--ID---------- SEX--- UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

· continue IV Abs

· CXR R/V in WR.

(O'Donnell)

Addit CNS pt sedated on : Morphine 15mg/h
Midazolam 7·5mg/h

GCS 3/15

BSL's stable on Actrapid 2 units/h.

(O'Donnell)

WOUND MANAGEMENT 01/02/2000 1035hrs.
Attempted again to contain wound exudate. Still discharging copious amounts of straw colour fluid. Peri wound skin remains intact. Some shaving rash. Keep intact till leaking profusely. Keep re-enforcing edges with opsite.
K Walsh drc

1-2-00 1100hrs Dr Ulyatt WR

- inotropes , MAP ≈ 70
- Mg + PO4 OK
- Na 147 due to hypovolaemia + salt retention (on dextrose solutions)
- osmolality high
- Hb adequate
- Not tolerating enteral feeding (IL aspirates)
- No bowel opening yet despite cathartics. , PR → empty
- laparotomy yesterday
- continuing large insensible losses (g.t, ↑temp).
- 9 days of ventilation
- pb ≈ 100
- prolonged aPTT ∴ ? tracheotomy today
- Creat stable, urea decreasing

CLINICAL EXAMINATION

Rx: 2000mls/hr Dextrose infusion, 500mls Albumin stat
∴ - TPN → Adjust rate of infusion ↓ NGT dosage / to 40mls/hr
∴ - want positive fluid balance (7L in total)
∴ - continue current management
∴ - AXR (over-expose) = supine
∴ - Cease heparin / skip dose tomorrow am
∴ - Tracheotomy approx 10am tomorrow
∴ - Cease NGT water
∴ - Erythromycin 250mg NGT qid to improve emptying of stomach
∴ - Centre marker
∴ - Aim MAP 90 mm Hg

1/2/00 11:30 **NUTRITION & DIETETICS** RN

- Biochem: Hb 78 WCC 32.5 Na 147↑ K 4.4 Cr 0.16 Ur 21.8 Glc 5.9 Alb 24 Bil 49 AST 44 ALT 47 Alk 56 3Sk/D Stupid Arterial - 2U
- BNO - 9 days Temp 40.0° Ventilated + Sedated
- Feeds NG feeds were ceased due to aspiration of 1L
- Plan 1) To commence NGF Ultracal @ 40ml/hr 20/24 To cease water in NGF. ↑ feed rate as per protocol to goal regime of 110ml/hr of Ultracal over 20/24
2) To commence TPN - Prenix 42ml/hr and 10% intralipid
3) Erythromycin to be commenced
4) To review pt tolerance of feeds and rate tomorrow. If tolerating NGF @ 110ml/hr consider ceasing TPN. Will need to ↑ NGF rate to ~ 185ml/hr to meet pts ↑ requirements from burns, wound times, ↑ temp.

J Anderson JA #084

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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14-06-1957
M

SELF EMPLOYED

continued 1.2.00
0200 NG aspirated 300mls brown fluid.
output IDC 110mls to 150mls hrly of clear urine
wound-dressing remains intact, some ooze of serous fluid to (R) side when lying on that side appears to have large collection of fluid under dressing though.
FBC shows positive 744mls since MN yesterday.
GCS 3/15 blinks eyes now PEARL.
Occasionally had hiccups overnight when disturbed for cares.
PAC shows ... toilets attended. [signature]

01/02/00 Night Shift Summary
0750 am

O'Donnell (JHO) 42 yo ♂ c̄ Multi organ failure 2° to severe pancreatitis

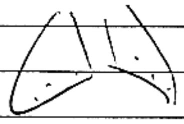
Day (11) ICU

pt quite stable this shift

Resp remains on SIMV / PC
F_iO_2 50% Sats ~ 97%
PS 25 cm H_2O
PEEP 10 cm H_2O
Rate 14
Tvol b/t 600 - 800 ml

ABG's this am:

pH	7.46
pCO_2	39
pO_2	101
HCO_3	27
BE	3.8
SO_2	98 %


AE (R) = (L)
bibasal creps

CNS Inotropic support maintained:

NAd 21 µg/min

DA 15mg/h.

Dobut 60 µg/kg/h.

pulse 132

BP 90/40 (MAP 56) ABP

119/53 (MAP 72) NBP

CVP 13.

UO ~ 130ml/h.

other bloods

Hb 78 stable

Renal Cr 0.16

Ur 21.8

Na^+ 144

K^+ 4.7

~~continues on~~

Abdo still signif distended

Wound drains: 50 - 200ml this shift

NGT aspirates ~ 300ml this shift.

temps up to 39.5 this shift.

Plan continue PC/SIMV

Inotropes as charted

continue to add H_2O to NG Feeds

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

Under Section 91 and Section 141 of the ...

CLINICAL EXAMINATION

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ICU WARD ROUND **Tuesday, 1 February 2000** **DR D ULYATT**

Name: Terence Lindsay UR No. 778512

Remains on 50% oxygen, but good pH. The metabolic parameters, apart from persistent hyponatraemia. Has a creatinine of 0.16, though his urea is coming down. Also has a persistently prolonged APTT, thus waiting for a tracheostomy tomorrow.

1. Skip his morning dose of Heparin, which will be after the ward round.
2. Increase his intravenous watering with 200 mls/hr of 5% Dextrose.
3. Cease the gastric water, but continue with some gastric feeding, at say, 40 mls/hr, plus some Erythromycin 250 mgs/6 hourly gastrically, as a prokinetic agent.

Abdominal x-ray of high penetration to assess his bowel faeces and commence on TPN in case he doesn't feed of pre-mix 42 mls/hr and intralipid 10% 500 mls/day. Mr Lindsay currently has a mean arterial pressure of about 70. We should give him a volume challenge of 500 mls of 4% Albumen and observe the response. If his blood pressure rises, this will indicate that he is currently hypovolemic and will be a new benchmark for the day.

1/2/00

I want to return his colon to his abdomen this week – closure over a [large] piece of mesh.

This will ↑ pressures but will probably improve gut function

No need for necrosectomies at present

[signature]

1·2·00 **PHYSIOTHERAPY**

ventilation continues.

Chest – ↓ BS bases (L) = (R). Scattered creps throughout.

Rx: Bagging + vibes

N. Saline + suction – Tolerated Rx well.

Suctioned sml amt creamy secretions

Plan: R/v am.

[signature] (wilson)

1/2/00 – NURS – 1500 – Critical / stable. Remains sedated GCS 3. PEARL – Ventilation continues PC SIMV Rate 14 PS 25 Peep 10 FiO2 50% Sats 97-98 % Same AE ↓ bibasal crackles. Minimal secretions on suctioning. —— inotrop support continues same unchanged as charted. Haemodynamically stable on same. Aiming for a MAP 70. Required 1000mls NSA + maintenance fluids increased to 200mls/hr. Feeds to 40-1 PR panadol c̄ some effect. peripheries warm c̄ good capillary

HPH 45-1 1/92 Chart B

0627

DATE:

Actin. Wound - abdo distended +++ dressing offended by Kim Ches. Wound oozing ++++. S/B Dr Carmody for mesh closure Thurs/Friday plan for trache tomorrow before 10nd. Wife aware and willing to sign consent. LMH heparin @ m dose U/O satisfactory T100. NG Feeds recommenced @ 40mls/hr. TPN to commence when available + for erythromycin NG
Visited by family.

PHILLIPS

1/2/00 Day (11)
2no Note WR notes.
1605 ① Fluid status - good haemodynamic response to iv fluids
- thought to be intravasc. depleted
⇒ ↑ 5% Dextrose maintenance
- colloid boluses as needed for BP / UOP

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

② Ventilation - stable
- oxygenating well on 50% O_2 - pO_2 > 100.
PCSIMV, insp. pressure 25, rate 14, PEEP 10 (tot. rate ~ 18)
- for trache tomorrow - w/hold a.m heparin

③ Bowel issues - still no BM.
- NG feeds restarted
- plan to reduce TPN if NG tolerated
- AXR -

④ Pancreatitis - remains febrile
- no helpful micro
- on meropenem
- WCC falling

⑤ Haemodynamics - inotropes remain unchanged
- BP robust c MAP 90-100 - no weaning plans currently

⑥ Surgical plans - probably for mesh closure Thursday/Friday.

B Mr Shepherd
SHO.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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NO RELIGION	SELF EMPLOYED	

1/2/00 2200hrs Condition remains initially unchanged remains ventilated and sedated. Air entry decreased bibasally suctioning yields thick sputum MAP ↓ 66 at 1700hrs 500 mls Albumin given stat, MAP > 80 for remainder of shift. Patient tolerating NG feeds aspirate at 1700hrs 60mls which was returned Abdominal wound oozing +++ Patient for Tracky tomorrow consent signed by wife. Medlyn

1/2/00
Claydon
0100H

Evening Shift Summary

① Resp.– further improvement in gas XC:
PO_2 80 on FiO_2 0.40

② CVS – still requiring colloid boluses intermittently for ↓ BP. MAP overall ~ 80-90.
CVP 12.
UO maintained

③ Febrile to 39°
– blood recultured.

⇒ for Tracheostomy mane (consent)
need withold heparin o/n.
need AXR repeated mane – thanks.

R Claydon

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE: 2.2.00 Nursing 0030

Ventilation PC SIMV FiO2 40%, TV 900-1020 Rate 14 - breathing up to 24 PEEP 10 PS 25.

SaO2 97% - 98%. Chest air entry both side c coarse creps

Suctioned - ETT - G/A Thick creamy sputum

- Nose - L/A yellow thin sputum.

- O. Pharynx - M/A of [illegible] saliva & white debris

mouth tongue has white coating - Nil stat ordered - none in stock at present.

CVS ABP 120-135/45-70 MAP 70 to 90 Monitored ST ↓130-140

febrile 39 to 39⁸. CVP +10 to +14

Neuro GCS 3/15 PEARL Blinks occassionally sedated c Morphine midaz. 15mg/7.5mg.

Support - Noradrenaline 21mcg/min / Dopamine 15mg/hr / Dobutamine 60mg/hr.

BSL 11.6 to 15.3 titrated c Actrapid 4 to 10 U's/hrly.

Maintenance 5% Dext 200mls/hrly.

TPN @ 42mls/hrly, Intralipids x1 bottle 500mls

NG feeds 40mls hrly ultracal until 0200 & now turned off for O.T today.

Output NGT Asp 130mls returned.

IDC 90-150mls/hrly

Wound - dressing intact some seepage of straw fluid.

tepid sponged & PR panadol 1g given 0300 for temp.

pt shaved oral nasal & penile toilets given.

Attempted to clean mouth with toothbrush & paste but only knocked scabs off lips + made them bleed - pt grimaced & grimacing & breathing up c [illegible] ? uncomfortable, now has 1 fan on gently for temp. more settled. [signature]

2/2/00 Shift Summary Day (12) ICU

0650 am

O'Donnell Terry v. stable this shift.

(JHO)

Resp continues on PC/SIMV FiO2 0.4

SO2 98%

Rate 14 (Spont 19)

PS 25

PEEP 10

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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ABG's @ 0050 am

pH	7.43	HCO_3	24	on 90% O_2
pCO_2	37	BE	0.6	
pO_2	76	sO_2	97	

= stable

CXR signif diffuse opacities bilat, better than 2/2/00
= air bronchograms in (R) UL
? dense consolidation (R) UL
nil PNX, flail chest

pt settled on a bolus of Morph & Midaz (15 : 7.5)
and some Phy / ribes
nil further episodes of tachypnoea this shift

Currently on PC/SIMV FiO_2 0.4
PEEP 15
PS 15
Rate 20 → 27

ABG this am : on 40%

pH	7.42	HCO_3	25
pCO_2	38	BE	0.8
pO_2	84	sO_2	97%

CNS stable Continues on same ionotropes
Dopamine, Dobutamine, NAd

pulse 138
BP 131/47 NBP
138/64 89 (ABP)

CVP 23

Afebrile WCC ↓ to 29.8 but stable.
Hb 84.

CLINICAL EXAMINATION

Renal stable Cr ~~0~~ 012
Ur 10-5

UO 125 - 250 ml/h.

currently on Maint fluids 200ml/h 5% Dext.

