DATE and TIME	CLINICAL NOTES (**For all entries** please end each entry with your signature, name in capitals, grade and contact number)
6/9/15 1100	23+6 ↑ PD → PD
	CLD
	Mild bilat ventriculomegaly
	Vent - low flow. 0.06 l/min.
	No signif desats.
	F: 180ml/kg/d NGT + bottle
	EBM
	gav + bottle
	PU ✓ BO ✓
	Wt ↑ to 1.985 kg.
	Meds: Gaviscon
	NaCl
	Furosemide
	Spironolactone.
	O/E pink, well
	HS I-II-0
	Chest clear,
	Abdo soft.
	Plan cont curr feeds.
	to check on list for Palivizumab.
	PD
7/9/15 04.40	STS VENTRESS BREARLEY CON
	Called to r/v Child G urgently at 02:35.
	Had very large projectile vomit (reaching chair next to cot + canopy). Abdo appeared discoloured purple and distended. Child G distressed + uncomfortable. Red in face + purple all over. O_2 ↑ to 1L via nasal cannula. Desat to 80's but HR ok. Full feed (45mls aspirated) large watery stool passed after which abdo slightly better + Child G relaxed and appeared back to usual self.
2857	Planned to cannulate, ~~IV~~ IV fluids + bloods but 2362

PLEASE AFFIX PATIENT LABEL IF AVAILABLE

NHS Number:

CC Nurse NHS: Personal Data CC Personal Data

Child G
First Name PD 05/2015 FEMALE

Surname [redacted]

Date of Birth

PAEDIATRIC DEPARTMENT

Countess of Chester Hospital NHS
NHS Foundation Trust

HISTORY SHEET

LOCATION:

DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)
7/9/15 cont.	STI VENTRESS continued. unfortunately delayed due to delivery of another preterm baby. called out of theatre to say Child G gone apnoeic + dusky. Dr Brearley called in. On arrival sats 50% in FiO_2 100% Receiving IPPV from nurse. HR ok Took ~ 5mins for sats to pick up. Moved to room 1. Pink + well perfused with mask CPAP. Active so tried for IV access x 2 unsuccessfully. Child G then had further profound apnoea + ↓ HR to 70, sats 40%. Perfusion ↓ CRT 3secs. IPPV given + gradual improvement again. When sats ↑ perfusion also improved. Decision to intubate due to 2 profound desats + concerns re abdo so not keen for CPAP. No IV access so no drugs used. Intubated size 3.0 ETT. 8cm at lips. Blood stained fluid noted coming up from trachea / between cords. Capnograph positive + good bll air entry. • Dr Brearley in attendance then. Vent settings 18/5 rate 40. FiO_2 weaned down to 30%. Good gas 30 mins post intubation. ↓ to 16/5 Large leak noted on ETT but good air entry + sats so left. • IV Vit K given due to blood from trachea • Approx 05:30 had further profound desat. HR ↓ to 60 + sats to 40%. ETT Taken off vent + IPPV neopuff via ~~face~~ Capnograph still positive + chest movement ok

2858

2363

WWG316 Feb 2011

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DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)
7/9/15 Cont...	STS VENTRACES continued...

Recovered slowly but desat when back on vent
? ventilator problem ~~as~~ so flow sensor changed + then whole ventilator changed.
Large leak remained but sats + HR Ok.

06.05 – profound desat to 40% + HR ↓ to 80.
Decision to reintubate.
IPPV given via ETT initially → HR 120 but sats remained 50 despite ↑ PIP to 26 + 100% O_2.
ETT removed at 06.10. Thick secretions ++ in mouth. Blood clot at end of ~~ETT~~.
- IPPV via facemask given. Despite jaw thrust + guedel poor chest movement + sats ↓ to 17%. HR ↓ to 70.
Dr Brearey called in urgency.
- NG aspirated as abdo appeared v large. ~100mls aspirated
Sats gradually ↑ after this
- Reintubated at 06:15 size 3.5 ETT. with intubation drugs
Tight fit through cords.
Blood stained fluid in oropharynx.
Suctioned below cords but nil obtained.
Secured at 8cm at lips.
Capnograph positive. Good b/l air entry.
Clinically leak much better.
- Vent 20/6 rate 40. 60% O_2 but weaning

X-Ray Review

Time of X-Ray film: Date: 7/9/15 Time 04:48 + 06.36.

ET Tube Position: good
UAC / UVC Position: n/a
Long line Position: n/a
OGT / NGT Position: in stomach
Comments (Viscera / bones / soft tissues):
Lungs – chronic lung disease parchy ++ b/l
Abdo – generalised gaseous distention

Sign: Personal Data Date 7/9/15 Time 07:45
Name: VENKATESAN Designation STS

Plan (d/w Dr Brearey)
- Pancuronium bolus then start midaz infusion
- Gas in 30 mins

PD VENKATESAN

- Continue morphine 30.
- NBM + IVI
- Cefotaxime
- parents updated

PD PD VENKATESAN

PLEASE AFFIX PATIENT LABEL IF AVAILABLE

NHS Number: .....

CC Nu NHS: PD CC Child G

Child G

PD 7/05/2015 FEMALE

First Na [redacted]

Surnan

Date of Birth: PD 7-/7-/7

PAEDIATRIC DEPARTMENT

Countess of Chester Hospital NHS
NHS Foundation Trust

HISTORY SHEET

LOCATION: .....

DATE and TIME	CLINICAL NOTES (For all entries please end each entry with your signature, name in capitals, grade and contact number)
7/9/15	Called in at 0330
0815	History as Dr Ventress' entry Large vomit & loose watery stool earlier followed by desat & bradycardia. Intubated by Dr Ventress size 3-0 ETT on my arrival & connected to ventilator. A small amount of blood visible on intubation Blood samples taken & sent ; IV cefotaxime commenced. CXR showed satisfactory ETT position & lung fields bronchiectasis with CLD but nil dorsal AXR - gaseous abdomen , no perforation. Good ABG good gas post intubation 0530 - further desat + brady on rest Dr Ventress changed ETT to 3.5 with less leak & better F/V loops. Post- intubation gas satisfactory compensated metabolic acidosis. → IV 10ml/kg fluid bolus + IV dopamine infusion to start. as one further bradycardia since then + poor perfusion. Sedation - morphine + midazolam 60µg/kg/hr. For further gas at 0900 Will need discussion with APH/CWH as now needing inotropic support + vent. Parents fully updated. Personal Data ENGLEE Coat

2860 2365

WWG316 Feb 2011 40038544