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SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

OBSTETRICS/GYNAECOLOGY/PAEDIATRIC SPECIALTY TEAM
[illegible] HOSPITAL
[illegible], CO. TYRONE, NORTHERN IRELAND, BT74 6AY
TELEPHONE: [redacted] FACSIMILE: [redacted]

FAX COVER SHEET

TO: Dr Ceeva — FROM: Children's Ward. Eve Hosp

DEPARTMENT: I.C.U. R.B.H.S.C — OBS/GYNAE/PAED SPECIALTY TEAM

NO. OF SHEETS (Incl. cover sheet): 15 — REFERENCE:

DATE: 13/4/00 — EXTENSION: 2328

☐ URGENT ☐ REPLY ASAP ☐ PLEASE COMMENT ☑ FOR YOUR INFORMATION

COMMENTS:

Details of Notes for Lucy Crawford on Admission as Requested by telephone

TO BE FILLED IN BY FAX OPERATOR:

SIGNATURE: TIME:

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061-017-042

LC-Royal

CH 461358 Page: 4

Referral to Crus Hospital Date 12.4.00

Consultant ..... Department Children 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

Address [redacted]

Date of Birth 5 11 98

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
Happy + Not drinking
o/e Temp 38°
Mucosa moist
Ears - Throat -
CVS - RS - Abd

Provisional Diagnosis: ? UTI

Past History:

Present Medication:

Known Allergies:

Needs fluids

Other Relevant Information:

DOCTOR'S OR PRACTICE STAMP

Dr E Connor
Granville

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

MR48

LC-Royal 061-017-043

(4)

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 every time she eats or drink. ~~She p dur~~ 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 [redacted]
Delivery:
Birth Weight:
Admission to Neonatal Unit: none

Method of Feeding / Age of Weaning: [redacted]
Pervious Hospital Admissions:
[redacted]

Serious Illness and Systemic Review:
none

061-017-044

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: none that aware of

Social History:

House: [redacted]

Child lives with: [redacted] Heating: [redacted]

Schooling: [redacted] Pets:

Child minder: [redacted]

Developmental History:

Gross Motor:

Fine Motor and Vision:

Hearing and Speech:

Social:

Family History:

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.

ERNE HOSPITAL

SURNAME	FIRST NAME(S)	HOSPITAL NO
CRAWFORD	LUCY.	123008

CONTINUATION SHEET

DATE	
12/4/00 19:30	Chest: Clear. CVS S1, S2, + 0 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/Cult - ½ fluid after ½ Cannulation. - Hb = 12.1 WBC = 15.0 Neuts = 13.7 Plts = 397 Na 137. K = 4.1. Cl 105. CO2 16. U = 9.9. Cr = 45 Cre 45. Urinalysis - Protein ++ Ketones ++ No Leucocyte ≈ 2300 - I.V. line inserted. [redacted] Dr McGregor.
13/4/00 3:15	Called Dr O'Donohoe to assess the condition Ampicillin
13/04/00 05:1	± 03:00 Mother noticed Lucy Rigid. ± 5 mins later → Rectal diazepam 2.5 mgs P.R. There had been diarrhoea before this episode and subsequently. → ↓ resp effort → Bag + mask. Pulse palpable throughout - O2 sats

LPC 3/86/024

DAT.

~~= 100~~ ≈ 0330

85 ~~BMA~~ over 60g. / Capillary refill 2 secs. Pulse easily felt. Pupils dilated + unresponsive.

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

Dextrostix ≈ 12 ∴ ~~NSAA~~ normal saline.

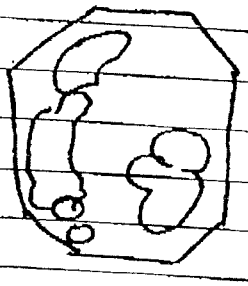
D/W Dr Mc Keague RVH
- for transfer - ? cause of respiratory arrest
? Poor conversion.

→ I.C.U. ≈ 0500

Cefotaxan 1gm I.V. ~~stat~~
Maintain ~~0.25g~~ 5gm I.V. over 1/2 hours

Donohoe

0500: CXR: NAD
AXR: Air ++ ? colon + small intestine



Donohoe

ERNE HOSPITAL

SURNAME	FIRST NAME(S)	HOSPITAL NO.
CRAWFORD	LUCY	12[illegible]00

CONTINUATION SHEET

DATE	
13/4/00 2:58	Called to see Lucy who had a fit according to nurse. Respiratory Rate 36/m HR. 140/m. Advised Rectal diazipam as she was still twitching her hands.
3:15.	Called Dr. O Donohue 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

Dr Mufahir

LPC 3/86/024

061-017-048

LC-Royal

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, ~~but~~	
	T 39° @ 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 @ 22°°	
			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}, kerones $^{++++}$, protein $^{++++}$ on testing	
			Large vomit at 24^{15}; I.V. fluids remaining at 100mls/hr	
		02°°	Large soft/runny pale green bowel motion, very offensive smelling, moved into side room. Specimens x3 for MC+S, Rotavirus, E. Coli and adenavirus taken. Apyrexial	
		02^{55}.	E/N McCaffrey, called by mum buzzing. child rigid in mothers arms.	
		03°°	E/N McCaffrey called myself (SN McManus) to see child. Child rigid in mums arms	

CRAWFORD

Lucy

123000

LC-Royal

061-017-049

13/04/00 08:53 FAX

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HOSPITAL

WARD

DATE	INVESTIGATIONS		NURSING PROGRESS (Including Non Regular Prescription)	Full Signature
			no loss of colour/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. @ 03¹⁵ = 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 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	

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061-017-050

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N.G.T tube inserted @ 04:00 and bagging continued. Flumazenil (Anexate) 1mg = 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
Pre Parents and family present
Spoken to by Dr O'Donohue & Dr Anderson. T. Jones.