CNS GCS 3/15 stable
on M:M 15 : 7.5 mg/h

nil further boli req'd after 0100 hrs
pt opens eyes / grimaces c PTY / moves etc

Metabolic Na^+ 134
K^+ 4.6

BSL's 4 - 10 Actrapid infusion running as per sliding scale

Abdo still signif distended
? BS heard this am
min wound loss recorded but sheets need reg. changing.

Nutrition on NG feeds : not tolerated → out of nose & mouth.

Plan Continue as per WR plan

Note pt was transfused 2x units PRC last pm and one of these ran through without being signed for.
~ approx 2000 hrs yesterday.

CNC has completed incident report.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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ABG's @ 0050 am

pH	7·43	HCO_3	24	on 90% O_2
pCO_2	37	BE	0·6	
pO_2	76	sO_2	97	

= stable

CXR signif diffuse opacities bilat, better than 2/2/00
air bronchograms in (R) UL
? dense consolidation (R) UL
nil PNX, flail chest

pt settled on a bolus of Morph & Midaz (15 : 7·5)
and some Phy / vibes
nil further episodes of tachypnoea this shift

Currently on PC / SIMV FiO_2 0·4
PEEP 15
PS 15
Rate 20 → 27

ABG this am :

pH	7·42	HCO_3	25
pCO_2	38	BE	0·8
pO_2	84	sO_2	97%

CNS stable Continues on same ionotropes
Dopamine, Dobutamine, NAd

pulse 138
BP 131/47 NBP
138/64 89 (ABP)

CVP 23

Afebrile WCC 6 to 29·8 but stable
Hb 84

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ABG's pH 7.48
pCO_2 36
pO_2 80
HCO_3 26
BE 3.0
SO_2 97
} nil real change from last pm.

CNS Continues on same ionotropes
nil fluid boluses req'd o/night

pulse 138
BP 132/50 MAP 77
CVP 12

Renal: Cr 0.14 } stable
Ur 14.2 }
Dextrose 200ml/h for maintenance.

UO 150ml/h
(+) FB 3.5 l since 1300hrs yesterday

Abdo/GIT Still v. distended
? quiet BS heard
wound: 100ml drained this shift.

→ Nutrition TPN + Intralipid (x1 o/night) and NG feeds.

Metabolic BSL's 11 - 14
on Actrapid as per slid scale

Na^+ 138
K^+ 4.1

febrile o/night to 39°

CLINICAL EXAMINATION (Cont.)
DATE:

CNS GCS 3/15, but appears responsive to triggers
eg fan, requests from RN

continues on M:M infusion 15 : 7.5 mg/h.

Plan: pt for tracheostomy this am

· R/V CXR in WR

· Note from yesterday's WR stated Dr Ulyatt had requested a (+) FB of 7 l → I will check this c̄ day staff

· continue as per plan

PRIVILEGED AND CONFIDENTIAL

Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

ICU WARD ROUND **Wednesday, 2 February 2000** **DR D ULYATT**

Name: Terence Lindsay UR No. 778512

Percutaneous tracheostomy with the CIAGLIA technique. Bronchoscopic assistance provided by Dr Anne Leditschke. Minimal bleeding. Paralysed and sedated through the procedure using Vecuronium and Ketamine 200 mgs and 200 mcgs of Fentanyl. Following the procedure, his alveolar arterial tension difference had widen, given him sats of 90% on 50% oxygen. He responded well to bagging with the ventilator. To reduce the incidence of volu trauma, the inspiratory pressure on the ventilator was adjusted to provide tidal volumes of 550-650 mls/breath and to compensate for his minute ventilation, the respiratory rate was increased to 18, suggesting a blood gas in 1 hr to check that his PCO2 is controlled. Mean arterial pressure is 80 on Noradrenaline, Dobutamine and Dopamine with a heart rate of 130, CVP of 10. In the presence of 10 of PEEP, that suggests that he may be hypovolemic and I think a volume challenge is indicated. Suggest 500 mls of 4% albumon over 1 hr. Biochemistry and haematology is slowly improving, with a white cell count now down to 26.4. His renal function is steadily improving. Urea is now down to 14 with a creatinine of 0.14. Resume enteral feeding and gradually increase the volumes as per the Dietitian. His external jugular line needs to be replaced with a Subclavian tomorrow and note his chest x-ray is looking much worse with worsening ARDS.

2.2.2000 PHYSIOTHERAPY.
Ventilation continues. Sats ≈ 95% on 50% O_2.
Chest: ↓ BS throughout.
Rx: Continuing bagging + sxes. N/Saline + Sx.
P/O mod amt clearing blood stained sputum
Plan: R/V am
(Physio)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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2·2·00 1435hrs · N' Notes. Pt remains sedated + Ventilated as previous day. Remains Intropic dependant on Nor-adrenaline, dobutamine and dopamine. as per obs chart. Percutaneous tracht inserted today as per previous page. Chest - ↓ & sounds both crackles throughout. Stomach observes to be protruding out more today. ? OT Thursday. Urine output ≈ 100mls. To commence Bowel prep this afternoon, followed by NG feeds Oral thrush offensive continue both Nilstat. Visited by family — Rainbow RN. Remains febrile 38°. — Rainbow RN

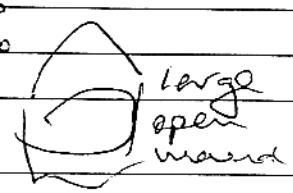
2/2/00 WR NOTES NOTED.

plan: O.T. tomorrow ≈ 1300 for
further assessment & partial
closure of wound

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

2/2/00 Day
RMO Refer to WR summary
1700h ① Oxygenating well post tracht
aiming tidal volumes 550-650 mL.
- SaO_2 96% - 99% on 50% O_2 - aim to wean
pending ABG's.
② BP stable on current inotropes, still
requiring fluid boluses to maintain MAP >80
③ Renal fn gradually improving
④ On 100 mL Golytely/hr for 10/24 aiming
to mobilise bowels per Dr Ulyatt
⑤ For mesh closure 1300h - family aware
- will need consent mane

BE/ T 38.5 PR 134 BP 124/60 RR 26
Chest ↓AE L>R Abdo



CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

HB " "

CNS GCS 3+T

Plan - Wean O_2 as able
Continue current inotropes
Further NSA bolus
Attempt to re-establish NG feeds -
can reduce TPN once tolerating NG feeds
Aim MAP 85-90.
Needs CVL/art line change next 1-2/7
B. [illegible]
SHO.

Nursing Entry: 2245 2.2.00. Generally stable. GCS on morphine + midazolam 3-5. CVS. BP maintained with 2 bags Blood + some NSA. MAP > 80. Monitor Sinus Tachy continues rate 130-140 Temp ↑ 39.5 Tepid sponge Panadol PR + [illegible]. Inotropic support unchanged. Renal output > 200/hour. Vent tolerating trachy - spontaneous resps up to 50 on turns. Seen with bolus M+M. Guedel airway insitu to prevent biting tongue. Green bile suctioned from nose + nasopharynx early in shift + [illegible] cease. Large N/G Bile aspirate - cease feed N/G on free drainage for review in AM — [illegible]

3/2/00
RMO
Claydon
Evening Shift:
main issues:
① Resp - ↑ 2450h:

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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AFFIX LABEL HERE

following a turn: tachypnea to 50-60
— much more alert:
trying to open eyes
& frowning++ c̄ suction.

chest: bronchial breathing RUZ

→ c̄ physio: thick sputum & plugs

CXR: overall improved cf yesterday
except — ↑ air-bronchograms in
RUL. no PTX

→ settled c̄ suction
& bolus sedation:

RR now 28
Sats 97% PO2 76 on FiO2 0.40
PCO2 37

→ probably mostly 2° to being
"lighter" wrt sedation

② ng feeds - large aspirates & c̄ free drainage
→ go lightly & bile regurging through nose
∴ ceased.

③ BP stable - MAP maintained
85-90

④ UO good.

(P) - bolus sed^{n} ℞ turns
- R/v CXR mané wrt RUL Δ^{s}
- R/v ng feeds mané

RClaydon

03/02/00 NURSING (ICU) 0650hrs. CNS: GCS 3/15. On Morphine 7.5mg/Midazolam 15mg/hr. PEARL (Size 3). Facial grimacing ℞ discomfort.

CVS: Monitored in ST HR 144-133. Art BP. 135/57-147/75. MAP 87-97. Remains inotropic dependent - Noradrenaline, dopamine, dobutamine. CVS 8-10. ↓BP @ 0615hrs approx to ~85/40 (Art) (NiBP 95/34). ↑BP to 140-150 systolic after 10mins approx. Remains febrile but ↓T from 39^{8}-38^{6}°C.

RESP: Remains on PC-SIMV PS 15, FiO_2 0.4, PEEP 15, ~~RR 20 and ℞ + 18 spontaneous~~ RR 21-38 (20/pm mand). Tachypnoeic @ commencement of shift after turning. Settled ℞ PT by nursing staff & bolus morphine & midazolam (5mls) AE R=L & ↓ bibasally. Creamy sputum suctioned from trachy. 1/24.

GIT: Abdo remains distened & wound oozing +++. NGT on F/D.

ELIMINATION: U/O & 60-230mls/hr. BNO.

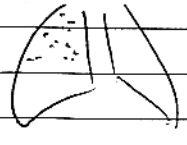
For OT today. Cont ℞ close monitoring. WHughesRN (MACNIGHT)

3/2/00 0800 D'Donnell (JHO)

Night Shift Summary — Day (13) ICU

⊛ episode of mod. resp distress this shift.

@ ~ 2215 am : RR ~ 57-60.
Sats ~ 88-90%.
Good TVol of 300-700 ml.



↓AE (R) UZ
bronchial breathing + (R) UZ.
transm. sounds +

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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· pt may need R/V of his sedation consid. episode this am and ↑ response to pain

· R/V CXR in WR

· tds PTY today please (O'Donnell)

Addit pt needs new CVL
new Art line

R/V by Dr Carmody —
* Plan is to take pt back to OT lunchtime to try and replace some of bowel into abdo.

3/2/00 * Ask surgeons for Jejunal tube
WE

Sdlc.

3/2/00 12 30 **NUTRITION & DIETETICS** RN

Biochem: Na 136 K 4.6 Cr 0·12 Ur 10·5 g/l 55 AST 56 ALT 39 AlkP 82 WCC 29·8 H 6 84
Temp 39° UO 125-250ml BSL 4-10 SS Actrapid
Feeding NG feeds ceased - not tolerated. TPN was continued 42ml/hr + 10% Intralipid
Est Req's ~15·5 - 16·0 MJ/day
Pt for OT today for replacement of some bowel into abdo. To revert jejunal tube in OT.
Plan ① If no jejunal tube Continue TPN. D to 2 day (84 ml/hr) + 10% Intralipid This will provide ~12 MJ.
- Will need to consider ↑ prot/kg for Intralipid to meet req's.
② If jejunal tube — commence feeding via Abacard @ 30ml/hr. ↑ according to protocol to rate of ~~80ml/hr~~ 150ml/hr over 20/24.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

DIETITIAN cont. when rate tolerated @ 60ml/hr
↓ TPN to 42ml/hr + 10% intralipid.
- Cease TPN when tolerating NJ feed @ ~ 120ml/hr.
③ To r/v tomorrow unless otherwise required.
J Anderson [illegible] #684

ICU WARD ROUND **Thursday, 3 February 2000** **DR D ULYATT**
Name: Terence Lindsay UR No. 778512

Sodium is now 134, reduce IV Dextrose to that required for drugs only. Review tomorrow. Continue to give 4% Albumin as needed for colloid resuscitation. Going to theatre for a mesh closure. Can we ask Dr Carmody if he would consider placing a jejunostomy or a naso-jejunal tube while Mr Lindsay is in theatre? Needs a replacement of his central venous access and his arterial line. In the meantime, we will need an increase in his TPN. Plan to slowly wean his sedation over the next few days and try and get him spontaneously breathing. I'm sure he has 2 units available for him for theatre today?

