

Evaluation/Progress Rep

Morning: 08-13 ⁰⁰ PM Time: 15 ⁰⁰ PM	Evening: 08-13 ⁰⁰ PM Time: 15 ⁰⁰ PM	Night:	Time:
(1A) 1st set of brain stem death tests carried out at 08 ⁵⁰ am by Dr Hazelle + Dr Ch'shuta. Pa negative for brain death. Parents informed.	death tests carried out at 13 ⁰⁰ pm. Ventilator discontinued at 13 ⁰⁰ pm.		
(1B) Tachycardic all morning. BIP 110/60. Pyrexia 37.7°C. Ventilator discontinued at 13 ⁰⁰ pm. Pronounced analgesia.			
(1C) 2nd set of brain stem death tests as per (1A).			
(1E) Fluids discontinued at 13 ⁰⁰ pm. All lines removed.			
Signature: <i>Mu'hammad</i>	Signature: <i>Mu'hammad</i>	Signature:	

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

[Signature]

Evaluation/Progress Report

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Morning:	Time:	Evening:	Time:	Night:	Time:
Signature:		Signature: <i>Mel'Anthony</i>		Signature:	

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

Evaluation/Progress Report

Morning: 13.04.00	Time: 13.04.00	Evening: 13.04.00	Time: 13.04.00	Night:	Time:
A) Remained intubated and ventilated throughout the day. Ventilator settings changed as per blood gases. Presently FIO ₂ 40% Pressure 22/15 Rate 12 bpm. SIMV (PCRS).					a) Intubated and ventilated overnight + pressures. Rate increased and O ₂ ↑ to 40% for short time. b) 40% this am. due to being acidotic on blood gas.
Secretions 2m - 3m on chart. Acidotic on blood gas.					minimal secretions on suction.
B) Cardiovascularly unstable on occasions throughout the day. Very tachycardic HR 220 bpm and hypertensive BP 160/110 (Initially bradycardic and hypotensive requiring adrenaline infusion). Adrenaline discontinued when ↑ BP and ↑ HR. K ⁺ 2.0 on occasions. - Potassium infusion is progress @ 4ml/hr. Very cold. Temperature unrecordable on admission - warmed up with Blue Huggie and blankets to 38.6°C. On Cefotaxime T.I.D.					B. Tachycardic overnight - heart rate 199 this am. Temp 37.3°C overnight. No respiratory effort.
C) No analgesia or sedation given throughout the day. Lucy remained 'flat' and unresponsive.					BP hard to measure this am due to flexing of arms.
D) Pupils fixed and dilated since admission - some choroidal flexion of legs. CT scan - abnormal. No activity recorded on EEG.					c. no analgesia or sedation overnight.
E) IV fluids in progress throughout the day commenced on 0.9% NaCl - changed to 0.45% NaCl & 2.5% Dextrose. Initially fluids 2/3 maintenance - regime then changed to 40ml/hr however if urinary output remains low.					D. Pupils remain fixed & dilated. Shagging movements of shoulders & abnormal flexion of arms.
output. NG tube inserted, no free drainage - no aspirate.					No cough or gag reflex.
F) Diuresis + + + DDAVP given x 3 bolus and then DDAVP infusion commenced.					E. in fluids initially 0.45% NaCl & 2.5% Dext but changed
Presently running at 4mls/hr. Good urinary output continues - dilute urine.					Signature:
Signature: S/N V. Mc Gudden					Signature: S/N V. Mc Gudden

Name: Lucy Stanford

Hosp. No. 401358

Date: 13/4/00

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

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Name: Lucy Crawford Hosp. No. 461358 Date: 14/4/00

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Name: _____ Hosp. No. _____ Date: _____

Date: