultures taken.			
			4.10am. Very unwell. Pupils dilated.			
			+ unresponsive HR ↑ 160min. Pur.			
			Rash Petechia upper chest ? 2° vomiting.			
			? Ap. SaO2 98% initially 98% 08L O2			
			but sats ↓ quickly + became apnoeic.			
			Intubated c Anaesthetist Size 6 ETT orally			
			(No drugs given prior to intubation).			

Name: Racheal Ferguson Hospital Number: AH.313854 Ward: ICU

151847 HC5

RF - CORONER

012-002-072

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST
TRANSFER REFERRAL SHEET

Patient Name: RACHAEL FERGUSON Hospital No: AH 313854

Date of Admission: 7/6/01 Ward: Wd 6

Present Location: ICU

Principal diagnosis: INITIAL – APPENDICITIS
LATER ? MENINGITIS ? ENCEPHALITIS

Reason for Transfer: TO PAED ICU BELFAST

Time of decision: 09.00 (CONFIRMED)

Referring Consultant : DR NESBITT

Receiving Consultant : DR. Crean

Results of Relevant Investigations: ? Sub.achnoid hae.

Current Drug Therapy: 2.4 mg IV Cefotaxime } TDS.
1.2 mg IV Benzylpenicillin }
Nil else.

CHECKLIST:

Family informed: (Yes) / No

Was patient full attended: (Yes) / No

ITEMS TO BE SENT WITH PATIENT:

Case Notes: - Originals Yes / (No)
- Copies: Yes / No

X-Rays - Originals (Chest) (Yes) / No
- Copies Yes / No
CT XRays (Not sent). Faxed up

Patients Belongings: Yes / (No)

Signature: M Fowler S/N

RF - CORONER

012-002-073

TRANSFER RECORD SHEET

Patients Name: RACHEL FERGUSON Hospital No: AH 313854

Date: 9th June 2001 Time of Departure: 11.10am.

PATIENT INTERVENTION / MONITORS:

Tracheal Intubation:	Yes / (No)	Size of E.T.T.:	6.0
Ventilated (Manual)	Yes / (No)	Type of Ventilator:	Drager Portable
(Mechanical)	(Yes) / No	Mode of Ventilation:	SIMV IPPV.
Central Venous Lines	Yes / (No)	C.V.P. Monitoring	Yes / (No)
E.C.G.	(Yes) / No	SAO_2	(Yes) / No
Blood Pressure (Direct)	Yes / (No)	ET CO_2	(Yes) / No
(Indirect)	(Yes) / No	Urinary Catheter	(Yes) / No
Chest Drain	Yes / (No)		

Time	11.10 AM	11.20 AM	11.30 AM	11.40 AM	11.50 AM	12 MD	12.10 PM	12.20 AM				
H.R.	105	105	104	103.	105.	103	103	104				
Rhythm	SR	SR	SR	SR.	SR	SR	SR	SR.				
B.P. (Cuff NBP)	96/47	96/47	94/50	93/47	98/50	99/45	97/46					
C.V.P.	N/A	N/A.	N/A	N/A	NA.	N/A	N/A	N/A				
SAO_2	100%	100%	100%	100%	100%	100%	100%	100%				
Insp. O_2												
Resp. Rate	10.	10	10	10	10	10	10					
Tidal Volume	200	200	200.	200.	200	200	200.					
Airway Press.	+18	+16	+16	+16	+16	+16	+16					
Peep cms H_2O	+2	+2	+2	+2	+2	+2	+2					
ET CO_2	34	34	34	34	34	33.	35.					
PUPILS	E	E	E	E	E	E	E					
Right Size	7	7	7	7	7	7	7					
Right Reaction	F	F	F	F	F	F	F					
Left Size	7	7	7	7	7	7	7					
Left Reaction	F	F	F	F	F	F	F					

SIZE OF PUPIL

1 2 3 4 5 6 7 8

FLUID	VOL.	STARTED AT	RATE	SIGNATURE
NaCl + KCl	1L	9am	40mls	[signature]

DRUG	DOSE	TIME	SIGNATURE

Time of Arrival: 12.20 pm. Tick if journey uneventful: ✓

Any Important Episode of: Desaturation Hypotension Arrhythmia Hypertension Other

If Yes, Please elaborate:

Evaluation:

