RACHEL FERGUSON

COPY ALTNAGELVIN
HOSPITAL NOTES

PAGES 1-69

RF - FAMILY

068a-046-199

CONFIDENTIAL

313854

313854

1992

AFFIX LABEL OR ENTER

AH 313854

FERGUSON

[redacted]

CASENOTE NO: AH 313854

[redacted]

RF - FAMILY

068a-046-200

PLEASE ARRANGE A FOLLOW-UP APPOINTMENT FOR THIS PATIENT

TO BE SEEN BY .....

AT THE ..... CLINIC

IN ..... WEEKS

Altnagelvin Area Hospital
ADMISSION RECORD

Casenote number: AH 313854
Surname: FERGUSON
Forenames: RACHAEL
Date of Birth: 04/02/1992
Age: 9Y Sex: FEMALE
Title: MISS
Phone: 71267734
Address: [redacted]
Post Code: [redacted]

Prev. Name:

Temp. Address

Post Code:
Phone Number:

FAMILY DOCTOR

Name: DR ASHENHURST
Address: WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY

Post Code: BT47 1AU
Phone Number: [redacted]

EPISODIC DOCTOR
(if different from usual G.P.)

Name: DR E.M. ASHENHURST
Address: WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY

Post Code: BT47 1AU
Phone Number: [redacted]

PERSONAL DETAILS

Religion: [redacted]
Marital Status:
Place of Birth:
CSA Number:
Occupation or School:
Occupation (HOH):
Benefits:

NEXT OF KIN

Name: MARIE
Relationship:
Address: [redacted]

Post Code: [redacted]
Phone (Home):
(Work): [redacted]

ADMISSION DETAILS

Consultant: MR GILLILAND
Specialty: GENERAL SURGERY
Referred by: Accident
Admission Reason:
Operation/Procedures:

Theatre time (mins):
Expected length of stay:
Method of Admission: EMERGENCY-VIA A&E
Accidents: Non Trauma
Source of Adm: USUAL RESIDENCE
Transf. from:
Intended Management: NORMAL ADMISSION
Category: HEALTH SERVICE PTNT

Admission Date: 07/06/01

Time: 09:41 PM

Ward: CHW

Admitted By: JB1

RF - FAMILY

068a-046-201

PERSONAL DATA SHEET

[redacted]

SURNAME: Mr./Mrs./Miss .....

FIRST NAMES .....

DATE OF BIRTH .....

HOSPITAL NUMBER — S13854

ADDRESS .....

.....

OCCUPATION .....

RELIGION RC

SPECIAL INFORMATION EG. SENSITIVITIES

.....

.....

.....

.....

.....

.....

PATIENT'S BLOOD GROUP

GR ..... H.R .....

ENTERED BY :—

GENERAL PRACTITIONERS NAME & ADDRESS:—

Ashurst

.....

.....

.....

NEAREST RELATIVE OR FRIEND

NAME Mrs [redacted]

DDRESS .....

.....

Tel. No. to be used in emergency 71267734

IN THE EVENT OF DEATH:—

DATE AND TIME .....

.....

CAUSE OF DEATH —

(i) (A) .....

DUE TO (B) .....

DUE TO (C) .....

(ii) .....

.....

IN-PATIENT TREATMENT

	DATE ADMITTED	WARD	DATE DISCHARGED	DIAGNOSIS	OPERATION/TREATMENT
1	7/6/01	CHW			
2					
3					
4					

AFFIX LAB

SURNAME

FIRST NAME(S)

DATE OF BIRTH

HOSPITAL NO.

[redacted]

Rachel.

Ferguson

CONSULTANT

WESTERN HEALTH and SOCIAL SERVICES BOARD

ALTNAGELVIN GROUP OF HOSPITALS

PAEDIATRIC

CLINICAL NOTES

DATE	
23/3/92	
27/4/92	[redacted]
	[redacted]
	[redacted]
	[redacted]
	[redacted]
	[redacted]

S 9

WESTERN HEALTH AND SOCIAL SERVICES BOARD
LONDONDERRY, LIMAVADY AND STRABANE UNIT OF MANAGEMENT
ALTNAGELVIN AREA HOSPITAL
LONDONDERRY BT47 1SB Telephone [redacted]

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

23 March 1992

Dear Dr Ashenhurst

RE: [redacted]

[redacted]

Your sincerely

Dr J O'Donnell
SHO in Paeds

sr

WESTERN HEALTH & SOCIAL SERVICES BOARD

ALTNAGELVIN AREA HOSPITAL

LONDONDERRY BT47 1SB

TELEPHONE- LONDONDERRY [redacted]

DATE:

IN CONFIDENCE

Dr Ashenhurst
Health Centre
Waterside
LONDONDERRY

PATIENTS NAME: Rachel Ferguson

ADDRESS [redacted]

DATE OF BIRTH: 04 02 92 HOSP. NO: 313854 DATE OF ATTENDANCE: 27 April 1992

Dear : Dr Ashenhurst

[redacted]

Yours sincerely

Dr A Kinney
SHO in Paeds

sr

RF - FAMILY

068a-046-205

ALTNAGELVIN AREA HOSPITAL

LABOUR WARD BABY OBSERVATION CHART

NAME [redacted] DATE 4.2.'92

SEX Girl.

D.O.B. & TIME 4.2.92 @ 6.58 pm

Wt:- [redacted]

HOSPITAL NO. [redacted]

HC: [redacted]

OBSERVATIONS - 1/2 hourly x 2 hours Hours x 3-12 hours

length. [redacted]

TIME	TEMP.	COLOUR	RESPS.	APEX RATE	URINE	MEC.	FEEDING & AMOUNT	COMMENTS
[redacted]								

RF - FAMILY

068a-046-206

WESTERN AREA HEALTH AND
SOCIAL SERVICES BOARD
ALTNAGELVIN GROUP OF HOSPITALS

BABY'S WEIGHT CHART

BW. 67

Affix label or enter

[redacted]

RF - FAMILY

068a-046-207

Date of birth 4.2.97 at 6.58 a.m. p.m. Sex Female

Type of delivery [redacted]

Period of gestation [redacted] Membranes ruptured [redacted]

Apgar score [redacted] Respirations established ✓

Resusicitation [redacted]

Birth weight [redacted] grams. Length [redacted] cms.

Head circumference [redacted] cms. Temperature [redacted]

Ortolanni test -ve/+vc Guthrie test

[redacted]

RF - FAMILY

068a-046-208

Northern Ireland Child Health System

Maternal / Neonatal Discharge Form

CHS 3

1991)

[redacted]

RF - FAMILY

068a-046-209

IF PATIENT ADMITTED OR REFERRED TO OUT PATIENT'S, THIS COPY TO PATIENT'S CASENOTES.
IF PATIENT NOT ADMITTED OR REFERRED, DESTROY THIS COPY.

Altnagelvin Area Hospital
Accident & Emergency

TRIAGE CODE: 3

DATE/TIME: 7/6/01 20:01
CHI NO.
A&E NO. 01/19050

INCIDENT: Unwell.
SOURCE

SURNAME / SEX / FORENAMES

AED NO AH 01AE19050
MISS RACHAEL
FERGUSON 04/02/92
[redacted]
L
HOSP NO. AH 313854
11267134
STATUS

NEXT OF KIN

COMPUTER CODES: TRIAGE / DOCTOR / NURSE / ADMIN.

G.P. DR ashenhurst

TEMP. 36°C
PULSE
B.P. 126/76
RESP.

TRIAGE NOTES
Abdominal pain
Sudden onset.

NURSE McGonagle TIME 8:05 pm

CONSULTANT: McKinney/Steele
SEEN BY DR. Bhelly
TIME 8.05 pm

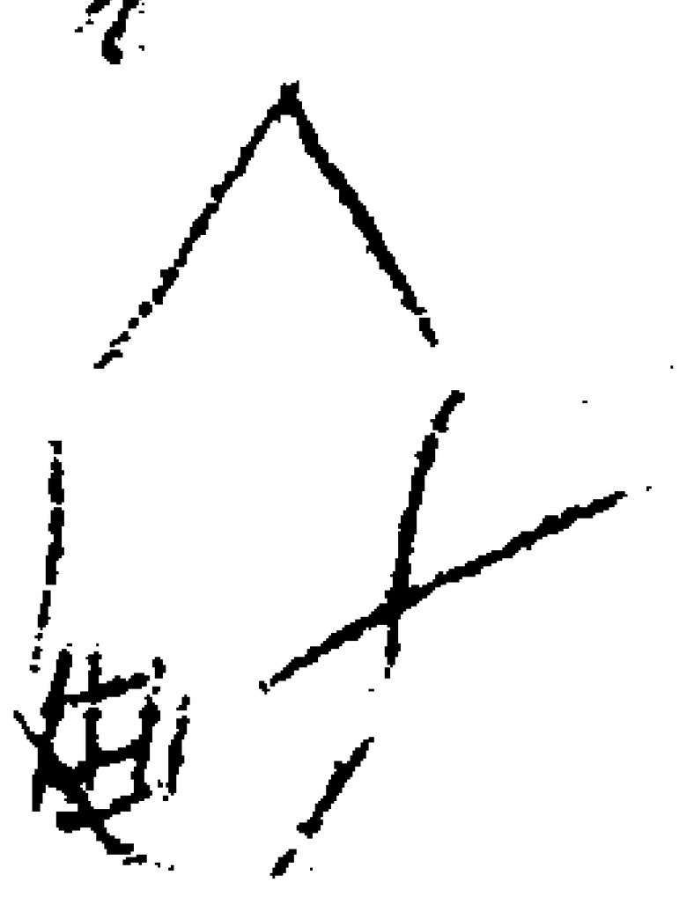
HISTORY/EXAMINATION & DIAGNOSIS/TREATMENT

wt approx 26 kg.
C/O sudden onset of abd Pain
~ 4.30pm.
↑ed severity since
Nauseated
° vomiting
Pain on urination

DHx
° Allergies

PMHx
Nil of note.

O/E



> Tender
Rebound +
Guarding +
Tender over
McBurney Pt.

HAEMATOL / BIOCHEM / BACTERIOL / OTHER

X-RAY REQUEST:

LMP
IGNORE A POSSIBLE PREGNANCY? YES NO

TO EXCLUDE:

RADIOGRAPHER

X-RAY INTERPRETATION

DIAGNOSIS
Appendicitis?
Surgeons

TREATMENT

TETANUS TOXOID
COURSE
BOOSTER

DRUG TREATMENT DISPENSED	ROUTE	DOSAGE	TIME/FREQ.	PRESCRIBED BY	DISPENSED BY
Cyclimorph	IV	2mg	1 hour	[illegible]	2020

DR'S SIGNATURE & TIME: Bhelly

NURSING ADVICE ETC GIVEN
Admit Ward 6

NURSE SIGNATURE & TIME

FINAL PLACEMENT

DISCHARGE	
REFER TO GP	
REFER OP	
REVIEW A&E	
ADMIT WD:	6
DNW/CTA	

RF - FAMILY

068a-046-210

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME RACHEL.

FIRST NAME(S) Ferguson.

