

POTENTIAL PROBLEMS	AIM OF CARE	NURSING ACTION	EVALUATION	NAMED NURSE
Risk of obstruction	To maintain clear airway	Nurse in semi-prone position or similar recovery position, according to type of surgery procedure. Nurse beside O2 & suction. Emergency equipment and drugs at hand	Clear airway maintained	Gang
Risk of shock	Early detection & swift action	To observe closely, maintaining 1/4 hourly T.P.R. Blood Pressure, colour, sweating and drowsiness. Careful maintenance of body temperature with aids, e.g. blankets before admission and use of warm gavage. To observe administration of I.V. fluids as prescribed, checking site 1/4 hourly. Observation of any drains and catheter due to surgery	Observation recorded & stable. V fluids discontinued in recovery	Gang
Pain	Control pain	Early detection of pain & discomfort before reaching peak. Administration of analgesia as prescribed	Caudal & Standalone pre-operatively	Gang
Risk of inadequate communication	To provide complete report of patient in Theatre	To provide brief analysis of anaesthetic surgery recovery and pain relief procedures	Report given to ward staff	Gang
Fretfulness	Allay anxiety	Keep patient painfree and comfortable. Reassure patient by verbal and non-verbal communication. Allow patient to return to parents as soon as possible	Transferred when awake. The the	Gang

RBHSC

POTENTIAL PROBLEMS	AIM OF CARE	NURSING ACTION	NAY 3 NURSE	COMMENTS	SIGNATURE
Risk of injury associated with transfer	Safe transfer	At least 2 persons to assist and ensure brakes are on		Safely transferred	
Injury due to unsafe positioning	Will not sustain injury	Position appropriate for Anaesthesia and surgery		Positioned appropriately	
Injury from use of diathermy	Will not sustain injury	Apply diathermy indifferent electrode appropriately. Correct size plaque applied to machine. Make sure skin is not in contact with metal	N. Allen	N/A	N. Allen
Skin damage	Minimise the risk of skin damage	Assess skin condition - 1 Before surgery 2 After surgery		Visible skin appears intact	
Risk of retention of foreign body	Ensure Foreign body is not retained	Check and record all swabs needles and instruments. Report count to Surgeon	Finalen	all correct	
Risk of infection	Minimise the risk of infection	Ensure aseptic techniques and sterility are maintained	Finalen	aseptic technique adhered to	
Hyper or Hypo Thermia	Minimise risk of unnecessary Heat	Maintain adequate theatre temperature. Use heating aids as necessary	Rid	Theatre environment lower	Rid.

U.M. 364377
MSTF ROOM STRAIN

04/08/91
Male

W.O.P. CONSULTANT
EHSSB

AGE D.O.B. SEX
CONSULTANT O. Savage RELIGION/BAPTISM
NAME KNOWN BY Adair

NEXT OF KIN (Relationship) Mum
NAME Debbie Strain
ADDRESS 206b Ave
TEL NO. Day [REDACTED]
WHO ACCOMPANIED PATIENT Mum & granny
WHO MAY CONSENT TO TREATMENT Mum

SCHOOL/PLAYGROUP/NURSERY

Booked admission for orthodopy and
REASON FOR ADMISSION insertion of gastrostomy
PARENTS/PERCEPTION OF ADMISSION

DATE AND TIME OF ADMISSION 8.40 am. 15/10/95
fully understand

PREVIOUS ILLNESSES/HOSPITAL ADMISSIONS/CONTACT WITH
INFECTIOUS DISEASES

PREVIOUS ILLNESSES Dysplastic kidneys
obstructive uropathy

HOSPITAL ADMISSIONS

funduplication - March 92
Bilateral Nephrectomy of uterus Nov 91 - Jan 92
RECENT CONTACT WITH INFECTIOUS DISEASES Admissions X 5 times
None known

IMMUNISATIONS RECEIVED

all up to date

CURRENT MEDICATION one alpha v.i.d. Sodium bicarbonate

KNOWN ALLERGIES

~~Penicillin~~ Ketof asyhe. Iron supplement
Erythropoietin. 1000 units/week
Ciprofloxacin and Zinnat