1320hrs N/Notes 3-2-00. Ventilation unchanged. Remains febrile at 38°. Opening eyes to command on occasions. GCS 3-4. Inotropes continue, NG feeds ceased for OT for naso-jejunal tube. Wound oozing copious amounts of ooze, dressing re-inforced. Urine output >100mls/hr. Remains tachycardic 137 BPM. Family visited. awaiting transfer to theatre - [illegible]

3/2/00 Day
RMO
1755h ① OT today - no further necrosectomy
- mesh closure
- NJ tube inserted - fine for immediate use - please start enteric feeds.
- Ⓛ subclav. CVL inserted - about 7 cm too "short" but proximal lumen aspirates blood ✓
On return to ward - hypotensive ~ 80/, PR 145, ~~tachypnoeic~~ ~~peak~~ airway pressures >48 (on VCSIMV).
Required brief spell of 100% O_2
O_2 progressively weaned to 60%
ventilation returned to ACSIMV.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------------SEX---UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

3/2/00 Nor Adren briefly escalated to 25 mcg/min
RMO → quickly weaned back to 21 mcg/min once
(cont^d) 500 ml NSA had restored MAP to ~90.
(2) Nutrition - for enteral feeds to start this p.m please
- TPN at 84 ml/hr pending establishment of NJ feeds - watch BSL's.
(3) Fluid status - thought to be water replete
- boluses as needed o/night for BP/UOP.
(4) No new micro helpful - continue meropenem
(5) Aim to wean O_2 as possible.
(6) Cr stable 0.12 + remains polyuric.

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

[signature] Shepherd SHO.

3/2/2000 Physiotherapy
Chest - generalised crackles
Tachypnoeic + ↑ intervention - bagging ineffective as ? sedation
Ov-R
weban - 1/4 thick creamy secretions. [signature] Murphy

3/2/00 : 2300 HRS Nursing Report: Unstable this evening post op. Pt difficult to settle Resp rate frequently up to 50/min Eyes opening spontaneously Sweating profusely appears to be in pain Morphine & Midazolam bolus 5mls given frequently without good response morphine + Midazolam ↑ 20mg/10mg/hr. 2200HRS. GCS 6. Pt tending to clench jaw this pm but has not bitten tongue as yet. CVS. Remains tachycardic 130-140 Temp 38.7 - 39.5 per nasal probe. Mean arterial BP between 60-80. Chest physio - thick yellow sputum suctioned but Pt really uncompliant when bagged. Wound: Large amounts serous ooze. > 300mls in bed when turned 2100HRS. CV lines all changed to (L) subclavian. (R) tips sent for culture - visited by wife + parents this pm [signature]

CLINICAL EXAMINATION

4/2/00
RMO Evening Shift:
Claydon

- major issue this shift =

"light" wrt sedation →
eyes open spontaneously
→ tachypnea ++ (50-60)
c bowls, suctioning

chest - AE reasonable
R & L more equal than
y'day.

ABG - PO_2 79
on FiO_2 0.60 indicating
↑d O_2 req^ts.
→ h'ever sats maintained 97-98%.

→ has had many boluses
of m.m, given likely abdo.
pain.

→ d/w Dr Stevens ~2130h → if need arises
o/n can use propofol infusion
to get over post-op situation

UO good ✓

ongoing wound loss+
- has had 1x500ml colloid

- MAP maintained.

Aim to wean O_2 as much as possible.
Perhaps fentanyl boluses pre-turns may help.

R Claydon

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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4/2/2000 0030 Medication error.
At 2310 Patient was inadvertently given 56mg Morphine and 26mg Midazolam. Incident report written. RN Gina and Dr Clayton notified. Infusion ceased. Patient appeared to have no adverse reaction to this medication error. Respiratory rate stable at 30-40 breaths per minute. B.P stable 140/60. Infusion recommenced at 20/10 morphine/midaz at 0030. ——— V/L REDDICLIFFE

4/2/2000 0615 Nursing entry -
VENT - Remains on pressure control, F_iO_2 60%. PEEP 15 Pressure Support 15. Suctioning producing a moderate amount of creamy sputum. Resp rate 25-40, >50 when distressed with turns & suctioning.
AE crubles R=L.
CVS - Remains inotrope dependant nor-adrenaline - 21 mcg/min
Dopamine - 15 mg/hr.
Dobutamine - 60 mg/hr.
Monitor in Sinus tachycardia 130-140.
B.P stable 110-140/45-60.
Remains febrile 39°
CNS - Has required 20 morphine and 10mg midaz per hour for sedation. Has required 100ug fentanyl bolus prior to turns.
Nutrition - TPN 84 mls/hr I/C Intralipid.
BSC's 11.5 - 12.7. Insulin infusion continues as ordered. 30 mls/hr Osmolyte via Jejunostomy tube commenced at 0130.
Tube aspirated at 0600 (3mls returned).
Wound - Dressing remains untouched. Large loss of straw coloured fluid this shift. (approx 2l into bed linen and blues)
Renal - IDC insitu 60-140 mls/hr.
Oro pharynx - Large amount old blood stained secretions suctioned from nares and mouth.

——— V/L REDDICLIFFE.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

4/2/00 RITTO-GOLIKOV
0820hrs NIGHT SHIFT REPORT.

- pt a little more settled - required one bolus of m/m given ∵ pt tachypneaic to 40.
- required 100 µg fentanyl prior to turns, still v distressed & tachypneaic but less so.

CVS :- stable
- BP 126/55, MAP 80 PR 140.
- INOTROPE SUPPORT.
  - noradrenaline 21 mcg/min
  - Dopamine 15 mcg /~~min~~ hr
  - Dobutamine 60 mg /~~min~~ hr

Resp :- V remains at
FiO2 60%
Peep 15
PS 15
RR 25-40.

ABG'S pH 7.40
pCO2 40
PO2 85
HCO3 24
BE 0.0

Sats 93%.

GIT :- tolerating feeds.

Renal :- Cr 0.13, U 11.4 ∴ stable
- but ↓ Na 129 & ↑ K 4.7

Coags :- ↑ APPT remains.
- Hb 71

Plan :- continue to replace ardo losses
- ? ↑ Na intake.
- monitor Hb

M Golikov

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

![Mater Public Hospitals logo]

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION		SELF EMPLOYED

4/2

Very well.

Feed at maximum rate.
(Don't bother aspirating!).
Can be turned / positioned.

I'm not planning to take Terry back unless he gets sick from the abdominal point of view.

Will tighten mesh ~ 1/week. - can be done in ICU.
McCarion

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

WOUND MANAGEMENT 04/02/2000 1100hrs.
Leaking large amount of wound exudate at both ends. Attempted to patch same. Re-enforced or change dressings / prn. K Uriah RN/C

4-1-00 1200hrs ICU wr
- 2nd / shift out of wound after OT yesterday
- Distress with turns
- tolerating ↑ enteral feeds ; O_2 sats 98%
Px :- Wean M:M to maintain patient comfort
: 2x Redivac drains over mesh + cover with Opsite → low P suction
: Reduce TPN to 40mls/hr + then discard bag after it has been hung for 24hrs
: Wean FiO_2 to keep O_2 sats ≥ 98%.
- 2U packed cells ; Albumin maintenance / bile (Harman)
: Keep incision changed to NS , chase micro
[illegible]

4/2/00 **NUTRITION & DIETETICS**

Feed changed to elemental feed ~~Vital HN~~ Alitraq to ↑ absorption. Will order extra Alitraq for Monday. ~~Vital HN~~ Alitraq Goal rate for ~~Vital HN~~ Alitraq 150mls/hr x 20/24 via ~~jejunostomy~~ nasojejunal tube. Commence at 60mls/hr and increase according to protocol to 150mls/hr x 20/24.

If only 80mls/hr tolerated, → TPN 1.5l/day Prem ~~Mix~~ ie 65mls/hr x 24/24 as well as NJ feeds would make up total kJ to ~ 12,600 kJ (3,000 cals)

If only 100mls/hr ~~Vital HN~~ tolerated of Alitraq → 1l/day Premix ie 42mls/hr x 24/24 as well as NJ feeds would make up to total of 12,600 kJ (3,000 cals)

#684

4.2.00 Nursing 1400hrs. Resp Pt remains intubated & trachy and ventilated PC, FiO_2 weaned to keep Sats >95%. Presently @ .40 Sats 97-98%. AE R=L ↓ bases, suctioned large amount of thick creamy sputum from trachy bag- suctioned & physio Large amounts of black coffee ground coloured fluid from pharynx. TV ÷ 800 RR 20-40bpm. Peep 5 PS 15

CVS: Mantar ST ÷ 130bpm, pt became hypotensive MAP 60mmHg 500mls 4% NSA given stat & effect. MAP @ desired 90mmHg. CVP 14-15. Temp 39° 1g panadol duo given & 36° Pt continued to sweat ++++. Tepid sponge given, pt much more comfortable now. Peripherally warm and well perfused, limbs quite oedmatous, arms elevated & effect.

CNS Pt remains on IV Morphine 20mg/Midazolam 10mg/hr GCS 10 & trachy. Does not move any limbs. open eyes spontaneously, sedation to cont

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bilirubin	Blood	Urobilinogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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continue 4/2/00 1400hrs Nursing - to keep comfortable. In/Out: nasojejunal tube insit. feeds commenced at 80mls ↑ 60mls of osmolyte. To be changed to Alitraq when arrives. Awaiting 2units PC to be cross matched, path taken Hb 7. Inotropes continue @ same rate. BNO. TPN to cease @ 2000hrs. if Alitraq is @ 150mls/hr and tolerated. BSL 14.3 mmol/l 8units actrapid /hr. General. PAC, mouth + eye care attended. Abdo dressing attended by wound CNC. Pt dressing dry and intact @ time of report. Requested Redivac drains on either side on low suction under op-site over mesh if still oozing. Nil pressure areas observed. IDC insit. draining 20-200mls/hr of golden, clear coloured urine. ✓ arterial line to be changed today. Dr aware. ~~Mrs~~ Family ~~Ms~~ visited in am. Natt RN (PATTISON) arc

ICU WARD ROUND **Friday, 4 February 2000** **DR D ULYATT**

Name: Terence Lindsay UR No. 778512

Laparotomy was meshed yesterday and new central line was placed. Mainly sedated on Morphine and Midazolam. Plan for a slow wean now, attempting to maintain patient comfort only. Problem with containing the fluid losses from the laparotomy. Recommend putting 2 curled up redivac drains over the mesh and covering the mesh then with an ob-site incise dressing sticking it down around the edges, connecting the redivac drains to low pressure suction. Jejunal feeding has been successfully started and is being increased. He remains on TPN at 84 mls/hr and to reduce the TPN to 40 mls/hr and discard the bag when it has been hanging for 24 hours. Not planning for any further TPN over the weekend. His saturations on 60% oxygen and PEEP of 15 are 98-99%. Plan to wean the inspired oxygen as long as his sats of 95% or above are maintained. Continue ventilation as is. Transfuse 2 units for a haemoglobin of 70. Continue with Saline and Albumin for his intravenous fluid loads and maintenance. Note that his renal function is well maintained, but his urea has risen, indicating that he is behind on fluid. Albumin is only 24, so he will need to continue with Albumin loads. Coagulation profile is quite satisfactory given that he is on low dose Heparin. Cease Erythromycin. We can give Golitely via the jejunal tube to clear his bowels. Continue the Cisapride. Continue the Meropenem. Microbiology sheet needs updating for the last 5 days.

4·2·00 PHYSIOTHERAPY.
Ventilation continues. Sats ≈ 95% on 40% O2. PEEP 15.
Chest: Fair BS throughout. Transmitted sounds.
Rx = Continuing bagging + vibes.
Saline ↑ SUCTION
Plan: R/V Resp. physio.

PREVIOUSLY HELD CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

4/2/00 1630

General improvement noted.

Lowered ↑ abdo distension over past 24 hrs
mixed
following feeds

other obs stable

D/W Dr. Carmody
- leave alone
- cont. feeds.

S/L
SHAW

4/2/00 Nursing Notes.
Continued to ↑ feeds to 150 mls/hr now Pt began to regurgitate Black Bile fluid feeds ceased @ 2100. NG tube irrigated 2215 & left in situ on free drainage - for 4/24ly aspiration
Wound Redressed - Bilat. redivac placed
c no effect wound redressed @ 2130 Continues to drain fluid ++++. Vent orders exchanged
N Parkes R.N.