DATE OF BIRTH 4/02/92

HOSPITAL NO.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

SURGICAL

CLINICAL NOTES

DATE	
	surgical SHO review
7/8/01	Periumbilical pain started at 4 PM.
	pain is constant, shifted mainly to the
	Right iliac fossa.
	no vomiting
	She had her dinner at 5.10 PM.
	no apetite to eat at the moment.
	last Bowel motion this PM — normal.
	no urinary symptoms.
PMH	no asthma, no heart problem, no epilepsy
	no operations
Med.	— nil
Allergy	no known drug allergy
Social	lives with parent
F.H	no history of anesthetic problem
	Heart disease in the family
Systemic	no sore throat
	no chest symptoms

RF - FAMILY

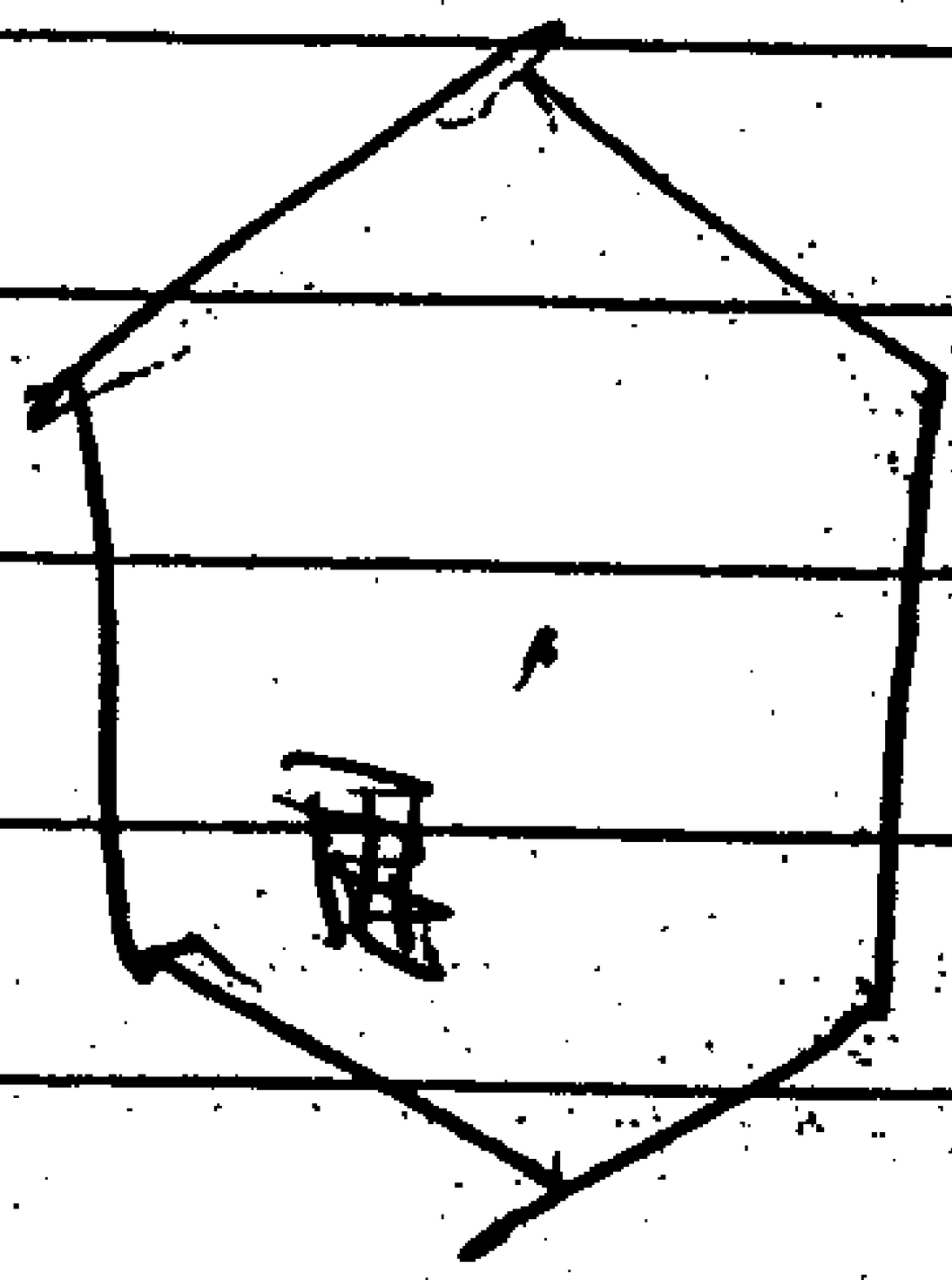
068a-046-211

DATE

o/Ex. Appearance
p. 100/min BP 126/76

chest → clear
Heart → WNL
CNS → Grossly intact
throat → not congested
slight enlarged tonsils

Abdomen →
pointing pain over
McBurney's point



Tender Right iliac fossa
+ Guarding
mild rebound
mildly tender on percussion

Bowel sounds → normal

Opinion → acute Appendicitis / obstructed Appendix

plan → Fasting
IV fluids
Consent ✓ done.
Appendectomy

B. [signature]

/6/01
...a - 137
... - 3.6
...b 1 - 107
... 2 - 22
...nes - 48
...lucos - 7.2
...atin - 47
...Prot - 69

... - 11.7
...BC - 9.06
...lt - 339.

RF - FAMILY
068a-046-212

SURNAME

FIRST NAME(S)

DATE OF BIRTH

HOSPITAL NO.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

SURGICAL

DATE

CLINICAL NOTES

8/6/01 Art appendicectomy
Bile of pain Apyrexial
Contin. obviously

J

9.6.01 J Johnston 0315

Called to see regarding Pt.

Day 1 postop. appendicectomy.

Unresponsive for 5-10mins c̄ contraction + flexion of upper limbs

Not classical tonic-clonic

Assoc urinary incontinence.

Unresponsive to 5mg diazepam pr.

Given Diazemuls 10mg

o/e Apyrexial 36.

Still unresponsive due to diazepam.

P 80bpm regular rhythm normal character + volume. JVP ↔ hs I+II+ nil

Chest clear good ae. vesicular BS.

nb No known history of epilepsy

Pt postop complications

? 2° vomiting + electrolyte abnormality.

DW PRHO urgent check EP, Ca^{2+}, Mg^{2+}, FBP ☐

ECG ☐

✓ by reg/consultant

Jeremy Johnston JEREMY JOHNSTON SHO

DATE

9:00 Called to see patient
- C/O Appendicectomy Headache Vomiting
- Had fit ? Sec to electrolyte imbalance ? Meningitis.
- Pt is on intubation, being monitored.. Rash over upper half
P/A - soft Pupils dilated & fixed
- Distension
- Resuscitation being carried out
- NGT
- Catheter
- Repeat urea & Electrolytes, Lumbar puncture

Fit sec to Electrolyte imbalance / Meningitis
urgent CT scan is organised.

RF - FAMILY

ALTNAGELVIN HOSPITALS HEALTH & SOCIAL SERVICES TRUST

CONSENT FORM

[redacted]

MEDICAL OR DENTAL INVESTIGATION, TRE[redacted]ATION

Patient's Surname ..... Ferguson .....

Other Names ..... Rachel .....

Date of Birth ..... Hospital Number ..... Sex : *(please tick)* Male ☐ Female ☐

DOCTORS OR DENTISTS *(This part to be completed by doctor or dentist. See notes on the reverse).*

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate.

..... Appendectomy .....

.....

I confirm that I have explained the operation, investigation or treatment, and such appropriate options as are available and the type of anaesthetic, if any (general/local/sedation) proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient.

Signature ..... R Makan ..... Date : ..... 7/6/01 .....

Name of doctor or dentist ..... R Makan .....

PATIENT/PARENT/GUARDIAN

1. **PLEASE READ THIS FORM AND THE NOTES OVERLEAF VERY CAREFULLY**

2. If there is anything that you do not understand about the explanation, or if you want more information, you should ask the doctor or dentist.

3. Please check that all the information on the form is correct. If it is, and you understand the explanation, then sign the form.

I am the patient / parent / guardian *(delete as necessary)*

I agree
- to what is proposed which has been explained to me by the doctor/dentist named on this form.
- to the use of the type of anaesthetic that I have been told about.

I understand
- that the procedure may not be done by the doctor/dentist who has been treating me so far.
- that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons.

I have told
- the doctor or dentist about the procedures listed below I would **not** wish to be carried out without my having the opportunity to consider them first.

.....

.....

Signature ..... M FERGUSON .....

Name .....

Address .....
(if not the patient)

Date .....

LPC 04/98/006

RF - FAMILY 068a-046-215

Anaesthetic Record

DATE 7/06/01 Procedure Appendicectomy.

Dr. GUND / Dr. Jamison.

Primary Technique

- Inhalational / IV ☑
- Spinal ☐
- Epidural ☐
- Local ☐
- Sedation ☐

Monitors

- ECG ☑
- BP ☑
- O2 analyser ☑
- Agent analyser ☑
- Steth pre/ oes ☐
- Capnograph ☑
- Pulse Oximeter ☑
- N-M blockade ☐
- Temp. _____

- CVP _____ ☐
- Art _____ ☐
- PA catheter ☐
- urinary catheter ☐
- other _____
- Warming blanket
- Fluid warmer

TECHNIQUE

Retrospective note dated 13/6/01.
Patient only received 200mls of noted fluids below when in theatre.
Suture bag removed prior to leaving theatre

Jamison (SHO).
witnessed by

Fluids total
Hartmann's 1L.

Blood Loss

Signed:

Airway O N T
Laryngeal Mask
Intubation
Size #6.0

- No ETT/Airway ☐
- ET ☑
- blind ☐
- fibreoptic ☐
- awake ☐
- rapid sequence ☐

Easy / Mod / Diff

- Bain ☐
- Circle ☑
- Humidifier ☐
- O2 supplement ☐

RR 16 x TV 280
Paw 13.

IV Cannula
#22G

Position

ONDANSETRON	2mg.																		
Pentangl	25+25mg.																		
PROPOFOL	100mg.																		
SCOLIN	80mg.																		
CYCLIMORPH 10	1/2 ml.																		
MIVACURIUM	2mg.				1mg.														
Metrogyl	250mg.																		

TIME 11.30 12

BP – V ^
HR – ●

220 200 180 160 140 120 100 80 60 40 20

SAO2					98	97	97												
ETCO2					43.	45	44												

RF - FAMILY

068a-046-216

NAESTHE Dr-GUND.

URGEON

EIGHT 25K	HEIGHT	BSA
P	HR	TEMP.
GE	PREMEDICATION	
EX : M ☐ F ☐		

AH 313854
MISS MAUMAEL
FERGUSUN
[redacted]
F
07/02/52
OP:N2KS
WD/UP:
CONSULTANT:

REANAESTHETIC EVALUATION:

Parent Not available at the moment.
Interpreter PJ. Hensely.
Had dinner at 5:10 P.M.
(solids).
No significant Past history
to the knowledge.
Cervious oriented.
Talked to [redacted] mother in OTarea.
negative Past history
Counseled for Paracetamol Suppository.

CVS
WNL.

RS
NAD.

CNS
Cervious oriented.

METABOLIC

MOUTH / AIRWAY Loose canine (Lowe Rt.)
MP-I.

