PAEDIATRIC INTENSIVE CARE UNIT - R.B.H.S.C.

HOSP. NO:

SURNAME: ROBERTS

FIRST NAME: CLAIRE

NAMES TO BE CALLED:

CHILD'S ADDRESS: [redacted]

TELEPHONE NO: [redacted]

AGE: 9 10/12

D.O.B: 10-01-87

BIRTHWEIGHT:

RELIGION: [redacted] BAPTIZED: YES / NO

NEXT OF KIN: Mother - Jennifer Roberts

RELATIONSHIP TO CHILD: Parents

ADDRESS:

As above

TELEPHONE NOS. [redacted]

WORK: HOME [redacted]

WITH WHOM DOES THE CHILD RESIDE:

As above

RELATIONSHIP TO CHILD:

WHO HAS PARENTAL RESPONSIBLITY FOR THIS CHILD:

Mum - Dad

TELEPHONE NO:

NAME OF SCHOOL/PLAYGROUP/NURSERY:

Tor Bank Special School

(Downpatrick)

DATE: 23-10-96 TIME:

REASON FOR ADMISSION:

Respiratory Arrest

ACCOMPANIED BY: Nurse · Doctor

WHY DO THE PARENTS THINK THE CHILD HAS BEEN ADMITTED:

Due to Respiratory Arrest and needing further care.

MEDICAL DIAGNOSIS:

? Viral

PREVIOUS RELEVANT HISTORY/ADMISSIONS:

Mental Handicap

Severe learning difficulties.

Epilepsy (No seizures in past 3 yrs)

No hospital admissions for approx 8 yrs.

Admissions as baby + toddler with seizures.

CONSULTANTS:

DR Steen

CR – RVH

PARENT(S) CARER(S) RESIDENT: [redacted]

WHERE: [redacted]

LIKES TO BE KNOWN AS: [redacted]

DO THEY WISH TO PARTICIPATE IN THE CARE OF THE CHILD?

Yes as far possible

SOCIAL ARRANGEMENTS:

Parents staying in Room 2.

NAME AND AGE OF SIBLINGS:

[redacted]

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Combes. Hill.

TELE. NO:

NAME OF HEALTH VISITOR:
ADDRESS:

TELE NO:

SOCIAL WORKER / OTHER CONTACTS:

IMMUNISATION	DATE OR AGE ADMINISTERED
DIP	1ST.....
TET	2ND.....
PERT	3RD.....
MEASLES / MEASLES / RUBELLA	YES / NO
BOOSTER DIP TET POLIO (PRE SCH)	YES / NO
B.C.G ADMINISTERED	.....

DATE OF LAST TETANUS
see chart for date

None known

ALLERGIES:

None known

CURRENT MEDICATIONS AND METHOD OF ADMINISTRATION:

ANY LOOSE TEETH:

OTHER PROSTHESIS:

SIGNATURE OF NURSE TAKING HISTORY:

DATE:

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WARD FACILITIES - TICK BOX WHEN EXPLAINED TO PARENTS:

PARENTS ACCOMODATION WITH NO SMOKING POLICY	☐
PARENT INFORMATION	☐
PARENT SHOWER / TOILET FACILITIES	☐
TELEPHONE	☐
DINING ROOM FACILITIES	☐
SOCIAL WORKER	☐

PAEDIATRIC INTENSIVE CARE UNIT PATIENT ASSESSMENT

NAME :- Claire Roberts **DoB:-** **HOSP. No.:-** 328770 **DATE & TIME:-** 22/10/96 7am **NURSE'S SIGN:-** S[illegible]