RF - CORONER Signature

012-002-074

ALTNAGELVIN HOSPITALS
HEALTH AND SOCIAL SERVICES TRUST

AFFIX LABEL OR ENTER (in Block Letters)

MOUNT SHEET
RADIOLOGICAL REPORTS

ALTNAGELVIN AREA HOSPITAL
DIAGNOSTIC IMAGING DEPT.
REQUEST TO THE RADIOLOGIST

O/P Ward .... Consultant Gilliland / MAKER

To Avoid Shortcoming: This Section Must Be Completed

Name of Patient (In Block) FERGUSON RACHAEL

Address [redacted]

D.O.B. 4.12.92 Hos. No. AH313854

Date of Last X-Ray 8/6/01

STATUS
NHS
Private
Non U.K.
Cat II

OBLIGATORY
L.M.P.
Ignore A Possible Pregnancy
Yes No

Examination Requested

Xray chest

Date 9/6/01 Doctor's Signature [signature]

Clinical Data

POST APPENDICECTOMY
RESPIRATORY COLLAPSE
? ~~[illegible]~~
CEREBRAL EVENT ? NATURE

For Departmental Use Only

Appointment For:

Room	Films Used			Radiographer
Portable.	35 x 43	30 x 40	Others	AF / EC.
	35 x 35	24 x 30		Checked
LPC 9/87/039	64kV.	18 x 24		
		1.6mAS. Supine		XRR. 17

1043

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012-002-075

nsive Care Unit
. R. GILLILAND
EM ASHENHURST

SURNAME FERGUSON
FORENAME(S) RACHAEL
CASENOTE AH 313854
UPCI
D.O.B./SEX 04-FEB-1992 FEMALE
DATE TYPED 11-JUN-01 VW
DICTATED 11-JUN-01 12:32

ENHANCED CT SCAN OF BRAIN 09-JUN-01 08:51
Diagnostic Code

unenhanced and enhanced scans were performed.
Hyperdensity is noted in relation to the meninges and there is loss of definition of the basal cisterns in keeping with raised intra-cranial pressure.
The grey white matter differentiates and is preserved.
Following contrast injection there is no interval change.
In particular, as requested a sub-dural empyema has been excluded.
I have discussed this case with Dr Steven McKinstry, who feels that appearances are more in keeping with cerebral oedema which is highlighting the meninges and normal structures.

CONTINUE...

Dr. C.C.M. Morrison Consultant Radiologist
09-JUN-01 ALTNAGELVIN HOSPITAL
ENHANCED CT SCAN OF BRAIN

0

Intensive Care Unit
MR. R. GILLILAND
DR EM ASHENHURST

SURNAME FERGUSON
FORENAME(S) RACHAEL
CASENOTE AH 313854
UPCI
D.O.B./SEX 04-FEB-1992 FEMALE
DATE TYPED 11-JUN-01 VW
DICTATED 11-JUN-01 12:32

CONT/
A sub-arachnoid haemorrhage is therefore unlikely.

Dr. C.C.M. Morrison Consultant Radiologist
09-JUN-01 ALTNAGELVIN HOSPITAL
ENHANCED CT SCAN OF BRAIN

0

RF - CORONER

Start date : 07.06.01 Start time : 00:00

End date : 10.06.01 End time : 23:59

Name : RACHAEL FERGUSON (AH 313854)

GP Name : DR E.M. ASHENHURST

Address : WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY
BT47 1AU

NHS No. :
Religion : [redacted]
D.o.B. : 04 Feb 92 (9yrs) Sex : Female

Admission Date : 07 Jun 01
Discharge Date : 10 Jun 01

Ward : CHILDRENS UNIT (CHW)
Consultant : MR ROBERT GILLILAND (RG)
~cialty : GENERAL SURGERY (SUR)
C... inator : SN DAPHNE PATTERSON