ASA Status: 1 2 3 4 5 E

HAEMATOLGY
WNL

BIOCHEMISTRY

URINANALYSIS

ECG

CXR

DRUG USE :

SMOKING: ☐ NO
☐ YES _____

DRUG ALLERGY :
? NIL

Pt. to be taken ajt 11.00 p.m.

PLAN FOR ANAESTHESIA :
GA E intubation.
Paracetamol suppository 500mg.
Parents to be informed about.

signature : [signature] date : 7/6/01

PERIOPERATIVE EVENTS :
Prolonged sedation due to opioids.

POST OP. RECOVERY :
Routine Obs.
Analgesics as prescribed

signature : [signature] date : 8/6/01

RF - FAMILY

068a-046-217

O.F. 49

AH 813854

[redacted]

F

ION

SURGEON'S REPORT

SURGEON ..... Mr. Makar .....

ASST. .....

ANAESTHETIST ..... Drs. Jamison, Gunal .....

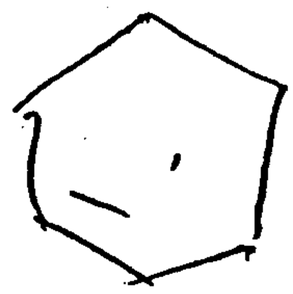
OPERATION PERFORMED

Appendectomy

FINDINGS

Mildly congested appendix.
Fecalith in lumen
peritoneal clear fluid reaction
no evident diverticula at 12 cm ± 3 feet of small Bowel

DESCRIPTION OF PROCEDURE



Grid iron incision
muscle splitting
ligation of mesoappendix
ligation of Appendix base 2/0 vicryl
purse string 2/0 vicryl
retrograde suction appendix
Wound closed in layers using 2/0 vicryl
Skin closed with 3/0 vicryl Rapid

Flagyl 200 mg TID I.V today then PO/OR supp

Local anesthetic
1 gm of Marcain 0.25%

NAME OF NURSE TAKING CASE ..... S/N V. Ayton .....

SIGNATURE: ..... Vivienne Ayton .....

NAME OF NURSE CHECKING SWABS ..... S/N McGrath .....

SPECIMEN FOR HISTOLOGY: (YES) NO

DELETE THAT WHICH DOES NOT APPLY

COMPLETED BY SURGEON

SIGNATURE ..... R Makar .....

DATE ..... 7/6/01 .....

RF - FAMILY

068a-046-218

GEN00013
C : 60

Altnagelvin H & S S Trust
Glenshane Rd. L'Derry BT47 6SB

STERILE

31/05/2001

21/05/2002

GEN00013 C : 60

GENERAL CUTTING SET NO. 8

THEATRE

Pa	Checked	Pre-Op	Post-Op

HEALTHEDGE
01484 322777

Do Not Use If Packing Damaged
Store In A Clean, Dry, Dust Free Environment

RF - FAMILY

068a-046-219

Theatre Nursing Care Plan

AH 313854
MISS RACHAEL
FERGUSON
[redacted]
F
04/02/92
GP:W245
WD/OP:
CONSULTANT:

Date: 1 / 7-6-07.
Time: / 11-20pm
Procedure(s) .....
.....Appendicectomy.
.....

Allergies
None Known ☑
Yes (specify) ☐
.....
.....

Mobility Impairment
None ☑
Yes (specify) ☐
.....
.....

Special Needs
Hearing .....
Sight .....
Language .....
Prosthesis .....
None ☑

Skin Integrity
Healthy ✓
Reddness .....
Raised Temp .....
Discoloured .....
Broken areas .....

Level of Response
Alert ☑
Drowsy ☐
Asleep ☐
Premedicated
Yes ☐
No ☑

Throat Pack
Yes ☐ No ☑
Time In.....
Time Out .....

Risk Score .....

Comments :

	Yes	No	Comment
Identity band present	✓		
Consent form signed	✓		
Operation site marked		✓	
Crowns/ loose teeth	✓		Bottom Right
Dentures/ plate removed	N/A		
Drains/ catheters insitu		✓	
Blood grouped			See notes
Blood crossmatched			

Venupuncture site.....Right arm.....
IV infusion site .....''.....''.....
Arterial line .....—.....
C.V.P. site .....—.....

	Yes	No
Cricoid Pressure	☑	☐
ECG Monitor	☑	☐
Oxygen Monitor	☑	☐
Co2 Monitor	☐	☐

Flexoplate Applied Yes ☑ No ☐
Bipolar
Site .....Right thigh.....

Anesthetist ; Drs Jamison
Gund

Type of Anaesthetic (please specify)

1 Local ☐	2 General ☑	3 Regional ☐
.....	Oral tube 7.0	.....

Controlled Drugs Used :
Fentanyl
Cyclimorph } I.V. @ induction

Signature/Title : MMC Grad

RF - FAMILY

Intra – Operative Nursing Care

Time into Theatre /

Patient Position:

Supine ✓
Prone .....
Lateral .....
Lithotomy .....
Other .....

Arms

Right	Left
☐	☑ At side
☑	☐ Armboard
☐	☐ Other

Tourniquet:

Yes ☐ No ☑

Site .....

Pressure .....

Time On .....

Time Off .....

Pressure Relieving Aids:

None .....
Type .....
Site .....

Moving Aids:

Easy Glide ☐
Multiglide 2 way ☐
Multiglide 1 way ☐
Other ☐

Warming Blanket:

Yes ☐ No ☑

Temp. Setting .....ºC

Comments: Voltarol supp 12.5mg. 3 @ 11.40pm.
Paracetamol " 500mg 3 Marcain 0.25% 5ml to wound.

Surgeon:	**Assistant:**	**Scrub Nurse:**	**Checking Nurse:**
Mr. Makar		S/N V. Ayton	S/N M McGrath

Swab/ Instrument Counts:

	Taken before incision			Correct at closure	
	Yes	No		Yes	No
Raytex Swabs	✓			✓	
Packs	✓			✓	
Tonsil Swabs					
Needles	✓			✓	
Scalpel blades	✓			✓	
Instruments	✓			✓	
Tapes/ sloops					
Other					

Surgeon Informed

Yes ☑

No ☐

Wound Closure:

Clips ☐ Sutures ☑

Packs Left Insitu:

(specify)

Drainage:

Prosthesis/ Implants:

Type:

Site:

Signature/ Title: .....M.M.C. Grath.....

RF - FAMILY

068a-046-221

Recovery Area Care

Post Operative Recovery Position:

	Yes	No	Comment
Airway Control	✓		
Suction Applied	✓		
I.V. Infusion Chkd.	✓		To be recommenced on ward.
Catheter Drain Chkd.	N/A		
Drains (other) Chkd.	N/A		
P.V. Loss	N/A		
W nd Chkd.	✓		
st Chkd.	N/A		

Skin Integrity:

Healthy	✓
Redness	
Raised Temp	
Discoloured	
Broken Areas	

Oxygen Administration:
Prescription Method

Initially in recovery.

Analgesia:
Drug Given: Route: Time:

Comments

SERVATIONS

Time	12.45 Am	12.55 Pm	1.05 Am	1.15 Am	1.30 Am
Level of Conciousness	asleep	asleep	asleep	awake	awake
Response to Stimulii	yes	yes	yes	yes	yes
Breathing Spontaneously	yes	yes	yes	yes	yes
Airway	ET tube	ET tube	clear	clear	clear
Oxygen Saturation	99%	99%	99%	99%	99%
Respiratory Rate		24	18	20	18
Blood Pressure	117/65	102/72	105/57	116/66	
Pulse	116	109	108	111	117
eripheral Circulation	good	good	good	good	good
ain	—	—	—	—	—
C.A./ Epidural Commenced	—	—	—	—	—

ecovery Nurse Signature MMC Gwath **Ward Nurses Signature**

RF - FAMILY

SURNA AH 313854

FIRST MISS RAGNAEL FERGUSON F

DATE ([redacted] 04/01/92

HOSPI 5F5/W395

MO/GP: ________

DAT. CONSULTANT: ________

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

PAEDIATRIC

CLINICAL NOTES

9/6/01 written 0620 Paeds 2nd Term SHO

9yr ♀ Surgical Pt.
Post appendicectomy D1
Vomiting today — U+E (N) 7/6/01
No diarrhoea No temp.

Fairly stable until ~ 03⁰⁰
— tonic seizure + bed wet
HR ↑
given 5mg PR diazepam
10mg IV "
lasted ~ 15 mins

Called to see patient ~ 04¹⁰
O/E. Looks very unwell
Unresponsive
Pupils dilated + unresponsive
Apyrexic BM = 9
Face flushed + widespread red macular rash
Petechiae neck + upper chest
↳ probably 2° vomiting
HR 160 /min
Sats 97% 100% mask

RF - FAMILY

PCS 9

068a-046-223

Sounds ratty — ? aspirated
Chest - transmitted sounds
Abdo soft
Not ~~hypo~~ hypertonic
↳ limbs floccid
Plantars ↓↓

Imp ? seizure 2° electrolyte problem
? cerebral lesion

Na+ reported as 118 Mg = 0.59
K = 3 Calcium normal

↳ FBP/U+E/Ca/Mg/Gas/BC already taken
face mask O_2 + placed on side
Dr McCord contacted to come in
Transferred to Treatment room

↳ initially sats 99% on 8L O_2
sats then ↓ to 80's + poor resp effort

↳ Anaesthetist not happy
Bag + mask vent + then intubated
by anaesthetist - Size 6 ETT

↳ PCR meningo. ab taken ✓
100mg/kg IV Cefotaxime
50mg/kg IV benzylpen
Catheterised size 10 foley
(5ml water)
0.9% NaCl @ 213 maint. 1 = 40ml/hr
1ml IM Magnesium sulphate 50%.
Urgent CT brain

Trauma

RF - FAMILY

068a-046-224

LPC 10/85

AH 313854

MISS RACHAEL [redacted] F

[illegible]

MO/OPS ___

CONSULTANT: ___

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

PAEDIATRIC

CLINICAL NOTES

DATE	
~~08~~/06/01	Retrospective note
06:15	Recalled to see
	9yr old – post-op appendicectomy
	– restless / agitated / tonic posturing – ? decerebrate
	→ needed PR + IV Diazepam
	– looked coned / collapsed + apnoeic
	→ dilated fixed pupils.
	– Anaesthetic assessment → IPPV
	– fundi: sharp / pupils unreactive / unresponsive
	Urgent CT brain – verbally ⓝ. Discharge ? marked hyponatraemia ? low Mg ++
	Fluid restrict [illegible] maintain fluids.
	~~[illegible]~~ [illegible] / Lv (≡ ⅓ maintenance)
	To ICU. ? stabilise / electrolyte correct.
	[signature]

5651
DV
14.5
R. FERGUSON
0°C
467
?.0
41

HCO3	16.1
TCO2	1?.8
BE	4.8
SBC	21.3
BEecf	7.8
[illegible]	99.4

UNITS
Gas mmHg
B.P. mmHg
Hb

0430 9/6/01

0430 9/6/01

Na 118 | Mg 0.59
K 3
Urea 2.1 | Calcium 2.19
Creat 43 | alb 41
gluc 11

Hb 12.1
wcc 17 — N: 15
Plat 319 [signature]

RF - FAMILY

068a-046-225

9th JUNE 01. EMERGENCY CT. OF HEAD.