4/2/00 Evening
RMO. Problems
2350h ① ? Bilious reflux from nose and mouth
- was on NJ feeds of 150 ml/hr → ceased.
- reflux ⊕ve for blood.
- D/W Dr Wyatt → NGT 14G inserted under direct vision by Dr Harman
- copious gastric contents aspirated : black, sl. bilious
- for free NG drainage + 94/24 aspirator.
- restart feeds at ~~150~~ 100 ml/hr at 0400h + watch NG drainage for signs of enterogastric reflux.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION		SELF EMPLOYED

4/2/00 - ↑maintenance 5%D in meantime
RMO - Losec 20 mg bd IV started - Zantac ceased (per Dr Ulyett)

(2) Micro review - nil of note
- meropenem continues
further set of blood c/s taken.

(3) Wound issues - reviewed by surgeons as above
- nil further action required currently

(4) Nutrition - no further TPN available
- attempt to reinstitute NG feeds.
- watch BSL's closely

Note: Actrapid infusion has been noted to have been running at "12" (? U/hr ? ml/hr) since at least MD with no apparent titration to sliding scales.
BSL's OK until now: 2.9 → 20 ml 50%
Dextrose + recheck in ½ hour.
Cease Actrapid for now.

(5) Ventilation non problematic - continues on PCSIMV c ↑spont. rate (since abdo closed)
FiO_2 60% c SaO_2 ≥ 95%.

(6) ? Aspiration (slow) 2° to (1)
Await a.m. CXR & ? need for ↑Ab cover.

(7) Haemodynamically stable - remains unchanged on inotropes BP 150/70 HR 135
- has had 2U PRC for Hb 70
- 500 ml NSA given for ↓ing UOP (~60 ml/hr) c some effect.

Plan - As above
Attempt to restart NG feeds - overnight.
Cease Actrapid for now, 50% Dextrose as needed
N.saline or NSA boluses as required

B. Shepherd
SHO.

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CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

05/02/00 0600 c̄ POLITCH. RN: NEURO// PT SEDATED ē MORPHINE/MIDAZOLAM. GCS = 6/10. PT WITHDRAWS FROM PAINFUL TO HANDS. PUPILS = SIZE 3mm. PT RECEIVED ACETAMINOPHEN (CROSS RATE 952, BP SYSTOLIC 160) WITH ROLLING.

RESPS// INTUBATED/VENTILATED. PCV - RATE = 20 - SPONTANEOUS RATE = 0 - 30. INSPIRATORY PRESSURE = 17 cmH2O, PRESSURE SUPPORT = 15 cmH2O. PEEP = 7.5 cmH2O. TV = 350 - 250 mls. FiO2 = 0.4. O2 SAT = 95 - 96%. PT SUCTIONED REGULARLY - SMALL/MODERATE AMOUNTS OF THICK CREAMY SECRETIONS.

CVS// HR = ST = 130 - 150 - BP = 152/56 (83), CVP = 12 - 16 cmH2O - PT PERIPHERALLY WARM OEDEMATOUS IN HANDS & FEET. PULSES - FAINT BOTH FEET

INPUT// IV - N[illegible] = 10.5 mls/Hr (21 mcg/min) DOBUTAMINE: 12 mls/Hr (60 mg/Hr) DOPAMINE = 7.5 mls/Hr (15 mg/Hr), MORPHINE/MIDAZOLAM INFUSION = 20 mls/Hr (20 mg/5 mg/Hr) INSULIN = 1.5 mls/Hr = (5 UNITS/Hr), 5% DEXTROSE = 130 mls/Hr N/G FEED = 60 mls/Hr

OUTPUT// IDC IN SITU - URINE OUTPUT = 80 - 160 mls/Hr. BNO. N/G TUBE ON FREE DRAINAGE ≅ 200 mls/Hr OF DARK LIQUID.

GENERAL// BSL = 10.0 mmols, CONTROLLED ē INSULIN VIA SLIDING SCALE; TEMP = 39.8 (BEEN CONTINUOUS THROUGH LAST NIGHT) - WOUND DRESSING ≅ OOZING +++. DRESSING REINFORCED ē COMBINES & TOWELLING. FULL WASH ATTENDED, TRACH + DRESSINGS ATTENDED. NO PHONE ENQUIRIES [signature]

5/2/00 RMO - GOLIKOV
0815 hrs

NIGHT SHIFT REPORT

pt a little more stable O/N.

① CVS
BP 139/55 MAP 85
PR 140
CVP 14.

on NA 21 mcg/kg/min
Dobutamine 60 mg/hr
Dopamine 15 mg/min

He has been v stable CVS wise
can we perhaps start to wean inotropes?

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

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5/02/00 WR DR ULYATT
1130 am
O'Donnell Day 15 ICU Multi organ failure 2° to severe pancreatitis
JHO

CXR looks mildly improved
NAd currently @ 19ug/min.

FiO2 0·4
Still febrile 38⁴

⊖FB of 3L today, but this does not account for insens losses and wound losses, which have been signif.

Plan · ↑ Meropenam to 1g 98h

· continue Omeprazole
start Sucralfate 1g qid via NGT

· watch 4h NGT aspirates

· ↑ TPN (Allitraq) to 160ml/h.
(aim for this for 1/52 and then change to another TPN : Immune Modulator)

· ↓ sedation. Aim to WEAN. Watch for signs of withdrawal & bolus if observed.
M:M now 15:5 mg/h

· start NSaline 120ml/h as maint. b/c Urea is ↑ and Na⁺ is ↓

· Vol. challenge i 4% Albumex 500ml stat x 2 this shift (observe response)

↳ if ↓ O2ation, then xs fluid in lungs
if ↑ BP UO and ↓ NAd, continue to give fluid.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE: 5.2.00

Nurses notes. 1500hrs.
Fair day.
CNS- reduced sedation to 15mg morphine + 5mg midazolam.
CVS- noradrenaline reduced to 8μg/min. + BP still 135/45.
Remains intermittently febrile with profuse skin actions. Tepid sponging + panadol brought T down to 36°. HR 130s-140s. CVP +15
Resp RR + 16/min, I.P up to 20 + P.S. up to 20. Scant tracheal asps but copious oro + naso pharyngeal asps resp still +15
GIT- BS active, ward reinforced x2. 3L colonic lavage commenced via NJT. (? just retrieving back up NGT).
Renal - output adequate
Endocr - BSL's 7.7-9.9. On sliding scale insulin currently @ 5units/hr.
Visited by family.

(Houghton)

5/2/00 Shift Summary
1600 hrs
O'Donnell (JHO)

- pt v. stable this shift
- BP has remained good ie 143/50 and NAd has successfully been weaned to 6μg/min

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Under Section 91 and Section 141 of the Health Rights Commission Act 19

- Good UO
- afebrile now (since 10am)
- pt has tolerated weaning of sedation ✓

Plan as per WR
NSA bolus if ↓ UO or ↓ BP
↓ maint fluids ONLY if O2 ation drops

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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(2) Resp:- FiO_2 40%.
- SIMV
- MAND RATE 20
- SPON - 25.
- PEEP 15.

ABG's pH 7.40
PCO_2 36
PO_2 58 ↓
HCO_3 22
BE -2.4
Sats 92%.

(3) GIT:- black ↑ (+) blood aspirate in ng tube placed yesterday evening → ~130 mls drained during night.
- jejunal feeds were ceased for a few hrs + then restarted last night at 50mls, has been gradually ↑ + is now 100mls/hr
- maintenance IV fluids have been ↓ at same time.
- position of ng tube hasn't been visualised on CXR yet
- wound losses continue.
- BNO

- cs pt to have further / regular Go lightly?
- Senna cot mixtures have been withheld over last few days, are they to be ceased?
- jejunal tube:- note that no medications are to go down, does this include cisapride & Sorbitol?

CLINICAL EXAMINATION

(4) Metabolic :-

BSL's Stable after BSL of 2.9 earlier this evening.

(5) Renal :-

U 0.13
Cr 14.6
K 4.6
Na 134.
U/O 90-180 mls/hr

(6) T 38° this shift.
meropenam continues
Blood cultures taken prev shift.

(7) Haem : Hb 78
WCC 37.9.

Plan:- R/V inotropes
- monitor PO_2
- R/V Hb
- observe ng tube aspirates

5/2/2000 PHYSIOTHERAPY 8, 11:30.
SIMV PEEP 15 FiO_2 40% SpO_2 97%.
Assc. Bs (R) = (L) = Fair Transmitted Sounds.
R/: MHI, Exp Vibes, s/o ± NaCl
do a.m. m/a yellow
p.m. s/a creamy. Lisa Coles.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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5·2·00 PHYSIOTHERAPY.
Ventilation continues
Chest: Transmitted sounds throughout
↓ BS bases.
Rx: Normal saline + atrovent
Exp wkd
Suctioned s/a creamy secretions
L/a crude secretions - gastric
Plan: R/v am.
(Ward nurses)

5·2·00 NURSING 2310HRS CNS: Patient sedated on Morphine + Midazolam 10mg/5mg GCS 6 occasionally spontaneous eye opening Query smiled at family members. CVS: Monitored in ST HR 125-155 BP 110-160/40-60 CVP 15-20 Temp 37.9 - 39.0°C Noradrenaline weaned to 4mcg from 8mcg/min. Dobutamine 60mg/hr Profuse skin actions when febrile given 1gram Paradol and tepid sponge RESP: Ventilated on PC-SIMV Rate 16 initially Rate 12 became very tachypnoeic sweaty, agitated O2 Sats dropped to 88% Put back onto rate 16 FiO2 40% O2 Sats 95-97% TV. 600-700. P.S. 20 Sensitivity 2 PEEP 15 ~~Insp~~ Inspiratory pressure 20 Inspiratory time 1.4 AE ↓BS (CR). Suctioned several times small amount obtained Copious oral and naso sputum obtained GIT: BS active, wound reinforced nil further dressings Colyte given bowels opened semi formed query some to nasal returning through nasogastric tube. 1000mls obtained from free drainage bag BSL low at 1600 3.2 Actrapid infusion switched off rechecked now 9.6 Actrapid infusion back on at 5units/hr RENAL: Urine output >80 NSA given due to low output GENERAL: Visited by family.
SNielsen RN (NIGHTSON)

ADDIT: Atrovent commenced at 30mls increased to 60mls/hr Basic care attended to all areas Pressure points pulled back up
SNielsen RN (NIGHTSON)

CLINICAL EXAMINATION

DATE:

2305 Evening
512100 Problems
Rmo.

(1) ARDS ? poor gas exchange
- FiO_2 transiently ↑ to 45% ⇒ weaned back to 40% (following physio + ducts)
- oxygenating well now ~ 96%
- remains on PCSIMV + rate reduced to 12 ⇒ tachypnoea to 40 ⇒ returned to 16.

(2) Abdominal wound - ongoing ooze ++
- given NSA 4/1 bolus as ↓BP to ~ 110/0, LVOP to 6 cmH₂O, ↑HR to ~150/min (? good effect).

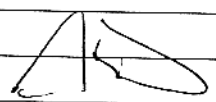
(3) Haemodynamically fairly stable ? successful wean of NorAdren to 4 mcg/min

(4) GIT - Golytely success ! - 2 × bowel motions - now establishing on ~~NG~~ NJ feeds

(5) Sedation - single bolus given to settle ↑RR to 45 ↑HR to 155 following turn.

O/E/ T38.2 PR 135 BP 125/50 RR 25-35

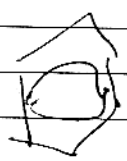
Chest



↓AE L>R
Transmitted sounds.

Apparently smiled at family members.

Abdo



large wound ? mesh.