Planned Discharge Date : -

~ned Nurse : SN DAPHNE PATTERSON

Date Effective : 07 Jun 01

Problems/Expected Outcomes	Actions
Pain (Actual) To provide optimum pain control	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Assess/record location & severity of pain Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - ADMITTED WITH SUDDEN ONSET OF ABDOMINAL PAIN ,SEEN BY SHO IN A&E AND BLOODS TAKEN FOR FBP AND IV CANULA INSERTED ,CYCLOMORPH GIVEN IN A&E AT 8.20PM FOR PAIN ,ON ADMISSION TO WARD COMPLAINING OF ONLY SLIGHT PAIN -FASTING ,FOR THEATRE THIS PM ,CONSENT FORM SIGNED AND SEEN BY ANTHETISIST Nurse Id: SN DAPHNE PATTERSON	Position child comfortably Nurse Id: SN DAPHNE PATTERSON Nurse child in quiet environment Nurse Id: SN DAPHNE PATTERSON Take & record vital signs every ... Nurse Id: SN DAPHNE PATTERSON Take & record vital signs 4 hourly Nurse Id: SN DAPHNE PATTERSON Administer medication as prescribed Nurse Id: SN DAPHNE PATTERSON Assess pain following medication Nurse Id: SN DAPHNE PATTERSON Encourage parental participation in care Nurse Id: SN DAPHNE PATTERSON

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Problems/Expected Outcomes	Actions
Pain (Actual) To provide optimum pain control	Report changes in severity to doctor Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - WENT TO THEATRE AT 11.10PM FOR APPENDICECTOMY ,PAIN RELIEF GIVEN IN THEATRE -CYCLOMORPH AND FENTANYL GIVEN AND VOLTEROL AND PARACETAMOL GIVEN AT 11.40PM ,NO COMPLAINTS OF PAIN SINCE RETURN TO WARD Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 NO CO PAIN TO DATE. SEEN BY DR THIS AM AND TO HAVE SIPS OF FLUIDS AS TOLERATED. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 CHILD CONTINUED TO COMPLAIN OF HEADACHE LAST PM. PR PANADOL GIVEN WITH APPARENT EFFECT AND CHILD SETTLED TO SLEEP. NO COMPLAINTS OF ABDOMINAL PAIN. Nurse Id: SN ANN MARIE NOBLE	
Parental anxiety (Actual) To minimise anxiety and promote parental presence	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Promote open visiting for parents Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - PARENTS PRESENT ON ADMISSION AND SPOKEN TO BY DR IN A&E AND NURSING STAFF, ALL CARE EXPLAINED Nurse Id: SN DAPHNE PATTERSON	Keep parents informed of investigations Nurse Id: SN DAPHNE PATTERSON Keep updated on child's progress/treatment Nurse Id: SN DAPHNE PATTERSON Encourage talks with medical & nursing staff Nurse Id: SN DAPHNE PATTERSON Provide positive reassurance when needed Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Parental anxiety (Actual) To minimise anxiety and promote parental presence	Encourage parents to voice their opinions Nurse Id: SN DAPHNE PATTERSON Encourage parents to continue giving care Nurse Id: SN DAPHNE PATTERSON Record information given to parents Nurse Id: SN DAPHNE PATTERSON
01 05:00 Carry care forward, review on - PARENTS STAYED OVERNIGHT AND ALL CARE EXPLAINED Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 PARENTS PRESENT AND SPOKEN TO BY DR THIS AM, APPEARS HAPPY WITH THE PLAN OF CARE. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 PARENTS CONTACTED EVENTUALLY AS NOT ANSWERING TELEPHONE AND INFORMED OF CHILD,S CONDITION. DAD SPOKEN TO BRIEFLY BY PAEDIATRIC REG AND INFORMED OF CHILD,S ILL CONDITION. MUM INFORMED AND ALSO PRESENT ON TRANSFER. SPOKEN TO BY PAEDIATRIC CONSULTANT DR MC CORD. BOTH APPEAR UPSET. Nurse Id: SN ANN MARIE NOBLE	
Child & parents education re:condition (Actual) Child & parents will understand condition & care	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Provide relevant literature to read Nurse Id: SN DAPHNE PATTERSON Encourage talks with medical staff Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - ALL CARE AND TREATMENT EXPLAINED TO PARENTS Nurse Id: SN DAPHNE PATTERSON	Utilise visual aids available for education Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Child & parents education re:condition (Actual) Child & parents will understand condition & care	Encourage questions Nurse Id: SN DAPHNE PATTERSON Ensure that plan of care is understood Nurse Id: SN DAPHNE PATTERSON Keep updated on changes in care & reason why Nurse Id: SN DAPHNE PATTERSON Document information given to child/parents Nurse Id: SN DAPHNE PATTERSON
06.01 05:00 Carry care forward, review on - Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 ALL CARE EXPLAINED AND NO CONCERNS EXPRESSED. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 SEE PREVIOUS PROBLEM. PARENTS SPOKEN TO RE CONDITION AND PREPARED FOR WHAT TO EXPECT BY DR MC CORD Nurse Id: SN ANN MARIE NOBLE	
Risk of dehydration (IV fluids insitu) (Actual) Maintain adequate hydration 07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON Evaluation: Carry care forward, review on - COMMENCED ON NO 18 SOLUTION RUNNING AT 80MLS PER HR Nurse Id: SN DAPHNE PATTERSON	Check prescribed fluids Nurse Id: SN DAPHNE PATTERSON Set rate & flow as prescribed Nurse Id: SN DAPHNE PATTERSON Inspect infusion rate hourly Nurse Id: SN DAPHNE PATTERSON Encourage oral fluids, record Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Risk of dehydration (IV fluids insitu) (Actual) Maintain adequate hydration	Reduce IV fluids accordingly Nurse Id: SN DAPHNE PATTERSON Keep parents informed Nurse Id: SN DAPHNE PATTERSON Encourage parental participation Nurse Id: SN DAPHNE PATTERSON Record fluid balance chart daily Nurse Id: SN DAPHNE PATTERSON Manage IV set as per procedure Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - IV FLUIDS -NO 18 SOLUTION RUNNING AT 80MLS PER HR OVERNIGHT Nurse Id: SN DAPHNE PATTERSON 08.06.01 17:00 Carry care forward, review on 08.06.01 IV FLUIDS NO. 18 SOLUTION RUNNING AT 80MLS/HR. TOLERATING SMALL SIPS OF WATER. Nurse Id: SN MICHAELA MC CAULEY 09.06.01 06:00 Carry care forward, review on 09.06.01 TRANSFERRED WITH NACL 0.9% AT 40MLS/HR HAD BEEN ON SOLUTION 18 AT 80MLS/HR. Nurse Id: SN ANN MARIE NOBLE	
Risk of infection due to IV cannula (Potential) Prevent infection at venflon site 07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON Evaluation: Carry care forward, review on - IV CANULA INSERTED IN LEFT ARM	IV cannula to be inserted as hospital policy Nurse Id: SN DAPHNE PATTERSON Complete cannula chart 1 hourly (if in use) Nurse Id: SN DAPHNE PATTERSON