There is evidence of a SUB-ARACHNOID haemorrhage with raised intracranial pressure.

No focal abnormality demonstrated.

[signature] CONS. DR. G. MORRISON

8.30AM. RE-Scanned at the request of N.S.U., R.V.H.

To exclude a subdural empyema?

CT. OF HEAD.

An enhanced scan was performed. No evidence of a subdural empyema.

[signature] Cons.

ALTNAGELVIN HOSPITALS HEALTH
AND SOCIAL SERVICES TRUST

SHEET NUMBER FC.89

FEED CHART

AFFIX LABEL OR ENTER (in Block Letters)

Surname: Leslie Ferguson

First Name(s)

Hospital No. 313854

FEED Continue normal diet

DATE	TIME	FOOD	AMOUNT REQUIRED IN 24 HOURS	AMOUNT REQUIRED EACH FEED	AMOUNT TAKEN	VOMIT	STOOL
8/6/01	10.25am					LARGE VOMIT	

RF - FAMILY

068a-046-227

WESTERN AREA HEALTH & SOCIAL SERVICES BOARD

ALTNAGELVIN GROUP OF HOSPITALS

4 HOURLY T.P.R. CHART

Month June

Affix Label or Enter in Block Letters
Full Name
Hospital No.
Ward
Consultant

Rachel Ferguson
D.O.B 4/2/92
Hosp No 313854

SHEET No. T.P.R. 1.

DAY	7	8th																	DAY
DAY OF DISEASE																			DAY OF DISEASE
	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.	A.M.	P.M.			
F°	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10	2 6 10			C°
107°																			41°
106°																			
105°																			40°
104°																			
103°																			39°
102°																			
101°																			38°
100°																			
99°																			37°
98°																			
97°																			36°
96°																			
95°																			35°
PULSE 150																			150
140																			140
130																			
120																			130
110																			
100	105																		120
90																			110
																			100
70																			90
60																			80
																			70
RESPIRATION 50																			60
45																			50
40																			45
35																			40
30																			35
25																			30
20																			25
15																			20
10																			15
5																			10
																			5
WEIGHT	25 kgs																		WT.
STOOLS																			B.O.
AMOUNT OF URINE																			AMT OF URINE
VOMITING																			
MENSTRUATION																			

RF - FAMILY

068a-046-228

Patient Name and Details

Rachel
Ferguson.

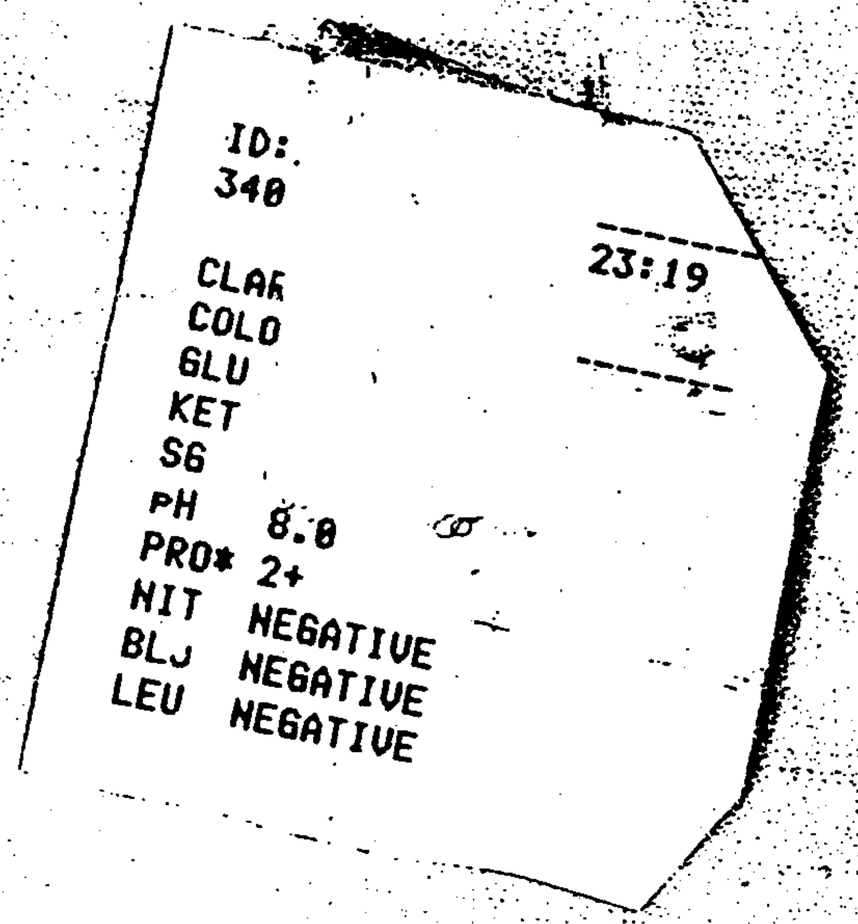
PAEDIATRIC UNIT
ALTNAGELVIN AREA HOSPITAL

Date:

7/6/01

DATE	TIME	TEMP.	PULSE	B/P	RESP. RATE	Pain Rating Score	Analgesia given	Signature	COMMENTS
[illegible]	9.5?pm	36.6	93	103/61	24	0-1.		D Patterson.	C/o slight central abdominal pain on admission. Colour pale.
	1.55am	36.4	100.	96/49.	24	0	—	DPatterson.	Sleeping but easily roused on return to ward. Wound site satisfactory.
	2.15	36.8.	96	94/48	24	0	—	DPatterson	Sleeping. Wound site satisfactory. Colour pink.
	2.25am		90.	85/45	20.	0			Asleep @ present. Colour pink W/site satisfactory.
	3am	37.	84.	78/41.	20	0	—	ANoble	W/site ✓. Child asleep. Colour ✓.
	3.30am		88.	83/47.	20	0	—	ANoble	well settled W/site Satis ✓ IVI ✓.
	4am		82	83/57	20	0	—	ANoble.	W/site satisfactory. n/c pain IVI ✓
	5am	37.2.	103	93/45	20	—	—	AN.	n/c pain Colour good W/site ✓ IVI ✓.
	7am	36.2	89	94/49	22	—	—	An	Asleep ✓ colour good. Wound site satisfactory
	9am	36.9	100		24	—	—	JHewitt	No c/o pain. colour good ZVZ ✓
	1Pm	36.6	90		22			Mbruce	No ooze from wound site Not c/o pain
	6Pm	36.9	92		20			AR	Asleep.
	21:15	35.9	101		21			DR	
								Stairchist.	Colour flushed → pale. Vomiting [illegible] c/o headache

·6·01.



RF - FAMILY

068a-046-230

WESTERN HEALTH and SOCIAL SERVICES BOARD
Altnagelvin Group of Hospitals

OBSERVATION SHEET

O.S.24

Date	Time	Pulse	B.P.	Observations
7.6.01.	8pm		126/76.	c/o abdominal pain. Onset approx 6pm. Tender ++. c/o pain on urination. no vomiting. Colour Pale o/A. bloods ✓
		36°C.		
	2020	88	109/74.	Cyclimorph. 2mg IV.
		SpO_2	100%.	

Leader Ferguson

ARITY:
LOR: LT. YELLOW
U* 3+
T* TRACE
1.025
6.0
O* 1+
NEGATIVE
NEGATIVE
NEGATIVE

REG NO AH 01AE19050
MISS RACHAEL
Pat [redacted]
04/02/92
Ho
Co
HOSP NO. AH 313854 068a-046-231

RF - FAMILY

WESTERN HEALTH and SOCIAL SERVICES BOARD
Altnagelvin Group of Hospitals

OBSERVATION SHEET

O.S.24

Date	Time	Pulse	B.P.	Observations
9/6/01.	3.05am			Child found on side having
		HR 76	T37²	been incontinent. Appeared
				agitated and face & neck
				flushed – fists tightly clenched
				& teeth. O2 @ 5l/min + unresponsive
				5mgs Diazepam given pr.
				– Still fitting – 10mgs diazepam
	3.15am		SaO2 99%	given IV. – Lasted approx
	3.30am	T36.6		15 minutes
				Cold to touch. Still agitated.
				EP, Calcium + Magnesium taken
				& glucose. O2 continued via
	4.10am	124	104/73	face mask.
	4:30am			BM 9.7 mmol/s.

RF - FAMILY

AH 313854
F MISS RACHAEL
FERGUSON
F
[redacted]
H
C
04/02/92
OP:W2[illegible]
FE/UP: _____ 068a-046-232
CONSULTANT:

FERGUSON

[redacted]

04/02/92
GP:N245
RO/OP:_____
CONSULTANT:_____

DRUG TREATMENT SHEET

DRUG ALLERGY / CORTICOSTEROIDS /
PREVIOUS RELEVANT THERAPY

Date Admitted 7/6/01 | Discharged/ Transferred

Age	Sex	Weight (Kg)
9yrs	F	25 Kgs

	Date Treatment Started	Approved Name of Drug (Block Letters)	Dose	[redacted]	Special Instructions	Indicate Prescribed Times by a Tick (8.00 / 14.00 / 22.00)	Signature of Prescriber	Cancelled Intials
1	7/6/01	DICLOFENAC	125	[redacted]	8 hrly		Vijay	
2	7/6/01	PARACETAMOL	500 mg	[redacted]	8 hrly		Vijay	
3	7/6/01	Flagyl	500mg	[redacted]	TID	— — —	Rachel	
4								
5								
6								
7								
8								
9								
10								
11								
12								

RF - FAMILY

068a-046-233 Cr

Unit No.	Surname	Christian Name(s)	Consultant
313554	Ferguson	Rachel	[redacted]

RECORDING SECTION FOR PREMEDICATION DRUGS GIVEN

Date	Premedication Prescribed	Dose	[redacted]	Signature of Prescriber	Signature of Nurse Administering

ONCE ONLY DRUGS

Date	Approved Name of Drugs (Block Letters)	Dose	[redacted]	Special Instructions	Signature of Prescriber	Time Given	Given By (Full Signature Please)
7/6/01	9. MORPHINE 1mg/ml upto 5mg.			in RECOVERY	Vijay Johnston.		
7/6/01	ZOFRAN 2mg	2 mg		9/ Reyd.	Vijay Johnston.		
7/6/01	DICLOFENAC.	12.5 mg		in Theatre	Vijay Johnston.	11.40pm	MMC Grath.
7/6/01	PARACETAMOL	500mg		in Theatre	Vijay Johnston.	11.40pm	MMC Grath.
8-6-1	Valoid	25mg		STAT	MCrn		
9.6.1	Valoid	25mg		STAT	MCrn	10-15pm	MCrn
9.6.01	DIAZEPAM	10mg		STAT	J Johnston	0315	J Johnston
9.6.01	DIAZEPAM	5mg		STAT	J Johnston	3.05	J Johnston
9/6/01	Magnesium Sulphate 50%	1ml		(=2mmol)	[redacted]	0520	[redacted]
9-6-01	CEFOTAXIME	2.5g			J Johnston	} given at 05[illegible] by Dr Johnston	
9-6-01	BENZYLPENICILLIN	1.2g			J Johnston		

RF - FAMILY

068a-046-234

[redacted]