SURNAME | FIRST NAMES | HOSPITAL No

061-017-051

LC-Royal 13/04 '00 09:51 TX/RX NO. 2229 P12

13/04/00 08:53 FAX 012

S1

OMAGH/FERMANAGH HOSPITAL &
COMMUNITY SERVIC[illegible] NIT
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, ↓ pyrexia, urine

Patients understanding of Present illness: smells strong.

Rel. Past History of Illness/Operations:

[redacted]

Medications on Admission: Kept in Hospital?/Retd?

Calpol given @ 18.30.

FINAL DIAGNOSIS:

SUMMARY OF PROBLEMS:

Diarrhoea & vomiting.

Next of Kin: Relationship [redacted]

Address.

Tel. No. Home [redacted] Business.

Other:

Informed? YES/NO

Dependents?

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

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 McDonnell

LPC 2/86/014

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LC-Royal 13/04 '00 09:51 TX/RX NO. 2229 P08

061-017-052

LC-Royal 13/04 '00 09:51 TX/RX NO. 2229 P09 061-017-053

PATIENT ASSESSMENT

MENTAL STATUS Appearance/behaviour: Floppy + slightly flushed.

Consciousness/awareness: Conscious.

COMMUNICATING: Speech activity:

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

Perceptions:

Hearing Aid? R. Ear / L. Ear ——— Worn? Yes / No

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

PHYSICAL STATUS VITAL SIGNS: Temp. 38⁶ °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.

ELIMINATION: describe pattern/problems/dependence etc.

Can / ~~cannot~~ feed self?

Menstrual Cycle:

Bowels: Bowels last opened Mon, usually goes 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.

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? ———

Prescription Card? Tablets to take home? Own tablets returned? Valuables returned? Yes? / No? ——— Book signed?

Community Services involved:

Signature of Nurse:

LC-Royal
13/04 '00 09:51 TX/RX NO. 2463 P13
061-017-054
13/04/00 08:53 FAX

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	Indicate Prescribed Times by a Tick: 6.00	8.00	12.00	14.00	18.00	22.00	24.00	Signature of Prescriber	Cancelled: Date	Cancelled: Initials
1	12/4/00	PARACETAMOL	120	OR/PR.	PRN 4-6°								Dunjahi		
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

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

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SPECIAL RECORDING SECTION FOR PREMEDICATION DRUGS GIVEN

Date	Premedication Prescribed	Dose	Time Given	Signature of Prescriber	Signature of Nurse Administering

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	[signature]	0300	
	Flumazenil					0400	[signature]

LC-Royal
13/04 '00 09:51 TX/RX NO. 2229
061-017-055 P14
13/04/00 08:53 FAX
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DAILY FLUID BALANCE CHART

AFFIX LABEL HERE OR ENTER

24 Hours beginning 12/4/00

FULL NAME Lucy Crawford

HOSPITAL NUMBER

CONSULTANT

NOTE: 1 oz = 30 MLs.

TIME	INTAKE				OUTPUT				REMARKS
	Intake by Mouth		Intravenous or other routes		Urine	Faeces	Vomit	Tube	
	Amount	Type	Amount	Type					
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.									
9 p.m.	50	Juice.			2 omb				Kelonas ++++ Prolix +++
10 p.m.	100	Dioralyte							
11 p.m.			0						
12 mid			100/100	No IB.	DAMP				
1 a.m.			100/200				tot.		
2 a.m.			100/200						
3 a.m.			100/200						
4 a.m.			500	N/Saline					Diahoeea +++.
5 a.m.			5						
6 a.m.									
7 a.m.									

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

ERNE HOSPITAL ENNISKILLEN

LPC 1 85 O.

rm No 1182.

061-017-056

LC-Royal

SPERRIN LAKELAND HEALTH & SOCIAL SERVICES TRUST

OBSERVATION SHEET

NAME: Lucy Crawford. WARD: C/W

DATE	TIME	TEMP-ERATURE	PULSE	B.P.	RESP.	REMARKS
2/4/00	19.30.	38^{6}.				O/A. Floppy slightly flushed
	20.30	38^{7} (AF)				B.M 3.6 m mol/l
						Paracetamol 120 mg I.L.
	22.30	38^{3} (AF)				
	23.30	37^{4} (AF)			26	asleep
	03.15		163	98/60		B/P 144
						B.M: 13.6 113.
	03.20	Continuous Cardiac ECG Monitoring + SaO_2.				
	04.00					B.M. 8.3