The ROYAL HOSPITALS

THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

(12)

MEMORANDUM

MEDICAL LEGAL UNIT

Telephone [redacted]

Date : 06-09-2000
Your ref :
Our ref : CH461358

De Mr CRAWFORD,

RE: LUCY CRAWFORD [redacted]

Your request for copy/copies of notes has been received. On receipt of the fee listed below, copy/copies of notes will be forwarded to you.
The fee has been calculated as follows:

Search Fee: £ 6.80
Photocopying Fee: £ 10.00
Postage: £ 1.00
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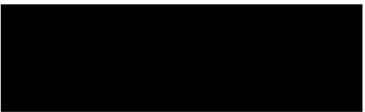
TOTAL FEE: £ 17.80

Cheques should be crossed, made payable to the Royal Group of Hospitals Trust, and forwarded to the above address.
PL SE COMPLETE ENCLOSED FORM/~~FORMS~~ AND RETURN WITH PAYMENT.

Yours faithfully

L. Miller
---------------------------
Medical Legal Records Officer

Solicitors MR N. CRAWFORD



PATRON: HRH The Duchess of Kent
The Royal Victoria Hospital
The Royal Maternity Hospital
The Royal Belfast Hospital for Sick Children
The Dental Hospital

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL
HEALTH AND SOCIAL SERVICES TRUST

180 Falls Road, Belfast BT12 6BE Northern Ireland
Telephone 028 9024 0503

015-012-038

1

**THE ROYAL BELFAST HOSPITAL FOR SICK CHILDREN**
**184 FALLS ROAD, BELFAST BT12 6BE**

## MEDICO-LEGAL UNIT – APPLICATION FORM

**Tel: [redacted] 3 ext [redacted] Direct Line: [redacted]**

NAME OF APPLICANT: ____________________

ADDRESS: ____________________ Tel: ____________

NAME OF PATIENT: ____________________

ADDRESS: ____________________

DATE OF BIRTH: ____________ DATE OF INJURY: ____________

DATE OF ATTENDANCE AT HOSPITAL: ____________________

TYPE OF INJURY OR TREATMENT: ____________________

| ACCESS TO HEALTH RECORDS (NI) ORDER 1993 | TICK AS REQUIRED | ADMIN OF JUSTICE ACT 1970 | TICK AS REQUIRED |
|---|---|---|---|
| 1. COPY OF CASUALTY NOTES (INC FRACTURE NOTES IF APPLICABLE) | | 1. NAME OF DOCTOR TREATING PATIENT | |
| 2. COPY OF RELEVANT HOSPITAL NOTES | | 2. COPY OF CASUALTY NOTES | |
| 3. A DOCTOR (APPOINTED BY YOU) TO VIEW XRAYS AT RBHSC | | 3. COPY OF RELEVANT HOSPITAL NOTES | |
| 4. COPY XRAYS | | 4. YOUR REQUEST FOR A MEDICAL LEGAL REPORT TO BE FORWARDED TO THE APPROPRIATE DOCTOR | |
| 5. COPY OF PHYSIO NOTES | | | |

I CONFIRM THAT NO LEGAL ACTION IS INTENDED AGAINST THE ROYAL HOSPITALS, THE DEPARTMENT OF HEALTH OR ANY OF ITS SERVICES.

SIGNED: ____________________ DATE: ____________

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*FOR OFFICE USE ONLY*

| ACTION TAKEN | DATE | INITIAL |
|---|---|---|
| RECEIVED | | |
| HOSPITAL NO: | | |
| SENT FOR PERMISSION | | |
| FEE:– FEE REQUESTED | | |
| NOTES BACK TO FILE | | |
| RECEIPT NO: RECEIPT SENT | | |
| COPIES SENT | | |

The ROYAL HOSPITALS

# The Royal Belfast Hospital For Sick Children
## INPATIENT / OUTPATIENT ADVICE NOTE

HOSPITAL No. [illegible]

☑ Emergency ☐ Elective ☐ Non-elective ☐ Daycase ☐ Outpatient new/1st/2nd/ongoing

Dear Doctor

Your patient was seen/admitted: [illegible] /4 /00

and discharged/transferred on: 14 /4 /00

Consultant I/C/M: [illegible]

Ward: ICU

Referred by ☐ A&E ☐ GP ☐ OP ☐ W ☑ Other

Please place address label here

| Diagnosis | Code |
|---|---|
| 1. CEREBRAL OEDEMA ? | |
| 2. | |
| 3. | |
| 4. | |

Major clinical features (current)

Investigations (and results)

CT BRAIN – Cerebral oedema + coning

| Underlying conditions and co-morbidities | Code |
|---|---|
| 1. VIRAL GASTROENTERITIS | |
| 2. | |
| 3. | |
| 4. | |

| Social/other factors affecting care | Code |
|---|---|
| 1. | |
| 2. | |

| Procedures | Date | Code |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

Comments (including information given to patient/parents)

→ Transferred from Erne Hospital c̄ D+V + cerebral oedema – Brainstem tests – ve on 14/04/00 : ~~Ventilator~~ ~~[illegible]~~ RIP

| Complications | Date | Code |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

Discharge/recommended medications

| Drug | Dose & freq. | Duration |
|---|---|---|
| | | |

Review arrangements

1. With GP in
2. By hospital in
3. Other, whom / when

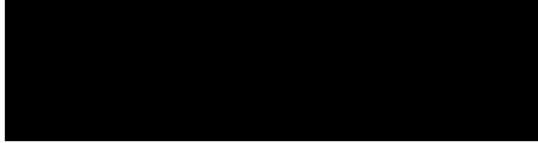
Signed [signature] ☐ Consultant ☑ Reg ☐ SHO ☐ Clin. Asst.

BLOCK LETTERS [illegible] Date 17 / 04 / [illegible]

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

**ERNE HOSPITAL**
ENNISKILLEN, CO. FERMANAGH. BT47 6AY. TELEPHONE 01365 324711/9. FACSIMILE 01365 326131.

Re: Lucy Crawford,



5/4/98.

Dear Dr McKaigue,

Thank you for accepting Lucy for transfer. She presented at approximately 1930 with a history of fever, vomiting and drowsiness. ... I.V. at approx. 11 ... capillary refill >2 secs

Initial investigation

Hb = 12.1 WBC = 15.0 Platelets = 397
$Na^+$ = 137 $K^+$ = 4.1 $Cl^-$ : 105 $CO_2$: 16
urea = 9.9 glucose = 4.5 creatinine = 45.

At approx. 03⁰⁰ her mother noticed her very rigid. She was given diazepam 2.5mg pr (but it is not likely much was absorbed because of diarrhoea shortly afterwards). There were a number of episodes of diarrhoea – watery blood o mucus.

She responded ($O_2$ sats) to bagging and was intubated ≈ 04⁰⁰.

Her pulse was palpable throughout

P.T.O.



SPERRIN LAKELAND IS A HEALTH AND SOCIAL SERVICES TRUST
ESTABLISHED UNDER ART.10 OF THE HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1991

this time. Her pupils were fixed and dilated from $03^{30}$ when I first looked at them

CXR: NAD.

AXR: Distended loops of bowel ? colon.

She had 1gm of Claforan @ $05^{00}$ and 5gm mannitol @ $05^{30}$ (with a brisk diuresis).

Sincerely

Dr J. M. O'Donohoe

Chart No. 461358.

# WESTERN HEALTH AND SOCIAL SERVICES BOARD

**TRANSI[FER]**

ERN 123000
MISS CRAWFORD
LUCY

Rel C Z.

TIME OF TRANSFER: am/~~pm~~

FROM: Erne ICU

TO: Sick Childrens ICU

SPIRITUALLY ATTENDED:

05/11/1998 WARD/~~AED~~ 5

NEXT OF KIN: Parents May & Neville.
RELATIONSHIP:

NOTIFIED - YES/~~NO~~

NAME:

ADDRESS: S/A.

TELEPHONE NO. DAY: NIGHT:

**TRANSFERRED WITH PATIENT**

| VALUABLES | CLOTHING |
| --- | --- |
| | |

DENTURES:

**NURSING REPORT**

MENTAL STATE: ☐ Orientated Disorientated ☐

ALLOWED UP: AMBULANT ☐ With Help TO SIT ☐

☐ Without Help CHAIRFAST ☐

WALKING OR OTHER AIDS: Pupils fixed and dilated

DIET ☐ CAN CANNOT ☑ FEED SELF

Catheterised size 10 FG 3mls in balloon

CONTINENT/INCONTINENT ☐ URINE FAECES ☐

PRESSURE AREAS:

INCIDENT/ACCIDENT:

ANY OTHER INFORMATION (DETAILS OF CARE, TREATMENT ETC.)

LAST MEDICATION GIVEN AND TIME: Diazepam 2.5mg PR @ 0300 — Annexate IV

Claforan 1gm IV. Mannitol 10% (25mls) IV.

DATE: 13/4/00

SIGNED: [signature]

Ward Sister/Charge Nurse 015-012-043

Referral to ....Gme.... Hospital Date ...12.6.99...

Consultant .................... Department ...Childrens ward...

Please arrange: ~~Emergency Admission~~
~~Normal / Urgent~~ / Semi ~~Urgent Appointment for O.P Clinic~~

Details of Patient:

Surname: Crawford — Mr. / Mrs. / Miss

Forenames: Lucy

Previous Surname: ____ — Date of Birth: 5 / 11 / 98

Address:

Occupation: ____

Phone No.: ____

Postcode: ____

Hospital Number:

Date of Last Attendance at this Hospital ..........

Date of Last Attendance at any other Hospital ..........

Name of Hospital:

Reason for Referral: Pyrexia - not responding to Calpol

History / Examination: Drowsy + lethargic
Floppy ↑ Not drinking
o/e Temp 38°

Provisional Diagnosis: Mucosa moist

Past History: Ears ✓ Throat -
CVS ✓ RS ✓ Abd

Present Medication: Δ ? UTI

Known Allergies: –  Needs fluids

Other Relevant Information:

DOCTOR'S OR PRACTICE STAMP
DR E Conner
Cunnahilla

Doctors Signature ....[signature].... (Cypher No.) ..........

R48

015-012-044

# Paediatric Admission

Date: 12/4/00 Time: 19.30 Name: Lucy.
Consultant: Dr. O'Donohue DOB: 15-11-98
Source of admission: GP. Hospital Number:
History from: mum & dad. Address:

**Presenting Complaints:** 17 months ♀
Fever - 36 hours.
Vomiting 36 hours.
Drowsy - 12 hours.

History of Presenting Complaints:
According to mum Lucy is not feeding as usual for the past 5 days.
Since yesterday she is running fever & vomiting everything she eats or drink. ~~stoo~~ she passes stool normally. now for the past 12 hours she is very sleepy.
no H/O rash convulsion or cough.

Past Medical History:
Pregnancy and Gestation
Delivery
Birth Weight:
Admission to Neonatal Unit:

Method of Feeding / Age of Weaning:
Pervious Hospital Admissions:

Serious Illness and Systemic Review:

015-012-045

Immunisation:

| | 1st | 2nd | 3rd | pre-school |
|---|---|---|---|---|
| Diphtheria/Tetanus | ✓ | ✓ | ✓ | |
| Whooping cough | ✓ | ✓ | ✓ | |
| Polio | ✓ | ✓ | ✓ | |
| Hib | ✓ | ✓ | ✓ | ////////////// |
| MMR | ✓ | ////// | ////// | |
| TB (BCG) | | ////// | ////// | ////////////// |
| Meningococcal-C | | | | |

Infectious diseases:

Other Vaccinations:

Medication:

| Drug: | Dose | Frequency: | Mode of Delivery: |
|---|---|---|---|
| Calpol | PRN | | |

Allergies: [redacted]

Social History:
House: [redacted] Heating: [redacted]
Child lives with [redacted] Pets
Schooling: [redacted] Child minder: [redacted]

Developmental History:
Gross Motor:
Fine Motor and Vision:
Hearing and Speech:
Social:

Family History: [redacted]
Similar illness [redacted]
Relevant history [redacted]
Abortion/ Stillbirth/ Neonatal deaths:
Cigarette smoking [redacted]
Disability [redacted]

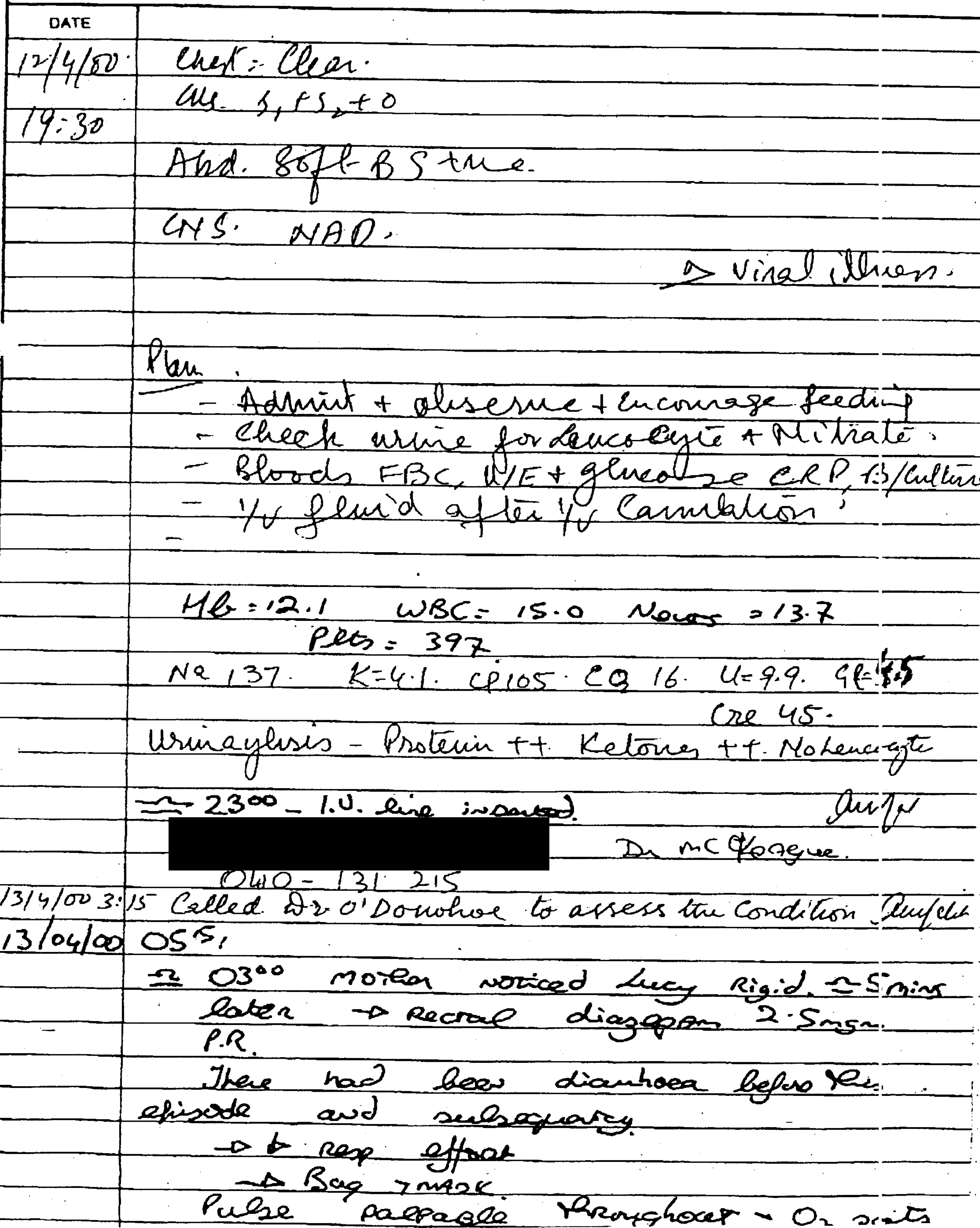
Genogram: [redacted]

EXAMINATION

General look: Conscious + Pink
Temp: 38 °C HR: 140/min RR: 40/min
Weight: 9.14 Kg.
Height:
Head circumference

Capillary refil >2 seconds.