PARENTERAL DRUGS

	Date	Approved Name of Drug (Block Letters)	Dose	Special Instructions	Indicate Prescribed Times by a Tick 8.00	14.00	22.00	Signature of Prescriber	Cancelled Initials
A	7/6/01	CYCLIMORPH. '10'	1/4 ml	6 hrly PRN.				Vijay F.	
B	~~7/6/01~~	~~Metronidazol (Flagyl)~~	~~200 mg~~	~~8 hrly~~					
C	~~3/6/01~~	~~2 Fraw~~	~~2 mg~~	~~8 hrly 8 doses~~					
D	8-6-01	CEFOTAXIME	2.5g					D Davies	7/6/01
E	~~8/6/01~~	~~BENZYLPENICILLIN~~	~~1.2g~~					J Johnston	
F								J Johnston	
G	9/6/01	Cefotaxime	1.2 g	50mg/kg 8 hrly		✓	✓	D Davies	
H	9/6/01	benzylpenicillin	1.2g	50mg/kg 8 hrly		✓	✓	D Davies	
I									
J									
K									
L									
M									
N									
O									
P									
Q									
R									

RF - FAMILY

068a-046-235

15½ x 11½ 150922

Unit No.	Surname	Christian Name(s)	Consultant
313854	Ferguson	Rachel	

DRUG ADMINISTRATION RECORD (Continuation)

Date	For Review	RECORD FOR REGULAR PRESCRIPTION DRUGS AND "AS REQUIRED" DRUGS GIVEN AT STANDARD T: 6	8	12	14	18	22	24	RECORD FOR "VARIABLE DOSE" DRUGS AND AS "REQUIRED DRUGS" GIVEN AT NON-STANDARD TIMES — Enter Reference Letter/Number, Time Dose (if variable) and initial your entry	EXCEPTIONS TO PRESCRIBED ORDERS REASON
2/6/0				3			3		1+3 at 8am 2C 9.30pm AH	

RF - FAMILY

068a-046-236

NOTES ON PRESCRIBING AND ADMINISTRATION

PRESCRIBING

1. Please use approved names BLOCK LETTERS Metric Dosage.
2. Please ensure that the correct section is used for each prescription.
3. Place a tick in the appropriate time columns when treatment is to be given at these times.
4. Please sign your name against each prescription.
5. When changing prescriptions make sure that you cancel with a single straight line those drugs which are to be discontinued, and complete the cancelled section with date and initials.

ADMINISTRATION

1. The senior nurse must ensure that a record is made on the patients Drug Administration Record every time a drug is administered, by entering the initials of the nurse giving the dose, in the appropriate box.
2. Nurse must check carefully to see that all drugs prescribed for a certain time are administered.
3. If a drug is refused enter reference number/ letter and circle it e.g. ② or Ⓐ
4. If a patient is absent enter reference number/ letter and draw a diagonal line through it. e.g. Ⓑ or Ⓜ
5. If drug not given for reasons other than 3 and 4 above enter reference number/letter and draw a cross through it e.g. Ⓧ or Ⓜ
6. **N.B.** Always enter reason for **Non** Administration of a Drug in the "Exceptions to Prescribed Orders" Column.

GENERAL

1. External preparations should be prescribed on this record in the relevant section. The Nurse should make a record of applying or administering external preparations by the same method as internal preparations.
2. **Antibiotic prescriptions are valid for seven days only unless otherwise specified.** Therapy should be reviewed after seven days unless otherwise specified.

it No.	Surname	Christian Name(s)	Consultant
3 13854	Ferguson	Rachel	

150923 8.1/4 x 11 1/2

ALTNAGELVIN [?]OSPITAL NEO NATAL INTENSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDS

Name: Rachel Ferguson Date: 3/6/01 Wt.: Age: 9yrs

FB. 49

TIME	INPUT 1 Amt.	INPUT 1 Total	2 Amt.	2 Total	3 Amt.	3 Total	4 Amt.	4 Total	5 Amt.	5 Total	6 Amt.	6 Total	OUTPUT ASPIRATE Amt.	VOMIT Amt.	URINE Amt.	URINE Total	STOOLS Total	LAB SUGAR	HAEMOCUE	Signature	I.V. SITE	Comments	Signa
SPECIFY FLUID	No 18 c 30mls/hr																						
08.00	150	80												vomit									
09.00	150	160																		[illegible]			
10.00	150	240																					
11.00	150	320												large vomit	PU.					VMR			
12.00	150	400																		VMR			
13.00	150	480												vomited ++						VMR			
14.00	150	560																		LAB			
15.00	150	640																		[illegible]	✓		
16.00	150	720												vomited ++						VMR			
17.00	150	800																		VMR			
18.00	150																			[illegible]			
19.00	150	960																					
20.00	150	1040																		VMR			
21.00	150	1120																		NM	✓		
22.00	150	1200												vomiting coffee grounds ++						[illegible]	✓		
23.00	150	1280												vomited small amount x3						[illegible]	✓		
24.00	150	1360												small coffee ground vomit						[illegible]	✓		
01.00	150	1440																		[illegible]			
02.00	150	1520																		[illegible]	✓		
03.00	150	1600																		[illegible]	✓		
04.00	150	1680																					
05.0																							
06.0																							
07.0																							

Intravenous Total	
Oral Total	
TOTAL INTAKE	

RF - FAMILY

Urine Total	
Other Total	
TOTAL OUTPUT	

068a-046-237

5 kg 11 Maint = 65 ml/hr

213 maint = 40 ml/hr

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	1000	Ssh 18.		80	IMED 960	11445	[signature]	212003	✓ MRice S/N — 12.10 pm
2	1000ml	0.9% NaCl		40			[signature]	01C19BB	A Hill S/N.
3									
4									
5									
6									
7									
8									
9									
10									

ALTNAGELVIN HOSPITAL NEO NATAL INTENSIVE CARE UNIT
FLUID BALANCE FOR I.V. FLUIDS

Name Rachel Ferguson Date 7/6/01 Wt. ..... Age 8 years

FB. 491

	INPUT												OUTPUT										
	INTRAVENOUS								ORAL														
SPECIFY FLUID	1		2		3		4		5		6		ASPIRATE	VOMIT	URINE		STOOLS	LAB SUGAR	HAEMOCUE	Signature	I.V. SITE	Comments	Signatu
TIME	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Total	Amt.	Amt.	Amt.	Total	Total						
08.00																							
09.00																							
10.00																							
11.00																							
12.00																							
13.00																							
14.00																							
15.00																							
16.00																							
17.00																							
18.00																							
19.00																							
20.00	100																						
21.00	Bottle																						
22.00	100	—																					
23.00	150	60																				RP. —	
24.00	At Theatre																						
01.00																							
02.00	150	140																					
03.00	150	220																					
04.00	150	300																					
05	150	380																					
06	150	460																					
07	150	540																					

Fasting ↓

Intravenous Total	
Oral Total	
TOTAL INTAKE	

Urine Total	
Other Total	
TOTAL OUTPUT	

RF - FAMILY

068a-046-239

PARENTERAL NUTRITION FLUIDS PRESCRIPTION SHEET

	Amount (ml)	TYPE OF FLUID	NAME and AMOUNT of ADDITIVES	Rate ml/hour	Type of pump	Serial number of pump	Prescribed by (Signature)	Batch No. Date of Expiry	Time erected + erected by (Signature)
1	1 litre 80ml/Hour	No 18	—	80ml/Hr	1-00	11445	R Muh	07C 1985. 2/2000	10.15a Sister/ I. Beg
2									
3	~~80ml/h~~ [illegible]								
4									
5									
6									
7									
8									
9									
10									

01/85/064

RF - FAMILY

068a-046-240

Surname FERGUSON Hosp. No. AH 313854
Forename RACHAEL Ward ALTNAGELVIN AED
Year of Birth 04/02/1992 Sex F Consultant MR L A MCKINNEY

Profile FBC Department Haematology

1/1 7/6/2001 Acc no : 349

Hgb	Hct	RBC	MCV	MCH	MCHC	RDW	PLT
11.7	.335	3.96	84.6	29.5	34.9	12.4	339

WBC	LY	MO	NE	EO	BA
9.06	3.18	0.53	4.84	0.48	0.04

<CR> to Quit / <P>revious / <N>ext / <L>atest

Sortres Inquiry Press <PF1><PF3> For Help

ALTNAGELVIN HOSPITAL
LABORATORY (TEL:3559/3379)

Lab Number : 5380
Doctor : MR K J S PANESAR

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALTNAGELVIN WARD 6**
Address : [redacted]
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 119	mmol/L	(135 - 145)
Potassium	* 3.4	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	22	mmol/L	(22 - 28)
Urea	2.5	mmol/L	(2.5 - 6.5)
Glucose	* 7.1	mmol/L	(3.9 - 6.7)
Creat	* 22	umol/L	(53 - 106)
T Protein	68	g/L	(60 - 79)
Total Bilirubin	* 20	umol/L	(1 - 17)
Alk Phosphatase	* 152	U/L	(20 - 90)
AST	* 59	U/L	(13 - 42)
ALT	22	U/L	(10 - 55)
GGT	12	U/L	(1 - 50)
Calcium	2.36	mmol/L	(2.10 - 2.6)
Phosphate	0.97	mmol/L	(0.60 - 1.50)
Albumin	40	g/L	(36 - 51)
Magnesium	0.83	mmol/L	(0.75 - 1.25)

ALTNAGELVIN HOSPITAL
LABORATORY (TEL:3559/3379)

Lab Number : 1747
Doctor : MR K J S PANESAR

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALTNAGELVIN WARD 6**
Address : [redacted]
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 118	mmol/L	(135 - 145)
Potassium	* 3.0	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	* 15	mmol/L	(22 - 28)
Urea	* 2.1	mmol/L	(2.5 - 6.5)
Glucose	* 11.0	mmol/L	(3.9 - 6.7)
Creat	* 43	umol/L	(53 - 106)
T Protein	72	g/L	(63 - 79)

[redacted]

RF - FAMILY

068a-046-243

ALTNAGELVIN HOSPITAL
LABORATORY (TEL:3559/3379)

Lab Number : 1742
Doctor : MR K J S PANESAR

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALTNAGELVIN WARD 6**
Address : [redacted]
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Sodium	* 119	mmol/L	(135 - 145)
Potassium	* 3.0	mmol/L	(3.5 - 5.1)
Chloride	* 90	mmol/L	(96 - 108)
CO2	* 16	mmol/L	(22 - 28)
Urea	* 2.3	mmol/L	(2.5 - 6.5)
Glucose	* 9.9	mmol/L	(3.9 - 6.7)
Creat	* 44	umol/L	(53 - 106)
T Protein	71	g/L	(63 - 79)
Alk Phosphatase	* 158	U/L	(20 - 90)
Calcium	2.19	mmol/L	(2.10 - 2.6)
Phosphate	1.22	mmol/L	(0.60 - 1.50)
Albumin	41	g/L	(36 - 51)
Magnesium	* 0.59	mmol/L	(0.75 - 1.25)

[redacted]

RF - FAMILY

068a-046-244

ALTNAGELVIN HOSPITAL
LABORATORY (TEL:3559/3379)