RF - CORONER

Problems/Expected Outcomes	Actions
Risk of infection due to IV cannula (Potential) Prevent infection at venflon site	
Nurse Id: SN DAPHNE PATTERSON	Complete cannula chart 4 hourly(not in use) Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - IV CANULA REMAINS INSITU ,SAME PATENT AND SITE SATISFACTORY Nurse Id: SN DAPHNE PATTERSON	
[illegible].06.01 17:00 Carry care forward, review on - IV CANNULA REMAINS INSITU, SITE APPEARS SATISFACTORY. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 IV CANNULAS X 2 IN PLACE AND ARTERIAL LINE IN LEFT WRIST BY ANAESTHETIST. TRANSFER TO CT AND ICU ARRANGED BY DR,S. Nurse Id: SN ANN MARIE NOBLE	
Pre-operative care (Actual) To prepare patient both physically & psychologically	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Orientate child to ward Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - FASTING ,CONSENT FORM SIGNED , FOR THEATRE LATER TONIGHT Nurse Id: SN DAPHNE PATTERSON	Give information on pre/post operative care Nurse Id: SN DAPHNE PATTERSON
	Take & record vital signs (baseline) Nurse Id: SN DAPHNE PATTERSON
	Take & record weight & urinalysis Nurse Id: SN DAPHNE PATTERSON
	Ensure consent signed and charted Nurse Id: SN DAPHNE PATTERSON
	Fast for @least 4 to 6 hours before surgery Nurse Id: SN DAPHNE PATTERSON