015-012-046



E/1/X

# ERNE HOSPITAL

| SURNAME | FIRST NAME(S) | HOSPITAL NO. |
|---|---|---|
| CRAWFORD | LUCY. | 123000 |

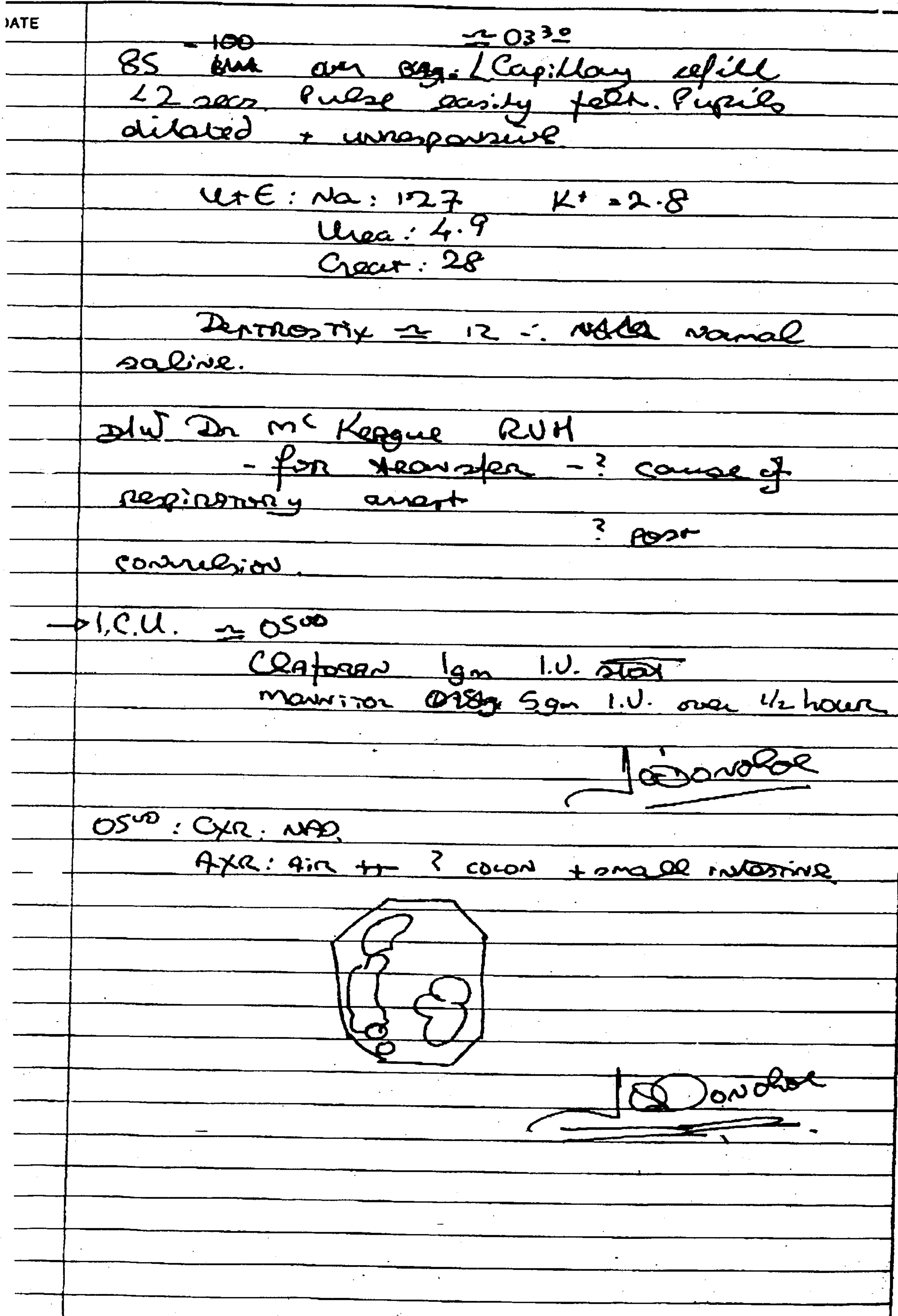
## CONTINUATION SHEET

| DATE | |
|---|---|
| 12/4/00 | Chest - Clear. |
| | ALL S, FS, +0 |
| 19:30 | |
| | Abd. soft BS +ve. |
| | CNS. NAD. |
| | → Viral illness. |
| | Plan. |
| | - Admit + observe + Encourage feeding |
| | - Check urine for leucocyte + Nitrate. |
| | - Bloods FBC, U/E + glucose CRP, B/culture |
| | - I/V fluid after I/V Cannulation |
| | Hb = 12.1 WBC = 15.0 Neuts = 13.7 |
| | Plts = 397 |
| | Na 137. K=4.1. Cl 105. CO 16. U=9.9. Gl=5.5 |
| | Cre 45. |
| | Urinalysis - Protein ++ Ketones ++ No leucocyte |
| | ≃ 23⁰⁰ - I.V. line inserted. [signature] |
| | [redacted] Dr McGoogue. |
| | O40 - 131 215 |
| 13/4/00 3:15 | Called Dr O'Donohoe to assess the condition [signature] |
| 13/04/00 | 05⁵¹ |
| | ≃ 03⁰⁰ Mother noticed Lucy Rigid. ≃ 5 mins later → Rectal diazepam 2.5mg P.R. |
| | There had been diarrhoea before the episode and subsequently. |
| | → ↓ resp effort |
| | → Bag + mask |
| | Pulse palpable throughout - O₂ sats |

LPL 3/88/024



015-012-047



DATE

≃ 0330

85 ~~100~~ over bag. ↓ Capillary refill <2 secs. Pulse easily felt. Pupils dilated + unresponsive

U+E: Na: 127  K+ = 2.8
Urea: 4.9
Creat: 28

Dextrostix ≃ 12 ∴ ~~NaCl~~ normal saline.

D/W Dr McKeague RUH
- for transfer - ? cause of respiratory arrest
? post convulsion.

→ I.C.U. ≃ 0500
Claforan 1gm I.V. ~~stat~~
Mannitol ~~[illegible]~~ 5gm I.V. over 1/2 hour

J O'Donohoe

0500: CXR: NAD.
AXR: air ++ ? colon + small intestine

J O'Donohoe



13/04 '00 09:51 TX/RX NO 2220

E/1/X

# ERNE HOSPITAL

| SURNAME | FIRST NAME(S) | HOSPITAL NO. |
| --- | --- | --- |
| CRAWFORD | LUCY | 123000 |

## CONTINUATION SHEET

| DATE | |
| --- | --- |
| 13/4/00 | Called to see Lucy who had a fit |
| 2:58 | according to nurse. Respiratory Rate 36/m |
| | HR. 140/min. Advised Rectal diazipam as |
| | she was still twitching her hands. |
| 3:15. | Called Dr. O Donohoe to assess the patient |
| 3:20 | Dr O Donohoe came to see the patient |
| | had developed respiratory arrest and |
| | was making few respiratory efforts, |
| | Ambu bagging done, Cardiac + Pulse oximeter |
| | attached. |
| | Passed large foul smelling stool, |
| | NaCl .9% 500ml given over 60 minutes. |
| | Anaesthetist called put in Endotracheal tube |
| | Pupil fixed + non responding to light. |
| | Heart rate above 100 during the whole time |
| | BP. 90/65 on average. Did not developed |
| | cyanosis. O2 Sat - 85% to 100%. |
| | Catheterized (urinary). |
| 4:45. | Shifted Adult ICU, to be shifted to |
| | ICU Paed in RBHSC by Dr O'DONOHOE |
| | [signature] |

LPC 3/86/024

015-012-049

HOSPITAL

WARD c/w

| DATE | INVESTIGATIONS | | NURSING PROGRESS (Including Non Regular Prescription) | Full Signature |
|---|---|---|---|---|
| 12/4/00 | Urinalysis ✓ | | Admitted via GP c̄ above history. | |
| | B.S.U. ✓ | | Ametop cream applied at 19.30. | |
| | Bloods ✓ | | E/B Dr Malik ✓ unable to cannulate, ~~but~~ | |
| | T39² @ 8.40 | | sips of oral fluids taken and same tolerated. | |
| | BM 3.6 mmols | 20.30. | Dr O'Donohue called to see, as child sleepy | |
| | | | and lethargic. PR paracetamol 120mg given @ 22⁰⁰ | |
| | | | Lucy seen by Dr Donohue; bloods taken | |
| | | | and cannula inserted into left hand. | |
| | | | I.V. fluids of No18 solution commenced | |
| | | | at 22³⁰ at 100mls/hr, to encourage | |
| | | | urinary output. Urine specimen obtained | |
| | | | at 21⁰⁰, ketones⁺⁺⁺⁺, protein⁺⁺⁺⁺ on testing | |
| | | | Large vomit at 24¹⁵; I.V. fluids remaining | |
| | | | at 100mls/hr | |
| | | 02⁵⁰ | Large soft/runny pale green bowel motion, | |
| | | | very offensive smelling, moved into side | |
| | | | room. Specimens x3 for MC+S, Rotavirus, | |
| | | | E. Coli and adenovirus taken. Apyrexial. | |
| | | 02⁵⁵. | E/N. McCaffrey, called by mum buzzing. | |
| | | | child rigid in mothers arms. | |
| | | 03⁰⁰ | E/N McCaffrey called myself (SN McManus) | |
| | | | to see child. Child rigid in mums arms. | |

CRAWFORD ( LUCY ( 123000

HOSPITAL

WARD

| DATE | INVESTIGATIONS | | NURSING PROGRESS (Including Non Regular Prescription) | Full Signature |
|---|---|---|---|---|
| | | | no loss of colour, no cyanosis. pulse and respirations | |
| | | | satisfactory. Dr Malik bleeped to see by | |
| | | | EN McCaffrey & Lucy put on to side and | |
| | | | oxygen therapy commenced at 5l/minute | |
| | | | Lucy remaining rigid with lip smacking and twitching | |
| | | | of eyelids when Dr Malik arrived. History given to | |
| | | | Dr Malik; and full examination given. | |
| | | | P.R diazepam 2·5mg given. Large watery | |
| | | | offensive stool within one minute of | |
| | | | giving. BP 144/34 P=160 R=22 T=36·2°C. | |
| | | | B.M. @ 03[15] = 13·4mmols/l I.V. fluids | |
| | | | changed to 0.9% Saline and run | |
| | | | freely into I.V. line Decreased respiratory | |
| | | | effort noted at 03[20]. airway inserted and | |
| | | | bagging commenced by Dr Malik. Dr Donohue. | |
| | | | in attendance. Repeat U+E's ordered | |
| | | | chest and abdominal X-ray ordered and | |
| | | | anaesthetist requested to attend. | S McManus |
| | | | Intubation x 2 attempted by Dr O'Donohue | |
| | | | unsuccessful. Bagging continued with | |
| | | | good $SaO_2$ level maintained in the 90's | |
| | | | H.R stable @ 120-140 Colour pale | |
| | | | ) B.M V 8·3 @ 04.00 ) Suction P.R.N. | |

T tube inserted @ 04:00 and bagging continued. Flumazenil (Anexate) 1ml = 100 mcg given I.V. @ 04.00.
Urinary catheter size 10 insert. Small amount of clear residual urine present.
Bagging continued with good saturation maintained in the 90's until transfer to Wd 5 @ ≈ 05.00 A.M. for transfer to RBHSC ICU.
Parents and family present
Spoken to by Dr O'Donohue & Dr Anderson. T. Jones.

SURNAME | FIRST NAMES | HOSPITAL No.

OMAGH/FERMANAGH HOSPITA'
COMMUNITY SERVICI JNIT
ERNE HOSPITAL

## PATIENT PROFILE

Surname: Crawford
Forenames: Lucy
Marital Status
Address: [redacted]
Date of Birth: 5/11/98. Age 1½ Ward C/W. Hosp. No. 123000.
Date Admitted: 12/4/00 Time Admitted: 19.30 Consultant: Dr. O'Donohue.
Occupation: [redacted] G.P. Dr. Connor.
Religion: [redacted]
Allergies/Reactions: None known.
Vaccinations up to date.

Relevant Family History of Illness
None relevant.

Rel. Past History of Ilness/Operations:
Bronchiolitis.

Reason for Admission? Vomiting from yesterday, ō pyrexia, urine smells strong.
Patients understanding of Present illness:

Medications on Admission: Kept in Hospital?/Retd?
Calpol given @ 18.30.

FINAL DIAGNOSIS:

SUMMARY OF PROBLEMS:

Diarrhoea ½ hr ago.

Next of Kin: May & Neville
Relationship: Parents
Address:
Tel. No. Home [redacted]
Business:
Other:
Informed? YES/NO
Dependents?
No. of Children: [redacted]
Place in Family: [redacted]
Lives with: [redacted]
Type of Accommodation: [redacted]
Facilities Lacking:
Community Services: [redacted]
Social Report Requested: YES/NO
Dentures:
Valuables:
Property Book No.
Valuables to Relatives? Administration?
Supp. Benefit? YES/NO
[redacted]
Signature of Nurse: L. McDonell

Fr.

