

ASSESSMENT OF ACTIVITIES OF LIVING		Usual Routine what he/she can/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 4. Swollen Collapse 3am. Intubated and ventilated. Pupils fixed and dilated. Color very pale.	6 Personal Cleansing & Dressing. Requires Assistance	
2	Communicating Unconscious	GCS 3.	7 Controlling Body Temperature Hypothermic - Cold to touch	
3	Breathing Intubated on admission with size 2.5 ET tube (oral) Tube changed to size 4.0 ET tube via LT nostril. -- intubated sinus node. A ventilation TV 1.5 Resp Rate 20. O2 levels 94% - 100% size 1. Hypertension	8 Mobilising	9 Working & Playing Toddler	
4	Eating & Drinking H/O Vomiting. W Flows via the peripheral line. 100% pressure			
5	Eliminating Nappies - Diarrhoea x 4. Catheterised with size 1.0 catheter. Express in balloon			