ERN 123000
BABY CRAWFORD
LUCY
[redacted]
05/11/1998 WARD/OPD

Referral to Crae Hospital Date 12.4.20

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
Floppy Not drinking

o/e Temp 38°
Mucosa moist

Provisional Diagnosis:

Past History: Recent Throat -
CVS - RS - Abd

Present Medication:

Known Allergies: ? UTI
Needs fluids

Other Relevant Information:

DOCTOR'S OR PRACTICE STAMP

DR C Connell
Emmadville

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

Paediatric Admission

Date: 12/9/02 Time: 19.30 Name: LUCY.
Consultant: Dr. O'Donohue DOB: 15-1-1998
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 drinks. She passes stool normally.
Now for the past 12 hours she is very sleepy.
no H/O rash, convulsion or cough.

Past Medical History: [redacted]
Pregnancy and Gestation:
Delivery: [redacted]
Birth Weight:
Admission to Neonatal Unit: none.
Method of Feeding / Age of Weaning: [redacted]
Pervious Hospital Admissions: [redacted]
Serious Illness and Systemic Review: [redacted]

Immunisation:

	1st	2nd	3rd	pre-school
Diphtheria/Tetanus	✓	✓	✓	
Whooping cough	✓	✓	✓	
Polio	✓	✓	✓	
Hib	✓	✓	✓	//////////////////
MMR	✓	//////	//////	
TB (BCG)		//////	//////	//////////////////
Meningococcal-C				

Other Vaccinations:.....

.....

.....

Infectious diseases:

Medication:

Drug:	Dose	Frequency:	Mode of Delivery:
Calpol	PRN.		

Allergies:.....none that aware of.....

[redacted]

EXAMINATION

General look: Conscious + Pink Weight 9.14 kg.

Temp: 38.°C HR: 140/min RR: 40/min Height:.....

Head circumference:.....

Capillary refil >2 Seconds.

E/1/X

ERNE HOSPITAL

SURNAME	FIRST NAME(S)	HOSPITAL NO.
CRAWFORD	LUCY.	123003

CONTINUATION SHEET

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

LPC 3/86/024

DATE

≈ 0330

BS ~~BMA~~ 100 on BBg. / Capillary refill < 2 secs. Pulse easily felt. Pupils dilated + unresponsive.

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

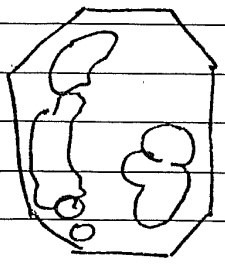
Dextrostix = 12 ∴ ~~NAD~~ normal saline.

D/W Dr Mc Keague RUH
- for transfer - ? cause of respiratory arrest
? Post convulsion.

→ I.C.U. ≈ 0500
CRAFORAN 1gm I.V. ~~stat~~
MANNITOL ~~@~~ BBg 5gm I.V. over 1/2 hour

J O'Donohoe

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



J O'Donohoe

E/T/A

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 diazepam 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, Ambu 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
14/4/00	Yesterday Dr Peter Crain rang from PICU RBHSC to enquire what fluid regime Lucy had been on. I told him a bolus of 100mls over 1 hour followed by 0.18% NaCl/ Dextrose 4% at 30 ml/hour. He said he thought that it had been NaCl 0.18% Dextrose 4% at 100 ml/hour. My recollection was of having said a bolus as over 1 hour and 30 ml/hour as above. * Lucy had had 50 mls of fluid PO before I saw her. I gave her 100mls

LPC 3/86/024

DATE

while waiting for the EMLA cream to take effect.
Maintenance ≈ 100 ml/kg ≈ 1000 ml
-(150 PO + 100 ml bolus) = 750 ≈ 30 ml/hour.
Immediately pre transfer I had discussed ~~and~~ fluid rate for the journey. Dr Anderson calculated 40 ml/hour (? = 1000/24) but I thought continuing at 30 ml was appropriate.

J O'Donohoe

18/4/00
09[10] :- PM - verbal report via PICU R.U.H.

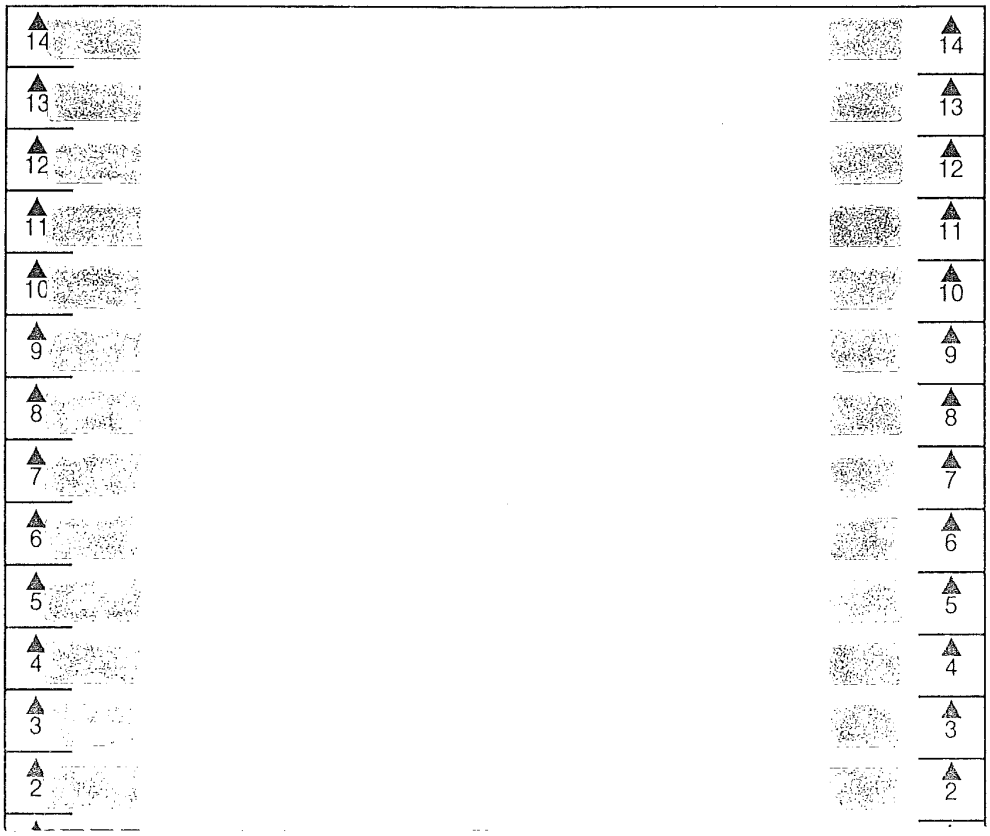
ROTA gastroenteritis ? cardiac oedema.