## PATIENT ASSESSMENT

**MENTAL STATUS** Appearance/behaviour: Floppy & slightly flushed.

Consciousness/awareness: Conscious

COMMUNICATING: Speech activity: — Perceptions:

Hearing: describe — No obvious problems. — Hearing Aid? R. Ear / L. Ear — Worn? Yes/No

Eyesight: describe — Contact Lenses? / Spectacles? — Worn? Yes/No

**PHYSICAL STATUS** VITAL SIGNS: Temp. 38.6 °C; Pulse /min. Regular/Irregular — Blood Pressure

BREATHING: Colour/difficulty: Slightly flushed. — Respirations /min. Regular/Irregular

Cough/sputum: describe No cough

NUTRITION: Weight: 9.14 Height: Condition of mouth/teeth: 12 teeth Moist tongue.

Diet: Ordinary. Appetite: Poor at present × 5 days. Dislikes:

Discomforts assoc. with eating/drinking: tends to be picky. — (Can) ~~cannot~~ feed self?

ELIMINATION: describe pattern/problems/dependence etc. — Menstrual Cycle:

Bowels: Bowels last opened Mon, usually open daily — Aperient/other used?

Bladder: Urine smells strong today. — Urinalysis: Ketones +++ Protein ++++.

REST/ACTIVITY: Sleep pattern: Sleeps all night. — Sedation/other aids?

Mobility: describe limiting factors: Usually active, but floppy & tired today. — "At risk" of falling? Yes/No

Personal Hygiene: dependent for? Dependent for all care. — ~~Can~~ (cannot) dress self?

Skin condition: describe Intact. — Prosthesis/appliances?

SAFETY/SECURITY: Smokes Yes/No — "At risk" Yes/No — Type? — Alcohol?

Pain: describe — Helped by?

Other:

BELONGING/ESTEEM NEEDS: describe

Hobbies, interests, comforters:

**DISCHARGE PLAN** Date of discharge: To: — Relatives informed? Yes/No

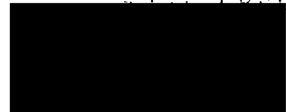
OPD. Appt: Yes/No Clinic: Date booked — Valuables returned? Yes/No — Book signed?

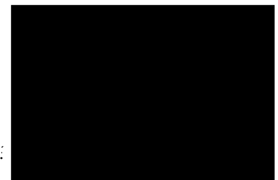
Prescription Card? Tablets to take home? Own tablets returned?

Community Services involved:

Signature of Nurse:

CLINICAL NOTES



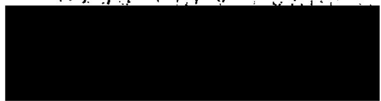


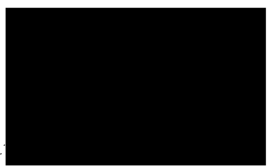
**INPATIENT PICU**

| DATE/TIME | |
|---|---|
| 13/4/00 | 18/12 ♀ Dr. ................ |
| 08^30 | Emergency t/f from Erne Hospital |
| | PC Unresponsive |
| | Fixed dilated pupils |
| Initial Ix | Unwell since Tues. Attended G.P – NAD |
| Hb 12-1 | |
| Wbc 15.0 | Yesterday – poor intake x 2/7 |
| Plts 397 | occ. sips |
| | ↑ temps |
| Na 137 | Vomiting |
| K 4.1 | |
| Cl 105 | A+E last night |
| $CO_2$ 16 | – 3hrs to get IV access |
| Urea 9.9 | – IVf commenced @ 22^30 |
| Creat 45 | – Antipyretics Rx |
| Glu 4.5 | – ↑ unresponsive during the night |
| | Developed diarrhoea as inpt |
| | V. watery + profuse – °Bld / Mucus |
| | At 3am Mum → erratic breathing |
| | Given PR diazepam |
| | No jerking / teeth clenched noted |
| | Responded to bagging |

CLINICAL NOTES

CH 461358
MISS LUCY ...





| DATE/TIME | |
|---|---|
| 09⁰⁰ | Contacted by Anaesthetist in Erne Hospital. |
| | Repeat U+E |
| | Na 127 |
| | K 2.7 |
| | renal function - normal |
| | L McLaughlin (SHO) |
| 13/4/00 | Paed Neurology |
| 10.30 | 18/12 |
| | 11/4 : Vomiting everything - not eating |
| | Went to bed [illegible] - brought home at 12 → GP |
| | at 2.30 - checked out - felt to be OK - [illegible] |
| | Slept quite well Tuesday pm |
| | 12/4 - Boiled water - vomited. |
| | [illegible] at home - listless |
| | lethargic |
| | ~~still vomiting~~ |
| | vomiting |
| | Mum home lunchtime - still lethargic → |



BELFAST B112 6BE

| DATE/TIME | CLINICAL NOTES |
| --- | --- |
| | Given Calpol 2pm |
| | Drank water - kept down |
| | Watched Tweenies 3.30 |
| | Still drinking - |
| | Fell asleep, unresponsive - |
| | Rang Contracts 6.30, Still pyrexic |
| | Brought → Out of hours |
| | → Erne (19.30) |
| | |
| | Tried IV placement x 3 hours. Trying to vomit |
| | Dr O'Donohoe called |
| | Tried Dioralyte. |
| | Got IV c. 10pm |
| | |
| | Eyes glazing, moaning 11.20, went back to sleep |
| | 00.15 - restless, vomited |
| | |
| | Offensive diarrhoea → green (02.10) |
| | → Side ward |
| | "Warm" |
| | |
| | 3am - restless |
| | abnormal breathing |
| | Arms, legs fits - tonic |
| | |
| | Pupils not reacting, unconscious |
| | Intubated 4 am |
| | |
| | → PICU 8am |

CLINICAL NOTES

CH 461358
MISS LUCY CRAWFORD

| DATE/TIME | |
|---|---|
| | One water 16 |
| | ave bottle 13 |
| | |
| | Bronchiolitis |
| | C/S – well 7lbs 2oz |
| | Vaccination ✓ |
| | |
| | ° Meds. |
| | |
| | ? given sedation |
| | |
| | O/E – Cold (31°) Pale. |
| | Unresponsive. |
| | Pupils fixed & unresponsive. |
| | |
| | No corneal or gag reflex |
| | No doll's eye reflex |
| | |
| | Fundi (N) – No haemorrhages |
| | No papilloedema |
| | |
| | Reflexes present but diminished |
| | |
| | No hepatomegaly |

| DATE/TIME | CLINICAL NOTES |
| --- | --- |
| | Sum – Assuming paralysis has worn off, and she has been given no sedation, findings would suggest that she shows no sign now of brainstem function. |
| | For CT stat, then probably for EEG. |
| | DDx ? infection – ? herpes |
| | ? haemorrhagic shock encephalopathy |
| | ? metabolic, e.g. urea cycle defect |
| | ? cerebral oedema for other cause. |
| | No cause is clinically evident as yet |
| | I would suggest, as well as EEG/CT, the following |
| already done – | U/E, LFT<br>Ammonia<br>Clotting screen, including FDP etc<br>Herpes titres. |
| | + Urine for Organic acids. + Toxicology<br>If for LP, check herpes PCR. |
| | D Monahan |
| | ? Stools for culture gone from Emerg. |
| | [signature] |

11

CLINICAL NOTES

| DATE/TIME | |
|---|---|
| 13/04/00 $13^{40}$. | to cover period from admission to |
| McWAGE PICU at $08^{00}$ to $09^{00}$ | |
| | received patient from transfer team from the |
| | Erne Hospital. patient intubated (oral tube) and ventilated |
| | colour good, AE both lungs. |
| | dopamine infusion at 1·5 ml via peripheral |
| | iv line. HR initially noted to be ~ 110 min |
| | but within a few minutes had dropped to |
| | 70/min. child hand-bagged and hyperventilated. |
| | but no improvement in heart rate. peripheral |
| | pulse palpable BP 75/45. pupils fixed and |
| | dilated. central line organised. |
| | [signature] |
| 13/04/00 | |
| $13^{50}$ | Dr - CHIKAMTA |
| | - Central line (Right internal ~~Jugu~~ Jugular |
| | vein) inserted + Left femoral Arterial |
| | line inserted between 08·35 to $08^{50}$ Hours |
| | [signature] |

BELFAST 01 12 00C

| DATE/TIME | CLINICAL NOTES |
|---|---|

**WARD ROUND - THURSDAY 13 APRIL 2000 - PICU**
**CONSULTANT - DR P CREAN**

**LUCY CRAWFORD**

Eighteen-month old girl, transferred from Erne Hospital this morning.
She has been unwell since Tuesday, poor intake of oral fluids, lethargic.
Yesterday she was pyrexia, vomiting. Was taken to the Erne Hospital last night at 7.00pm, IV access was difficult and the parents say it took three and a half hours to establish an intravenous line.
During this time she was fairly unresponsive.
In the early hours of this morning, mother noticed that her breathing became erratic and she developed a seizure. She was given rectal Diazepam and at 3.30am her pupils were noticed to be fixed and dilated.
She was intubated and ventilated and transferred to the PICU in RBHSC.
She is currently haemodynamically stable on mechanical ventilation and requires an Adrenaline infusion to maintain her blood pressure.
Apparently she has had Manatol and is still polyuric.
She has a metabolic acidosis of -10 and the Sodium on ward testing is 140.
She is unresponsive to painful stimuli and I was able to change her endotracheal tube without any medications.
I am awaiting faxes of her notes from the Erne Hospital and she is to be reviewed by a Paediatric Neurologist this morning.

P Crean

| DATE/TIME | CLINICAL NOTES |
|---|---|
| | Neurology. |
| 13.4.00 | CT today shows obliteration of the cisternal |
| — | cisterns suggesting that she has coned. |
| 7.45 | Reasonable white matter / grey matter |
| | differentiation seen, but her EEG shows |
| | isoelectric pattern. |
| | |
| | Lucy's prognosis, in my opinion, is hopeless, and |
| | indications are that she is brain dead. |
| | She will need brain stem tests, and on |
| | discussion with her parents, we will defer |
| | these until tomorrow. |

13

CLINICAL NOTES

AFFIX LABEL HERE

Lucy Crawford

DATE/TIME

In the meantime, overnight, if she deteriorates, her parents are agreeable to her not being actively resuscitated.

If she succumbs, a PM would be desirable — coroner will have to be informed.

I will leave tonight by plane, and will perform brainstem tests tomorrow.

Donncha Hanrahan
Cons Paed Neurology

**WARD ROUND - FRIDAY 14 APRIL 2000 - PICU**
**CONSULTANT - DR A M CHISAKUTA**

**LUCY CRAWFORD**

This ~~eighteen~~ Seventeen-month old girl admitted from Erne Hospital yesterday still remains unresponsive.
She has required mechanical respiratory support during the last 24hrs.
An infusion of Desmopressin was discontinued during the night.
At 09.00 this morning, she had a negative brain stem viability test (1st test).

PLAN:
1 Await repeat second set of tests.

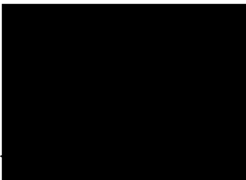
[signature]

10.30 2nd tests brain stem
Dr D. Hanrahan + Dr. A. Chisakuta
→ NEGATIVE

015-012-062

| DATE/TIME | CLINICAL NOTES |
| --- | --- |
| 14.4.00 11.30 | Blood Cultures negative to date. (After 24 hrs). |
| | Phoned Erne lab : Urine culture |
| #6449 | - no significant growth. |
| | Stools all sent to Altnagelvin. |
| | Altnagelvin lab : |
| | · Stool cultures → no pathogens isolated to date. |
| | · Rota / adenovirus available at 4.30 pm tonight |
| | · full report Salmonella + campylobacter requires further 24 hr culture. |
| | Transplant team (Eleanor Donaghy) contacted again by Dr Hanrahan - will ring back. |
| | Coroner (Dr Curtis on behalf of coroners) contacted by Dr Hanrahan - case discussed, Coroners PM is not required, but hospital PM would be useful to establish cause of death + rule out other Δ. |
| | Parents consent for P.M. ✓ |
| | C Stewart |
| | Organ donation discussed with family. Willing to donate any organs for Tx. |
| | Solid organs - unsuitable because causative organism unknown. |
| | Heart will be removed at post mortem & sent to Royal Brompton Hosp who will await culture results |
| | Eleanor Donaghy |
| | Transplant Co-ordinator |

CLINICAL NOTES



CH 461058
MISS LUCY CRAWFORD

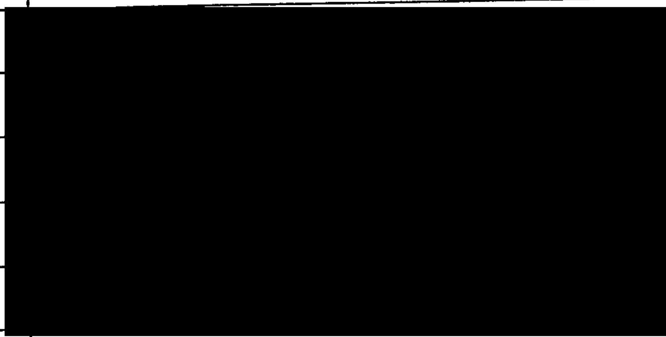
WD/OP

| DATE/TIME | |
|---|---|
| 14.4.00<br>14.30 hrs. | After discussion re. transplant/organ retrieval, Lucy was extubated @ 13.00 hrs<br>Parents in attendance<br>13.15: No heart beat, no signs life.<br><br>Spoke to Pathologist Dr D. O'Hara<br>· Autopsy form ✓<br>· Consent (written) by parents ✓<br>· Heart to be retrieved for heart valve donation during PM.<br><br>C Stewart<br>SpR |
| 4/05/00 | Contacted by<br>– re death certificate<br>– spoke c̄ Dr Stewart – had been waiting for pm result<br>– PM result on front of chart<br>– ~~Gastroenteritis~~<br>– spoke c̄ Dr Hanrahan<br>– Cause of death 1. Cerebral oedema<br>2. Dehydration<br>3. Gastroenteritis<br><br>→ will contact Funeral Undertaker |

(O'Donoghue)

WNC 762

| DATE/TIME | CLINICAL NOTES |
|---|---|
| | – spoke c̄ undertaker – will send Death Cert |



[signature]

| DATE/TIME | CLINICAL NOTES |
|---|---|
| [illegible]/00 | Interview with parents. |
| | They have met Dr O'Donoghue, who ~~say that~~ did not have the notes. |
| | I went over the events around Lucy's death, and encouraged them to re-attend Dr O'Donoghue to clarify events in the Erne. |
| | I will see them again if required. |
| | [signature] |
| 1/6/00 | Contacted Dr O'Donoghue who will see Lucy's parents again, but he would rather wait for the pm report. |
| | [signature] |

IC 762

17

# PICU CAREPLAN RBHSC

Day 2. 14.04.00.

