PICU CAREPLAN RBHSC

NAME: RACHEL FERGUSON HOSP. NO. 76554 DAY NO. (2) DATE: 10|06|01

SUMMARY: 9 yr old girl transferred from Altnagelvin yesterday. Appendicectomy on 7|06|01, started vomiting on 8|06 and in the early hours 09|06 – prolonged seizure after which pupils where fixed and dilated. Intubated - transferred to ICU. CT Scan shows cerebral oedema, transferred here 9|6|01 pm → Brain stem tests at 5pm showed → ASSESSMENT OF CONDITION/NEEDS → No sign of brain stem activity

1. PHYSICAL

(A) Respiratory

1 (2) 3 4 5

Intubated & ventilated

Secretions mucoid – minimal

Servo → Vol. control.

(B) Cardiovascular

1 (2) 3 4 5

Hypereric.

Blood pressure falling slowly 68 systolic

(C) Pain/Sedation

1 2 3 4 (5)

No sedation required/ requested

(D) Neurology

1 2 (3) 4 5

G.C.S. = 6

Pupil size = 8 non reactive pupils fixed

No seizures observed

2nd Brain stem death tests to be carried out.

Continuum symbols Morning 8am ● Eve 2pm ▲ Night 8pm ■ 2am

GOALS AND PLANNED CARE * Na 118 *

Monitor ventilation* 1 (2) 3 4 5

Saline suction x 3-4 hrly.

Continuously monitor cardiovascular status 1 (2) 3 4 5 Record vital signs hrly.

Care of I.A. line *

Heating blanket as required

C.V.P. line blocked.

Ensure Rachel **is painfree and relieve anxiety** 1 2 3 4 (5)

Administer analgesis and sedation as prescribed

Observe for signs of neurological deficits 1 2 (3) 4 5

Records G.C.S. at start of each shift and/or 1 hrly.

Brain stem death tests completed 09.45

nsg ve

063-016-039

RF - ROYAL

OS13447-6

(E) Nutrition/Hydration | 1 | (2) | 3 | 4 | 5

NUTRITION ASSESSMENT SCORE ( )

2/s maintenance fluids as prescribed

Regular U+E tests

(F) Elimination | 1 | (2) | 3 | 4 | 5

Urinary output large.

BND.

(G) Skincare/Wound Care | 1 | (2) | 3 | 4 | 5

Mobility | (1) | 2 | 3 | 4 | 5

Hygiene | (1) | 2 | 3 | 4 | 5

Requires all care.

No dsge for abdominal wound.

(II) Psycho/Social/Cultural | 1 | 2 | (3) | 4 | 5

Parents - siblings + relatives all in attendance.

(III) Circumstantial

2d Brain stem tests negative.

Discussed with parent + ventilator removed

11.35am. Nursed on mum's knee.

To go for Coroners PM.

Record intake hrly. Record B.M. stix x 6 hrly. Weigh x as directed | 1 | 2 | 3 | 4 | 5

Care of I.V./Central Lines* ~~x~~ **required**

Record urinary output hrly. | (1) | 2 | 3 | 4 | 5

Aspirate nasogastric tube x 4 hourly

Record type and amount of aspirate & free drainage. Urinalysis 6 hrly.

1	(2)	3	4	5
(1)	2	3	4	5
(1)	2	3	4	5

Ensure Rachel's **skin is clean and healthy.** Daily bed bath

Provide care to eyes and mouth.* x 2 **hrly**

Turn x 2 hrly, use manual handling aids as required. Pressure area care x 4 hrly

Provide Rachel's | 1 | 2 | (3) | 4 | 5 | **parents/relatives with support and information**

Rachel parents spoken to by Dr Coo- + Dr Hanrahan.

063-016-040

RF – ROYAL

Pau