18/4/00 Blood culture: no growth
11[00] Urine: no significant growth (white top bottle)
Stool: sent to Alwargolvin re 0157 ~~[illegible]~~ - no specimen received.
But rotavirus + adenovirus negative

J O'Donohoe

SPERRIN LAKELAND TRUST
HAEMATOLOGY

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:



Lab Number : 896
Sample Date : 12/4/2000
Time : 20:47

Ward : ERN CHILDRENS WARD 3

Name : CRAWFORD LUCY
Sex : F
Hosp No : ERN123000
D.o.B : 05/11/1998
Doctor : DR J M O'DONOHOE

F B C

Test	Result		N. Range
Hb	12.1	g/dl	(10.5-13.5)
WCC	15.0	$x10^9/l$	(5.5 - 16.5)
RCC	4.64	$x10^{12}/l$	(3.6 - 5.2)
Hct	37.0		(.36-.45)
MCV	* 79.8	fl	(83-105)
MCH	26.1	pg	(23-31)
MCHC	32.7	g/dl	(30-35)
RDW	* 16.3		(9.0-15.5)
PLAT	397	$x10^9/l$	(150 - 440)

D W C C

	$x10^9/l$		
Neutrophils	13.6	*	(1.5-8.5)
Lymphocytes	0.8	*	(4.0-10.5)
Monocytes	0.6		(0.05-1.1)
Eosinophils	0.0		(0-0.70)
Basophils	0.0		(0-0.2)

FBC, HAEMATOLOGY ERNE HOSPITAL 12/4/2000

ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION
WGPO 140

Tel. 0181 992 0062 Ref: 5085

RF (LC Aftermath) 162-001b-009

ERNE HOSPITAL
CHEMISTRY REPORTS

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:

1 [redacted]

Gazelco Tel. 0181 992 0062 REF. 5085-3

Lab Number	: 420	Name	: CRAWFORD LUCY
Sample date	: 12/4/2000	Sex	: F
Time	: 20:50	Hosp No.	: ERN123000
		D.o.B.	: 05/11/1998
Hosp/Ward	: ERN CHILDRENS WARD 3	Doctor	: DR J M O'DONOHOE

TEST	RESULT	UNITS	(Range)
Sodium	137	mmol/L	(135-145)
Potassium	4.1	mmol/L	(3.5-5.1)
Chloride	105	mmol/L	(96-108)
CO2	* 16	mmol/L	(22-28)
Urea	* 9.9	mmol/L	(2.5-6.5)
Glucose	4.5	mmol/L	(3.9-6.7)
Creat	* 45	umol/L	(53-106)
T Protein	67	g/L	(63-79)

Glucose tested on non fluoride sample

E, CLINICAL CHEMISTRY Erne Hospital 12-Apr-2000

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE TOP EDGE OF REPORT ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION

ERNE HOSPITAL
CHEMISTRY REPORTS

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:

[redacted]

Time :

Hosp/Ward : ERN CHILDRENS WARD 3

Hosp No. : ERN123000
D.o.B. : 05/11/1998
Doctor : DR J M O'DONOHOE

TEST	RESULT	UNITS	(Range)
Sodium	* 127	mmol/L	(135-145)
Potassium	* 2.5	mmol/L	(3.5-5.1)
Chloride	104	mmol/L	(96-108)
CO2	* 18	mmol/L	(22-28)
Urea	4.9	mmol/L	(2.5-6.5)
Glucose	* 10.9	mmol/L	(3.9-6.7)
Creat	* 28	umol/L	(53-106)
T Protein	* 46	g/L	(63-79)