DENTAL (include crowns, plates) loose teeth

OTHER PHYSICIAN

DETAILS

COMMUNITY REFERRAL

GP YES/NO

O.P. YES/NO

MEDICATION YES/NO

HEALTH VISITOR

DISTRICT NURSE

SOCIAL WORKER

OTHERS

NURSING ASSESSMENT

USUAL NORMAL ROUTINES

COMMUNICATING AND SPECIAL NEEDS	Eyesight - no probs n's a bright cheerful hearing. no problems chatty boy.	Good form on admission
MAINTAINING A SAFE ENVIRONMENT	sleeps in a bed at home. needs to be supervised	ambulant in situ outside for wheeled
BREATHING AND CIRCULATION	no problems usually.	observations stable no problems
CONTROLLING BODY TEMPERATURE	normally afebrile	apexic on admission
EATING AND DRINKING	Nil orally. Takes Bolus feeds of 200 mls during day 1500 mls feeds overnight	fasting on admission
EXCRETING	polyuric. Passes large amount of urine. needs nappies	output monitored
POSTURE AND MOVEMENT	walks runs unaided. no problems	up & around in ward
REST AND SLEEP	sleeps in a bed at home usually sleeps all night	provide comfortable surroundings
PERSONAL HYGIENE	needs help with washing.	provide care required
DRESSING	needs help dressing	in ward for washing + dressing
PLAY AND EDUCATION	enjoys playing with toys + with other children.	play specialist to arrange play etc.
EXPRESSING SEXUALITY	as for 4 year old boy.	dress in boy's clothes
MEETING SPIRITUAL NEEDS	as parents wish. R/c (family)	as parents wish
SOCIAL HISTORY	lives at home with grandparents + mum	

VITAL SIGNS

T. 36.4 P. 96
R. 26 B.P. 106/61
HT. WT. 21 Kg

URINALYSIS

CONDITION OF SKIN HAIR AND TEETH

Has eczema occasionally

SIGNATURE OF ACCOUNTABLE NURSE

M. M. M.
S.M.C. C. W. D. R.

DATE AND TIME

9.00 am

REDACTED

[illegible]

AS - ROYAL

PATIENT'S NAME Adam Strain
058-0 364377 i. No.

364377

058-020-059

WNC 763/OS 3778

058-020-060

PATIENT'S NAME

REG. No.

ROYAL BELFAST HOSPITAL FOR SICK CHILDREN

NURSING CARE PLAN

DATE	PROBLEM	GOALS	NURSING ACTIONS	REVIEW DATE/SIG	DATE GOALS ACHIEVED
18/10/95	Post operative pain	To ensure patient is pain free	Observe closely for signs of pain and give analgesia as prescribed by doctor	18/10/95 Post op	18/10/95 O.C.I.D.O.
	Reduced level of consciousness due to anaesthetic	To ensure a full recovery	1. Monitor oxygen saturation 2. Maintain pulse waveform 3. Check & record TPR 4 hourly 4. Report any deviation in vital signs immediately to doctor	J. McIlhenny	
	Post-operative debility	To ensure parents are fully informed prior to discharge	1. Explain outcome of surgery & what to observe for following discharge 2. Explain about wound care 3. Complete community liaison form 4. arrange R/S appointment if required	before discharge J. McIlhenny	18/10/95

PATIENT'S NAME Adam Strain

HOSP. B68 234/5C

HOSPITAL NO 364 377

CHA 214

ROYAL MELFAST HOSPITAL FOR SICK CHILD

NURSING CARE PLAN

DATE	PROBLEM	GOALS	NURSING ACTIONS	REVIEW DATE/SIG	DATE GOALS ACHIEVED
18/10/95	Patient + parental anxiety due to admission to hospital	To alleviate anxiety	Meet parents and Adam on admission. Explain layout of ward and introduce to staff and other patients. Adam has been in previous ward before. Explain all procedures to parents and give simple explanations to Adam. Encourage parents and family to remain with child throughout admission.	18/10/95 J. H. H.	18/10/95 J. H. H.
	Requires preparation for surgery and anaesthetic	To ensure fitness for same	1. Ensure Adam is fasting. 2. Apply ID band to arm. 3. Check + record temp + pulse. 4. Weigh + record in medical notes. 5. Dress in theatre gown + appropriate clothes.		18/10/95
			6. Apply EMLA cream to arm site.		
			7. Ensure bladder is empty - Adam wears nappies.		
			8. Ensure consent obtained by Dr.		

PATIENT'S NAME: Adam Stein

HOSP: RBHSC

HOSPITAL NO: 364377

AS - ROYAL

058-020-062