RESPIRATORY

Had respiratory arrest in Allen Wd.
Being bagged on admission

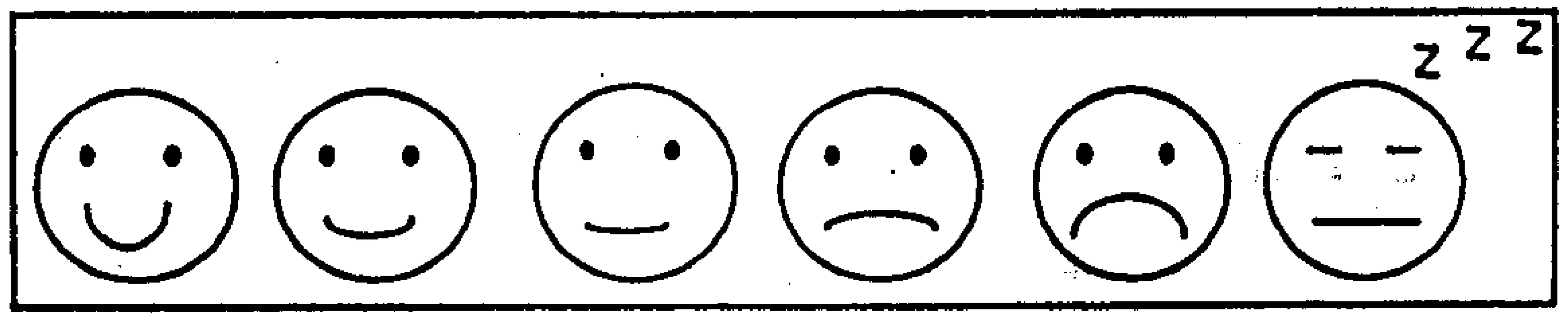
On admission

Maintaining own airway	:- Yes/No (No circled)
Method	:- Self/oral airway/ET tube/tracheostomy (ET tube circled)
Size & length of tube	:- 7
O2 Therapy	:- Yes/No (Yes circled)
Method	:- Facemask/headbox/ventilator/T-piece — Bagging
Secretions	:- Type & amount
Specimen to lab.	:- Yes/No (No circled)

PAIN/SEDATION

On admission

Pain relief	:- Yes/No (No circled) - Sedation/analgesia/paralysis
Mode	:- PCA/infusion/epidural/ oral or rectal preparation/intermittment



Use pain scale if appropriate

CARDIOVASCULAR

On admission

Colour/perfusion	:- Pallor/cyanosis/well perfused (Pallor circled)
Cardiac rate	:- Bradycardic/tachycardic/ normal (normal circled)
Cardiac rhythm	:- Sinus rhythm/arrthymia (Sinus rhythm circled)
Blood pressure	:- Hypotensive/hypertensive/normal (Hypotensive circled)
Drug therapy	:-
Pacing wires insitu	:- Yes/No (No circled)
Pacing box	:- Sensing/pacing

NEUROLOGY

GCS 3.

On admission

CNS status	:- Conscious/unconscious/irritable/drowsy (unconscious circled)
Coma scale	:- 3
ICP monitor	:- Yes/No (No circled) - Type ....

Temperature:- 37 Heart Rate:- 140 Respirations:- 18 Blood Pressure:- 89/51 Weight:- 25 kgs.

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NUTRITION / HYDRATION

On admission

Nil By Mouth :-

Type of fluids insitu :- Midazolam infusion

B.M. Stix :- 4

Central line sites :- Day No:

Peripheral line sites :- Rt subclavian Day No:

Arterial line site Rt dorsal. Day No: 1

Nasogastic tube insitu :- Yes/No

Gastrostomy tube insitu :- Yes/No

ELIMINATION

Urinary Catheter Size
inserted
22/10/96.

On admission

Catheterised :- Yes/No Catheter Size:- Day No:

Urinalysis :-

Date of last bowel motion :-

Wound Drain :- Yes/No Site:- Day No:

P.D. Cannula :- Yes/No

Chest Drain :- Yes/No Site:- Day No:

Colostomy :- Yes/No

Ileostomy :- Yes/No

HYGIENE/MOBILITY/WOUND CARE

On admission

Skin Intact :- Yes/No

Sites of (1) Wounds.....

(2) Skin Breaks/Pressure Sores.....

(3) Condition of Mouth.....

(4) Condition of Eyes.....

(5) Condition of Hair/Nails.....

Paralysed :- Yes/No

Spontaneous Movements :- Yes/No

Any Immobilising Injuries /Fractures :- Yes/No

Site/s :-

PSYCHOLOGICAL/SOCIAL/CULTURAL.

learning difficulties
Epileptic

On admission

Comforter :- Yes/No

Toys :- Yes/No

Religion :-

Baptised :- Yes/No

CIRCUMSTANTIAL

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NAME: Claire Roberts **HOSP. No.** 328770 **INTENSIVE CARE UNIT** Paeds **DATE:** 22/10/96

SUMMARY: 9½ yr old girl with learning difficulties and Epileptic admitted to Allen Wd 32 hrs ago with ↓ level of consciousness due to ? aetiology. Had sudden respiratory arrest at 3am 22/10/96. CT Scan showed severe swelling.