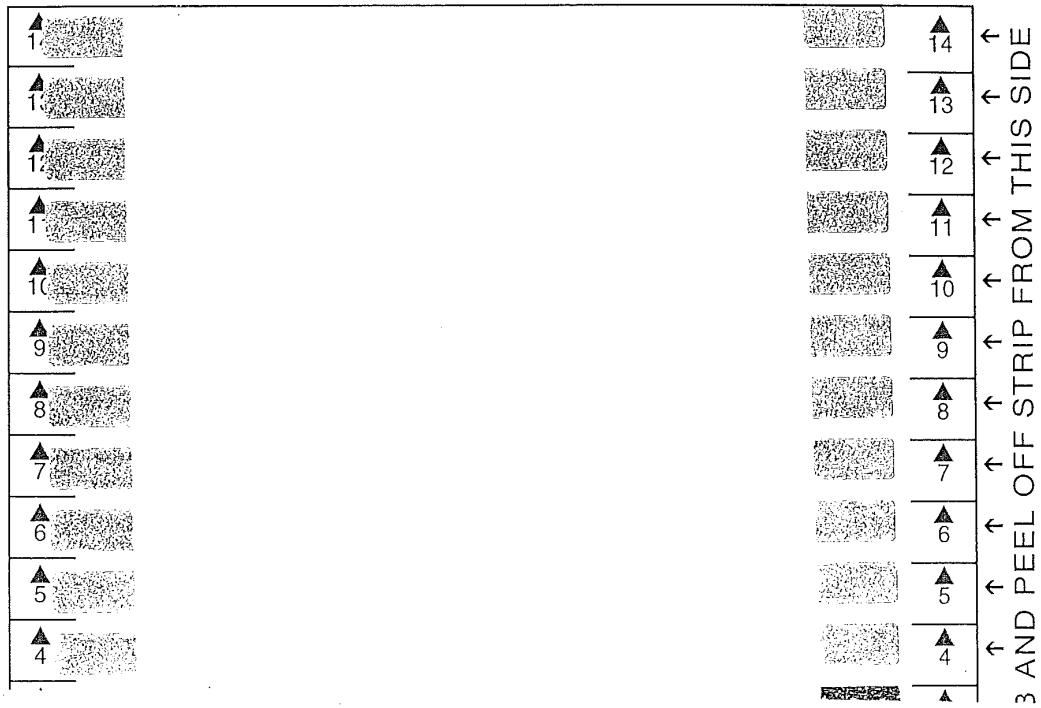
Glucose tested on non fluoride sample

[redacted] CLINICAL CHEMISTRY Erne Hospital 18-Apr-2000

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE TOP EDGE OF REPORT ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION

ERNE HOSPITAL
CHEMISTRY REPORTS

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:



Lab Number : 494
Sample date : 12/04/2000
Time : 20:50

Hosp/Ward : ERN CHILDRENS WARD 3

Name : CRAWFORD LUCY
Sex : F
Hosp No. : ERN123000
D.o.B. : 05/11/1998
Doctor : DR J M O'DONAHOE

TEST	RESULT	UNITS	(Range)
C-Reactive Protein	* 11.2	mg/L	(0-10)

CRP, CLINICAL CHEMISTRY Erne Hospital 13-Apr-2000

CHEMISTRY REPORTS

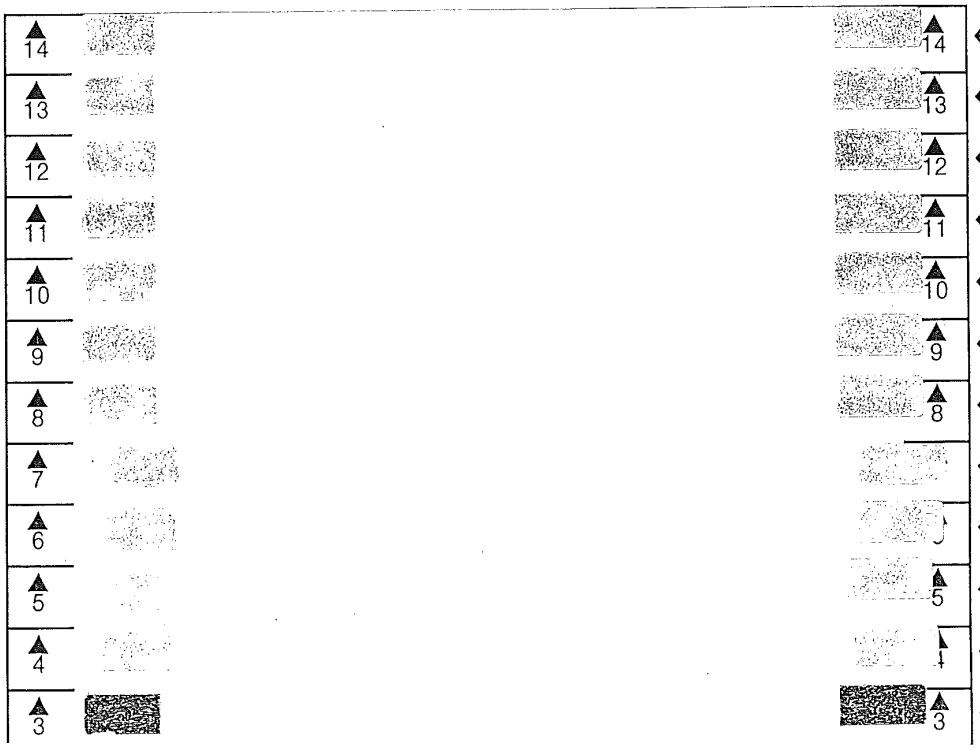
PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE TOP EDGE OF REPORT ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION

Tel. 0181 992 0062 REF. 5085-3

RF (LC Aftermath) 162-001b-012

SPERRIN LAKELAND TRUST
BACTERIOLOGY & HISTOLOGY

UNIT No.:
SURNAME:
FIRST NAME(S):
DATE OF BIRTH:



Tel: 0181 992 0062 Ref: 5085

URINE CULTURE

SPERRIN LAKELAND LABORATORIES
MICROBIOLOGY

Date / Time of Sample: 12/4/00 21.05

159
URINE
WEEK 15

SURNAME	FORENAMES	NHS PATIENT	CLINICAL SUMMARY
CRAWford	Lucy	✓	Vomiting

D.O.B.	SEX	ADDRESS	PRIVATE PATIENT	ANTIBIOTIC TREATMENT
5/11/98	F			None

HOSP/H.C.	CONS / G.P	UNIT No.	WARD
ERNE		123000	C/O

AFFIX LABELS TO BOTH COPIES

M.O.'s SIGNATURE

URINE EXAMINATION

CHEMISTRY:
PROTEIN NIL
GLUCOSE NIL
KETONES ~~NIL~~ +++
NITRATES NIL
BLOOD NIL

CULTURE* organisms per ml.	
NO GROWTH	
NO SIGNIFICANT GROWTH	✓
MIXED GROWTH - *Please Repeat*	
* SIGNIFICANT (100,000 or more)	

MICROSCOPY:
PUS CELLS
RED CELLS
ORGANISMS
YEASTS
CASTS
EPITHELIAL CELLS
CRYSTALS

*CULTURE
1
2
3

SENSITIVITY	1	2	3
AMPICILLIN			
TRIMETHOPRIM			
CEPHRADINE			
NITROFURANTOIN			
CO- AMOXYCLAV			
CIPROFLOXACIN			
GENTAMICIN			
PIPERACILLIN			
CEFTAZIDIME			
PIPERACILLIN			
IMIPENEM			
FLUCLOXACILLIN			
MUPIROCIN			

