WHSSB
OMAGH/FERMANAGH HOSPITA
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

Occupation: Telephone engineer. 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. ? pyuria, urine

Patients understanding of Present illness: smells strong-

Rel. Past History of Iness/Operations:

Bronchiolitis

Medications on Admission: Kept in Hospital?/Retd?

Calpol given @ 18.30.

FINAL DIAGNOSIS:

SUMMARY OF PROBLEMS:

Diarrhoea 1/52 ago.

Next of Kin: [redacted]
Relationshi

Address:

Tel. No. Hom [redacted]
Business:

Other:

Informed? YES/NO

Dependents?

No. of Children: [redacted]
Place in Family

Lives with:

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

LPC 2/86/014

027-017-055

LC Erne Hospital

PATIENT ASSESSMENT

MENTAL STATUS Appearance/behaviour: Floppy + slightly flushed.

Consciousness/awareness: Conscious.

COMMUNICATING: Speech activity:

Perceptions:

Hearing: describe / Eyesight: describe: No obvious problems.

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.

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 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 ~~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 cares.

~~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:

LC Erne Hospital

027-017-056

HOSPITAL WARD

DATE	INVESTIGATIONS		NURSING PROGRESS (Including Non Regular Prescription)	Full Signature
			no apnoeasis. no loss of colour, 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 144/84 P=160 R=22 T=36.2°C. B.M. @ 03¹⁵ · 13.4mmols/l I.V. fluids changed to 0.9% Saline and run freely into I.V. line. Decreased respiratory effort noted at 03²⁰; 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 SaO₂ 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/C Dr Anderson (anaesthetist). Size 4 and E.T tube inserted @ 04:00 and bagging continued. Flumazenil (Anexate) 250 = 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 Ward 5 @ = 05.00 A.m for transfer to RBHSC ICU. Per Parents and family present Spoken to by Dr O'Donohue + Dr Anderson.	T. Jones.

SURNAME FIRST NAMES HOSPITAL No.

CRAWFORD LUCY 123000

HOSPITAL)) WARD c/w

DATE	INVESTIGATIONS		NURSING PROGRESS (Including Non Regular Prescription)	Full Signature
12/4/00.	Urinalysis ✓		Admitted via GP c above history.	
	B.S.U. ✓		Anatop cream applied at 19.30.	
	Bloods ✓		E/B Dr Malik, ✓ unable to cannulate,	
	T 39.2 @ 8.40.		sips of oral fluids taken and same tolerated.	
	BM 3.6 mmol/l	20.30.	Dr O' Donohue called to see, as child sleepy	
			and lethargic. PR paracetamol 120mg given @ 22.00	
			Lucy seen by Dr Donohue; bloods taken	
			and cannula inserted into Left hand.	
			I.V. fluids of No18 solution commenced	
			at 22.30 at 100mls/hr, to encourage	
			urinary output. Urine specimen obtained	
			at 21.00, ketones ++++, protein ++++ on testing	
			Large vomit at 24.15; I.V. fluids remaining	
			at 100mls/hr	
		02.50	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	
		02.55	E/N McCaffrey, called by mum buzzing.	
			child rigid in mothers arms.	
		03.00	E/N McCaffrey called myself (SN McManus)	
			to see child. Child rigid in mums arms	

CRAWFORD LUCY 123000