GCS E4 M6 V-T

Plan - Continue to escalate feeds to target
Aim to wean O_2 as possible
↓ Mand. rate to 14
Boluses of colloid ± N.Saline as required

B Mulholland
SHO

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------- SEX--- UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

6/2/00 Nursing 0630 hrs: Episode of continued desaturation ↓87% on FiO2 ·40. During episode tachypnoea ↑50, HR=155, BP labile 92-156 systolic, temp ↑39°. Despite repositioning on to back, bag + suctioning of only moderate creamy sputum, bolus morphine + midazolam, NSA fluid load did not settle until FiO2 ↑·50 after noted hypoxia on ABG. Gradual improvement and now currently FiO2 ↓·45 to keep O2 Sat 94%. PC/SIMV ventilation weaned to 0 x14 breaths but to support above episode RR ↑16 machine breaths. Haemodynamically more stable and Noradrenaline weaned to 2mcg/min with Dopamine Dobutamine unchanged. BSL more stable on 3units/hr all night. Opens eyes spontaneously does not seem to focus, no limb movement, PEARL size 5. Temperature reduced post Panadol + large diaphoresis. NGT aspirate minimal with free drainage only further 300mls. Tolerating NJT feeds ↑80 mls/hr. U/O 70-160/hr. BO x1 soft Stool. Noted low Hb and transfused P.Cells x1.

CPorter RN (PORTER)

Add.t: Wound unchanged with moderate ooze. CPorter RN.

6/2/00 RMO-GOLIKOV
0745hrs

NIGHT SHIFT SUMMARY

Pt a little more unstable overnight.

(1) Resp
- pt was unstable b/n 0100 - 0300
- tachypnea - 40-50 /min
- desaturated - 87%.
- hypotensr.

ABG taken at time. at 0625 hrs

FiO2 40%	· pH 7·47	FiO2 50%	7·45.
	· pCO2 34		36
	· PO2 47		77
	· HCO3 25.		24
	· 89%		1.0
			96%

CLINICAL EXAMINATION

- repeated suctioning wasn't productive.
↳ pt required period of time on FiO_2 100%.
- CXR - no new changes.
- pt settled when
  - rate ↑ to 16
  - ↓ FiO_2 ↑ to 50%.
  - ↑ NA to 4 µg/min (prev 2).
- now has been weaned to FiO_2 45%.
  Other parameters remain constant.
- breathing up still
  Total 27/min (mand 16).

(2) CVS - has required less colloid only 500mls NSA this shift.
- However Hb at time of resp distress was 74
  ∴ given 1 unit PRC.
- Hb later was 77 (~ ½ bag of blood given by this stage)
- 2nd unit has been x matched but not given yet.

BP 140/52
MAP 87
CVP 14.
PR 147

- NA has been weaned to 2µg/min
- Dobutamine 60mg/hr
- Dopamine 15mg/hr.

(3) GIT - taking jejunal feeds - Nitrg 80mls/hr
- ng drainage 300mls 0/N.
- Bo further BM after success on evening shift.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

- FiO2 to 0.60 -
NA ↑ BP.

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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PHYSIOTHERAPY 6 2.00
Remains on PS Ventilation
Chest crackles throughout (R)
Sputum M/A thick dirty
Gagging + coughs N saline ↓ suction)
Rev R/V 7.00 pm [signature] (Cuckoo DT)

6/2/00 Shift Summary
1555 hrs
O'Donnell pt stable
(JHO) much more alert
GCS $E_4 V_T M_6$ on M:M 15:5 mg/h.

CVS stable pulse 140

BP 169/71 MAP 107

Dobutamine now @ 10mg/h.
NAd @ 2 μg/min.
Dopamine 15mg/h.

Resp Sats 95% on FiO_2 0.45
breathing up to 34 c̄ PS of 25cm H_2O

ABG's this pm ∴ improved

Good UO
tolerating N-J feeds.

Plan ↓ PS to 20cm H_2O to try and ↓ rate

continue to wean Dobut.
[signature]

MHPH 45-1 1/92
F0627 Chart B

DATE:

6.2.00 NURSING 2230HRS CNS: Sedated with morphine 15mg midazolam 5mg GCS 5-6 starting to try and mouth words squeezed hand occasionally. CVS: Noradrenaline and Dobutamine weaned successfully this shift.
HR ST 130-140 BP 120-166/50-80 CVP 14-16 Temp 38-39.3°C
RESP: Ventilated on PSV 45% FiO_2 PEEP 15 T.V. 500-700
PS 24 weaned from 25 didn't tolerate PS 20 Sensitivity 2
Nil other changes AE crackles O_2 Sats 94-97% when PS ↓20 O_2 Sats decreased to 91-92%. GIT: BSL stable
Actrapid infusion changed according to sliding scale
BO x 2 faecal containment device applied query applied or holding well. Naso-jejunal tube insitu flushing well Feed increased to 140mls appears to have tolerated well. Feed ran out at 10pm to recommence at 2AM
Naso gastric tube blocked removed at 2100HRS. Patient then sedated with fentanyl and midazolam, with paralyse nil success at reinserting naso gastric tube
Patient remains sedated at time of writing report.
RENAL: Urine output >120mls/hr. GENERAL: Skin tears under arms left ~~as~~ alone nothing applied Wound ~~redressed~~ padded Visited by family — S Nielsen RN (NIELSON)

RMO Evening
0020h Issues
7/2/00 ① ~~Rx~~ Inotropes - Noradren } weaned completely
Dobutamine
Maintaining BP + ~~U~~ well

② Ventilation - still intermittently hyperventilates
No mand rate
P. support weaned to 24
Oxygenation fair on 45% O_2 96%
Tv ~ 600 ml x 25-30

③ NGT blockage - removed (+ sucralfate ceased)
- attempted reinsertion under direct vision
$\bar{c}$ IV sedation + 10mg cisatracurium (per Dr O'[illegible])
→ unable to site as unable to view hypopharynx.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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(4) BSL's :- ~ 7·5

(5) Temp :- febrile to 39°
- Blood cultures taken.
- WCC ↓ through 21·7.

(6) CNS :- GCS 6 + tube
on m:m
15 : 5.

(7) Renal :- UO remains 70-160 mls/hr.
Cr 0·11
U 15·2
K 3·9
Na 141.

Plan :- R/V need for further bloods
- Cont ↓ wean
- continue NA wean.
- continue feeds at current rate.

M Solvason

6/2/2000 **PHYSIOTHERAPY** 7:30.

AVSC : AE (R) = (L) = Fair
Transmitted Sounds.

R² : Bagging Vibes s/o ↑ NACl.
p/o M/a 'creamy' secretions.

Lisa Coles.

CLINICAL EXAMINATION

DATE:

6/2

well

No changes

Omeprazole + Sucralfate neutralize each other

No upper GI Bleed seen when I endoscoped him on Thursday.

6/2/00 WR DR ULYATT

1130 hrs

O'Donnell pt stable

(VHO) Good diuresis i ↑ fluid load yesterday

MAP maintained

FiO2 0.45 (after last pm's episode of desat^n and tachypnoea)

note R/V by Surgeons this am.

Plan

- 2 x units PRC for fluid challenge (to avoid depleting MAH's stores of NSA)
- Wean Dobutamine : aim to cease this in next 24h. ie ↓ to 50mg/h (↓ by 10mg/h each hour)
- aim for MAP ≥ 80 mm
- for PSV i PS of 25cm H_2O

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

0200 Nursing icu

1400 hrs. Condition fairly stable this shift. Ventilation is now PSV ; FiO_2 .45% Peep 15, PS 25. Resp. breathing up 26-28. crackles heard both sides. Sputum sp but very sticky. Renal 30-200 mls per hr. Cardiac S.Tacky, 120-150 beats per min. Temp 39.4-38.2 this shift. wound redressed and drainage bags attached. Neuro - v. with limbs GCS 6-7 BP fairly stable. For 2 units of blood. Operation PM. Food. Vital N/G feed 80 mls per hr. to ↑ to 150 next shift. No allitrac left in pharmacy. ——— SBittner

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION	SELF EMPLOYED	

7/2/00 1645hrs NURSING. Pt not stable at start of my shift. Episode of tachypnoea, tachycardia & hypertension per obs sheet, Pt much more settled now and obs quite stable. Will continue to observe
R.N. Hudson

7/2/00 Day
RMO See WR notes.
1750h

(1) Acute tachypnoea following physio to RR60
Associated ~~BP~~ to 190/- & ↑ HR to 150.
(?) not communicating pain
Boluses of sedation ? some effect
Associated ↓ SaO_2 to 89% on 40% O_2 & 12.5 PEEP.
Gradually settled
CXR - ? wedges - S/B Dr Leditschke
- monitor response to a dose of 20 mg Lasix.

(2) Inotropes weaned completely & maintaining BP & UOP well

(3) NJ tube appears well positioned on AXR - NG not reinserted at this stage - watch for signs of gastroparesis.

(4) BSL's improved - now 8.

Plan - Watch response to lasix ? ↑ oxygenation
May need PEEP ↑ to 15
F_iO_2 ↑ to 50% for now given ↓ pO_2 on ABG.

B McShane
SL/O.

PREVENTED
CONFIDENTIAL
Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

11/87
MRI

CLINICAL EXAMINATION (Cont.)
DATE:

7/2/00 2230hrs NURSING. Pt stable at present. GCS 8, PEARL 4mm, ? some possible hallucination. Airway clear + pt ventilated on PSV FIO2 .50, INSPRESS 24, INSP TIME 1.4 SECS, O2 sats 96-98%. Chest sounds decreased in bases + crackles bilat. Body extremities still very oedematous. Bowel sounds present, N/G feed changed to ultracal at 150 ml/hr + ~~to~~ G+J tolerated. Wound reinforced x 1 + patent at present. Several episodes of loose B.O + large flatulanes, faecal containment device applied with good result so far. Pt temp upto 39.4°C tonight. panadol given, tepid sponge + fan applied, temp now 38.9°C + pt appears less symptomatic. Hygiene cares attended to. Art. line patent but needs to be watched ~~S.A.~~. R.N. Dawson

7/2/00 Shift Summary - Evening
2335
O'Donnell
(JHO)

pt stable this shift

nil further episodes of tachypnoea / desatura"

Resp- on PSV FiO2 0.5 Rate ~ 24
Sats 95%. Good Vt's
(responded well to bolus Lasix @ 1600 after being tachypnoeic earlier)
PS 24
PEEP 12.5 (have not needed to ↑ this)

ABG's pH 7.42 HCO3 27
pCO2 42 BE 3.1
pO2 109

∴ ↓ FiO2 to 0.45 - pls rpt ABG in ~4h.

W BSL's Stable 5 - 8

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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OE
- BP 124/60 HR 130
CVP 16 Sats 97%

chest - widespread harsh insp-crackles

HS I — II —

(P) → CXR
- attempt wean PS again (↓ to 24 currently)
- could probably take O_2 ↓ to 0.40 ✓
([illegible])

R Claydon

7/2/00
[illegible] Progress Noted. [illegible]
TNI (N)
[illegible]

? [illegible] acute lung injury.
For leucoagglutination testing today — Referred to Blood Bank
[illegible]

7/2/00 NUTRITION & DIETETICS 1230 hrs
Alitraq not considered to be necessary as malabsorption is not a problem. Polymeric feed should be absorbed adequately.
Change to Ultracal 150 mls/hr x 20/24.
This will provide 13,200 kJ, 111 gm protein
684 [illegible]

CLINICAL EXAMINATION

7·2·00 Nursing ICU

1300hrs. Ventilation Peep & V 12·5 Pressure support 24 FiO_2 40%. PSV. Resp. Rate 21-38 usually ↑ when on pain or distressed over treatment. T 38·3 remains up despite panadol. Cardiac - BP stable. 122/56 - 132/56. HR → sinus tachy 128 - 148. CVP. 13-17. O_2 sats 95% - 96% on 40% FiO_2. Weaning dopamine. Infusions left are mims + insulin currently on 5 units per hr. Urine - 40-200 m/l per hr. Movement off. Neuro - very weak limbs, GCS 5 but nods appropriately to questions. Skin on back & groin reddened with a couple of broken areas. Bowels have opened again 3 times this shift. N/G feeds changed to ultracal 150 m/s per hr. For Xray 2pm. Will attempt dressing at 1330hrs. Relatives have visited. Generally holding his own. ——— Skittmer. RN

ICU WARD ROUND **Monday, 7 February 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No. 778512

This man has had multiple organ dysfunction complicating pancreatitis and gastrografin aspiration. From a gas exchange in perspective, he is slowly improving. He is on 45% O_2 15 of PEEP and pressure support ventilation with an inspiratory pressure support of 25 and has a PO2 of 86 and PCO2 of 40. The rest rate is about 24. Haemoglobin is stable. White cell count is coming down, is now 19.4. Sodium is drifting up at 146, so he needs a bit more free water. His creatinine is now normal at 0.1, urea is 13.3. Glycaemic control is fair on insulin, but his blood glucose this morning is 12. We will need to review this. He is interactive on 7 of Midazolam and 20 of Morphine and appears to have adequate analgesia. He is tolerating his naso-jejunal feeds, but note that his naso-gastric tube was clagged by Sucralfate fate, which has now been ceased. Bowels are working. He is going to have an abdominal x-ray to sort out where his naso-jejunal tube is, as the naso-gastric has come out. We will review the situation and defer replacement of the naso-gastric tube at this stage. Have ceased his Folate, Vitamin K, Cisapride and Ventolin.