COMMENT: RECEIVED IN WHITE TOP BOTTLE

M.O. SIGNATURE: RG | Date of Report: 14/4/00 | PHONE: ERNE HOSPITAL EXTENSION 2365
TYRONE COUNTY HOSPITAL EXTENSION 2145

PEEL AWAY PROTECTIVE STRIPS SUCCESSIVELY, STARTING WITH NO. 1 - PLACE TOP EDGE OF REPORT ALONG PRINTED LINE IMMEDIATELY ABOVE EACH ADHESIVE LAYER. PRESS HARD FOR GOOD ADHESION

WGPO 120

ERNE HOSPITAL

DATE & LAB REF No. ERN 123000 MISS CRAWFORD LUCY

584 MISC. WEEK 15

NUMBER

SURNAME (Block Letters [redacted]

PRIVATE CATEGORY PRIVATE / NHS / NON-UK

D.B. SEX

PHYSICIAN/SURGEON JOD

05/11/1998 WARD/OPD CHILDREN

S LAB Nos. YES/NO

HOSPITAL No. 123000

CLINICAL DIAGNOSIS and HISTORY Fever

COMMUNITY ACQUIRED: Y / N

NATURE OF SPECIMEN Blood

TIME SPECIMEN TAKEN 23:00

DATE TAKEN 12-4-00

ANTIBIOTIC TREATMENT

ANY ADDITIONAL SENSITIVITIES REQUIRED

EXAMINATION REQUIRED Blood C/S

M.O's. SIGNATURE [signature]

STAINS

GRAM STAIN —:

ZIEHL NEELSON STAIN —:

13-4-00 No growth

14-4-00 " "

15-4-00 " "

CULTURE AND SENSITIVITIES

ORGANISMS	ANTIBIOTICS / SENSITIVITIES*												
	AP	PG1	T	ER	TM	CTX	GM	CXM	Cx	AUG	CIP	MZ	

*PLEASE REFER TO THE BACK OF THIS REPORT FOR FULL LIST OF ANTIBIOTICS

DATE 17-4-00

SIGNATURE [signature]

RF (LC Aftermath)

PATIENT PROFILE

SPERRIN LAKELAND HEALTH & SOCIAL CARE TRUST ERNE HOSPITAL

SURNAME: CRAWFORD FORENAMES: LUCY MARITAL STATUS S

ADDRESS: [redacted]

DATE OF BIRTH: 5/11/98 AGE: 1½ WARD: 5/ICU HOSPITAL NO.: 123000

DATE ADMITTED: 13/4/00 TIME ADMITTED: 1.40 am TYPE OF ADMISSION: Emergency

OCCUPATION: G.P.: Connor CONSULTANT: I. O Donohue

RELIGION: [redacted] C. Ance: DR T. Auterson

ALLERGIES/REACTIONS: None Known. N. Nurse

1. Nurse

NEXT OF KIN: May & Neville

RELATIONSHIP: Parents

ADDRESS: S/A.

TELEPHONE NUMBER: HOME [redacted] BUSINESS OTHER

INFORMED? YES NO

RELEVENT FAMILY HISTORY OF ILLNESS	REASON FOR ADMISSION: Requiring ventilation following ? Resp Arrest after fit
—	PATIENTS UNDERSTANDING OF PRESENT ILLNESS
RELEVANT PAST HISTORY OF ILLNESS/OPERATIONS	—
Bronchiolitis Nov '99	Parents Present.
	MEDICATIONS ON ADMISSION KEPT IN HOSPITAL?/RETD?

DEPENDENTS:

NUMBER OF CHILDREN:

PLACE IN FAMILY: [redacted]

LIVES WITH: Parents. [redacted]

TYPE OF ACCOMMODATION:

FACILITIES LACKING: None

COMMUNITY SERVICES:

H. Visitor.

FINAL DIAGNOSIS: Collapse, Intubated, Ventilated

DISCHARGE PLAN | DATE OF DISCHARGE: | RELATIVES INFORMED? YES? NO?

DISCHARGED TO:

OPD. APPT: YES? NO? CLINIC? DATE BOOKED

VALUABLES RET'D. YES? NO? BOOK SIGNED?

PRESCRIPTION CARD? TABLETS TO TAKE HOME? OWN TABLETS RETURNED?

COMMUNITY SERVICES INVOLVED:

SIGNATURE OF NURSE:

SOCIAL REPORT REQUESTED? ~~YES~~ NO

DENTURES: Own baby teeth

VALUABLES:

PROPERTY ROOM NUMBER: None

VALUABLES TO RELATIVES? — ADMINISTRATION?

SUPPLEMENTARY BENEFIT? ~~YES~~ NO

SIGNATURE OF NURSE:

LPC 1/94/043

162-001b-015

RF (LC Aftermath)

ASSESSMENT OF ACTIVITIES OF LIVING	Usual Routines what he/she can/cannot do independently	Patient's problems (actual/potential) (p) = potential	DATE

1 Maintaining a Safe Environment Admitted with H/o generally unwell, fever + Vomiting & diarrhea x /4. Sudden collapse 3am, Intubated and Ventilated Pupils fixed and dilated. Colour very Pale

2 Communicating Unscious GCS 3.

3 Breathing Intubated on admission with size 4-0 ET tube (oral) Tube changed to size 4.0 ET tube via Lt nostril. - Ventilated SIMV mode of Ventilation TV 1-5 Resp Rate 20, O2 100% Sats levels 94% - 100% Size 1 Airway insitu

4 Eating & Drinking H/o Vomiting

IV fluids via Rt peripheral line

5 Eliminating Nappies - Diarrhea x /4

Catherised with size 10 catheter. 3mls in balloon

6 Personal Cleansing & Dressing Requires Assistance

7 Controlling Body Temperature

Hypothermic, - Cold to touch

8 Mobilising

9 Working & Playing Toddler.

10 Expressing Sexuality [redacted]

11 Sleeping [redacted]

[redacted]