Lab Number : 1633
Doctor : MR L A MCKINNEY
AH 01AE19050

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALTNAGELVIN AED**
Address : [redacted]
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST		RESULT	UNITS	(Range)
Sodium		137	mmol/L	(135 - 145)
Potassium		3.6	mmol/L	(3.5 - 5.1)
Chloride		107	mmol/L	(96 - 108)
CO2		22	mmol/L	(22 - 28)
Urea		4.8	mmol/L	(2.5 - 6.5)
Glucose	*	7.2	mmol/L	(3.9 - 6.7)
Creat	*	47	umol/L	(53 - 106)
T Protein		69	g/L	(63 - 79)

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068a-046-245

ALTNAGELVIN HOSPITAL
LABORATORY (TEL:3559/3379)

Lab Number : 5424
Doctor : MR K J S PANESAR

Name : **FERGUSON**
Forename : **RACHAEL**
Clinic/Ward : **ALT - INTENSIVE CARE UNIT**
Address : [redacted]
Hosp No. : **AH 313854**
D.O.B. : 04/02/1992

TEST	RESULT	UNITS	(Range)
Urine Sodium	90	mmol/L	(-)
Urine Potassium	27	mmol/L	(-)
Urine Chloride	73	mmol/L	(-)
Urine Urea	58	mmol/L	(-)
Urine Phosphate	-	mmol/L	(-)
Urine Magnesium	-	mmol/L	(-)
Urine Creatinine	* 6.86	mmol/L	(3 - 18)

[redacted]

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068a-046-246

ALTNAGELVIN HOSPITAL

Name	: FERGUSON, RACHAEL
Sex	: F
D.O.B.	: 04/02/1992
Hosp.No	: AH 313854
Source Loc	: ALTNAGELVIN HOSPITAL
Ward/Clinic	: WARD 6
Cons/GP	: MR R GILLILAND

Received : 08/06/2001
Lab.Ref : 0105206

Copy to :

Specimen : APPENDIX

Secretary :- COK

CLINICAL HISTORY:

Right sided abdominal pain of 6 hour duration and tenderness and guarding.
Peritoneal fluid reaction.

PATHOLOGIST'S REPORT:

Received a 6 cm long appendix which grossly appears normal. On section, there is a faecolith 1 cm from the proximal margin. (4 BL NTR).

Histology of the entire appendix confirms the presence of a faecolith and Gram Stains show Gram Positive Cocci within the faecal material. There is no mucosal ulceration in the sections examined and there is no acute inflammation within the mucosa. In a few sections, there are occasional eosinophils and an occasional polymorph within the muscle layer but no plasma cells are seen. The serosal surfae shows no acute inflammation.

DIAGNOSIS:

APPENDIX : FAECOLITH

BS

Signed: Crosbie Pathologist:DR J CROSBIE (Altnagelvin Hospita

Date : 19/06/2001 Histopathology Report WHSSB Dept. of Pathology

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068a-046-247

AFFIX LABEL OR ENTER (IN BLOCK LETTERS)

SURNAME Ferguson
FIRST NAME(S) Rachael
DATE OF BIRTH
HOSPITAL NO. AH 313854.

WESTERN HEALTH and SOCIAL SERVICES BOARD

Altnagelvin Group of Hospitals

INTENSIVE CARE

CLINICAL NOTES

DATE	
9/6/01	A. Date (Anaesth)
8.30.	fast bleeped to Ward 6 @
	~F/8yr. had appendicectomy ↓ GA the night before.
	-Had been vomiting during the day suddenly started twitching → had a convulsions → Airway & sats maintained but suddenly SaO_2 ↓ to 80s & stopped breathing
	On my arrival → pt was cyanosed SaO_2 ~ 70% Apnoeic.
	IPPV c bag & mask SaO_2 improved to ~ 80%
	but vomiting +
	∴ Intubated c No 6.0 cuffed tube → cuff +
	Copious dirty secretions → sucked out
↓ Na. ↓ Mg.	Rest of Mx → as per ward notes ↓ ng gastric tube +
	C.T. scan ? Subarachnoid haemorrhage.
	Neurosurgeons informed → want contrast C.T. scan to rule out

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068a-046-248

3/97/128

DATE

[redacted]

abscess in the brain
Taken back to the C.T scan
for contrast C.T Scan
↓
no new findings.
Neurosurgeon contacted →
Nothing surgical seen
on the scan
- Not for tx
- But for transfer to RBHSC
when bed available.

May contact Dr Hanna for
advice as for is on call for
paed neurology at RBHSC.

Back to ICU
On Dräger Ventilator Servo 300 ventilated
200 X 8 FiO_2 50%
SpO_2 100% Chest clear

HR → 93/- BP 105/62 S,S

U O/P → 100-400ml/hr
Na ↓

Plan:- for transfer to RBHSC when bed available
- ↑ Na gradually over 24 hrs
- Cefotaxime & benlen given
- IVF → 1000ml (N) saline } 40ml/hr.
+ 40mmol KCl

[redacted]

EVALUATION SHEET

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
			Ventilated — Fluids changed to 0.9% NACL			
			Sod @ 40ml HR.			
			1M MGSO4			
			2.4mg IV Cefotaxime. } 5am.			
			1.2 mg IV Benzylpenicillin given }			
			Catherized size 10 foley (5ml water)			
			CT Scan ordered			
			(Initially sub-achnoid haemor found			
			& evidence of ICP. — Transferred to			
			ICU 7am Ventilation commenced via			
			SERVO.			
			Repeat CT Scan. — taken 9am.			
			Obs. (See chart) stable:			
			GCS 3. — Unresponsive Pupils			
			Large fixed & dilated.			
			Bed available in Sick Children's RVH.			
			Rachael fully attended	Family informed		
			Aware of condition — RVH by Ambulance			
			& police escort. 11.10am.			
			Uneventful journey to Belfast ARRIVED 12.20 PM S/N [redacted]			
			Neg balanced IL Obs satisfactory			
			Hyperthermic. T 33.5 on departure @ RVH.			
			FBP COAG EP Bone Profile MgSO4 sent.			
			Results given & staff in Sick Childrens.			

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Hospital Number:

Ward:

HC5

068a-046-250

EVALUATION SHEET

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
9/6/01.	10.10pm		New patient age 9yrs Rel/R/C. from WD 6 at Tamar with history as follows.			
			- admitted to WD 6 on 7/6/01 c abdominal pain. No past medical history. S Appendicitis. Appendix removed Thursday night - mildly inflamed - No problems during op.			
			on 8/6/01 - no concerns - Vomited x 6-7 times during day - was able to walk. NO temps/ diarrhoea.			
			Check by nurses 3am - incont urine - unresponsive - tonic. seizure HR ↑ 160.			
			Recieved 5mg Diazepam P.R.			
			10mg IV diazepam. - Seizure lasted 15min			
			Bloods FBP/U+E/Ca/Mg/ Cultures taken.			
			4.10am. Very unwell. Pupils dylated. + unresponsive HR ↑ 160 min. Purp. Rash Petechia upper chest? 2° vomiting. ? Asp. SaO_2 98% Intuccally 98% 08L O_2. but sats ↓ quickly + became apnoeic. Intubated c Anaesthetist Size 6 ETT orally. (No drugs given prior to intubation).			

Fully attended Conducted by Fr Mullan

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068a-046-251

Rachael Ferguson

HC5

Hospital Number: Att. 313854

Ward: ICU

ALTNAGELVIN HOSPITALS HEALTH AND SOCIAL SERVICES TRUST
TRANSFER REFERRAL SHEET

Patient Name: RACHAEL FERGUSON Hospital No: AM 313854

Date of Admission: 7/6/01 Ward: Wd 6

Present Location: ICU

Principal diagnosis: INITIAL – APPENDICITIS
GERD ? MENINGITIS ? ENCEPHALITIS

Reason for Transfer: TO BELFAST ICU

Time of decision: 0900 (ON FIRMING)

Referring Consultant : DR. NESBITT

Receiving Consultant : DR. Crean

Results of Relevant Investigations: ? Sub. achroid haem.

Current Drug Therapy: 2·4 mg IV Cefotaxime } TDS.
1·2 mg IV Benzylpenicillin }
Nil else.

CHECKLIST:

Family informed: Yes / No

Was patient full attended: Yes / No

ITEMS TO BE SENT WITH PATIENT:

Case Notes: - Originals Yes / No
- Copies: Yes / No

Patients Belongings: Yes / No

X-Rays - Originals (Chest) Yes / No
- Copies Yes / No
CT X Rays (Not sent) Faxed up.

Signature: [signature] S/N

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068a-046-252

TRANSFER RECORD SHEET

Patients Name: RACHEL FERGUSON Hospital No: A64 313854

Date: 9th June 2001. Time of Departure : 11.10 am.

PATIENT INTERVENTION / MONITORS:

Tracheal Intubation:	Yes / (No)	Size of E.T.T.:	6.0
Ventilated (Manual)	Yes / (No)	Type of Ventilator:	Draeger Portable
(Mechanical)	(Yes) / [redacted]	Mode of Ventilation:	& IMV IPPV.
Central Venous Lines	Yes / (No)	C.V.P. Monitoring	Yes / (No)
E.C.G.	(Yes) / No	SAO_2	(Yes) / No
Blood Pressure (Direct)	Yes / (No)	ET CO_2	(Yes) / No
(Indirect)	(Yes) / No	Urinary Catheter	(Yes) / No
Chest Drain	Yes / (No)		

Time	11.10 AM	11.20 AM	11.30 AM	11.40 AM	11.50 AM	12 Mid.	12.10 PM	12.20 AM				
H.R.	105	105	104	103.	105.	103	103	104				
Rhythm	SR	SR	SR	SR.	SR	SR	SR	SR.				
B.P. (Cuff. NBP)	96/47	92/47	94/50	93/47	98/50	97/45	97/46					
C.V.P.	N/A	N/A.	N/A	N/A.	N/A.	N/A	N/A	N/A				
SAO_2	100%	100%	100%	100%	100%	100%	100%	100%				
Insp. O_2												
Resp. Rate	10.	10	10	10	10	10	10					
Tidal Volume	200	200	200.	200.	200	200	200.					
Airway Press.	+18	+16	+16	+16	+16	+16	+16					
Peep cms H_2O	+2	+2	+2	+2	+2	+2	+2					
ET CO_2	34	34	34	34	34	33.	35.					
PUPILS	E	E	E	E	E	E	E					
Right Size	7	7	7	7	7	7	7					
Right Reaction	F	F	F	F	F	F	F					
Left Size	7	7	7	7	7	7	7					
Left Reaction	F	F	F	F	F	F	F					

SIZE OF PUPIL

1 .
2 .
3 ●
4 ●
5 ●
6 ●
7 ●
8 ●

FLUID	VOL.	STARTED AT	RATE	SIGNATURE
NACL + KCL	1L	9 am	Hourly	[redacted]

DRUG	DOSE	TIME	SIGNATURE

Time of Arrival: 12.20 pm.

Tick if journey uneventful : ✓

Any Important Episode of: Desaturation Hypotension Arrhythmia Hypertension Other

If Yes, Please elaborate:

Evaluation:

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068a-046-253

Signature

ALTNAGELVIN AREA HOSPITAL
DIAGNOSTIC IMAGING DEPT.