NAME: Lucy Crawford HOSP. NO. 461358 DAY NO. (1) DATE: 13/4/00

SUMMARY: 17 month old girl hx of vomiting + diarrhoea, seizure activity and ↓ consciousness. Admitted from the Hospital - intubated + ventilated central line + arterial line insitu - pupils fixed + dilated. hypothermic. condition critical.

| ASSESSMENT OF CONDITION/NEEDS | GOALS AND PLANNED CARE |
|---|---|
| 1. PHYSICAL | |
| (A) Respiratory — 1 (2) 3 4 5 | 1 (2) 3 4 5 |
| Intubated & ventilated — Secretions [illegible] | Monitor ventilation* — Saline suction x 4-6 hrly. + PRN |
| ● SIMV (PC + PS) Rate 12bpm, 7/10, 40% [illegible] | |
| → no cough / gag. | |
| (B) Cardiovascular — 1 (2) 3 4 5 | 1 (2) 3 4 5 |
| ■ Hypotensive and Bradycardic - Dopamine in progress via peripheral line | Continuously monitor cardiovascular status — Record vital signs hrly. |
| Temperature unrecordable via axilla | ~~Care of I.A. line~~ |
| △ IA line inserted left femoral [illegible] | |
| Dopamine ↗ Adrenaline commenced this am ↑ BP + Tachycardic - Adrenaline ↓ | |
| Rectal temp 36.6 | |
| • Tachycardic 200BPM + Hypertensive 110/60 | |
| Pyrexic 37.7°C. | |
| (C) Pain/Sedation — 1 2 3 4 (5) | 1 2 3 4 (5) |
| - No analgesia / sedation given - Lucy remains 'flat' - unresponsive to stimulation | Ensure Lucy is painfree and relieve anxiety |
| | Administer analgesis and sedation as prescribed |
| • No sedation / analgesia. | |
| (D) Neurology — 1 (2) 3 4 (5) | 1 (2) 3 4 5 |
| G.C.S. = 3 — Pupil size = 7 - fixed | Observe for signs of neurological deficits |
| □ Spinal movements noted extension (R) arm. | Records G.C.S. at start of each shift and/or [illegible] hrly. |
| • For Brain Stem Death Testing this am. | |

Continuum symbols — Morning 8am ● Evening 2pm ▲ Night 8pm ■ 2am ◆

17

015-012-066

| (E) Nutrition/Hydration | 1 | (2) | 3 | 4 | 5 |
|---|---|---|---|---|---|

NUTRITION ASSESSMENT SCORE (9)

Lt Int Triple Lumen inserted by Dr Green.
IV Fluids in progress 0.9% NaCl ✗ 0.45 NaCl + 2.5% Dex + KCl ✗
C/o 0.45% NaCl + 2.5% Dex.
2/3 maintenance 26mls/hr ✓ Replacing hourly urine output -10 ✗ 40mls/hr or urine output replaced (4 ... > 40mls)
KCl infusion ⊣ @ 4.30am.
• Fluid regime as charted.

| | 1 | (2) | 3 | 4 | 5 |
|---|---|---|---|---|---|

Record intake hrly. Record B.M. stix x with bloods hrly. Weigh x when well
Care of I.V./Central Lines* ✗

| (F) Elimination | 1 | (2) | 3 | 4 | 5 |
|---|---|---|---|---|---|

• Diuresis +++ Dilute urine – [illegible] Mannitol in Sunderland (920mls in ur. ..) on admission.
DDAVP infusion 4 ml/hr ⊣ @ 4.30am

| | 1 | (2) | 3 | 4 | 5 |
|---|---|---|---|---|---|

Record urinary output hrly. Aspirate nasogastric tube x 4-6 hourly
Record type and amount of aspirate & free drainage. Urinalysis 6 hrly.

| (G) | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Skincare/Wound Care | 1 | 2 | 3 | (4) | 5 |
| Mobility | (1) | 2 | 3 | 4 | 5 |
| Hygiene | 1 | 2 | (3) | 4 | 5 |

Skin intact – marks easily
Immobile – flat unconscious
• Requires all care.

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Skincare/Wound Care | 1 | 2 | 3 | (4) | 5 |
| Mobility | (1) | 2 | 3 | 4 | 5 |
| Hygiene | 1 | 2 | (3) | 4 | 5 |

Ensure Lucy's skin is clean and healthy. Daily bed bath
Provide care to eyes and mouth.* x 2-4 hrly
Turn x 2 hrly, use manual handling aids as required. Pressure area care x 4 hrly

| (II) Psycho/Social/Cultural | 1 | (2) | 3 | 4 | 5 |
|---|---|---|---|---|---|

Lucy's parents and 1 brother 13 (Wayne) and Sister (16) in attendance

| | 1 | (2) | 3 | 4 | 5 |
|---|---|---|---|---|---|

Provide Lucy's parents/relatives with support and information

(III) Circumstantial

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015-012-067

# Evaluation/Progress Report

**Morning:** $08^{00}$ - $13^{00}$ **Time:** $15^{00}$ pm | **Evening:** $08^{00}$ - $13^{00}$ **Time:** $15^{00}$ pm | **Night:** **Time:**

(1A) 1st set of brainstem death tests carried out at $08^{50}$ am by Dr Harold + Dr Chisokuta [illegible?]. Negative for brain death. Parents informed. Second set of tests conducted at $10^{30}$ am. Negative for brain death. Transplant co-ordinator contacted. Parents spoke to. Ventilation discontinued at $13^{00}$ pm.

(1B) Tachycardic all morning → . B/P 110/60. Pyrexic $37^{7}$°C. Ventilation discontinued at $13^{00}$ pm. Pronounced no heart beat at $13^{15}$ pm.

(1C) No sedation / analgesia.

(1D) Brain stem death tests as per (1A).

(1E) Fluids discontinued at $13^{00}$ pm. All lines removed.

**Signature:** | **Signature:** [signature] | **Signature:**

Name: Lucy Crawford Hosp. No. 461358 Date: 14.4.00

# Evaluation/Progress Report

| Morning: | Time: | Evening: | Time: | Night: | Time: |
|---|---|---|---|---|---|

C(F) Urinary catheter removed at $13^{15}$ pm.

C(S) Bed bathed, hair washed and all care given.

C(11) Parents + family present. Mum nursing Lucy at time of death. RIP.

| Signature: | Signature: [illegible] | Signature: |
|---|---|---|

Name: Lucy Crawford. Hosp. No. 461358. Date: 14.04.00

015-012-069

# Evaluation/Progress Repo[rt]

**Morning:** 13.04.00 **Time:** ⟶ 08⁰⁰ - 20⁰⁰hrs **Evening:** ⟶ 13.04.00 **Time:**

A) Remained intubated and ventilated throughout the day. Ventilator settings changed as per blood gases. Presently FiO2 40% Pressures 22/5 Rate 18bpm SIMV (PC/PS)
Secretions 2m - 3 mpg. Acidotic on blood gas - Soda Bicarb bolus given IV as per fluid chart
B) Cardiovascularly unstable on occasions throughout the day very tachycardic HR 220bpm and hypertensive BP 160/110 (Initially bradycardic and hypotensive requiring adrenaline infusion)
Adrenaline discont'd when ↑BP and ↑HR. K+ 2.0 on occasions - Potassium infusion in progress @ 4ml/hr. Very cold. Temperature unrecordable on admission - warmed up with Bair Hugger and blankets to 38.6°C. On Cefotaxime T.I.D.
C) No analgesia or sedation given throughout the day, Lucy remains 'flat' and unresponsive
D) Pupils fixed and dilated since admission - some abnormal flexion of legs. CT scan - abnormal. No brain activity recorded on EEG.
E) IV Fluids in progress throughout the day commenced on 0.9% NaCl - changed to 0.45% NaCl c 2.5% Dextrose c 20mmols KCl and then changed to 0.45% NaCl c 2.5% Dextrose.
Initially fluids 2/3 maintenance - regime changed to previous urinary output plus 1mls. Then changed to 40mls/hr however if urinary output >40mls/hr to have previous hrs urinary output. NG tube insitu, on free drainage - no aspirate.
F) Diuresis +++ DDAVP given x 3 bolus and then DDAVP infusion commenced presently running at 4mls/hr. Good urinary output continues - dilute urine.

**Signature:** S/N V. McCudden **Signature:** S/N V. McCudden

**Night:** **Time:**

a) Intubated and ventilated overnight. Rate + pressures increased and O2 ↑ 60% for short time. ↓ 40% this am. due to being acidotic on blood gas. Minimal secretions on suction.
B. Tachycardic overnight - heart rate 199 this am. Temp 37 - 37.5 overnight. No respiratory effort. BP hard to measure this am due to flexing of arms.
c. No analgesia or sedation overnight.
D. Pupils remain fixed & dilated. Shrugging movements of shoulders & abnormal flexion of arms. No cough or gag reflex.
E. IV fluids initially 0.45% NaCl c 2.5% Dex but changed

**Signature:**

Name: Lucy Crawford Hosp. No. 401358 Date: 13/4/00

015-012-070

# Evaluation/Progress Report

**Morning:** 13.04.00 **Time:** 08⁰⁰ - 20⁰⁰ hrs

G.i) Skin intact - marks easily.
G.ii) Out to sit on mum and sisters knee throughout the day.
G.iii) Bedbathed and hair washed by mum and sister this evening. Mouth and eye care PRN
11) Family circle visiting throughout the day. Mum and dad spoken to by Mr Hanrahan
see relatives counselling sheet

**Signature:** S/N V. Mc Crudden

**Evening:** 13.04.00 **Time:** 08⁰⁰ - 20⁰⁰ hrs

**Signature:** S/N V. Mc Crudden

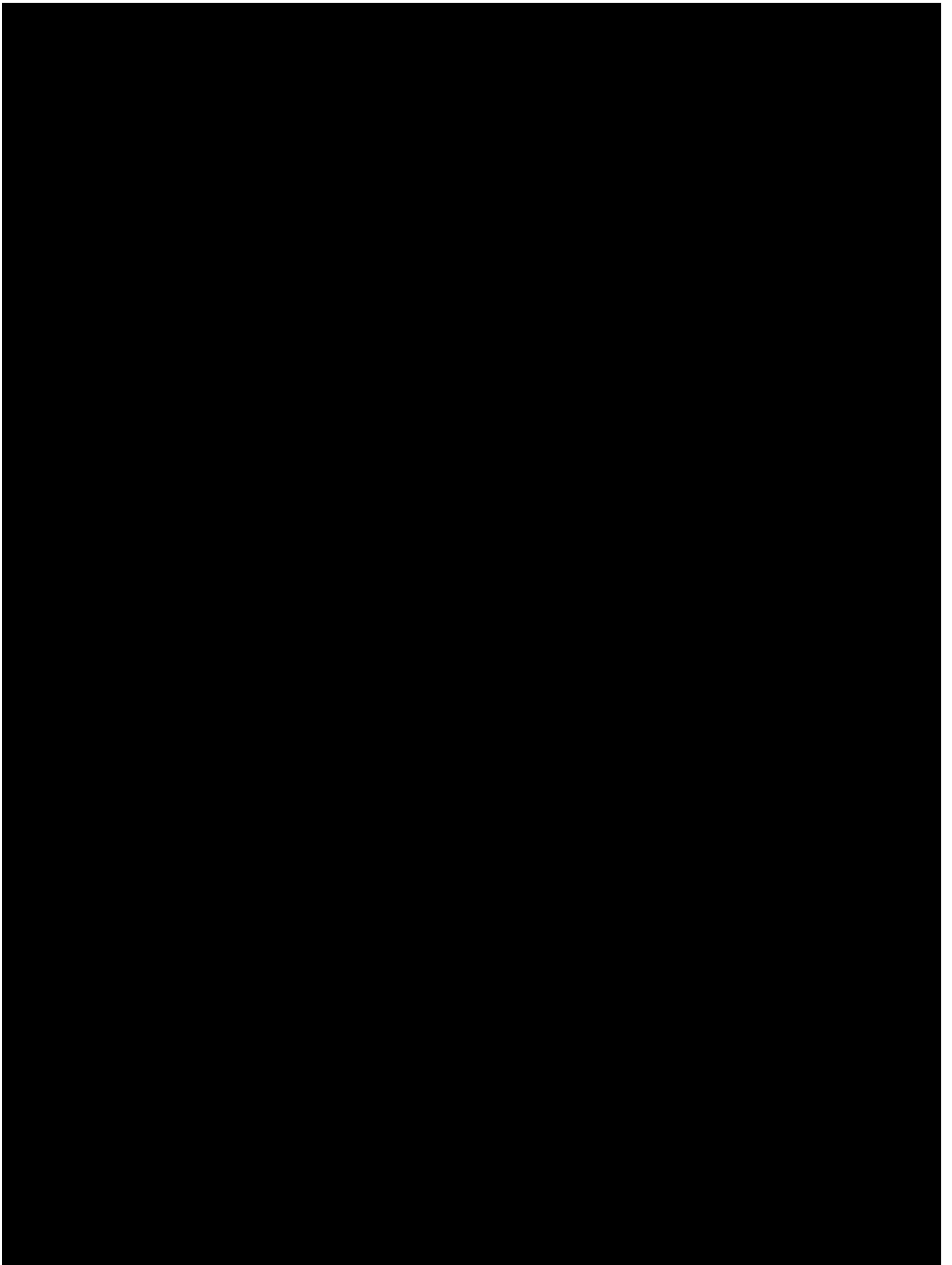
**Night:** **Time:**

to 0.9% NaCl this am as BM
↑ to 11. potassium infusion
H this am as potassium
↑ on blood gas. Total of 40mls
hr overnight.
F. DDAVP infusion discontinued
this am as urinary output
tailing off. BNO. NO
gastric aspirate
G. Skin intact, all care given
11. Out on mum, Dad and
sisters knee in early part
of night.
family circle present overnight

11. Chest xray c 6.30am
Slightly hazy.
111 Fluids changed back to 0.45% NaCl 1/c 2.5% Dex c 7.30am

**Signature:** [illegible]

Name: Lucy Crawford Hosp. No. 461358 Date: 13.04.00



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015-012-072

| CASENOTE NO: | 123000 |
| --- | --- |
| SURNAME, TITLE | Crawford Miss |
| FIRST NAME(S): | Lucy |
| D.O.B. | 5/11/1998 |

# ERNE HOSPITAL

ENNISKILLEN
CO. FERMANAGH
BT74 6AY

# CONFIDENTIAL

ALLERGY

**STICKER BOX**

| P.P. STICKER | (OTHER) |
| --- | --- |
| E.C.R. STICKER | (OTHER) |

123001

015-012-074

WG10890

6 June 2000

ERN: 123000

Dr E Connor
Erne Health Centre
ENNISKILLEN
BT74 6AY

Dear Dr Connor

**Re: Lucy Crawford DOB: 05/11/98**

| | |
|---|---|
| **Date of admission:** | **12 April 2000** |
| **Date of discharge:** | **13 April 2000** |
| **Diagnosis:** | **Viral illness** B34.9 |

This 17 month old girl was admitted to the ward with a history of fever and vomiting for the past 36 hours. Mum also stated that Lucy had been very sleepy for the past 12 hours. There was no history of rash, convulsion or cough. She had been admitted in the past for the treatment of bronchiolitis at the age of 1 year.