7/2/2000 **PHYSIOTHERAPY** +3.

Remains on P.S.V. Peep 12.5.
Ausc. AE ↓ at Bases
Transmitted Sounds
Rx: Bagging, Vibes, S/O 1 NaCl
p/o m/a thick yellow.

Lisa Coles.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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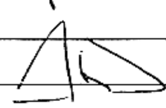
NO RELIGION

14-06-1957
M

SELF EMPLOYED

AFFIX PATIENT IDENTIFICATION LABEL HERE

7/2/00 Discussed further c̄ Dr Ulyatt - as
RMO NG drainage has not been excessive
0025h (300 ml over 13/24 yesterday)
-safe to leave out for now
-needs to be addressed mane.
Tolerating nutrition well
Ⓞ Ongoing fevers - further blood C/S taken.
O/E / T 39° PR 137 BP 175/76 RR 30
chest ↓ - muffled sounds



Plan - Continue PSV o/night
Aim to wean further in a.m.
Bloods ✓
Needs NGT mane

B Shepherd
SHO.

7/2/2000 Nursing Entry 0630hrs.
CNS: GCS - 8→9, Opens eyes to speech + sometimes spontaneously
no response in hands but withdraws feet to pain, Pupils - PEARL Size
T - 39³ → 38³ - given ii Panadol elixir via feeding tube at 0400hrs
CVS: HR (ST) 125 → 148, ABP - 180/80 → 105/42, NBP - Comparable,
CVP - 16 → 20, Peripheries warm + well perfused.
RESP: Ventilated - PSV breathing TV 500s → 700's at 24 → 34/min.
O2 65% & Sats 95 → 97%. PEEP - 15, P/S - 25. Suctioned PRN
small amounts of thick creamy sputum. AE R≥L - crackles in both lungs
G/IT: N/G feeds 160 mls/hr, appear to be tolerated - large bowel
actions x3 this shift - soft, unformed, greenish
Renal: IDC Urine measures 50 → 115 mls/hr.
IVT: 120 mls/hr, Dopamine 15mg/hr, morph + midaz 2mg + 7mg/hr
Insulin titrated to BSL.
Hygiene: O/C ≈ 2-3/24, Turns + PAC ≈ 3/24. washed anal
+ peri area each time BO.

H Owens RN

L EXAMINATION (Cont.)

/02/00
ydon Night shift :
00h

quite stable.

- much more alert (even smiled!)
GCS 7T

h'ever => unsettled periods (mainly
ē lying on sides): -
hypertensive + tachypnea.
~> settled ē reassurance
denied pain.

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Resp - remained on PS o/n
well tolerated! (PS 25
maintained TV's 600-700ml Peep 15)

mané ABG - pH 7.41 FiO_2 0.45
PO_2 86
PCO_2 40.

h'ever unable further wean o/n due to
periods of tachypnea.

CVS - stable - NA, dobutamine weaned
y'day; BP, UO stable o/n.

remains on renal dose DA.

good UO.

Git as previously mentioned - ng tube out
(unable re-insert on ev. shift ē sed^n, paralysis)
- needs to be addressed mané

CLINICAL EXAMINATION

EXAMINATION ON ADMISSION/OUTPATIENTS

Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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CVS a UO - stable since Dopamine ceased
>100 ml/hr
Cr 0.09

-v. alert at times o/nv
GCS E3 M4 T1
smiles, nods appropriately

Plan - continue v wean
as per todays WR plans

RClayden

8-2pm 10/3/hrs ICU WR Dr Leditschke

- Day 19
- PEEP 12.5, F_1O_2 0.40, spontaneous breaths
  - pCO_2 35, pO_2 70
- Metabolic alkalosis
  - BE 4.2, HCO3 27
  - plt 7.50
  - on Ultracal
  - diarrhoea -> now settling
- Electrolytes fine
- Neuro -> interactive
  -> 2mg morphine + 7mg midazolam per hour
- smelly wound, sloughy
- CVS stable, off inotropes
- Dependent oedema

CLINICAL EXAMINATION

- WCC ~20
- Reactive thrombocytosis plt 750
- Na 147 T
- Urea 13.3
- Creat 0.09

Rx:- Wean midazolam to 5mg/hr as tolerated to 3mg/hr tomorrow

:- ↓ PEEP to 10cm H_2O
:- Acetazolamide to ↓ oedema + improve alkalosis
:- T IV, Dextrose to 100mls/hr
:- Continue NJ feeds at current level

(C Harrison)

8/2/00 12:15 NUTRITION + DIETETICS RN

Biochem: Na 147 K 4.2 Cr 0.09 Ur 13.3 WCC 21.1
Bili 24 AST 69 ALT 58 Alk P 222
Temp 39.3 Pt tolerating NG feeds Ultrasal 150ml/hr 20/24. Feed, powders 2550ml fluid
Fluid intake 2550ml feed + 2100ml IV
Plan 1) Continue ½ current feed
2) RN daily
JAnderson JA #684

ICU WARD ROUND Tuesday, 8 February 2000 **DR A LEDITSCHKE**
Name: Terence Lindsay UR No: 778512

This man continues to slowly improve. His gas exchange is stable with a reduction in his PEEP from 15 to 12.5 yesterday. Blood gases this morning on 40%, pH of 7.5, PCO2 of 35, PO2 of 70. Note his metabolic alkalosis: he has had significant diarrhoea, which is now settling, and he also had a dose of Frusemide yesterday. He is also somewhat hypernatraemic with a sodium of 147. Haematology is stable. He is interactive neurologically and 7 mg/hr Midazolam and 21 mg/hr Morphine and appears comfortable. The plan for today is to reduce his PEEP to 10, to give him Acetazolamide as he is quite oedematous and this should also help his metabolic alkalosis. To increase his free water in 5% Dextrose from 60 to 100 mls/hr intravenously. To continue his naso-jejunal feeds as is. To reduce his Midazolam infusion to 5 mgs/hr and if this tolerated, tomorrow to reduce it to 3 mgs/hr with a view to weaning it slowly after that. Continue his Morphine as is at present.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

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M
SELF EMPLOYED

8/2
I'm very happy c [illegible].
I'll try to see his wound tomorrow (suggest after 11am)
[signature]

8.2.00.
Awake most shift, opens eyes to name, not moving limbs. Nodding appropiately. T > 39.4 > 40°. Hemodynamically stable. Tachycardia. AE = R+L ↓ Bases, S > mod of secretions via size 9mm trachy. O2 > 93%. 40% x PSV 10/24 PS TV > 600 Bowels working well in fecal containment device. U/O > 80ml/hr ↑ Maintance to 100ml from bowels. Actrapid continues on sliding scale. Family visited. [signature] (IRVING) RN

PHYSIOTHERAPY
8/2/00
Hypertensive ī Rx to 180-190 systolic ∴ quick Rx
Chest - ↓ BS bilaterally.
Vent. on PS 24, rate - breathing up to 34
Rx bag x vibes
Hills suction - mod to c/+ creamy secretions.
Plan - R/v AM. [signature] Murphy

8/2/00 RMO - GOLIKOV
1815 hrs SHIFT SUMMARY.
DAY 19 for PT in ICU
- pt stable today..
Resp:- weaned to 10 of peep today from (12.5)
- 40%. FiO2.

ABG'S:- PSV
pH 7.45
pCO2 40
pO2 78
HCO3 27.
BE 3.5
sats 97%.

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

GIT :- ↑ free fluids in IV
feeds 130 mls/hr : tolerating well.

CVS BP 153/60.
PR 139.
off Dopamine now.

CNS more reactive today & more awake.
· midaz weaned to 5mg/hr
· morphine still running 2mg/hr.

renal Cr 0.09
U 11.2
on acetozolamide (for diuresis & ↑pH)

metabolic pH improved ō acetozolamide 7.45 today.

Plan :- continue current Rx
- for further midaz wean tomorrow

Mahendra.

08/02/00 NURSING (ICU) 2220hrs. Stable shift. V/B wife & mother —
CNS: GCS 8/15. PEARL (Size 3) Sedated on Morphine 2mg & ↓Midazolam from 5mg to 3mg this shift due to "glassy" or gazed" look. Responding by shaking/nodding head & Smiling.
CVS: Monitored in ST. HR 130-140 Art BP 117/47 — 147/72. MAP 70-100 - CVP 10-16. Remains febrile 38.9 - 39.8 now → given reg PRN Paracetamol & tepid sponges.
RESP: PSV. FiO_2 0.4. PS/24. PEEP 10. RR 25-29. V_T 660-780. O_2 Sats 95-97%. AE R=L ~~= bilateral~~ = crackles. Small, thick

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

--ID----------SEX---UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

CNS — Dopamine ceased 1530 hrs
haemodyn. stable since then

pulse 135
BP 146/55 MAP 90
CVP 20

Renal — UO 90 - 200 ml/h

Cr 0·01 (Normal)!
Ur 10

Abdo — still markedly distended.
feeds: Ultracal 150 ml/h
tolerating this.

CNS — nil sedation
GCS E4 V T M4 9/15
nodding appropriately

Plan — slowly wean V if poss. (Have ↓ FiO2 to 0·45)

usual bloods / CXR mane

if further tachypnoea or ↓ Sats
try ↑ PEEP as well as ↑ FiO2

8/2/2000 Nursing Entry: 0630hrs
CNS: T - 39 ⇒ 39⁶. GCS - 8. PEARL size 4. opens eyes spontaneously + to speech when they are shut. does move limbs occasionally but severe weakness. Morphine + Midazolam 21mg + 7mg/hr.
CVS: HR (ST) 132 ⇒ 165. ABP 150/75. ⇒ 130/50. Peripheries warm + well perfused.
RESP: Ventilated PSV ↓c PEEP-12.5, PS-24, O2 ↓ to 40% + Sats 94 ⇒ 97%. Suctioned prn 3ml ⇒ mod yellow/green sputum. P+O ⟶

CLINICAL

DATE:

GIT: N/G feeds 150 mls/hr. Passing flatus, 200 mls faecal matter in containment device at ≈0530hrs - working well.
Renal: UOP - 100→180 mls/hr - no sediment - dark amber colour.
Meds: as charted.
WT: Stable past - 60 mls/hr. Insulin titrated to BSLs.
Wound: left intact thus stuff. ∴ drainage on bed & bluey's ≈200 mls.
Peris remains oedematous - as do hands.
Hygiene: Trans + PSE, O/C, periwash + back attns.
Back in good condition - no pressure areas

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

08/02/00
0650hrs — Night Summary:
RMO —
Claydon — v. stable.

Resp - good response wrt tachypnea after 20mg lasix yesterday a'noon.

o/n: no further episodes of tachypnea.

RR bw 24-30
Sats 95-96% on FiO_2 0.40 (↓d from 0.45 o/n)

ABG -
— pH 7.5 BE 4.2
— PCO_2 35 Sats 96%
PO_2 70
HCO_3 27

peep left at 12.5, PS24.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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08/02/00 NURSING (cont).

creamy sputum suctioned.

GIT: Dressing intact, reinforced on @ side @ 1900hrs as small amt leaking. Pt passing flatus. ≥ 450 mls loose dk green faeces collected from FCD — very offensive.

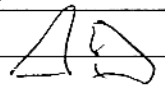
RENAL: U.O. 90-220 mL/hr.

Cont to observe. — W Hugo RN (McKNIGHT)

9/2/00 Evening
Reno

0040 h Remains settled

Ventilation - PSV support 24, F_iO_2 40%
RR 26-30 PEEP 10.