RF - CORONER

Problems/Expected Outcomes	Actions
Pre-operative care (Actual) To prepare patient both physically & psychologically	
	Provide clean theatre gown & bedlinen Nurse Id: SN DAPHNE PATTERSON
	Remove prosthesis/jewellery Nurse Id: SN DAPHNE PATTERSON
	Affix Emla cream Nurse Id: SN DAPHNE PATTERSON
.06.01 05:00 Carry care forward, review on - WENT TO THEATRE AT 11.10PM Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Achieved, CHILD WENT TO THEATRE AND RETURNED POST REMOVAL OF MILDLY INFAMMED APPENDIX Nurse Id: SN ANN MARIE NOBLE	
Requires investigation of abdominal pain (Actual) Find cause of abdominal pain	
7.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Keep child fasting ,until instructed Nurse Id: SN DAPHNE PATTERSON
	Prepare child for x-rays as ordered Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - BLOODS TAKEN FOR FBP ,Hb 11.7,WCC 9.06 Nurse Id: SN DAPHNE PATTERSON	Obtain urine for urinalysis and M.S.U. Nurse Id: SN DAPHNE PATTERSON
	Obtain urine for I.C.O.N (females) Nurse Id: SN DAPHNE PATTERSON
	Reassure parents, involve in care Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Requires investigation of abdominal pain (Actual) Find cause of abdominal pain	
08.06.01 17:00 Carry care forward, review on 08.06.01 NO FUTHER INVESTIGATIONS REQUIRED. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Achieved, CAUSE OF PAIN IDENTIFIED Nurse Id: SN ANN MARIE NOBLE	
Post surgery-at risk of complications (Potential) To reduce risk and ensure an uneventful recovery	
.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Nurse in recovery position until alert Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on Nurse Id: SN DAPHNE PATTERSON	Take/record vital signs 1/4 hourly X 2 hours Nurse Id: SN DAPHNE PATTERSON
	Take/record vital signs 1/2 hourly X 2 hours Nurse Id: SN DAPHNE PATTERSON
	Take/record vital signs 1 hourly X 2 hours Nurse Id: SN DAPHNE PATTERSON
	Take/record vital signs 2-4hourly - stable Nurse Id: SN DAPHNE PATTERSON
	Observe/record colour/level of consciousness Nurse Id: SN DAPHNE PATTERSON
	Observe/record urinary output Nurse Id: SN DAPHNE PATTERSON
	Ensure bowel motion within 2 - 3 days Nurse Id: SN DAPHNE PATTERSON
	Explain all procedures - answer questions Nurse Id: SN DAPHNE PATTERSON

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Problems/Expected Outcomes	Actions
Post surgery-at risk of complications (Potential) To reduce risk and ensure an uneventful recovery	
08.06.01 05:00 Carry care forward, review on - RETURNED FROM THEATRE AT 1.55AM FOLLOWING REMOVAL OF MILDLY CONGESTED APPENDIX ,FIRST DOSE OF IV FLAGYL GIVEN IN THEATRE TO HAVE FLAGYL SUPPOSITORIES AS PRESCRIBED , OBSERVATIONS SATISFACTORY OVERNIGHT ,HAS NOT PASSED URINE AS YET ,REMAINS FASTING Nurse Id: SN DAPHNE PATTERSON	
06.01 17:00 Carry care forward, review on 08.06.01 OBSERVATIONS APPEAR SATISFACTORY, CONTINUES ON PR FLAGYL. VOMIT X 3 THIS AM BUT TOLERATING SMALL AMOUNTS OF WATER THIS EVENING. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 CHILD CONTINUED TO VOMIT AND BE NAUSEATED. VOMITED COFFEE GROUNDS X 2. DR CONTACTED AND IV VALOID GIVEN WITH EFFECT. CONTINUED ONPR FLAGYL. AROUND 3 AM CHILD WAS NOTED TO BE RESTLESS AND HAD BEEN INCONTINENT. SHE THEN BECAME STIFF WITH HANDS DRAWN UP AND FISTS CLENCHED. PAEDIATRIC SHO CALLED AND PR DIAZEPAM 5MGS GIVEN WITH LITTLE EFFECT. 10MGS DIAZEMULS GIVEN IV WITH EFFECT AND SURGICAL JHO CONTACTED. BLOODS TAKEN FOR EP, CA AND MG. ECG CARRIED OUT. CHILD STILL AGITATED. HEART RATE FLUCTUATING FROM 78 TO 145BPM. DR INFORMED. NURSED ON SIED WITH O2 VIA FACE MASK AT 15L/MIN. UNRESPONSIVE BUT PERL.BM 9.6MMOLS. PAEDIATRIC REG CONTACTED AND DR MC CORD CONSULTANT. DETERIORATED VERY QUICKLY AND CHILD INTUBATED BY ANESTHETIST SIZE 6.0 ET TUBE IN SITU. COVERED WITH IV CLAFORAN AND BEN Nurse Id: SN ANN MARIE NOBLE	