I PHYSICAL — ASSESSMENT OF CONDITION/NEEDS	GOALS AND PLANNED CARE
(A) Respiratory (1) 2 3 4 5	(1) 2 3 4 5
No spontaneous respirations Needs ventilatory support. 62% O2. BPM 15 Pressures 20/3. Secretions minimal.	* Care of ventilated patient * To maintain blood gases within normal limits Suction 3-4 hrly.
(B) Cardiovascular (1) 2 3 4 5	(1) 2 3 4 5
Hypotension Dopamine infusion running. Temperature low	Requires dopamine to maintain blood pressure ↑ 100 Record B/P, HR, hrly.
(C) Pain/Sedation (1) 2 3 4 (5)	(1) 2 3 4 (5)
NIL.	Keep patient pain free.
(D) Neurolgy (1) 2 3 4 5	(1) 2 3 4 5
GCS 3. No response at all. Pupils size 7 and not reacting to light.	Record CNS observations hrly. Report any sign of seizure activity.

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

Nil orally.
NL saline running IV 80mls hrly.
KCL infusion running 4mls hrly.

To maintain U+E within normal limits
Record intake hrly

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

Passing urine well. Catheterized Size 12 catheter.
NBO

Record output hrly. Report any excess in amount of urine passed hrly.
Test Urine 4hrly.
* Care of catheterised patient ⊕

(G) Hygiene/Mobility/ Wound Care	1	(2)	3	4	5		1	(2)	3	4	5

~~[illegible]~~ ~~[illegible]~~ ~~[illegible]~~ Skin intact.

* Eye care *
* Mouth care *
Turn patient 2hrly

II PSYCHOLOGICAL AND SOCIAL/CULTURAL	1	2	3	4	5		1	2	3	4	5

Family present.

III CIRCUMSTANTIAL

23/10/96

[redacted]
Clare Roberts

MORNING: 8am – 2pm.	EVENING: 2pm - 6^{15}pm.	NIGHT:
(A) Ventilation changes as per cardex. Secretions moderate and minimal.	(A) Ventilation as per chart.	
(B) B/P ↓ at times 200mls HPPF given further 600mls HPPF given. Temperature remains low. Nursed on heating blanket.	(B) B/P ↓ at 2pm. 150mls HPPF given. Temperature ↑ 37^{5} on heating blanket.	
C) Remains pain free.	(C) No change	
D) GCS 3. No response. Pupils 7 not reacting to light	(D) No change.	
E) I.V. fluids as per chart.	(E) IV fluids changed to 5% N SALINE	
F) Urine excess. Commenced on DDVP infusion [illegible]. N.B.O.	(F) Urine output decreased.	
(G) All care given	(G) All care given.	
SIGNATURE:	SIGNATURE: A. Walker	SIGNATURE:

CP1.FORMS

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MORNING:	EVENING: 2pm - 6.15pm	NIGHT:
	(1) Brainstem test carried out.	
	Deceased 6.15pm.	
	Death certificate issued	
	For P.M. in am. Consent signed.	

SIGNATURE: SIGNATURE: SIGNATURE:

CP1.FORMS

Clan Roberts

MORNING:	EVENING:	NIGHT: 22/10/96.
		Admitted from Allenvale at 3am following respiratory arrest. Intubated and ventilated. Went to CT scan which showed diffuse swelling. Brain stem tests x 1 positive. ? for organ donation.

SIGNATURE: | SIGNATURE: | SIGNATURE:

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NAME CLAIRE ROBERTS HOSP. NO. 328770 D.O.B. 10 - 01 - 87

PERIPHERAL LINE		CENTRAL LINE		ARTERIAL LINE	
DATE of INSERTION	SITE	DATE of INSERTION	SITE	DATE of INSERTION	SITE
23/10/96	Rt arms.	23/10/96	Rt. Jugular.	23/10/96	Rt Dorsal