Chest —  transmitted sounds ↓ some crackles @ base

Nil further weaning attempted tonight

CVS - Stable off inotropes.
BP fairly robust 110-145/
Remains tachycardic ~130
UOP good ~100-200.

GIT - Ongoing diarrhoea.
Wound covered - mesh - ongoing ↑ losses
Tolerating feeds well
°Evidence regurgitat°.

CNS - GCS 8+T — per Dr Leditschke WR this p.m.
Midas 1 to 3 mg/hr, morph remains 2 mg/hr.

Infectious - Remains febrile to 40°C
Blood C/s taken.
No useful micro (checked)

Plan - Consider ↓ PEEP progressively to 5 t/m a.m.
Continue other measures.

ABH ✓

B McAlpine SHO.

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Under Section 91 and Section 141
of the ~~Health Rights~~ Commission Act 1991.

CLINICAL EXAMINATION

NURSING 0615

No sleep overnight! Stable until 0245, then ↓ BP 80/53 ↑HR-180 ↑ R.R. 50-55 ↓ Sats 90-92% L/A bronchospasm (approx 800ml) wound ooze at the time ± turn. 4% NSA 500ml x 3 given Febrile to 40° Paracetol given Temp ↓ 38° Sweating ++. H.R. 140-180 B.P. 135/55 Sats 93% on O_2 60% Air entry clear & equal then ↓ crackles. Chest X-ray showed Wet. Dr Leditschke notified. For Noradrenaline if BP ↓. No Lasix. Peep ↑15 CVP +14 R.R. remains @ 45-50. T.Vol. 700-850ml Monitor - Sinus Tachy. BSL 7.2-13.2mmol Sliding Scale Insulin Morph/Midaz 21/3mg/hr continues. Bolus' x 3 given + Midaz 5mg x2. ± no effect. Maintenance 100ml/hr. N/G feeds 150ml/hr. U.O. 25-150ml/hr. BO. x 1 300ml offensive green diarrhoea. Mod./amount creamy sputum aspirated from Trachy. Looks very uncomfortable ± breathing. All cares attended.

D. Mg (RN).

9/2/00
RMO
Claydon

Night Shift →

main issue =>

~0300h ē a turn =>

- became hypotensive BP to 80s (NIBP & ABP initially)
HR ↑ to 180 (ECG - sinus tachycardia)

=> following ? ~500-800ml ablo. loss.

=> ~~Started~~ given 1000ml. albumex bolus ē ↑ NIBP to ~100s.

(ABP ~90s). -? inaccurate

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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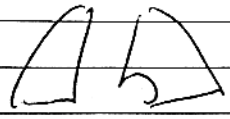
NO RELIGION	SELF EMPLOYED	

Resp :- FiO2 60%. RR 27.
SIMV Sats 96%
PS 24.



better than mane
→ ↓ crackles.

Awaiting ABG's.

GIT :- on 150 mls ultracal.
- clostridium difficile stool culture taken today.
- no aspirate.
- wound dressing taken down - some ↑ yellow secretion → Swab taken.

Metabolic :- BSL's 10-3 - 7.9.
-

CNS :- ↑ alertness some interaction ↑ rels.
M : M
2 : 3 nods

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Renal :- U/O good >110 /hr.

Plan :- wean FiO2 today.
- ↓ frusemide
- leave M : M's as is
- next bm needs further c. difficile cultures.

MLplunkett.

CLINICAL EXAMINATION

10/02/2000 2150hrs: VENT: VIA TRACHE - PSV ; FiO_2 ·60 ↓ ·50 ——— .
PEEP 15 ; PSUPP 24 ; RR 25-35. Equal air entry - decreased bibasally. Suctioned mod. amounts creamy brown ; using saline. s/b physio. SaO_2 >95%. ABGs as charted. ———— .
CVS: Monitor in sinus tachy. Rate N 130-140. MAP 75-95. ——— .
Norm to hot peripherally. Generalised oedema +++ CVP 12-14. —.
(L) CVC patent. Site not reddened. (R) radial A-line intact.
Bleeds / flushes well. Good distal perfusion. ———— .
Neuro: Slept for short periods. PEARTL. Opens eyes spontaneously. Moving eyes to indicate what side he wishes to turn to. Moved toes to command (by his parents). Appears appropriate. Very anxious at times (↑HR ; ↑BP ; ↑RR) - responds well to reassurance. Morphine @ 21mg/hr + Midazolam @ 3mg/hr. —.
Immuno: T° peaked 40.4°C - d/N RMO → NFOS. Given panadol. Cultures taken by pm RMO. Sponge given.
T° now 39.3°C. IV Meropenem continues. ———— .
G.I.T NJ tube insitu. Ultracal @ 150ml/hr. BO very small loose. ———— .
G.U.T Urine o/p via IDC N 200ml/hr. IV lasix decreased to qid.
Fluid balance from 1300hrs = approx +398ml. ———— .
Additional BSL 6.8-7.9 mmol/L. Actrapid infusion @ 3u/hr. —.
Abdo dressing attended by wound care specialist - leaking serous ooze ?150ml - dressing intact. PAC attended 2-3hrly ✓c Wardsmen. v/b wife ; parents ; and friends today. IVT @ 100ml/hr (5% DEXTROSE). Checked volume of 250ml + /hr with RMO → correct. S. O'Brien. RN (O'BRIEN - QSN)

2235h Evening
RMO
9/2/00 Stable shift

Resp - Remains on PSV
FiO_2 weaned to 50% as pO_2 >100 on 60%
PEEP remains 15
Support 24
Appears comfortable.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CONFIDENTIAL

Under Section 91 and Section 92 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

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NO RELIGION SELF EMPLOYED

9/2/00 N/ENTRY 1230
Episode of pulmonary oedema on night duty documented above on previous notes. Given a rate on ventilator at 0500 of 12 however patient became more distressed with rising airway pressures to 55cm H_2O attempting to breathe while pressure controlled breath of 1.9 sec was delivered. Rate weaned in back on PSV x 60% x 750 mls tidal volumes with PS 24 and peep 15. RR 55-35 this shift rate decreases when wife and mother in attendance counselling Terry, he is anxious about going to sleep and not being able to wake up again. Global creps at commencement of shift commenced on regular 40mg lasix 8/24 and air entry in all zones decreased in bases with creps limited to lower zones. No physio at 0800 due to pulmonary oedema. Saturations no less than 93%. Haemodynamically stable with BP increasing with increased anxiety. Remains in ST 130-140 b/min, CVP 12-15 cm H_2O and febrile to 39.5 although no paradol given sweating profusely. Urine output maintained >100 mls/hr aided by lasix. Bowels opening into drainage bag specimen sent of C. difficile. NJ continues at 150 mls/hr. Awake and interacting with relatives communicating by nodding head shaking and opening eyes GCS 10/15. Morphine continues at 8mg/hr midazolam at 3mg/hr. Not moving limbs to painful peripheral stimuli however able to move legs although has severe weakness. Wound continues to lose serous fluid it is for review by surgeons and to be redressed post inspection. For VSS of R) leg later today — P. Gre (LANE) CN

9/2/00 Pancreatitis / Gastrograffin aspiration
LEDITSCHKE Multi organ failure
Recovering slowly.
Hypotension & acute event O/N, then decrement in gas exchange after 1.5l 4% albumin.
Now BP Robust.
Persistently tachycardic, Persistent fever.
Adequate gas exchange on PEEP 15, 60% FiO_2
Ventilator dyssynchrony ~~with~~ ventilator breaths
Sputum thin ? Blood stained,
Not purulent no ↑ in volume
CXR c/w ↑ lung water
WCC fluctuating around 20.

Plan. Diuresis.

MHPH 45-1 1/92

Chart B

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

VSS lys - if neg consider CTPA.
Consider stopping Meropenem.
Chase Cultures.
wean to PSV.
leave midaz/morph as is.
consider NJ diazepam tomorrow to allow
Ceasing Midazolam.
Stop metoclopramide ∵ diarrhoea
faeces m/c/s x3 for c difficile

9/01/00 **PHYSIOTHERAPY** 1600hrs
Patient Rx x1 at 1130hrs no Rx 1st round due to pulmonary oedema.
- Patient remains ventilated
o/e Chest - some crackles (L) base, ↓BS bibasally.
Rx - MHI + exp vibs
- suction c NaCl p/o moderate amount of blood stained sputum
Plan - continue to R/V.
S Vickers (VICKERS) PT

9/2/00
RMO - GOLIKOV
Shift Report.

pt more stable this shift
CVS: • BP 140/54 MAP 84
• PR 146.
• CVP 14.

- Off inotropes now.
- has had 80 mg frusemide today
∴ cut back to 20mg qid.
- had bilat Dopplers of legs - awaiting formal report, verbal report says (N)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID--------------	SEX---	UR NO--
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TERENCE		
27-29 CULGOA CRES		14-06-1957
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Ph(B) 0419655702		
NO RELIGION	SELF EMPLOYED	

Sats & gas xc stable throughout
- not tachypneic

→ uo dropped off to 25ml/h
=> given further 500 ml.
thought to be 2° to hypovolemia
- h'ever ~ 0500 - 0530 h
=>
tachypneic 50-60
Sats ↓ to 91-92% on FiO2 0.50.

=> FiO2 ↑ to 0.60 stepwise

c Sats ↑ to 96%. CXR -
+ peep ↑ to 12.5 & clinically
- ↑ edema
=> phoned Dr Leditschke: Resp.
re. approp. mx given likely fluid o/load.
? lasix

→ advice: peep ↑ d to 15:
(d not for lasix yet, given 'soft' BP)
c PO2 stable (84) on FiO2: 0.60

→ remained tachypneic (50-60)
BP stabilised uo now >100ml
HR 140-150

∴ 0845 h after d/w Dr Leditschke -
given rate (for rest) ✓
- trial 40mg iv lasix

→ awaiting result.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991

note Hb rel. stable 88.
U+E Cr stable.

R Clayden

CLINICAL EXAMINATION

9/2/00 Dr Leditschke WR. DAY 20 ICU.

- Pt unstable last night.
- ↓BP after turn
- given 1½ l albumex.
- became tachypneaic & ~~↓~~ sats.

Now - on FiO_2 60%.
- CVP 15
- rate 12
- peep 12.5.

- CXR - some ↑ fluid, ~~but~~ slightly worse
- maintainence fluids were ceased.
- ongoing diarrhea - since sat
- MZ1 : M3 — ↑ better, more interaction ~ family.
- pain is ~~too~~ ongoing
- remains febrile, merepenam for >2/52 now.
  WCC remains the same.
- small → mod sputum still; whitish-cream.
  ∴

∴ Plan:- dry him out today & then attempt to ↓ peep tomorrow
- wean rate down today.
- restart maintenance
- cease maxalon; stool for C. difficile.
- need to exclude thromboembolism as cause of ~~det~~ deterioration
  ∴ for USS ~~of~~ legs today.
- for surgical R/V re wound.
- ∴ keep at M:M 21:3 for today
  ↓ ~~two~~ mid 3 tomorrow.
- watch loss of L cardiac ~~bor~~ border likely to be fluid ~~bec~~ not infection in light of Hx & lack of changes in temp, WCC etc
  ∴ watch for now.

MGoldhaber

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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10/2/00 RMO - GOLIKOV.
1600hrs

DAY SHIFT summary.

Pt more stabler todays, & more alert also.

Issues.

① CVS - Ro hypotension.
- BP 144/76 MAP 98
- PR 124.

② Resp - FiO_2 45%.
- has been weaned from 12.5 psup to 10 (at ~ 1545 hrs)
- continues CPS 24.

AE remains ↓ bilat but ↓↓ crackles

ABG: pH 7.49
pCO_2 44.
pO_2 91
HCO_3 33
BE in 9.1
Sats 98%.

- CXR ? developing consolidation RML
- sputum remains neg on culture
- blood cultures 6/2 (x2), 8/2, 9/2 remain neg.

③ T 38.3
- meropenem ceased ? the cause of a 'drug fever'
- needs to be free of Abx's for a few days & then reculture.
- MSU 9/2 - no growth yet.