RF (LC Aftermath)

EVALUATION SHEET

Date	Time	Prob. No.	Evaluation	Signature	B.O.	Communications/Instructions/Investigations
13/4/00.	4.35am		Transferred from Children's Wd following			
	Breathing		Respiratory Arrest post Epileptic type			
			fit. On admission intubated size 4.0 oral			
			ET Tube, Colour pale, Commenced on			
			SIMV mode of ventilation. TV 0.15 Resp			
			Rate 20, Oxygen 100%. No spontaneous breaths			
			taken. - Re-intubated with size 4.0 ET tube			
			via Lt Nostril. SAO2 levels 92%-99%			
	CVS		BP 92/49 ECG sinus rythm rate 112.			
	CBT.		Pupils fixed and dilated. Hypothermic.			
			Arterial line attempted but unsuccessful.			
			Mannitol 20% 25mls over 30mins as per Dr			
			O'Donohue. Clafaran 1gm IV stat. at 5.45am.			
			Size 14 NG tube passed orally. - No contents in			
			Stomach - NG removed by Dr.			
	Nutrition		IV fluids via Rt peripheral line, 30ml/hr			
			via Buritol.			
	Communication		Parents spoke to by Dr Auterson & Dr O'			
			Donohue. Aware of Lucy's ill condition			
			and of transfer to Belfast RVHSC.			
			Left Wd at 6.30am, Dr and Nurse			
			in attendance.			

Name: LUCY CRAWFORD Hospital Number: ERN 123000 Ward: SICU

 HC5

162-001b-017

RF (LC Aftermath)

NURSING CARE-PLAN

INTENSIVE CARE UNIT

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
MAINTAINING A SAFE ENVIRONMENT						
13/4/00	1. Altered level of	Detect any change.	Record neurological observations. ½° Condition dependent.			
	consciousness	Maintain Airway.	Maintain a clear airway. ✓			
	due to — ? Cause		Intubated size 4·0 ET Tube			
	—		Size 1 Airway insitu	daily		
	Unconscious		Constant Supervision			
	2. Altered mental status	Reorientate to time	Constant supervision.			
	Confusion.	place and person.	24 hour reality orientation programme.			
		Prevent injury to self	Explain nursing interventions to patient.			
		and others.				

Name: Hospital Number: Ward:

LPC 3/91/031

162-001b-018

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
BREATHING/RESPIRATION						
13/4/00	1. Inadequate gaseous	Correct O_2 admin.	Check O_2% and flow rate.			
	exchange due to —	Prevent dry airway.	Use nebuliner check water levels and temperature.			
	1		Record oxygen saturation levels.			
			Suction P.R.N.		M Reed	
	2. Unable to maintain	Protect airway.	Change tapes daily + P.R.N. ✓			
13/4/00	own airway so has	Detect misplaced tube.	Observe chest for even expansion. ✓			
	a) 4.0		Observe respiratory rate + colour.			
	Size ET/T~~rache tube~~		Daily chest X-Ray as ordered. 13/4/00 Portable		M Reed	
	Date intubated:					
	13/4/00					

Name: Lucy Crawford Hospital Number: 123000 Ward: 5

LPC 3/91/031

162-001b-019

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
13/4/00	3. Unable to breath	Safe ventilation	Maintain Ventilatory parameters/alarms. ✓			
	adequately, so has		Trained nurse with knowledge of ventilators to special ✓			
	mechanical ventilation		Administer Sedation as ordered.			
	SIMV Mode				MMcD	
	4. Unstable respiratory	Blood gases within	Daily monitoring of blood gases. 9.00 a.m./4.00 p.m. + P.R.N.			
	Status/Arterial line	acceptable limits.	Keep insertion site exposed.			
	in site.	Prompt detection of	Check for bleeding.			
		bleeding.	Check pressure bag and flush line P.R.N.			
	5. Actual/Potential	Chest clinically clear.	Chest physio with bagging and suction twice daily.			
	Respiratory Infection.	Early detection of	Twice Weekly Sputum for C + S Monday/Thursday a.m.			
		change.				

Na Hospital Number: Ward:

162-001b-020

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
CARDIOVASCULAR						
	1. Actual/potential.	Early detection and	E.C.G. Monitoring. ✓			
13/4/00	Unstable heart due to:	correction.	Observe for and record any arrhythmias. ✓			
			Administer prescribed medication.			
3/4/00	2. Actual/potential	Early detection and	Record vital signs ½ — 1 hourly. Condition dependent			
	unstable blood	correction.	Report and abnormality. ✓			
	pressure due to:		Administer prescribed medication.			
			Monitor C.V.P. 1 hourly.			
	3. Actual/potential		Check base-line observations.			
	low HB — due to:		Administer blood as prescribed.			
			Check for any reaction.			
			Record temp/pulse rate/resp rate ¼ hourly.			

Name: Lucy Crawford Hospital Number: 123000 Ward: 5/1cu

162-001b-021

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
NUTRITION, FLUIDS & METABOLISM						
	1. Naso-gastric tube.	Prevent aspiration of	Free drainage. Aspirate hourly and record.			
		gastric contents.	Check tube is in correct position.			
		Enable Enternal	Administer prescribed fluids.			
		Nutrition.				
13/4/00			Size 14 Salem Sump passed orally – No contents in stomach.			
			-NG removed		MM.	
	2. Unable to tolerate	Prevent complications.	Infuse fluids at prescribed rate.			
	N/G feeding so has		Daily dressing.			
	Parenteral Nutrition.		Observe central line site.			
			Change giving sets daily.			
			Observe for patency.			