On examination she was conscious and pink with a temperature of 38, heart rate 140 per minute and respiratory rate of 40 per minute. Capillary refill was more than 2 seconds. The rest of the systemic examination was unremarkable. She was seen by Dr O'Donohoe who inserted iv line and commenced her on iv fluids. Her FBC and U&E were normal apart from raised urea which was 9.9. Around 3.00 am the following morning Mum noticed that Lucy was rigid and rectal Diazepam 2.5 mgs was given PR. She had diarrhoea before this episode in the hospital. Repeat U&E showed sodium 127 and potassium 2.8. A few minutes after these fits Lucy stopped breathing and she was ventilated with bag mask. Dr O'Donohoe and Dr Auterson, Consultant Anaesthetist were called and they intubated her. She was transferred to ICU and later on from there she was transferred to Paediatric ICU in RHBSC.

Yours sincerely

Dr A Malik
SHO in Paediatrics

cc Mrs Denise Armstrong, Paediatric Liaison Health Visitor

/JI

Date 12 [illegible]

Referral to ...... Hospital

Consultant ...... Department ......

Please arrange: ~~Emergency Admission~~
~~Normal / Urgent~~ / Semi ~~Urgent Appointment for O.P Clinic~~

Details of Patient: Mr. / Mrs. / Miss

Surname Crawford

Forenames Lucy

Previous Surname

Address

Postcode:

Date of Birth 5 | 11 | 9[illegible]

Occupation

Phone No.

Hospital Number:

Date of Last Attendance at this Hospital ......

Date of Last Attendance at any other Hospital ......

Name of Hospital:

Reason for Referral Pyrexia - not responding to [illegible]

History / Examination: Drowsy + lethargic
Floppy Not drinking

o/e Temp 38°
Mucosa moist

Provisional Diagnosis:

Past History: [illegible] Throat -
CVS - RS - Abd

Present Medication: ? UTI

Known Allergies: Needs fluids

Other Relevant Information:

DOCTOR'S OR PRACTICE S[illegible]

Dr C [illegible]
[illegible]

Doctors Signature ...... (Cypher No.) ......

015-012-076

## Paediatric Admission

Date: 12 / 9 / 00 Time: 19:30 Name: LUCY.
Consultant: Dr. O'Donohue DOB: 15-11-98
Source of admission: GP Hospital Number:
History from: mum & dad Address:

Presenting Complaints: 17 months ♀.
Fever · 36 hours.
Vomiting 36 hours.
Drowsy - 12 hours.

History of Presenting Complaints:
According to mum Lucy is not feeding as usual for the past 5 days.
Since yesterday she is running fever & vomiting everything ~~she eats or drinks~~
~~she p do~~ she passes stool normally.
now for the past 12 hours she is very sleepy.
no H/O rash, convulsion or cough.

Past Medical History:
Pregnancy and Gestation.
Delivery:
Birth Weight:
Admission to Neonatal Unit

Method of Feeding / Age of Weaning:
Pervious Hospital Admissions:

Serious Illness and Systemic Review:

Immunisation:

| | 1st | 2nd | 3rd | pre-school |
|---|---|---|---|---|
| Diphtheria/Tetanus | ✓ | ✓ | ✓ | |
| Whooping cough | ✓ | ✓ | ✓ | |
| Polio | ✓ | ✓ | ✓ | |
| Hib | ✓ | ✓ | ✓ | ////////////// |
| MMR | ✓ | ////// | ////// | |
| TB (BCG) | | ////// | ////// | //////////////// |
| Meningococcal-C | | | | |

Other Vaccinations:.........................................

Infectious diseases:

Medication:

Drug: Calpol | Dose: PRN | Frequency: | Mode of Delivery:

Allergies: none that aware of

Social History:

House:............ Heating:...

Child lives with ...... Pets ...........

Schooling ....... Child minder:...

Developmental History:

Gross Motor:............................................

Fine Motor and Vision:..................................

Hearing and Speech:.....................................

Social:.................................................

Family History:

Similar illness.

Relevant history..

Abortion/ Stillbirth/ Neonatal deaths:..

Cigarette smoking

Disability......

Genogram:

EXAMINATION

General look: Conscious + Pink

Temp: 38 °C HR: 140/min RR: 40/min

Weight 9.14 Kg.

Height:..............

Head circumference:.....

Capillary refil >2 seconds.

E/1/X

# ERNE HOSPITAL

| SURNAME | FIRST NAME(S) | HOSPITAL NO. |
|---|---|---|
| CRAWFORD | LUCY | 123000 |

## CONTINUATION SHEET

| DATE | |
|---|---|
| 13/4/00 | Called to see Lucy who had a fit |
| 2:58 | according to nurse. Respiratory Rate 36/m |
| | HR. 140/m. Advised Rectal diazepam as |
| | she was still twitching her hands. |
| 3:15. | Called Dr. O Donohoe to assess the patient |
| 3:20 | Dr O Donohoe came to see the patient |
| | had developed respiratory arrest and |
| | was making few respiratory efforts, |
| | Ambo bagging done, Cardiac + Pulse oximeter |
| | attached. |
| | Passed large foul smelling stool, |
| | NaCl .9% 500ml given over 60 minutes. |
| | Anaesthetist called put in Endotracheal tube |
| | Pupil fixed + non responding to light. |
| | Heart rate above 100 during the whole time |
| | BP. 90/65 on average. Did not developed |
| | cyanosis. $O_2$ Sat. 85% to 100% |
| | Catheterized (urinary). |
| 4:45. | Shifted Adult ICU, to be shifted to |
| | ICU Paed in RBHSC by Dr O'DONOHOE |
| | [signature] |
| 14/4/00 | Yesterday Dr Peter Crean rang from |
| | PICU RBHSC to enquire what fluid |
| | regime Lucy had been on. I told |
| | him a bolus of 100mls over 1 |
| | hour followed by 0.18% NaCl / |
| | Dextrose 4% at 30 ml / hour. He said |
| | he thought that it had been NaCl 0.18% |
| | Dextrose 4% at 100 ml / hour. My recollection |
| | was of having said a bolus over |
| | 1 hour and 30 ml / hour as above. |
| | * |
| | Lucy had had 50 mls of fluid PO |
| | before I saw her. I gave her 100 mls |

3/86/024

015-012-079 A

DATE

while waiting for the EMLA cream to take effect.
Maintenance ≈ 100ml/Kg ≈ 1000ml
-(150 ml PO + 100ml bolus) = 750 ≈ 30ml/hour.
Immediately pre transfer I had discussed fluid rate for the journey. Dr Anderson calculated 40ml/hour (? = 1000/24) but I thought continuing at 30ml was appropriate.

J O'Donohoe

18/4/00
09:10 :- PM - verbal report via PICU R.U.H.

ROTA gastroenteritis ? cerebral oedema.

[signature]

18/4/00 11:00 Blood culture: no growth
Urine: no significant growth (white top bottle)
Stool: sent to Altnagelvin re 0157 ~~[illegible]~~ ~~[illegible]~~ - no specimen received.
But Rotavirus + Adenovirus negative

J O'Donohoe



015-012-079B

E/1/X

# ERNE HOSPITAL

| SURNAME | FIRST NAME(S) | HOSPITAL NO. |
|---|---|---|
| CRAWFORD | LUCY. | 123000 |

## CONTINUATION SHEET

| DATE | |
|---|---|
| 12/4/00 19:30 | Chest :- Clear. |
| | CVS S1, S2 + O |
| | Abd. Soft - BS +ve. |
| | CNS. NAD. |
| | → Viral illness. |
| | Plan. |
| | - Admit + observe + Encourage feeding |
| | - Check urine for Leucocyte + Nitrate. |
| | - Bloods FBC, U/E + glucose CR? B/Cult |
| | - ~~I/V fluid after I/V Cannulation~~ |
| | Hb = 12.1 WBC = 15.0 Neuts = 13.7. |
| | Plts = 397 |
| | Na 137. K = 4.1. Cl 105 CO2 16. U = 9.9. Gl = 4.5 |
| | Cre 45. |
| | Urinalysis - Protein ++ Ketones ++. No leucocyte |
| | ~ 23^00 - I.V. line inserted. [signature] |
| | [redacted] Dr McGorgue. |
| | 040 - 131 215 |
| 13/4/00 3:15 | Called Dr O'Donohoe to assess the Condition [signature] |
| 13/04/00 | 05^15: |
| | ~ 03^00 Mother noticed Lucy Rigid. ~ 5mins later → Rectal diazepam 2.5mgs P.R. |
| | There had been diarrhoea before this episode and subsequently. |
| | → ↓ resp effort |
| | → Bag + MASK. |
| | Pulse palpable throughout - O2 sats |

'86/024

015-012-080A

WHSSB
OMAGH/FERMANAGH HOSPITAL &
COMMUNITY SERVICES UNIT
ERNE HOSPITAL

**PATIENT PROFILE**

Surname: CRAWFORD  Forenames: LUCY  Marital Status

Address: [redacted]

Date of Birth: 5/11/98  Age 1½  Ward C/W  Hosp. No. 123000.

Date Admitted: 12/4/00.  Time Admitted: 19.30  Consultant: Dr. O'Donohue.

FR. Occupation: [redacted]  G.P. Dr. Connor

Religion: [redacted]

Allergies/Reactions: None known.
Vaccinations up to date.

Relevant Family History of Illness
None relevant.

Reason for Admission? Vomiting from yesterday, c pyrexia, urine smells strong.
Patients understanding of Present illness:

Rel. Past History of Ilness/Operations:
Bronchiolitis

Medications on Admission: Kept in Hospital?/Retd?
Calpol given @ 18.30.

FINAL DIAGNOSIS:

SUMMARY OF PROBLEMS:

Diarrhoea ½/52 ago.

Next of Kin: [redacted]
Relationship: [redacted]

Address:

Tel. No. Home / Business: [redacted]

Other:

Informed? YES/NO

Dependents?

No. of Children: [redacted]
Place in Family: [redacted]

Lives with: [redacted]

Type of Accommodation: [redacted]

Facilities Lacking:

Community Services: [redacted]

Social Report Requested: YES/NO

Dentures:

Valuables:

Property Book No.

Valuables to Relatives?  Administration?

Supp. Benefit? YES/NO

Signature of Nurse: L McDonell

LPC 2/86/014

015-012-081

MENTAL STATUS | Appearance/behaviour: Floppy & slightly flushed.

Consciousness/awareness: Conscious.

COMMUNICATING: Speech activity:

Hearing: describe } No obvious problems. — Perceptions:

Eyesight: describe } — Hearing Aid? R. Ear / L. Ear — Worn? Yes / No

Contact Lenses? / Spectacles? — Worn? Yes / No

PHYSICAL STATUS | VITAL SIGNS: Temp. 38.6 °C; Pulse /min. Regular / Irregular — Blood Pressure

BREATHING: Colour/difficulty: Slightly flushed.

Cough/sputum: describe No cough. — Respirations /min. Regular / Irregular

NUTRITION: Weight: 9.14 Height: Condition of mouth/teeth: 12 teeth Moist tongue.

Diet: Ordinary. Appetite: Poor at present & 5 days. Dislikes:

Discomforts assoc. with eating/drinking: tends to be picky. — (Can)/~~cannot~~ feed self?

ELIMINATION: describe pattern/problems/dependence etc. — Menstrual Cycle:

Bowels: Bowels last opened Mon, usually ~~[illegible]~~ daily — Aperient/other used?

Bladder: Urine smells strong today. — Urinalysis: Ketones ++++ Protein ++++.

REST/ACTIVITY: Sleep pattern: Sleeps all night. — Sedation/other aids?

Mobility: describe limiting factors: Usually active, but floppy & tired today. — "At risk" of falling? Yes? / No?

Personal Hygiene: dependent for? Dependent for all care.

Skin condition: describe Intact. — ~~Can~~/(cannot) dress self?

SAFETY/SECURITY: Smokes Yes? / No? — "At risk" Yes? / No? — Type? — Prosthesis/appliances?

Pain: describe — Alcohol?

Other: — Helped by?

BELONGING/ESTEEM NEEDS: describe

Hobbies, interests, comforters:

DISCHARGE PLAN | Date of discharge: To:

OPD. Appt: Yes? / No? Clinic: Date booked: — Relatives informed? Yes? / No?

Valuables returned? Yes? / No? — Book signed?

Prescription Card? Tablets to take home? Own tablets returned?