REQUEST TO THE RADIOLOGIST

O/P Ward ..... Consultant Gillibrand / MARKEY

STATUS
NHS ☐
Private ☐
Non U.K. ☐
Cat II ☐

To Avoid Shortcoming: This Section Must Be Completed

Name of Patient (In Block) ... FERGUSON RACHAEL

Address ... [redacted]

D.O.B. ... 4.12.92 Hos. No. ... AH3138554

Date of Last X-Ray ... 8.6.01

OBLIGATORY

L.M.P. ☐☐☐☐

Ignore A Possible Pregnancy

Yes No

Examination Requested

X ray chest

Date ... 9.6.01 ... Doctor's Signature ... ondoit

Clinical Data

POST APPEN DICECTOMY
RESPIRATORY COLLAPSE
~~?~~
CEREBRAL EVENT ? NATURE

For Departmental Use Only

Appointment For: ☐☐☐

Room: Portable.

Films Used: 35 x 43 | 30 x 40 | 35 x 35 | 24 x 30 | 18 x 24

Others: 64kV. 1.6mAs. Supine.

Radiographer: AF/LEC.

Checked

LPC 9/87/039

XRR. 17

84 043

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068a-046-254

Intensive Care Unit
MR. R. GILLILAND
DR EM ASHENHURST

SURNAME	**FERGUSON**
FORENAME(S)	**RACHAEL**
CASENOTE	AH 313854
UPCI	
D.O.B./SEX	04-FEB-1992 FEMALE
DATE TYPED	11-JUN-01 VW
DICTATED	11-JUN-01 12:32

ENHANCED CT SCAN OF BRAIN 09-JUN-01 08:51
Diagnostic Code

unenhanced and enhanced scans were performed.
Hyperdensity is noted in relation to the meninges and there is loss of definition of the basal cisterns in keeping with raised intra-cranial pressure.
The grey white matter differentiates and is preserved.
Following contrast injection there is no interval change.
In particular, as requested a sub-dural empyema has been excluded.
I have discussed this case with Dr Steven McKinstry, who feels that appearances are more in keeping with cerebral oedema which is highlighting the meninges and normal structures.

CONTINUE...

Dr. C.C.M. Morrison Consultant Radiologist
09-JUN-01 ALTNAGELVIN HOSPITAL
ENHANCED CT SCAN OF BRAIN

Intensive Care Unit
MR. R. GILLILAND
DR EM ASHENHURST

SURNAME	**FERGUSON**
FORENAME(S)	**RACHAEL**
CASENOTE	AH 313854
UPCI	
D.O.B./SEX	04-FEB-1992 FEMALE
DATE TYPED	11-JUN-01 VW
DICTATED	11-JUN-01 12:32

CONT/
A sub-arachnoid haemorrhage is therefore unlikely.

Dr. C.C.M. Morrison Consultant Radiologist
09-JUN-01 ALTNAGELVIN HOSPITAL
ENHANCED CT SCAN OF BRAIN

RF - FAMILY

Altnagelvin Hospitals Trust

Episodic Care Plan Print for RACHAEL FERGUSON (AH 313854)

Printed on 12.06.01 at 3:18 pm

Start date : 07.06.01 Start time : 00:00

End date : 10.06.01 End time : 23:59

Name : **RACHAEL FERGUSON (AH 313854)**

GP Name : DR E.M. ASHENHURST

Address : WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY
BT47 1AU

NHS No. :
Religion : [redacted]
D.o.B. : 04 Feb 92 (9yrs) Sex : Female

Admission Date : 07 Jun 01
Discharge Date : 10 Jun 01

Ward : CHILDRENS UNIT (CHW)
Consultant : MR ROBERT GILLILAND (RG)
Sp lty : GENERAL SURGERY (SUR)
Originator : SN DAPHNE PATTERSON

Planned Discharge Date : -

Named Nurse : SN DAPHNE PATTERSON

Date Effective : 07 Jun 01

Problems/Expected Outcomes	Actions
Pain (Actual) To provide optimum pain control 07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON Evaluation: Carry care forward, review on - ADMITTED WITH SUDDEN ONSET OF ABDOMINAL PAIN ,SEEN BY SHO IN A&E AND BLOODS TAKEN FOR FBP AND IV CANULA INSERTED ,CYCLOMORPH GIVEN IN A&E AT 8.20PM FOR PAIN ,ON ADMISSION TO WARD COMPLAINING OF ONLY SLIGHT PAIN -FASTING ,FOR THEATRE THIS PM ,CONSENT FORM SIGNED AND SEEN BY ANTHETISIST Nurse Id: SN DAPHNE PATTERSON	Assess/record location & severity of pain Nurse Id: SN DAPHNE PATTERSON Position child comfortably Nurse Id: SN DAPHNE PATTERSON Nurse child in quiet environment Nurse Id: SN DAPHNE PATTERSON Take & record vital signs every ... Nurse Id: SN DAPHNE PATTERSON Take & record vital signs 4 hourly Nurse Id: SN DAPHNE PATTERSON Administer medication as prescribed Nurse Id: SN DAPHNE PATTERSON Assess pain following medication Nurse Id: SN DAPHNE PATTERSON Encourage parental participation in care Nurse Id: SN DAPHNE PATTERSON

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Problems/Expected Outcomes	Actions
Pain (Actual) To provide optimum pain control	
	Report changes in severity to doctor Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - WENT TO THEATRE AT 11.10PM FOR APPENDICECTOMY ,PAIN RELIEF GIVEN IN THEATRE -CYCLOMORPH AND FENTANYL GIVEN AND VOLTEROL AND PARACETAMOL GIVEN AT 11.40PM ,NO COMPLAINTS OF PAIN SINCE RETURN TO WARD Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 NO CO PAIN TO DATE. SEEN BY DR THIS AM AND TO HAVE SIPS OF FLUIDS AS TOLERATED. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 CHILD CONTINUED TO COMPLAIN OF HEADACHE LAST PM. PR PANADOL GIVEN WITH APPARENT EFFECT AND CHILD SETTLED TO SLEEP. NO COMPLAINTS OF ABDOMINAL PAIN. Nurse Id: SN ANN MARIE NOBLE	
Parental anxiety (Actual) To minimise anxiety and promote parental presence	
06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Promote open visiting for parents Nurse Id: SN DAPHNE PATTERSON
	Keep parents informed of investigations Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - PARENTS PRESENT ON ADMISSION AND SPOKEN TO BY DR IN A&E AND NURSING STAFF, ALL CARE EXPLAINED Nurse Id: SN DAPHNE PATTERSON	Keep updated on child's progress/treatment Nurse Id: SN DAPHNE PATTERSON
	Encourage talks with medical & nursing staff Nurse Id: SN DAPHNE PATTERSON
	Provide positive reassurance when needed Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Parental anxiety (Actual) To minimise anxiety and promote parental presence 08.06.01 05:00 Carry care forward, review on - PARENTS STAYED OVERNIGHT AND ALL CARE EXPLAINED Nurse Id: SN DAPHNE PATTERSON 08.06.01 17:00 Carry care forward, review on 08.06.01 PARENTS PRESENT AND SPOKEN TO BY DR THIS AM, APPEARS HAPPY WITH THE PLAN OF CARE. Nurse Id: SN MICHAELA MC CAULEY 09.06.01 06:00 Carry care forward, review on 09.06.01 PARENTS CONTACTED EVENTUALLY AS NOT ANSWERING TELEPHONE AND INFORMED OF CHILD,S CONDITION. DAD SPOKEN TO BRIEFLY BY PAEDIATRIC REG AND INFORMED OF CHILD,S ILL CONDITION. MUM INFORMED AND ALSO PRESENT ON TRANSFER. SPOKEN TO BY PAEDIATRIC CONSULTANT DR MC CORD. BOTH APPEAR UPSET. Nurse Id: SN ANN MARIE NOBLE	Encourage parents to voice their opinions Nurse Id: SN DAPHNE PATTERSON Encourage parents to continue giving care Nurse Id: SN DAPHNE PATTERSON Record information given to parents Nurse Id: SN DAPHNE PATTERSON
Child & parents education re:condition (Actual) Child & parents will understand condition & care 07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON Evaluation: Carry care forward, review on - ALL CARE AND TREATMENT EXPLAINED TO PARENTS Nurse Id: SN DAPHNE PATTERSON	Provide relevant literature to read Nurse Id: SN DAPHNE PATTERSON Encourage talks with medical staff Nurse Id: SN DAPHNE PATTERSON Utilise visual aids available for education Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Child & parents education re:condition (Actual) Child & parents will understand condition & care	Encourage questions Nurse Id: SN DAPHNE PATTERSON Ensure that plan of care is understood Nurse Id: SN DAPHNE PATTERSON Keep updated on changes in care & reason why Nurse Id: SN DAPHNE PATTERSON Document information given to child/parents Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 ALL CARE EXPLAINED AND NO CONCERNS EXPRESSED. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 SEE PREVIOUS PROBLEM. PARENTS SPOKEN TO RE CONDITION AND PREPARED FOR WHAT TO EXPECT BY DR MC CORD Nurse Id: SN ANN MARIE NOBLE	
R... of dehydration (IV fluids insitu) (Actual) Maintain adequate hydration	Check prescribed fluids Nurse Id: SN DAPHNE PATTERSON Set rate & flow as prescribed Nurse Id: SN DAPHNE PATTERSON Inspect infusion rate hourly Nurse Id: SN DAPHNE PATTERSON Encourage oral fluids, record Nurse Id: SN DAPHNE PATTERSON
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	
Evaluation: Carry care forward, review on - COMMENCED ON NO 18 SOLUTION RUNNING AT 80MLS PER HR Nurse Id: SN DAPHNE PATTERSON	

Problems/Expected Outcomes	Actions
Risk of dehydration (IV fluids insitu) (Actual) Maintain adequate hydration	Reduce IV fluids accordingly Nurse Id: SN DAPHNE PATTERSON Keep parents informed Nurse Id: SN DAPHNE PATTERSON Encourage parental participation Nurse Id: SN DAPHNE PATTERSON Record fluid balance chart daily Nurse Id: SN DAPHNE PATTERSON Manage IV set as per procedure Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - IV FLUIDS -NO 18 SOLUTION RUNNING AT 80MLS PER HR OVERNIGHT Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on 08.06.01 IV FLUIDS NO. 18 SOLUTION RUNNING AT 80MLS/HR. TOLERATING SMALL SIPS OF WATER. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 TRANSFERRED WITH NACL 0.9% AT 40MLS/HR HAD BEEN ON SOLUTION 18 AT 80MLS/HR. Nurse Id: SN ANN MARIE NOBLE	
Risk of infection due to IV cannula (Potential) Prevent infection at venflon site	IV cannula to be inserted as hospital policy Nurse Id: SN DAPHNE PATTERSON Complete cannula chart 1 hourly (if in use) Nurse Id: SN DAPHNE PATTERSON
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	
Evaluation: Carry care forward, review on - IV CANULA INSERTED IN LEFT ARM	