Name: Lucy Crawford Hospital Number: 123000 Ward:

LPC 3/91/031

162-001b-022

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
NUTRITION, FLUIDS & METABOLISM (CONTD.)						
	3. Unstable blood glucose	Detect/Report	Monitor blood glucose _____ hourly.			
	due to:	abnormality.	Insulin as prescribed.			
			Monitor glucose in urine _____ hourly.			
	Diabetes/Parenteral					
	Nutrition.					
13/4/00	4. Actual/Potential	Early detection and	Accurate recording of fluid Intake/Output. Infuse fluids ✓		[illegible]	
	disturbances of fluid	correction.	at correct rate.			
	balance.		C.V.P. Monitoring _____ hourly.			
	Verbal to RE hand					
					11/4/00	
	5. Actual/Potential.	Early detection and	Check urea and electrolytes daily. 9.00 a.m.			
	Electrolyte Imbalance.	correction.	Administer fluids/electrolytes as prescribed.			
					-	

Name: Lucy Crawford Hospital Number: 123000 Ward: S/ICU.

LPC 3/91/031

162-001b-023

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
ELIMINATION						
13/4/00	1. Urinary Retention.	Prevent/detect.	Twice weekly C.S.U. for C & S on Monday/Thursday.			
	Urinary Catheter.	Infection, detect	Perineal care twice daily + P.R.N.			
	Size: 10	oliguric/polyuric	Record hourly urine output.			
	Date: 13/4/00 (c/w)	Regain bladder control.	Observe for signs of infection. ✓		[signature]	
	2. Unable to pass urine	Prevent/detect	Observe line/cannula for patency.			
	so has peritoneal	complications.	Administer fluids as prescribed.			
	dialysis.		Record intake and output accurately.			
			Report negative balance to Dr.			
	3. Constipation/	Prevent/detect.	Record when bowels has opened. ✓			
13/4/00	Diarrhoea. ✓		Observe colour and consistency. ✓		[signature]	
			Medication as prescribed.			
Name:		Hospital Number:		Ward:		

162-001b-024

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
ELIMINATION CONTD.						
	4. Colostomy/	Ensure hygiene, observe	Observe colour and shape of stoma.			
	Ileostomy.	that healthy and	Prevent skin soreness. Discuss with stoma therapist.			
		functioning.	Bag size: Bag type:			
			Encourage patient to verebral feelings about colostomy.			
			Teach patient stoma care.			
CONTROLLING BODY						
TEMPERATURE						
13/4/00	1. HYPOTMERMIA		Warm using Extra blankets		MKC	
	Temp below 36°C		Record temperature:			
	2. HYPERMERMIA		Cool using			
	Temp above 37.5°C		Record temperature:			

Name: Lucy Crawford. Hospital Number: 123000 Ward: 5/Ccu.

LPC 3/91/031

162-001b-025

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
HYGIENE						
13/4/00	1. Unable to care for	Maintain a high	Daily bed bath and personal care + P.R.N.			
	own hygiene	standard of hygiene.	Oral hygiene 2 hourly.			
	unassisted.		Eye care 2 hourly (if unconscious).			
	Toddler.		Requires full assistance		[signature]	

Name: Hospital Number: Ward:

162-001b-026

RF (LC Aftermath)

NURSING CARE-PLAN

WESTERN HEALTH & SOCIAL SERVICES BOARD - ERNE HOSPITAL

Date	Activity of Living Problem	Goal	Nursing Intervention	Date & Time of Evaluation	Prescriber's Signature	Discontinued Date and Signature
COMMUNICATION						
	1. Unable to communicate	To help communicate and	Introduce yourself to patient.			
	due to intubation/	prevent frustration.	Do not talk or discuss patients condition over them.			
	tracheostomy.		Explain each procedure to patient.			
			Use communication aids:			
	2. Unable to communicate	To help communicate	Use interpreter and non verbal skills to aid communication.			
	due to language	and prevent frustration				
	difficulty:					
	3.		Parents present. Spoken to by			
			Dr Auterson + Dr O'Donahue.			
			aware of Lucy's ill condition		MM	

Name: Hospital Number: Ward:

LPC 3/91/031

162-001b-027

Name: Lucy CRAWFORD.

D.O.B.:

Hosp. No.:

Date: 13/4/00.

Named Nurse:

Associate Nurse:

Consultant Anaes: Dr Anderson.

Consultant: Dr O' Dwyer.

Ventilator Name: Bennett.

Serial No:

Diagnosis: Resp Arrest post Epileptic fit.

No. of days in unit: 1st

No. of days intubated: 1st

Allergies: None known

APACHE Score:

VOLUMETRIC & SYRINGE PUMPS

TYPE	SERIAL NUMBER

LPC 09/98/082

LABORATORY RESULTS

							OTHER RESULTS
	TIME						
	SIGNATURE						
ES	SOD						
	POT						
	CHLORIDE						
	TCO_2						

RF (LC Aftermath)

ERNE HOSPITAL I.C.U.

DATE

TIME	00 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 21	00 22	00 23	00 24	00 01	00 02	00 03	00 04	00 05	00 06	00 07
40.0 220																								
39.5 210																								
39.0 200																								
38.5 190																								
38.0 180																								
37.5 170																								
37.0 160																								
36.5 150																								
36.0 140																								
35.5 130																								
35.0 120																								
110																								
100																								
PULSE (RED) 90																								
80																								
70																								
60																								
BP (BLACK) 50																								
40																								
30																								
TEMP. (BLACK) 20																								
10																								
0																								
R R																								
S																								
PUPILS EQUALITY																								
L R																								
S																								
CARDIOVASCULAR																								
CVP																								
PAP																								
PAWP																								
CO																								
CI																								

220 40.0
210 39.5
200 39.0
190 38.5
180 38.0
170 37.5
160 37.0
150 36.5
140 36.0
130 35.5
120 35.0
110
100
90
80
70
60
50
40
30
20
10
0

R = REACTION
YES ✓ NO -
S = Size • ● ◉
E = Equal
RECORD LARGER

RF (LC Aftermath)

VENTILATION MODE																					SIMV	SIMV			VENTILATION
TID. VOL.																					0.15	0.15			
AIRWAY PRESSURE																					35.1	34.2			
RESP. RATE																					20	20			
OXYGEN																					100%	100%			
SPONTANEOUS																					—	—			
MIN. VOL.																					1.76	1.67			
CPAP PEEP																									
PRESSURE SUPPORT																									
SENSITIVITY																									
CUFF AMOUNT																									
SATURATION																					100%	91%	98%		
PH																									
PCO2																									
PO2																									
$HC0_3$																									
BASE EXCESS																									
SECRETIONS																									
PHYSIOTHERAPY																									
INFUSIONS																									INFUSIONS

SPECIMENS SENT	TIME

URINE TESTING			
TIME			
SPG			
SUGAR			
ACETANE			
BLOOD			
PROTEIN			
Ph.			