Community Services involved:

Signature of Nurse:

HOSPITAL WARD 4/W

| DATE | INVESTIGATIONS | | NURSING PROGRESS (Including Non Regular Prescription) | Full Signature |
|---|---|---|---|---|
| 12/4/00. | Urinalysis ✓ | | Admitted via GP ē above history. | |
| | B.S.U. ✓ | | Ametop cream applied at 19.30. | |
| | Bloods ✓ | | E/B Dr. Malik ✓ unable to cannulate, ~~but~~ | |
| | T 39² @ 8.40. | | sips of oral fluids taken and same tolerated. | |
| | BM 3.6mmols | 20.30. | Dr O'Donohue called to see, as child sleepy | |
| | | | and lethargic. PR paracetamol 120mg given @ 22⁰⁰ | |
| | | | Lucy seen by Dr Donohue; bloods taken | |
| | | | and cannula inserted into left hand. | |
| | | | I.V. fluids of No18 solution commenced | |
| | | | at 22³⁰ at 100mls/hr, to encourage | |
| | | | urinary output. Urine specimen obtained | |
| | | | at 21⁰⁰, ketones⁺⁺⁺⁺, protein⁺⁺⁺⁺ on testing | |
| | | | Large vomit at 24¹⁵, I.V. fluids remaining | |
| | | | at 100mls/hr | |
| | | 02³⁰ | Large soft/runny pale green bowel motion, | |
| | | | very offensive smelling, moved into side | |
| | | | room. Specimens x3 for MC+S, Rotavirus, | |
| | | | E. Coli and adenovirus taken. Apyrexial. | |
| | | 02⁵⁵. | E/N. McCaffrey, called by mum buzzing. | |
| | | | child rigid in mothers arms. | |
| | | 03⁰⁰ | E/N McCaffrey called myself (SN McManus) | |
| | | | to see child. Child rigid in mums arms. | |

CRAWFORD LUCY 123000

no loss of colour, no cyanosis, pulse and respirations satisfactory. Dr Malik bleeped to see by EN McCaffrey & Lucy put on to side and oxygen therapy commenced at 5l/minute Lucy remaining rigid with lip smacking and twitching of eyelids when Dr Malik arrived. History given to Dr Malik, and full examination given. P.R diazepam 2.5mg given. Large watery offensive stool within one minute of giving. BP 144/134 P = 160 R = 22 T = 36.2°C. B.M. @ $03^{15}$ = 13.4mmols/l I.V. fluids changed to 0.9% Saline and run freely into I.V. line Decreased respiratory effort noted at $03^{20}$. airway inserted and bagging commenced by Dr Malik Dr Donohue in attendance. Repeat U+E's ordered chest and abdominal X-ray ordered and anaesthetist requested to attend. SMcManus

Intubation x 2 attempted by Dr O'Donohue unsuccessful. Bagging continued with good $SaO_2$ level maintained in the 90's H.R stable @ 120-140 Colour pale.
B.M V 8.3 @ 04.00. Suction P.R.N.
S/B Dr Anterson (anaesthetist). Size 4 oral E.T tube inserted @ 04:00 and bagging continued. Fliemazenil (Anexate) 1ml = 100 mcg given I.V. @ 04.00.
Urinary Catheter size 10 insert. Small amount of clear residual urine present. Bagging continued with good saturation maintained in the 90's until transfer to Wd 5 @ ≈ 05.00 A.m for transfer to RBHSC.ICU
Parents and family present
Spoken to by Dr O'Donohue & Dr Anterson. T. Jones.

015-012-084

# DRUG TREATMENT SHEET

DRUG ALLERGY / CORTICOSTEROIDS /
PREVIOUS RELEVANT THERAPY

| Date Admitted | Discharged/ Transferred | Age | Sex | Weight (Kg) |
|---|---|---|---|---|
| 12/4/00. | | 1½. | F. | 9.14kg |

| | Date Treatment Started | Approved Name of Drug (Block Letters) | Dose | Route | Special Instructions | 6.00 | 8.00 | 12.00 | 14.00 | 18.00 | 22.00 | 24.00 | Signature of Prescriber | Cancelled Date | Cancelled Intials |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Indicate Prescribed Times by a Tick | | | | | | | | | |
| 1 | 12/4/00 | PARACETAMOL | 120 | OR/PR. | PRN 4°-6° | | | | | | | | [signature] | | |
| 2 | | | | | | | | | | | | | | | |
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| 11 | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | |

015-012-085

| Unit No. | Surname | Christian Name(s) | Consultant |
|---|---|---|---|
| | | | |

## SPECIAL RECORDING SECTION FOR PREMEDICATION DRUGS GIVEN

| Date | Premedication Prescribed | Dose | Time Given | Signature of Prescriber | Signature of Nurse Administering |
| --- | --- | --- | --- | --- | --- |
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ONCE ONLY DRUGS

| Date | Approved Name of Drugs (Block Letters) | Dose | Route | Special Instructions | Signature of Prescriber | Time Given | Given By (Full Signature Please) |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 13/04/00 | DiAzepam | 2.5mg | PR | STAT | [illegible] | 03:00 | |
| | Flumazenil | | | | | 04:00 | [illegible] |
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015-012-086

## DRUG ADMINISTRATION RECORD (Continuation)

| Date | For Review | RECORD FOR REGULAR PRESCRIPTION DRUGS AND "AS REQUIRED" DRUGS GIVEN AT STANDARD TIMES | | | | | | | | RECORD FOR "VARIABLE DOSE" DRUGS AND AS "REQUIRED DRUGS" GIVEN AT **NON**-STANDARD TIMES | | | | | EXCEPTIONS TO PRESCRIBED ORDERS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 6 | 8 | 12 | 14 | 18 | 22 | 24 | | Enter Reference Letter/Number, Time Dose (if variable) and Initial your entry | | | | | REASON |
| 12/4/00 | | | | | | | | | | 1 at 21.00 BS | | | | | |
| | | | | | | | | | | | | | | | |
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### 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. 8 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.

015-012-087

© Kalamazoo 150923 8 1/4 x 11 1/2

| Unit No. | Surname | Christian Name(s) | Consultant |
|---|---|---|---|
| [illegible] | [illegible] | | [illegible] |

SPERRIN LAKELAND HEALTH & SOCIAL SERVICES TRUST

## OBSERVATION SHEET

NAME: Lucy Crawford. WARD: C/W.

| DATE | TIME | TEMPERATURE | PULSE | B.P. | RESP. | REMARKS |
|---|---|---|---|---|---|---|
| | | | | | | O/A. Floppy, slightly flushed. |
| 2/4/00 | 19.30. | 38.6 | | | | B.M 3 6 M Mols |
| | 20 30 | 38.7 (Ax) | | | | Paracetamol 120 mg P.R. |
| | 22. 30 | 38.3 (Ax) | | | | |
| | 23.30 | 37.4 (Ax) | | | 26. | asleep. B/P. 144 / 13. |
| | 03. 15 | | 163 | 98% | | B. M = 13.6 |
| | 03. 20. | Continuous Cardiac EEG Monitoring + SaO2. | | | | |
| | 04.00 | | | | | B.M. 8.3. |
| | | | | | | 139 |
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015-012-088

ERNE HOSPITAL
ENNISKILLEN

# DAILY FLUID BALANCE CHART

24 Hours beginning 12/4/00

NOTE: 1 oz = 30 MLs.

AFFIX LABEL HERE OR ENTER

FULL NAME Lucy Crawford

HOSPITAL NUMBER

CONSULTANT

| TIME | INTAKE: Intake by Mouth Amount | INTAKE: Intake by Mouth Type | INTAKE: Intravenous or other routes Amount | INTAKE: Intravenous or other routes Type | OUTPUT: Urine | OUTPUT: Faeces | OUTPUT: Vomit | OUTPUT: Tube | REMARKS |
|---|---|---|---|---|---|---|---|---|---|
| 8 a.m. | | | | | | | | | |
| 9 a.m. | | | | | | | | | |
| 10 a.m. | | | | | | | | | |
| 11 a.m. | | | | | | | | | |
| 12 noon | | | | | | | | | |
| 1 p.m. | | | | | | | | | |
| 2 p.m. | | | | | | | | | |
| 3 p.m. | | | | | | | | | |
| 4 p.m. | | | | | | | | | |
| 5 p.m. | | | | | | | | | |
| 6 p.m. | | | | | | | | | |
| 7 p.m. | Admitted. | | | | | | | | |
| 8 p.m. | | | | | 20mls ? | | | | Ketones ++++ Protein +++ |
| 9 p.m. | 50 | Juice. | | | | | | | |
| 10 p.m. | 100 | Dioralyte | | | | No | | | |
| 11 p.m. | | | 0 100/100 | No 18. | DAMP | Braecheld | | | |
| 12 mid | Refused | | 100/200 | | | Nappy 1+ | | | |
| 1 a.m. | | | 100/200 | | | not | | | |
| 2 a.m. | | | 100/200 | | | changed | | | |
| 3 a.m. | | | 500 | N/Saline | | | | | Diarrhoea +++ |
| 4 a.m. | checked | | 0 | | | | | | |
| 5 a.m. | | | | | | | | | |
| 6 a.m. | | | | | | | | | |
| 7 a.m. | | | | | | | | | |

| | Intake by Mouth | Intravenous or other routes | Urine | Faeces | Vomit | Tube |
|---|---|---|---|---|---|---|
| DAY TOTAL | ML | ML | ML | | ML | ML |
| NIGHT TOTAL | ML | ML | ML | | ML | ML |
| TOTAL FOR 24 HRS. | ML | ML | ML | | ML | ML |

| TOTAL INTAKE | | TOTAL OUTPUT | |
|---|---|---|---|

Form No M 182.

LPC 1 85 026

015-012-039

PARTICULARS OF INTRAVENOUS FLUIDS TO BE GIVEN

A = PRESCRIBED BY ____________________

B = ADMINISTERED BY ____________________

PATIENT NAME: ____________________

HOSPITAL NUMBER: ____________________

| NO. | DATE & TIME COMM | NAME, STRENGTH AND VOLUME OF FLUIDS (SERIAL NO.) | SITE | (HRS) | NAME, DOSE OF DRUGS ADDED | SIGNATURE DOCTOR/NURSE | |
|---|---|---|---|---|---|---|---|
| | 1/4/10 | SOL 18 | I/V | | | A | [illegible] |
| | | | | | | B | [illegible] Swift |
| | | | | | | A | |
| | | | | | | B | |
| | | | | | | A | |
| | | | | | | B | |
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| | | | | | | A | |
| | | | | | | B | |
| | | | | | | A | |
| | | | | | | B | |

PARTICULARS OF SUBCUTANEOUS FLUIDS TO BE GIVEN

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | A | |
| | | | | | | B | |
| | | | | | | A | |
| | | | | | | B | |
| | | | | | | A | |
| | | | | | | B | |

ATTACH ADDITIVE LABELS

015-012-090

015-012-091

## PATIENT PROFILE

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST — ERNE HOSPITAL

SURNAME: CRAWFORD FORENAMES: LUCY MARITAL STATUS S

ADDRESS:

DATE OF BIRTH: 5/11/98 AGE: 1½ WARD: 5/ICU HOSPITAL NO.: 123000

DATE ADMITTED: 13/4/00 TIME ADMITTED: 4⁴⁰ am TYPE OF ADMISSION: Emergency

OCCUPATION: G.P.: Connor CONSULTANT: I. O'Donohue

RELIGION: C Ance: Dr. T. Auterson

ALLERGIES/REACTIONS: None Known. N. Nurse

A. Nurse

RELEVENT FAMILY HISTORY OF ILLNESS

—

REASON FOR ADMISSION. Requiring ventilation following ? Resp Arrest after fit

PATIENTS UNDERSTANDING OF PRESENT ILLNESS

—

Parents Present.

RELEVANT PAST HISTORY OF ILLNESS/OPERATIONS

Bronchiolitis Nov '99

MEDICATIONS ON ADMISSION KEPT IN HOSPITAL?/RETD?

FINAL DIAGNOSIS: Collapse, Intubated, Ventilated

DISCHARGE PLAN | DATE OF DISCHARGE: | RELATIVES INFORMED? YES? NO?

DISCHARGED TO:

OPD. APPT: YES? NO? CLINIC? DATE BOOKED

VALUABLES RETD. YES? NO? BOOK SIGNED?

PRESCRIPTION CARD? TABLETS TO TAKE HOME? OWN TABLETS RETURNED?

COMMUNITY SERVICES INVOLVED:

SIGNATURE OF NURSE:

NEXT OF KIN:

RELATIONSHIP

ADDRESS:

TELEPHONE NUMBER: HOME / BUSINESS / OTHER

INFORMED? YES NO

DEPENDENTS:

NUMBER OF CHILDREN:

PLACE IN FAMILY:

LIVES WITH:

TYPE OF ACCOMMODATION:

FACILITIES LACKING:

COMMUNITY SERVICES:

SOCIAL REPORT REQUESTED? ~~YES~~ NO

DENTURES:

VALUABLES:

PROPERTY ROOM NUMBER:

VALUABLES TO RELATIVES? — ADMINISTRATION? —

SUPPLEMENTARY BENEFIT? ~~YES~~ NO

SIGNATURE OF NURSE: [signature]

LPC 1/94/043

...cannot do independently

Patient's problems (actual/potential) (p) = potential | DATE

1 Maintaining a Safe Environment Admitted with H/o generally unwell, fever + Vomiting & diarrhoea x 1/7. Sudden collapse 3am, intubated and ventilated. Pupils fixed and dilated. Colour very pale

2 Communicating Unconscious (GCS 3.)

3 Breathing Intubated on admission with size 4.0 ET tube (oral). Tube changed to size 4.0 ET tube via Lt nostril. – Ventilated SIMV mode of ventilation TV 1.5 Resp Rate 20, O2 100% Sats levels 94% – 100% Size 1 Airway insitu

4 Eating & Drinking H/o Vomiting
IV fluids via Rt peripheral line

5 Eliminating Nappies – Diarrhoea x 3/7
Catheterised with size 10 catheter. 3mls in balloon

6 Personal Cleansing & Dressing Requires assistance

7 Controlling Body Temperature Hypothermic, – Cold to touch

8 Mobilising

9 Working & Playing Toddler.

10 Expressing Sexuality [redacted]

11 Sleeping Normally sleep well

12 Dying [redacted]



...D - ERNE HOSPITAL
Discontinued Date
Signature

# EVALUATION SHEET

| Date | Time | Prob. No. | Evaluation | Signature | B.O. | Communications/Instructions/Investigations |
|---|---|---|---|---|---|---|
| 3/4/00. | 4^35 am | | Transferred from Children's wd following | | | |
| | Breathing | | Respiratory Arrest past Epileptic type | | | |
| | | | fit. On admission intubated size 4.0 oral | | | |
| | | | ET Tube, Colour pale, Commenced on | | | |
| | | | SIMV mode of ventilation. TV 0.15 Resp | | | |
| | | | Rate 20, Oxygen 100%. No spontaneous breaths | | | |
| | | | taken. - Re-intubated with size 4.0 ET tube | | | |
| | | | via Lt Nostril. SAO2 levels 92% - 99% | | | |
| | CVS | | B/P 92/49 ECG sinus rythm rate 112. | | | |
| | CBT. | | Pupils fixed and dilated - Hypothermic. | | | |
| | | | Arterial line attempted but unsuccessful. | | | |
| | | | Mannitol 20% 25mls over 30mins as per Dr | | | |
| | | | O'Donohue. Claforan 1gm IV stat. at 5^45 am | | | |
| | | | size 14 NG tube passed orally. - No contents in | | | |
| | | | stomach - NG removed by Dr. | | | |
| | Nutrition | | IV fluids via Rt peripheral line, 30mls/hr | | | |
| | | | via Buritol. | | | |
| | Communication | | Parents spoke to by Dr Anderson + Dr O' | | | |
| | | | Donohue. Aware of Lucy's ill condition | | | |
| | | | and of transfer to Belfast RVHSC. | | | |
| | | | Left wd at 6^38 am, Dr and Nurse | | | |
| | | | in attendance. | [signature] | | |