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Problems/Expected Outcomes	Actions
Named Nurse Details	

07.06.01 3895	

End of printout

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Altnagelvin Hospitals Trust

Front Assessment Print

Printed on 12.06.01 at 3:17 pm

Name : RACHAEL FERGUSON (AH 313854)

Address : [redacted]

NHS No. :

Religion : [redacted]

D.o.B. : 04 Feb 92 (9yrs) Sex : Female

Ward : CHILDRENS UNIT (CHW)

Consultant : MR ROBERT GILLILAND (RG)

Specialty : GENERAL SURGERY (SUR)

Originator : SN DAPHNE PATTERSON

GP Name : DR E.M. ASHENHURST

Address : WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY
BT47 1AU

Admission Date : 07 Jun 01

Discharge Date : 10 Jun 01

Planned Discharge Date : -

Named Nurse : SN DAPHNE PATTERSON

Date Effective : 07 Jun 01

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Preferred name : [RACHEL]

Type of admission : [EMERGENCY]

Mother & Father's name : [RAYMOND AND MARIE FERGUSON]

Mother & Father's telephone number : [redacted]

Baptised? : [redacted]

Reason for admission : [SUDDEN ONSET OF ABDOMINAL PAIN AT 4.30PM CENTRAL AND RIGHT SIDED]

Past Medical History : [NONE]

Relevant family illness : [NONE]

Medication on admission : [NONE ,CYCLOMORPH 2MG IV AT 8.20PM IN A&E]

Allergies : [redacted]

.thrie? : [redacted]

B. Place : [redacted]

Gestation : [redacted]

Type of Delivery : [redacted]

irth Weight : [redacted]

Vaccinations : [UP TO DATE + MEN C]

Infectious disease contact in last 3wks : [No]

If Yes, please specify? : [________________________________]

RF - CORONER

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Siblings : [redacted]
Who does child live with? : [redacted]
Support services prior to admission : [redacted]
Name of Health Visitor : [____________________]

Breathing : [NORMAL]
Comment on Breathing Pattern : [____________________]
[____________________]

Temperature(celsius) : [36.6]
Pulse (beats per minute) : [93]
Respirations (per minute) : [2]
Blood Pressure : [103/61]
Level of consciousness, on admission : [ORIENTATED]
Emotional level on admission : [TALKATIVE]

Weight on Admission : [25KG]
Eating & Drinking : [ORDINARY DIET]
Type of Milk : [COWS MILK]
Type of Food : [NORMAL]
Comment on Eating Pattern : [FUSSY]
Drinks from? : [CUP]

Toileting Pattern : [TOILET]
Urinary problems : [NONE]
Urinalysis : [____________________]
Faecal Pattern : [NO PROBLEMS]

Assistance with ADL's : [____________________]
[____________________]
[____________________]
[____________________]

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Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Communication - Right Ear : [GOOD]
Communication - Left Ear : [GOOD]
Eye sight - Right Eye : [GOOD]
Eye sight - Left Eye : [GOOD]
Wears Spectacles? : [No]
Speech : [GOOD]

Usual sleep pattern : [SLEEPS 10PM -7AM]
Favourite Toy/Dummy/Comforter? : [ ]
Valuables/Comforters taken home? : [No]

M...ity prior to admission : [INDEPENDENT WITH SUPERVISION]
Comments on Mobility : [ ]
[ ]
..in Condition : [INTACT]
Comment on skin condition : [ ]
[ ]
Splints,pressure garments,specialaids? : [ ]

Reaching Normal Milestones? : [Yes]
Comments on Milestones : [ ]
[ ]
Additional information : [ ]
[ ]
Identification armband insitu? : [Yes]
If not, why ? : [ ]

..iting Times Explained? : [Yes]
...ts staying overnight? : [Yes]
Visiting problems eg no car : [ ]
Ward Information Booklet Given? : [Yes]
.o smoking policy explained? : [Yes]

Security System explained? : [Yes]
Play therapist explained? : [Yes]
School teacher explained? : [Yes]
Any person shouldn't get information? : [ ]

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Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Information obtained from? : [PARENTS]
Information obtained by? : [DPATTERSON]

End of printout