RF (LC Aftermath)

FLUID INTAKE MLS PER 24 HRS								OUTPUT								
TIME	P.O.	NG	IV1	IV2	IV3	IV4	IV5	URINE	BOWELS	NG. ASPIRATE	NG FREE DRAINAGE	DRAIN 1	DRAIN 2	VOMITUS	BMs	REMARKS
8 am																
9 am																
10 am																
11 am																
12 md																
1 pm																
2 pm																
3 pm																
4 pm																
5 pm																
6 pm																
7 pm																
SUB-TOTAL																
8 pm																
9 pm																
10 pm																
11 pm																
12 mn																
1 am																
2 am																
3 am				Equal from C/Wt.												
4 am			MANITOL 25ml	NACL 250 2 used												
5 am				30												
6 am				30												
7 am																
SUB-TOTAL																
24 HR TOTAL			25.	310												
				Total Intake mls x 24 hrs								Total Output mls x 24 hrs				

162-001b-031

ALLERGIES:

DRUG PRESCRIPTION

DATE STARTED	DRUG/ SOLUTION	DOSE	FREQ	ROUTE	DR'S SIGN	TIMES AND SIGN	BATCH NUMBER	NURSE SIGNATURES	DRUGS DISCONTINUED: DATE DISCONT.	DRUGS DISCONTINUED: DRS SIGN
13/04/00	Claforan	1gm	stat	I.V.	✓	0 S'S ✓				
13/04/00	MANNITOL	0.5gm	stat	I.V.	✓	(25 mls 20% solution)				

THIS INFUSION CONTAINS AN ADDITIVE

ADDED BY J Smyth / T Jones

TIME 5.45 pm DATE 13.4.00

PATIENT'S NAME Lucy Crawford

ADDITIVE	AMOUNT	BATCH No.
Dopamine	200 mg/5ml	5052291
Dext. 5%	100ml	98 11 4550

RF (LC Aftermath)

162-001b-032

RF (LC Aftermath)

PRESCRIPTION FOR INTRAVENOUS FLUIDS									ADMINISTRATION RECORD				
DATE OF INFUSION	SOLUTION STRENGTH BATCH NUMBER	VOL (MLS)	BATCH NUMBERS ADDITIVES/DOSE	ROUTE OF ADM.	DURATION	DR'S SIGN	DRIP RATE	BATCH NO. OF G. SET	BAG ERECTED BY	BAG & LABEL CHECKED BY	USE 24HR CLOCK START	USE 24HR CLOCK FINISH	SERIAL NO OF PUMP

162-001b-033

NURSING CARE

	8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00	24.00	1.00	2.00	3.00	4.00	5.00	6.00	7.00
WOUND CHECK																								

RF (LC Aftermath)

DRESSINGS																							
DRAINS																							
ABD. GIRTH																							
PRESSURE AREA CARE																							
MOUTH CARE																							
EYE CARE																							
CATHETER CARE																							
CENTRAL LINE																							
ARTERIAL LINE																							
PERIPH. LINE																							

	DATE INSERTED & BATCH NO.	SIZE	SITE	TO BE CHANGED	DRESSED		DATE INSERTED & BATCH NO.	SIZE	SITE	TO BE CHANGED	DRESSED
ET / TRACHE		4.0	Lt Nostril			PERIPH. LINES			Rt hand		PRN
ART LINE											
CENTRAL LINE											
SWAN GANZ						NG TUBE					
						FOLEY CATHETER		10	R.U.		—

162-001b-034

WHSSB
OMAGH/FERMANAGH HOSPITAL &
COMMUNITY SERVICES UNIT
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:

Bronchiolitis.

Medications on Admission: Kept in Hospital?/Retd?

Calpol given @ 18.30.

FINAL DIAGNOSIS:

SUMMARY OF PROBLEMS:

Diarrhoea 1/52 ago.

Next of Kin: Mary & Neville.
Relationship: Parents.

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: J McDonell.

LPC 2/86/014

RF (LC Aftermath)

162-001b-035

RF (LC Aftermath)

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. 38.6 °C; Pulse /min. Regular / Irregular ____ ;

Blood Pressure

Respirations /min. Regular / Irregular ____

BREATHING: Colour/difficulty: Slightly flushed.

Cough/sputum: describe No cough.

NUTRITION: Weight: 9-14 Height: Condition of mouth/teeth: 12 teeth Moist tongue.

Diet: Ordinary. Appetite: Poor at present + 5 days. Dislikes:

Discomforts assoc. with eating/drinking: Tends to be picky.

(Can) / ~~cannot~~ feed self?

ELIMINATION: describe pattern/problems/dependence etc.

Menstrual Cycle:

Bowels: Bowels last opened Mon, usually daily

Aperient/other used?

Bladder: Urine smells strong today.

Urinalysis: Glucose ++++ 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? ____

~~Can~~ / (cannot) dress self?

Personal Hygiene: dependent for? Dependent for all care.

Skin condition: describe Intact.

Prosthesis/appliances?

SAFETY/SECURITY: Smokes Yes? / No? ____ "At risk" Yes? / No? ____ Type?