015-012-093

Name: LUCY CRAWFORD Hospital Number: ERN 123000 Ward: SICU

151647 HC5

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| HYGIENE | | | | | | |
| 13/4/00 | 1. Unable to care for | Maintain a high | Daily bed bath and personal care + P.R.N. | | | |
| | own hygiene | standard of hygiene. | Oral hygiene 2 hourly. | | | |
| | unassisted. | | Eye care 2 hourly (if unconscious). | | | |
| | Toddler. | | Requires full assistance | | [signature] | |

015-012-094

Name: Hospital Number: Ward:

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| ELIMINATION | | | | | | |
| 3/4/00 | 1. Urinary Retention. | Prevent/detect. | Twice weekly C.S.U. for C & S on Monday/Thursday. | | | |
| | Urinary Catheter. | Infection, detect | Perineal care twice daily + P.R.N. | | | |
| | Size: 10 | oliguric/polyuric | Record hourly urine output. | | [signature] | |
| | Date: 13/4/00 (CWd) | Regain bladder control. | Observe for signs of infection. ✓ | | | |
| | | | | | | |
| | | | | | | |
| | 2. Unable to pass urine | Prevent/detect | Observe line/cannula for patency. | | | |
| | so has peritoneal | complications. | Administer fluids as prescribed. | | | |
| | dialysis. | | Record intake and output accurately. | | | |
| | | | Report negative balance to Dr. | | | |
| | | | | | | |
| | | | | | | |
| | 3. Constipation/ | Prevent/detect. | Record when bowels has opened. ✓ | | | |
| 13/4/00 | Diarrhoea. ✓ | | Observe colour and consistency. ✓ | | [signature] | |
| | | | Medication as prescribed. | | | |

Hospital Number:

Ward:

015-012-095

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

## NURSING CARE-PLAN

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| **ELIMINATION CONTD.** | | | | | | |
| | 4. Colostomy/ | Ensure hygiene, observe | Observe colour and shape of stoma. | | | |
| | Ileostomy. | that healthy and | Prevent skin soreness. Discuss with stoma therapist. | | | |
| | | functioning. | Bag size: Bag type: | | | |
| | | | Encourage patient to verebral feelings about colostomy. | | | |
| | | | Teach patient stoma care. | | | |
| **CONTROLLING BODY** | | | | | | |
| **TEMPERATURE** | | | | | | |
| 13/4/02 | 1. HYPOTMERMIA | | Warm using Extra blankets | | [signature] | |
| | Temp below 36°C | | Record temperature: | | | |
| | 2. HYPERMERMIA | | Cool using | | | |
| | Temp above 37.5°C | | Record temperature: | | | |

015-012-096

Name: Lucy Crawford Hospital Number: 123000 Ward

SERVICES BOARD - ERNE ... Prescriber's Signature Discontinued Date and Signature

NURSING CARE-PLAN



| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued and Signatu |
|---|---|---|---|---|---|---|
| NUTRITION, FLUIDS & METABOLISM | | | | | | |
| | 1. Naso-gastric tube. | Prevent aspiration of | Free drainage. Aspirate hourly and record. | | | |
| | | gastric contents. | Check tube is in correct position. | | | |
| | | Enable Enternal | Administer prescribed fluids. | | | |
| | | Nutrition. | | | | |
| 13/4/00 | | | Size 14 Salem Sump passed orally | | | |
| | | | - No contents in stomach. | | | |
| | | | -NG removed | | [illegible signature] | |
| | 2. Unable to tolerate | Prevent complications. | Infuse fluids at prescribed rate. | | | |
| | N/G feeding so has | | Daily dressing. | | | |
| | Parenteral Nutrition. | | Observe central line site. | | | |
| | | | Change giving sets daily. | | | |
| | | | Observe for patency. | | | |

015-012-097

Name: Lucy Crawford Hospital Number: 123000

NURSING CARE-PLAN

ERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| NUTRITION, FLUIDS & METABOLISM (CONTD.) | | | | | | |
| | 3. Unstable blood glucose due to: Diabetes/Parenteral Nutrition. | Detect/Report abnormality. | Monitor blood glucose ______ hourly.<br>Insulin as prescribed.<br>Monitor glucose in urine ______ hourly. | | | |
| 3/1/20 | 4. Actual/Potential disturbances of fluid balance.<br>Venflon to R hand | Early detection and correction. | Accurate recording of fluid Intake/Output. Infuse fluids at correct rate. ✓<br>C.V.P. Monitoring ______ hourly. | | [signature] | |
| | 5. Actual/Potential. Electrolyte Imbalance. | Early detection and correction. | Check urea and electrolytes daily. 9.00 a.m.<br>Administer fluids/electrolytes as prescribed. | | [signature] | |

015-012-098

Name: Lucy Crawford    Hospital Number: 123000    Ward: 5/

SOCIAL SERVICES BO... | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| CARDIOVASCULAR | | | | | | |
| | 1. Actual/potential. | Early detection and | E.C.G. Monitoring. ✓ | | | |
| 13/4/00 | Unstable heart due to: | correction. | Observe for and record any arrhythmias. ✓ | | [signature] | |
| | | | Administer prescribed medication. | | | |
| 13/4/00 | 2. Actual/potential | Early detection and | Record vital signs ½ — 1 hourly. Condition dependent | | | |
| | unstable blood | correction. | Report and abnormality. ✓ | | | |
| | pressure due to: | | Administer prescribed medication. | | | |
| | | | Monitor C.V.P. 1 hourly. | | [signature] | |
| | 3. Actual/potential | | Check base-line observations. | | | |
| | low HB — due to: | | Administer blood as prescribed. | | | |
| | | | Check for any reaction. | | | |
| | | | Record temp/pulse rate/resp rate ¼ hourly. | | | |

015-012-099

Name: Lucy Crawford  Hospital Number: 123000  Ward: 5/14

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

# (NUR)SING CARE-PLAN

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| | **BREATHING/RESPIRATION** | | | | | |
| 13/4/00 | 1. Inadequate gaseous | Correct $O_2$ admin. | Check $O_2$% and flow rate. | | | |
| | exchange due to — | Prevent dry airway. | Use nebuliner check water levels and temperature. | | | |
| | ? | | Record oxygen saturation levels. | | | |
| | | | Suction P.R.N. | | [signature] | |
| | | | ! | | | |
| | | | | | | |
| | 2. Unable to maintain | Protect airway. | Change tapes daily + P.R.N. | | | |
| 13/4/00 | own airway so has | Detect misplaced tube. | Observe chest for even expansion. ✓ | | | |
| | a) 8.0 | | Observe respiratory rate + colour. | | | |
| | Size ET/~~Trache tube~~ | | Daily chest X-Ray as ordered. 13/4/00 Portable | | [signature] | |
| | Date intubated: | | | | | |
| | 13/4/00 | | | | | |

015-012-100

Name: Lucy Crawford    Hospital Number: 123000    Ward: 5

LPC 3/91/031

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

## NURSING CARE-PLAN

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| 13/4/00 | 3. Unable to breath | Safe ventilation | Maintain Ventilatory parameters/alarms. ✓ | | | |
| | adequately, so has | | Trained nurse with knowledge of ventilators to special ✓ | | | |
| | mechanical ventilation | | Administer Sedation as ordered. | | | |
| | SIMV Mode | | | | [signature] | |
| | | | | | | |
| | 4. Unstable respiratory | Blood gases within | Daily monitoring of blood gases. 9.00 a.m./4.00 p.m. + P.R.N. | | | |
| | Status/Arterial line | acceptable limits. | Keep insertion site exposed. | | | |
| | in site. | Prompt detection of | Check for bleeding. | | | |
| | | bleeding. | Check pressure bag and flush line P.R.N. | | | |
| | | | | | | |
| | | | | | | |
| | 5. Actual/Potential | Chest clinically clear. | Chest physio with bagging and suction twice daily. | | | |
| | Respiratory Infection. | Early detection of | Twice Weekly Sputum for C + S Monday/Thursday a.m. | | | |
| | | change. | | | | |

015-012-101

Hospital Number:

...Ward... Communications/Instructions/Inves...

N[illegible]RSING CARE-PLAN

# INTENSIVE CARE UNIT

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| MAINTAINING A SAFE ENVIRONMENT | | | | | | |
| 13/4/00 | 1. Altered level of | Detect any change. | Record neurological observations. 2° Condition dependent. | | | |
| | consciousness | Maintain Airway. | Maintain a clear airway. ✓ | | | |
| | due to — ? Cause | | Intubated size 4.0 ET Tube | | | |
| | — | | Size 1 Airway insitu | daily | [signature] | |
| | Unconscious | | Constant Supervision | | | |
| | | | | | | |
| | | | | | | |
| | 2. Altered mental status | Reorientate to time | Constant supervision. | | | |
| | Confusion. | place and person. | 24 hour reality orientation programme. | | | |
| | | Prevent injury to self | Explain nursing interventions to patient. | | | |
| | | and others. | | | | |

015-012-102

N[illegible] Hospital Number: Ward:

LPC 3/91/031

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

| Date | Activity of Living Problem | Goal | Nursing Intervention | Date & Time of Evaluation | Prescriber's Signature | Discontinued Date and Signature |
|---|---|---|---|---|---|---|
| COMMUNICATION | | | | | | |
| | 1. Unable to communicate | To help communicate and | Introduce yourself to patient. | | | |
| | due to intubation/ | prevent frustration. | Do not talk or discuss patients condition over them. | | | |
| | tracheostomy. | | Explain each procedure to patient. | | | |
| | | | Use communication aids: | | | |
| | 2. Unable to communicate | To help communicate | Use interpreter and non verbal skills to aid communication. | | | |
| | due to language | and prevent frustration | | | | |
| | difficulty: | | | | | |
| | 3. | | Parents present, Spoken to by | | | |
| | | | Dr Auterson + Dr O'Donahue. | | | |
| | | | aware of Lucy's ill condition | | [signature] | |

015-012-103

Name: Hospital Number: Ward:

LPC 3/91/031

015-012-104

| | FLUID INTAKE MLS PER 24 HRS | | | | | | | OUTPUT | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TIME | P.O. | NG | IV1 | IV2 | IV3 | IV4 | IV5 | URINE | BOWELS | NG. ASPIRATE | NG FREE DRAINAGE | DRAIN 1 | DRAIN 2 | VOMITUS | BMs | REMARKS |
| 8 am | | | | | | | | | | | | | | | | |
| 9 am | | | | | | | | | | | | | | | | |
| 10 am | | | | | | | | | | | | | | | | |
| 11 am | | | | | | | | | | | | | | | | |
| 12 md | | | | | | | | | | | | | | | | |
| 1 pm | | | | | | | | | | | | | | | | |
| 2 pm | | | | | | | | | | | | | | | | |
| 3 pm | | | | | | | | | | | | | | | | |
| 4 pm | | | | | | | | | | | | | | | | |
| 5 pm | | | | | | | | | | | | | | | | |
| 6 pm | | | | | | | | | | | | | | | | |
| 7 pm | | | | | | | | | | | | | | | | |
| SUB-TOTAL | | | | | | | | | | | | | | | | |
| 8 pm | | | | | | | | | | | | | | | | |
| 9 pm | | | | | | | | | | | | | | | | |
| 10 pm | | | | | | | | | | | | | | | | |
| 11 pm | | | | | | | | | | | | | | | | |
| 12 mn | | | | | | | | | | | | | | | | |
| 1 am | | | | | | | | | | | | | | | | |
| 2 am | | | | | | | | | | | | | | | | |
| 3 am | | | | Sent from C/W. | | | | | | | | | | | | |
| 4 am | | | MANITOL | NaCl. 250 infused | | | | | | | | | | | | |
| 5 am | | | 25ml | 30 | | | | | | | | | | | | |
| 6 am | | | | 30 | | | | | | | | | | | | |
| 7 am | | | | | | | | | | | | | | | | |
| SUB-TOTAL | | | | | | | | | | | | | | | | |
| 24 HR TOTAL | | | 25 | 310 | | | | | | | | | | | | |