Problems/Expected Outcomes	Actions
Risk of infection due to IV cannula (Potential) Prevent infection at venflon site	
Nurse Id: SN DAPHNE PATTERSON	Complete cannula chart 4 hourly(not in use) Nurse Id: SN DAPHNE PATTERSON
08.06.01 05:00 Carry care forward, review on - IV CANULA REMAINS INSITU ,SAME PATENT AND SITE SATISFACTORY Nurse Id: SN DAPHNE PATTERSON	
08.06.01 17:00 Carry care forward, review on - IV CANNULA REMAINS INSITU, SITE APPEARS SATISFACTORY. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 IV CANNULAS X 2 IN PLACE AND ARTERIAL LINE IN LEFT WRIST BY ANAESTHETIST. TRANSFER TO CT AND ICU ARRANGED BY DR,S. Nurse Id: SN ANN MARIE NOBLE	
Pre-operative care (Actual) To prepare patient both physically & psychologically	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Orientate child to ward Nurse Id: SN DAPHNE PATTERSON
	Give information on pre/post operative care Nurse Id: SN DAPHNE PATTERSON
	Take & record vital signs (baseline) Nurse Id: SN DAPHNE PATTERSON
	Take & record weight & urinalysis Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on - FASTING ,CONSENT FORM SIGNED , FOR THEATRE LATER TONIGHT Nurse Id: SN DAPHNE PATTERSON	Ensure consent signed and charted Nurse Id: SN DAPHNE PATTERSON
	Fast for @least 4 to 6 hours before surgery Nurse Id: SN DAPHNE PATTERSON

RF - FAMILY

Problems/Expected Outcomes	Actions
Pre-operative care (Actual) To prepare patient both physically & psychologically 08.06.01 05:00 Carry care forward, review on - WENT TO THEATRE AT 11.10PM Nurse Id: SN DAPHNE PATTERSON 08.06.01 17:00 Carry care forward, review on 08.06.01 Nurse Id: SN MICHAELA MC CAULEY 09.06.01 06:00 Achieved, CHILD WENT TO THEATRE AND RETURNED POST REMOVAL OF MILDLY INFAMMED APPENDIX Nurse Id: SN ANN MARIE NOBLE	Provide clean theatre gown & bedlinen Nurse Id: SN DAPHNE PATTERSON Remove prosthesis/jewellery Nurse Id: SN DAPHNE PATTERSON Affix Emla cream Nurse Id: SN DAPHNE PATTERSON
Requires investigation of abdominal pain (Actual) Find cause of abdominal pain 0[illegible].06.01 23:00 Nurse Id: SN DAPHNE PATTERSON Evaluation: Carry care forward, review on - BLOODS TAKEN FOR FBP ,Hb 11.7,WCC 9.06 Nurse Id: SN DAPHNE PATTERSON	Keep child fasting ,until instructed Nurse Id: SN DAPHNE PATTERSON Prepare child for x-rays as ordered Nurse Id: SN DAPHNE PATTERSON Obtain urine for urinalysis and M.S.U. Nurse Id: SN DAPHNE PATTERSON Obtain urine for I.C.O.N (females) Nurse Id: SN DAPHNE PATTERSON Reassure parents, involve in care Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Requires investigation of abdominal pain (Actual) Find cause of abdominal pain	
08.06.01 17:00 Carry care forward, review on 08.06.01 NO FUTHER INVESTIGATIONS REQUIRED. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Achieved, CAUSE OF PAIN IDENTIFIED Nurse Id: SN ANN MARIE NOBLE	
Post surgery-at risk of complications (Potential) To reduce risk and ensure an uneventful recovery	
07.06.01 23:00 Nurse Id: SN DAPHNE PATTERSON	Nurse in recovery position until alert Nurse Id: SN DAPHNE PATTERSON
Evaluation: Carry care forward, review on Nurse Id: SN DAPHNE PATTERSON	Take/record vital signs 1/4 hourly X 2 hours Nurse Id: SN DAPHNE PATTERSON
	Take/record vital signs 1/2 hourly X 2 hours Nurse Id: SN DAPHNE PATTERSON
	Take/record vital signs 1 hourly X 2 hours Nurse Id: SN DAPHNE PATTERSON
	Take/record vital signs 2-4hourly - stable Nurse Id: SN DAPHNE PATTERSON
	Observe/record colour/level of consciousness Nurse Id: SN DAPHNE PATTERSON
	Observe/record urinary output Nurse Id: SN DAPHNE PATTERSON
	Ensure bowel motion within 2 - 3 days Nurse Id: SN DAPHNE PATTERSON
	Explain all procedures - answer questions Nurse Id: SN DAPHNE PATTERSON

Problems/Expected Outcomes	Actions
Post surgery-at risk of complications (Potential) To reduce risk and ensure an uneventful recovery	
08.06.01 05:00 Carry care forward, review on - RETURNED FROM THEATRE AT 1.55AM FOLLOWING REMOVAL OF MILDLY CONGESTED APPENDIX ,FIRST DOSE OF IV FLAGYL GIVEN IN THEATRE TO HAVE FLAGYL SUPPOSITORIES AS PRESCRIBED , OBSERVATIONS SATISFACTORY OVERNIGHT ,HAS NOT PASSED URINE AS YET ,REMAINS FASTING Nurse Id: SN DAPHNE PATTERSON	
08.[redacted]1 17:00 Carry care forward, review on 08.06.01 OBSERVATIONS APPEAR SATISFACTORY, CONTINUES ON PR FLAGYL. VOMIT X 3 THIS AM BUT TOLERATING SMALL AMOUNTS OF WATER THIS EVENING. Nurse Id: SN MICHAELA MC CAULEY	
09.06.01 06:00 Carry care forward, review on 09.06.01 CHILD CONTINUED TO VOMIT AND BE NAUSEATED. VOMITED COFFEE GROUNDS X 2. DR CONTACTED AND IV VALOID GIVEN WITH EFFECT. CONTINUED ONPR FLAGYL. AROUND 3 AM CHILD WAS NOTED TO BE RESTLESS AND HAD BEEN INCONTINENT. SHE THEN BECAME STIFF WITH HANDS DRAWN UP AND FISTS CLENCHED. PAEDIATRIC SHO CALLED AND PR DIAZEPAM 5MGS GIVEN WITH LITTLE EFFECT. 10MGS DIAZEMULS GIVEN IV WITH EFFECT AND SURGICAL JHO CONTACTED. BLOODS TAKEN FOR EP, CA AND MG. ECG CARRIED OUT. CHILD STILL AGITATED. HEART RATE FLUCTUATING FROM 78 TO 145BPM. DR INFORMED. NURSED ON SIED WITH O2 VIA FACE MASK AT 15L/MIN. UNRESPONSIVE BUT PERL.BM 9.6MMOLS. PAEDIATRIC REG CONTACTED AND DR MC CORD CONSULTANT. DETERIORATED VERY QUICKLY AND CHILD INTUBATED BY ANESTHETIST SIZE 6.0 ET TUBE IN SITU. COVERED WITH IV CLAFORAN AND BEN Nurse Id: SN ANN MARIE NOBLE	

Problems/Expected Outcomes | Actions

Named Nurse Details

07.06.01 3895

End of printout

RF - FAMILY

068a-046-265

Altnagelvin Hospitals Trust

Front Assessment Print

Printed on 12.06.01 at 3:17 pm

Name : RACHAEL FERGUSON (AH 313854)

Address : [redacted]

NHS No. :

Religion : [redacted]

D.o.B. : 04 Feb 92 (9yrs) Sex : Female

Ward : CHILDRENS UNIT (CHW)

Consultant : MR ROBERT GILLILAND (RG)

Specialty : GENERAL SURGERY (SUR)

Originator : SN DAPHNE PATTERSON

Name Nurse : SN DAPHNE PATTERSON

GP Name : DR E.M. ASHENHURST

Address : WATERSIDE H.C.
GLENDERMOTT ROAD
LONDONDERRY
BT47 1AU

Admission Date : 07 Jun 01

Discharge Date : 10 Jun 01

Planned Discharge Date : -

Date Effective : 07 Jun 01

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Preferred name : [RACHEL]

Type of admission : [EMERGENCY]

Mother & Father's name : [RAYMOND AND MARIE FERGUSON]

Mother & Father's telephone number : [redacted]

Baptised? : [Yes]

Reason for admission : [SUDDEN ONSET OF ABDOMINAL PAIN AT 4.30PM CENTRAL AND RIGHT SIDED]

Past Medical History : [NONE]

Relevant family illness : [NONE]

Medication on admission : [NONE ,CYCLOMORPH 2MG IV AT 8.20PM IN A&E]

Allergies : [NONE KNOWN]

Guthri : [Yes]

Bi[illegible] Place : [ALT]

Ge[illegible]tion : [F/T]

Type of Delivery : [N/D]

Birth Weight : [7LBS 5OZ]

Vaccinations : [UP TO DATE + MEN C]

Infectious disease contact in last 3wks : [No]

If Yes, please specify? : [_____]

RF - FAMILY

068a-046266

Ward : CHILDRENS UNIT Assessment sheet : PAEDIATRIC ASSESSMENT

Siblings : [redacted]
Who does child live with? : [redacted]
Support services prior to admission : [redacted]
Name of Health Visitor : [_____]

Breathing : [NORMAL]
Comment on Breathing Pattern : [_____]
[_____]

Temperature(celsius) : [36.6]
Pulse (beats per minute) : [93]
Respirations (per minute) : [2]
Blood Pressure : [103/61]
Level of consciousness, on admission : [ORIENTATED]
Emotional level on admission : [TALKATIVE]

Weight on Admission : [25KG]
Eating & Drinking : [ORDINARY DIET]
Type of Milk : [COWS MILK]
Type of Food : [NORMAL]
Comment on Eating Pattern : [FUSSY]
Drinks from? : [CUP]

Toileting Pattern : [TOILET]
Urinary problems : [NONE]
Urinalysis : [_____]
Faecal Pattern : [NO PROBLEMS]

Assistance with ADL's : [_____]
[_____]
[_____]
[_____]

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Communication - Right Ear : [GOOD]
Communication - Left Ear : [GOOD]
Eye sight - Right Eye : [GOOD]
Eye sight - Left Eye : [GOOD]
Wears Spectacles? : [No]
Speech : [GOOD]

Usual sleep pattern : [SLEEPS 10PM -7AM]
Favourite Toy/Dummy/Comforter? : [_____]
Valuables/Comforters taken home? : [No]

Mobility prior to admission : [INDEPENDENT WITH SUPERVISION]
Comments on Mobility : [_____]
[_____]
Skin Condition : [INTACT]
Comment on skin condition : [_____]
[_____]
Splints,pressure garments,specialaids? : [_____]

Reaching Normal Milestones? : [Yes]
Comments on Milestones : [_____]
[_____]
Additional information : [_____]
[_____]
Identification armband insitu? : [Yes]
If not, why ? : [_____]

Visiting Times Explained? : [Yes]
nts staying overnight? : [Yes]
Visiting problems eg no car : [_____]
Ward Information Booklet Given? : [Yes]
No smoking policy explained? : [Yes]

Security System explained? : [Yes]
Play therapist explained? : [Yes]
School teacher explained? : [Yes]
Any person shouldn't get information? : [_____]

Ward : CHILDRENS UNIT

Assessment sheet : PAEDIATRIC ASSESSMENT

Information obtained from? : [PARENTS]

Information obtained by? : [DPATTERSON]

End of printout