Alcohol?

Pain: describe

Helped by?

Other:

BELONGING/ESTEEM NEEDS: describe

Hobbies, interests, comforters:

DISCHARGE PLAN Date of discharge: To:

Relatives informed? Yes? / No? ____

OPD. Appt: Yes? / No? Clinic: Date booked: Valuables returned? Yes? / No? ____ Book signed?

Prescription Card? Tablets to take home? Own tablets returned?

Community Services involved:

Signature of Nurse:

162-001b-036

HOSPITAL

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 sips of oral fluids taken and some tolerated.	
	T 39² @ 8.40.			
	BM 3.6 mmols	20.30.	Dr O' Donohue called to see, as child sleepy and lethargic. PR paracetamol 120mg given @ 22⁰⁰	
			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 21⁰⁰, ketones ++++, protein ++++ on testing.	
			Large vomit at 24.15; I.V fluids remaining at 100mls/hr	
		02³⁰	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.	
		03⁰⁰	E/N McCaffrey called myself (SN Nkl Name) to see child. Child rigid in mums arms.	

CRAWFORD. LUCY 123000

HOSPITAL

WARD

DATE	INVESTIGATIONS		NURSING PROGRESS (Including Non Regular Prescription)	Full Signature
			no cyanosis. no loss of colour, 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 144/134 P = 160 R = 22 T = 36.2°C. B.M. @ 03^{15} = 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.P V 8.3 @ 04.00. Suction P.R.N. S/B. Dr Anderson (anaesthetist). Size 4 oral.	

RF (LC Aftermath)

162-001b-038

E.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 Wd 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.

RF (LC Aftermath)

162-001b-039

RF (LC Aftermath)

DRUG TREATMENT SHEET

DRUG ALLERGY / CORTICOSTEROIDS / PREVIOUS RELEVANT THERAPY

Date Admitted	Discharged/ Transferred	Age	Sex	Weight (Kg)
12/4/00.		1½.	F.	~~3~~ 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 Intials
1	12/4/00	PARACETAMOL	120	OR/PR.	PRN 4°-6°								Amjahi		
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															

Unit No.	Surname	Christian Name(s)	Consultant
123000.	CRAWFORD.	Lucy.	Dr. O'Donohue.

162-001b-040

RF (LC Aftermath)

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	J DONALD	0300	
	FLUMAZENIL					0400	J DONALD

162-001b-041

RF (LC Aftermath)

DRUG ADMINISTRATION RECORD (Continuation)

RECORD FOR REGULAR PRESCRIPTION DRUGS AND "AS REQUIRED" DRUGS GIVEN AT STANDARD TIMES										RECORD FOR "VARIABLE DOSE" DRUGS AND AS "REQUIRED DRUGS" GIVEN AT **NON**-STANDARD TIMES					EXCEPTIONS TO PRESCRIBED ORDERS REASON
Date	For Review	6	8	12	14	18	22	24		Enter Reference Letter/Number, Time Dose (if variable) and Initial your entry					
12/4/03										1 at 21.00 BS					

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 (A)
4. If a patient is absent enter reference number/ letter and draw a diagonal line through it. e.g. 3 or M
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. X or M
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.

© Kalamazoo (B) 0232 324801 150923 8 1/4 x 11 1/2

Unit No.	Surname	Christian Name(s)	Consultant
123000.	CRAWFORD.	LUCY.	Dr. O'Donohue.

162-001b-042

ERNE HOSPITAL
ENNISKILLEN

DAILY FLUID BALANCE CHART

AFFIX LABEL HERE OR ENTER

FULL NAME Lucy Crawford

HOSPITAL NUMBER

CONSULTANT

24 Hours beginning 12/4/00

NOTE: 1 oz = 30 MLs.

	INTAKE				OUTPUT				REMARKS
TIME	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.					20ml				Keloines ++++ Probi ++++
9 p.m.	50	Juice.							
10 p.m.	100	Diocalyte							
11 p.m.			100/100	No IV.	DAMP				
12 mid			100/200				-1-.		
1 a.m.			100/200						
2 a.m.			100/200						
3 a.m.			500	N/Saline					Diahoeea +++.
4 a.m.			0						
5 a.m.									
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	

LPC 1 85 026

Form No M 182.

PARTICULARS OF INTRAVENOUS FLUIDS TO BE GIVEN A = PRESCRIBED BY _____

B = ADMINISTERED BY _____

PATIENT NAME: _____ HOSPITAL NUMBER: _____

NO.	DATE & TIME COMM	NAME, STRENGTH AND VOLUME OF FLUIDS (SERIAL NO.)	SITE	(HRS)	NAME, DOSE OF DRUGS ADDED	SIGNATURE DOCTOR/NURSE	
✓	12/4/00	SOL 18 ·	R/V			A	[signature]
						B	[signature]
						A	
						B	
						A	
						B	
						A	
						B	
						A	
						B	
						A	
						B	
						A	
						B	
						A	
						B	
						A	
						B	
						A	
						B	

PARTICULARS OF SUBCUTANEOUS FLUIDS TO BE GIVEN

						A	
						B	
						A	
						B	
						A	
						B	

ATTACH ADDITIVE LABELS

SPERRIN LAKELAND HEALTH & SOCIAL SERVICES TRUST

OBSERVATION SHEET

NAME: Lucy Crawford. WARD: C/W.

DATE	TIME	TEMP-ERATURE	PULSE	B.P.	RESP.	REMARKS
12/4/00	19.30.	38^{6}.				O/A. Floppy, slightly flushed.
						B.M 3.6 m mols
	20.30	38^{7} (AX)				Paracetamol 120 mg. P.R.
	22.30	38^{3} (AX)				
	23.30	37^{4} (AX)			26.	asleep
	03.15		163	98%		B.M = 13.6 B/P. 144 113.
	03.20. 04.00	Continous Cardiac ECG Monitoring + S_aO_2.				B.M. 8.3.