Total Intake

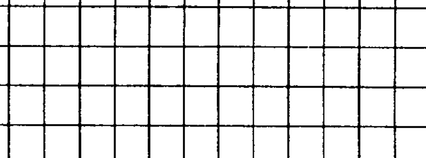
Total Output

# ERNE HOSPITAL I.C.U.

DATE

015-012-105

| TIME | | 00 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 21 | 00 22 | 00 23 | 00 24 | 00 01 | 00 02 | 00 03 | 00 04 | 00 05 | 00 06 | 00 07 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 40.0 220 | | | | | | | | | | | | | | | | | | | | | | | | | 220 40.0 |
| | 39.5 210 | | | | | | | | | | | | | | | | | | | | | | | | | 210 39.5 |
| | 39.0 200 | | | | | | | | | | | | | | | | | | | | | | | | | 200 39.0 |
| | 38.5 190 | | | | | | | | | | | | | | | | | | | | | | | | | 190 38.5 |
| | 38.0 180 | | | | | | | | | | | | | | | | | | | | | | | | | 180 38.0 |
| | 37.5 170 | | | | | | | | | | | | | | | | | | | | | | | | | 170 37.5 |
| | 37.0 160 | | | | | | | | | | | | | | | | | | | | | | | | | 160 37.0 |
| | 36.5 150 | | | | | | | | | | | | | | | | | | | | | | | | | 150 36.5 |
| | 36.0 140 | | | | | | | | | | | | | | | | | | | | | | | | | 140 36.0 |
| | 35.5 130 | | | | | | | | | | | | | | | | | | | | | | | | | 130 35.5 |
| | 35.0 120 | | | | | | | | | | | | | | | | | | | | | | | | | 120 35.0 |
| | 110 | | | | | | | | | | | | | | | | | | | | | | | | | 110 |
| | 100 | | | | | | | | | | | | | | | | | | | | | | | | | 100 |
| PULSE (RED) | 90 | | | | | | | | | | | | | | | | | | | | | | | | | 90 |
| | 80 | | | | | | | | | | | | | | | | | | | | | | | | | 80 |
| | 70 | | | | | | | | | | | | | | | | | | | | | | | | | 70 |
| BP (BLACK) | 60 | | | | | | | | | | | | | | | | | | | | | | | | | 60 |
| | 50 | | | | | | | | | | | | | | | | | | | | | | | | | 50 |
| | 40 | | | | | | | | | | | | | | | | | | | | | | | | | 40 |
| TEMP. (BLACK) | 30 | | | | | | | | | | | | | | | | | | | | | | | | | 30 |
| | 20 | | | | | | | | | | | | | | | | | | | | | | | | | 20 |
| | 10 | | | | | | | | | | | | | | | | | | | | | | | | | 10 |
| | 0 | | | | | | | | | | | | | | | | | | | | | | | | | 0 |
| R | R | | | | | | | | | | | | | | | | | | | | | — | — | — | | R = REACTION |
| | S | | | | | | | | | | | | | | | | | | | | | | | | | YES ✓ NO - |
| PUPILS EQUALITY | | | | | | | | | | | | | | | | | | | | | | E | E | E | | S = Size • ● ⬤ |
| L | R | | | | | | | | | | | | | | | | | | | | | — | — | — | | E = Equal |
| | S | | | | | | | | | | | | | | | | | | | | | | | | | RECORD LARGER |
| CARDIOVASCULAR | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CVP | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PAP | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PAWP | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CO | | | | | | | | | | | | | | | | | | | | | | | | | | |



| VENTILATION MODE | SIMV | SIMV | |
|---|---|---|---|
| TID. VOL. | 0.15 | 0.15 | |
| AIRWAY PRESSURE | 35.1 | 34.2 | |
| RESP. RATE | 20 | 20 | |
| OXYGEN | 100% | 100% | |
| SPONTANEOUS | — | — | |
| MIN. VOL. | 1.76 | 1.67 | |
| CPAP PEEP | | | |
| PRESSURE SUPPORT | | | |
| SENSITIVITY | | | |
| CUFF AMOUNT | | | |
| SATURATION | 100% | 91% | 98% |
| PH | | | |
| PCO2 | | | |
| PO2 | | | |
| $HCO_3$ | | | |
| BASE EXCESS | | | |
| SECRETIONS | | | |
| PHYSIOTHERAPY | | | |
| INFUSIONS | | | |

VENTILATION

INFUSIONS

| SPECIMENS SENT | TIME |
|---|---|
| | |

015-012-106

**URINE TESTING**

| TIME | |
|---|---|
| SPG | |
| SUGAR | |
| ACETANE | |
| BLOOD | |
| PROTEIN | |
| Ph. | |

ALLERGIES:

RUG PRESCRIPTION

| DATE STARTED | DRUG/ SOLUTION | DOSE | FREQ | ROUTE | DR'S SIGN | TIMES AND SIGN | BATCH NUMBER | NURSE SIGNATURES | DRUGS DISCONTIN. DATE DISCONT. | DRS SIGN |
|---|---|---|---|---|---|---|---|---|---|---|
| 13/04/00 | Claforan | 1gm | stat | I.V. | √ [illegible] | 0 S'S √ [illegible] | | | | |
| 13/04/00 | MANNITOL | 0.5gm | stat | I.V. | √ [illegible] | (25 mls 20% solution) [illegible] | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |

015-012-107

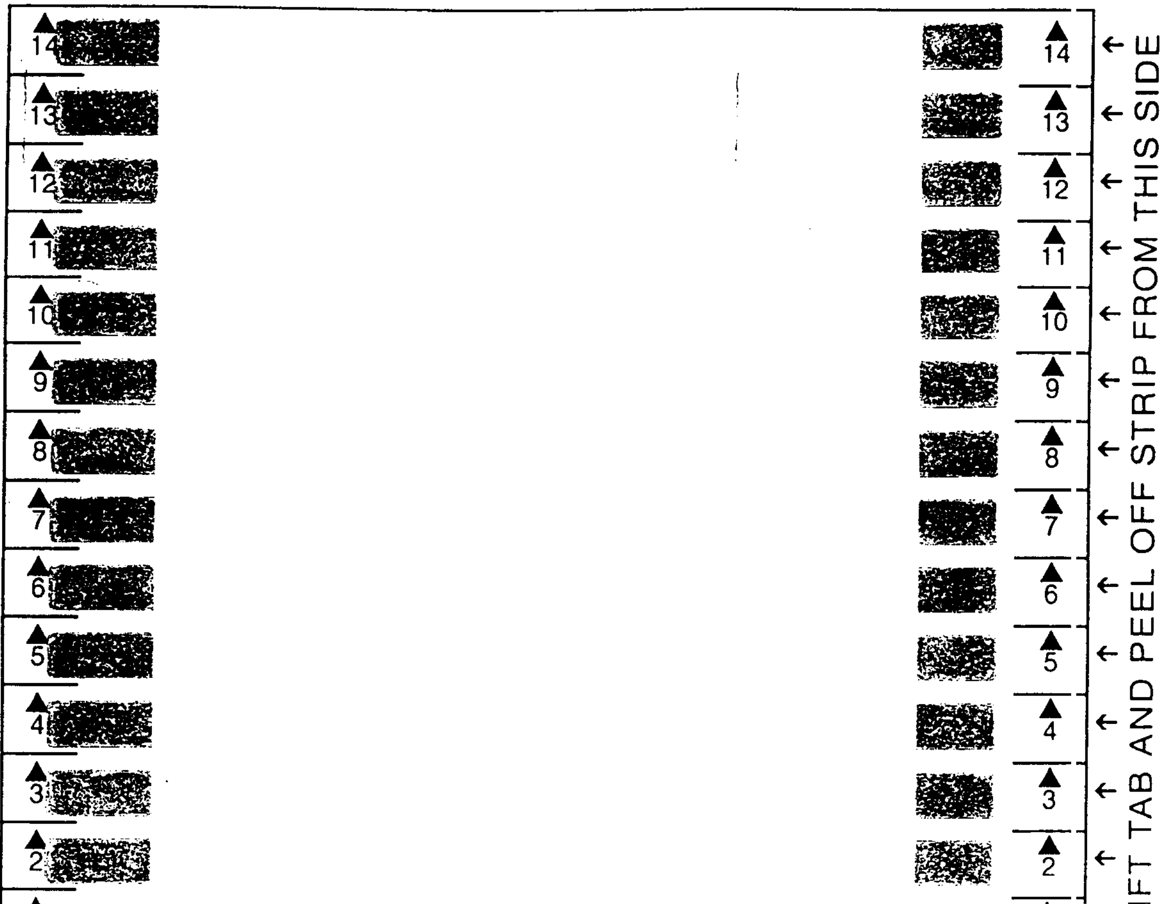
**THIS INFUSION CONTAINS AN ADDITIVE**

ADDED BY [illegible] / T. Jones
TIME 5.45 Am DATE 13.4.00
PATIENT'S NAME Lucy Crawford.

| ADDITIVE | AMOUNT | BATCH No. |
|---|---|---|
| Dopamine | 200 mgm | J052291 |
| Dext. 5% | 45mls | 98114550 |

SPERRIN LAKELAND TRUST
# HAEMATOLOGY

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:




Gazebo Tel. 0181 992 0062 Ref: 5085

Lab Number : 896
Sample Date : 12/4/2000
Time : 20:47
Ward : ERN CHILDRENS WARD 3

Name : CRAWFORD LUCY
Sex : F
Hosp No : ERN123000
D.o.B : 05/11/1998
Doctor : DR J M O'DONOHOE

F B C

| Test | | Result | | N. Range |
|---|---|---|---|---|
| Hb | | 12.1 | g/dl | (10.5-13.5) |
| WCC | | 15.0 | $x10^9/l$ | (5.5 - 16.5) |
| RCC | | 4.64 | $x10^{12}/l$ | (3.6 - 5.2) |
| Hct | | 37.0 | | (.36-.45 ) |
| MCV | * | 79.8 | fl | (83-105) |
| MCH | | 26.1 | pg | (23-31) |
| MCHC | | 32.7 | g/dl | (30-35) |
| RDW | * | 16.3 | | (9.0-15.5) |
| PLAT | | 397 | $x10^9/l$ | (150 - 440) |

D W C C
$x10^9/l$

| | | | |
|---|---|---|---|
| Neutrophils | 13.6 | * | (1.5-8.5) |
| Lymphocytes | 0.8 | * | (4.0-10.5) |
| Monocytes | 0.6 | | (0.05-1.1) |
| Eosinophils | 0.0 | | (0-0.70) |
| Basophils | 0.0 | | (0-0.2) |

896 HAEMATOLOGY ERNE HOSPITAL 12/4/2000

ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION
WGPO 140

015-012-108

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:

# ERNE HOSPITAL

Lab Number : 420
Sample date : 12/4/2000
Time : 20:50

Hosp/Ward : ERN CHILDRENS WARD 3

Name : CRAWFORD LUCY
Sex : F
Hosp No. : ERN123000
D.o.B. : 05/11/1998
Doctor : DR J M O'DONOHOE

| TEST | RESULT | UNITS | (Range) |
|---|---|---|---|
| Sodium | 137 | mmol/L | (135-145) |
| Potassium | 4.1 | mmol/L | (3.5-5.1) |
| Chloride | 105 | mmol/L | (96-108) |
| CO2 | • 16 | mmol/L | (22-28) |
| Urea | • 9.9 | mmol/L | (2.5-6.5) |
| Glucose | 4.5 | mmol/L | (3.9-6.7) |
| Creat | • 45 | umol/L | (53-106) |
| T Protein | 67 | g/L | (63-79) |

Glucose tested on non fluoride sample

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE TOP EDGE OF REPORT ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION

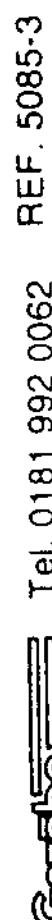
015-012-109

# ERNE HOSPITAL
# CHEMISTRY REPORTS

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:

14 13 12 11 10 9 8 7 6 5 4

AND PEEL OFF STRIP FROM THIS SIDE




Lab Number : 494
Sample date : 12/04/2000
Time : 20:50
Hosp/Ward : ERN CHILDRENS WARD 3

Name : CRAWFORD LUCY
Sex : F
Hosp. No. : ERN123000
D.o.B. : 05/11/1998
Doctor : DR J M O'DONOHOE

| TEST | RESULT | UNITS | (Range) |
|---|---|---|---|
| C-Reactive Protein | • 11.2 | mg/L | (0-10) |

G1

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE ... OF REPORT
ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HAR 015-012-110

ERNE HOSPITAL

UNIT NO.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:

Tel. 0181 992 0062 REF. 5085-3

Lab Number : 421
Sample date : 13/04/2000
Time :

Hosp/Ward : ERN CHILDRENS WARD 3

Name : CRAWFORD LUCY
Sex : F
Hosp No. : ERN123000
D.o.B. : 05/11/1998
Doctor : DR J M O'DONOHOE

| TEST | RESULT | UNITS | (Range) |
|---|---|---|---|
| Sodium | • 127 | mmol/L | (135-145) |
| Potassium | • 2.5 | mmol/L | (3.5-5.1) |
| Chloride | 104 | mmol/L | (96-108) |
| CO2 | • 18 | mmol/L | (22-28) |
| Urea | 4.9 | mmol/L | (2.5-6.5) |
| Glucose | • 10.9 | mmol/L | (3.9-6.7) |
| Creat | • 28 | umol/L | (53-106) |
| T Protein | • 46 | g/L | (63-79) |

Glucose tested on non fluoride sample

GJ

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE TO
ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FC 015-012-111

SPE

Ampicillin — Ap
Penicillin — PG1
Tetracycline — T
Trimethoprim — TM
Gentamicin — GM
Flucloxacillin — Cx
Chloramphenicol — C
Metronidazole — Mz
Amikacin — Ak
Erythromycin — Er
Cefuroxime — Cxm
Cephradine — CH
Tobramycin — NN
Fusidic Acid — Fc
Co-Amoxiclav — AUG
Mecillinam — MEC
Cefotaxime — CTX
Netilmicin — NET
Ciprofloxacin — CIP
Ceftazidime — CAZ
Vancomycin — VA

Use Generic drug names when prescribing, rather than brand names

E-Millar

TAB AND PEEL OFF STRIP FROM THIS SIDE

**ERNE HOSPITAL**

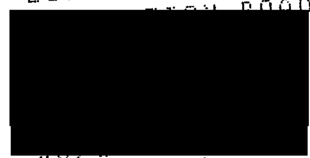
DATE & LAB REF No. ERN 123000 MISS CRAWFORD LUCY

584 MISC. WEEK 15

NUMBER

PRIVATE CATEGORY PRIVATE / NHS / NON-UK

SURNAME (Block Letters)



D.O.B. | SEX

PREVIOUS LAB Nos. YES/NO

PHYSICIAN/SURGEON JOD. | WARD/OPD CHILDREN | HOSPITAL No. 123000

CLINICAL DIAGNOSIS and HISTORY Fever | COMMUNITY ACQUIRED: Y / N

NATURE OF SPECIMEN Blood | TIME SPECIMEN TAKEN 23:00 | DATE TAKEN 12-4-00

ANTIBIOTIC TREATMENT | ANY ADDITIONAL SENSITIVITIES REQUIRED

EXAMINATION REQUIRED Blood C/S | M.O.'s SIGNATURE [signature]

STAINS

GRAM STAIN —:
ZIEHL NEELSON STAIN —:

CULTURE AND SENSITIVITIES

13-4-00 No growth
14-4-00 " "
15-4-00 " "

ANTIBIOTICS SENSITIVITIES*

| ORGANISMS | AP | PG1 | T | ER | TM | CTX | GM | CXM | Cx | AUG | CIP | MZ |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | | | | | | | | | | | | |

*PLEASE REFER TO THE BACK OF THIS REPORT FOR FULL LIST OF ANTIBIOTICS

015-012-112

159 URINE WEEK 15

DIVISION 2145

REPORT DIVISION

PEEL AWAY ALONG PR...
WGPO 120...

Gazebo Tel. 0181 992 0062 Ref: 5085