9/2 - C. difficile neg
- wound swab gram ⊕ cocci.

needs another 2 c. difficile for cultures

GIT - ↑ transaminases..
↳ watch
- otherwise tolerating feeds well.

CNS :- has been off midazolam since 1100 hrs today
- continues to have morphine 2 mg/hr
↳ will be weaned off this next
- doesn't seem uncomfortable
- very much more alert today
& reactive, GCS 11 + tube.
- following you around rm.

Renal • u/o good ~ > 70
(usually > 100)
• Cr 0.08, Urea 11.8
• ~~Fur~~ Frusemide 40 mg q6 hr.
aim to run at ~500 mls, currently ~1500 + mls.)

BSL's ō in range.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

Plan: continue current Mx
needs x2 sputa collected.

mGowan

10/4/00 Nurses Notes 2140hrs
CNS. more alert + awake this shift. appropriate responses at times. Attempting to verbalise often
Vent. Continues on PSV with 0°45% Peep 4 to 10 this shift
Insp pressure 20 Sensitivity 2 Press supp 24 TV 630-700
Sats 95-98%

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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specimens for C. difficile.

RClaydon

10-2-00 0945hrs ICU WR Dr Leditschke

- Respiratory function stable F$_{I}$O$_2$ 0.45 ; PO$_2$ 78
- Slaxs tachycardia 130
- BP increases on physical intervention but (N) between this } 150
- Wound → green discharge
  → wound swab gram +ve cocci
- Persistent fevers > 38°C.
- Sputum changed to thick brown colour.
- CXR - ? ↑ consolidation RML
  - but less parenchymal, + retrocardiac
- CVL site → 1/52 } look (N)
  Arterial line site 1/52 }
- Interactive with family
- Diarrhoea improving → has some consistency to it now
  - 1× Cl. difficile negative
- Fluid balance +1500 mls yesterday, +1500 ml today (but large insensible losses from wound + sweats)
- ↑ transaminases this am

Px:- Stop meropenem
:- Reculture
:- 2× more Cl. difficile stool samples
:- Wean PEEP as possible GLH
:- Continue diuretics (Harrison)
:- Chase yesterday's sputum culture → ? change Antibiotics.
:- Cease midazolam, start NJ Diazepam 2mg bd.
:- Surgical review of wound
:- Wean morphine as able (once stable off midazolam) PRN
(not in pain) (Harrison)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

ICU WARD ROUND Thursday, 10 February 2000 **DR A LEDITSCHKE**
Name: Terence Lindsay UR No: 778512

This man has somewhat better gas exchange, down to 45% with a PO2 of 78. Still on 15 of PEEP. Cardiovascularly he is in status quo with a persistent sinus tachycardia and his persistent temperatures above 39 continue. His renal function is stable. Note, however, that his transaminases have gone up associated with a hiccup in his alkaline phosphatase. His blood pressure is being adequately maintained. The plan is to stop his Meropenem, to completely reculture, to continue to try and obtain 2 further faeces cultures for C.difficile, although the diarrhoea seems to be less of a problem than it was and to push on with diuresis, weaning his PEEP as possible. Chest x-ray technically very difficult. There may be some developing consolidation on the right middle lobe. His sputum has changed colour to brown. So chase his sputum cultures from yesterday and consider different antibiotics. Cease Midazolam and put him on naso-jejunal Diazepam 2mgs bd. Ask the surgeons to view his wound again.

10-2-00 CNS - Midazolam ceased @ 1100hrs ~~continues~~ @ Morphine continues @ 2mg GCS 11 seems much more alert and interactive this afternoon CVS. monitored in sinus rhythm ↑130 CVP ↑13 T° 38.2 - 39.2 hypertensive ↑ 180/90 when cares attended otherwise normotensive Resp. RR 20-30 air entry equal FiO2 @ .45 SaO2 95% - 98% small to mod amt creamy brown secretions yielded on suction ET G/T - tolerating N-J feeds minimal BO in F.C.D. ABDO remains distended and dressing intact. RENAL Lasix ↑'d today maintaining good urine output - visited by family

[signature] EN (WHITE) QST

PHYSIOTHERAPY 10/2/00
Remains on PSV
Chest ↓ BS both bases
Sputum S/A cream
Rx bagging + vibs N saline + suction
For R/V in AM
[signature] (Murphy)

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION SELF EMPLOYED

9/2/00.

CVS - Somewhat less tachycardic ~130
BP robust 135/60
UOP remains good 110-150 mls/hr
CVP ~12.
HS " "

Abdo - Wound ē mesh as prev.
Ongoing losses
Tolerating NJ feeds well
°Further diarrhoea

Renal - Cr/urea stable + UOP good

CNS - Appears more alert GCS 10+T
Interacts ē staff + family.

Plan - Continue current measures.
Consider stat. lasix if deteriorating gas exchange.
Culture further stool.

B McShepherd
SHO.

10/2/2000

CNS: T - 39⁹ → 37⁴, GCS - 11, Severe limb weakness, opens eyes spontaneously, obeys commands by wiggling toes - at times. Panadol clear 1g at 0030 + 0530 hrs. Temazepam 30mg NJ at 0015 ‑c effect. after 0100hrs pt slept for periods of up to 1(ave) hour.

CVS: HR(ST) 120 → 130, ABP - 165/65 → 119/45. NBP comparable peripheries warm + well perfused. CVP - 9 → 13.

RESP: Remains ventilated. PSV. O_2 50% + ↓ to 45% at 0530hrs. PEEP - 15, P/S - 24, TV's 500's → 700's. Sats 94 → 98%. AE R≥L ↓ bases. Suctioned prn - Small → mod thick creamy sputum.

GIT: NJ feeds 150 mls/hr - small amount of faecal matter in containment device

Renal: 70 → 360 mls/h ‑c lasix 20mg IV QID. dark amber

IVT. 5% Dext - 100 mls/hr. Insulin titrated to BSL's.
— Morph + midaz 2mg + 3mg /hr.

Hygiene: ~~[illegible]~~ PRIVILEGED AND CONFIDENTIAL Under Section 91 and Section 141 of the Health Rights Commission Act 1991. ... S/C ✓, large amount of drainage from wound as above ≃ 200 → 300 mls/this shift

[signature]

MPHPH 45-1 1/92
F0627

Chart B

10/2/00

RMO Night shift
Claydon
0135 - v. stable o/n

BP stable ! HR ~130 CVP 12

Resp. - improving, now diuresed y'day !

RR ~ 24 o/n (no tachypneic episodes)
- Sats maintained 98% on 0.50 FiO_2
∴ weaned to 0.45 :

ABG - (0.45)
pH 7.47
pCO_2 43
PO_2 78
HCO_3 31
BE 7.0
Sats 97%

- peep remains 15.

Chest - harsh crackles RL zones esp. improved elsewhere

UO - reasonable
- ↓ing response to lasix
200 ml diuresis after 0400 dose
Cr 0.09.

F.Bal. - ~1000 ml tve - but not accounting for abdo. losses.

ongoing diarrhoea

(P) (1) → continue wean FiO_2 as able.
(2) please collect total 3x stool

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

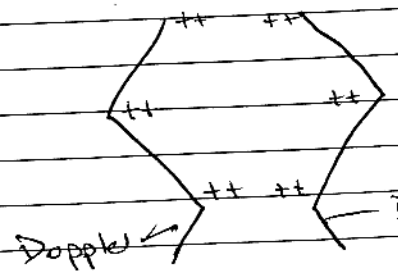
MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------- SEX--- UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

10/2/00 Nurses Notes cont
Haemodynamics: Continues in ST PR 120-135 BP 150/75 - 120/64
CVP 12-14. Temp febril 38°-39°. Given further panadol
at 1945 hrs. U/O 90-460 mls/hr
IV Therapy Morphine continues at 210 mg in 100mls @ 10 ml/hr
5% Dextrose @ 100 ml/hr for maintenance. Insulin infusion
of 100 u actrapid in 50mls as per sliding scale
N/G feeds continues at 170 mls/hr
BO x 2 This shift. faecal containment apparatus inserted
2nd Stool spec sent. for further C. specemin
Wound reinforced on Am shift OOze this
shift. To remain intact till R/V in 4/7
Condition improved this shift nurse alert reports
nil pain pt difficult to get comfortable. Given
diazepam to help settle. All cares attended to. Bell
RN (Grad)

11/2/00 Evening
RMO Problems
0050h (1) Cold (L) foot - noticed ~2330 h
- entire (L) foot cool below ankle
- never before noted
- circ obs. 0200h 10/2 noted feet warm
- (R) foot warm.
- pulses



- cap refill on (L) ~5-6 seconds cf ~2 sec on (R).
- foot sl. paler
- °(P) c/o pain
- not seen to wiggle toes.

Hx I II width

Imp - Hypoperfusion of (L) foot ? why ? vascular spasm ? emboli possible.
Note: is on medium dose heparin 5000 U tds

DATE:

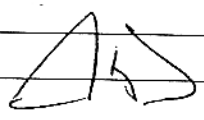
D/w Dr Leditschke
- requests surgical review
- Dr Giandazzo reg. contacted - will review - thanks Troy.

② Respiratory status - ventilating non-problematic on PEEP 10, PSV, F.O2 45%, SaO2 ≥95%
- chest clearer to auscultation than prev.

③ Fluid status - f.bal ~700 ml Qhr
- less tachycardic ~120-130
- BP robust

④ Fever ? Ab related
- Meropenem ceased
- No fever beyond 38.9 last 13/24

OE/ - T38° PR 120 BP 100/66 RR ~20,

Chest  AE fair L+R
↓ ventilated sounds.

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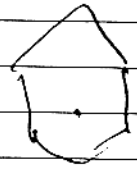
Abdo  meshed
~~soft~~ ~~open~~ wound as prev.

U as previous note.

Imp - Hypoperfused ① foot of recent onset ? cause

Plan - Await surgical opinion
Check bloods incl. CK + D-dimer

B M Shepherd
- SHO.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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NO RELIGION	SELF EMPLOYED	

ICU WARD ROUND **Friday, 11 February 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No: 778512

This man continues overall to improve slowly. His gas exchange is stable on 45% and 10 of PEEP. He has a PO2 of 85 and his PEEP has been weaned to 7.5 and FIO_2 has been reduced to 40% this morning. His white cell count is stable at 21. His sputum is now white and there were no organisms seen on gram stain yesterday. He remains febrile, off Meropenem at 38.2. His renal function is stable; however, note that his potassium is 3.4 and magnesium is 0.5, so he needs some replacement. Of note, he has had a cold lower left leg and left foot, but pulses at present on Doppler and he has reasonable capillary return., although reduced compared to the other foot. He is to have a swallow assessment and to sit out. He can have some Codeine Phosphate for his diarrhoea after his third faeces specimen has come back negative for C.difficile. BSL's have been between 10 and 12, but has been down to 4-5. We are going to investigate doing a urinary nitrogen excretion to assess his nutrition and wean his Morphine at 3 mgs/day as tolerated by patient comfort.

11·2·00 **SPEECH PATHOLOGY** 1230 hrs

Thank-you for referral for a swallowing assessment.
Trialed Thick/puree/Thin → cuff inflated.
Pt ¾ upright
OMA: ~~IV VII IX X~~ Nil gag elicited XII V.
Swallow reflex:
- Strong reflex triggered on all consistencies; good laryngeal elevation.
- Nil colour in secretions post trial swallowing.

Plan: Pt currently fasting for meave.
Monitor secretions for 4-6 hours.
If nil colour commence trial of soft diet/thin fluids.
Please keep upright (as possible); notify if colour in secretions etc.
R/V when OK to deflate cuff.

11-2-00 1300 hrs
- Discuss Dr Cowley (Pathology)
  - To assess protein balance / nutritional status, albumin / prealbumin / transferrin usually sufficient
  - Total body nitrogen balance too expensive
  - Can measure 24hr urea which is 85% of urinary nitrogen + then extrapolate by adding 15% but need to know normal protein losses for accurate depiction of total body losses

(Hanna)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE:

Nursing pm Shift. 11/2/00 1345 hrs.

CNS pt morphine ↓ to 18mg/hr – pt comfortable nil c/o pain this shift. Obeying all limbs weakened strength. PEARL size 3. CVS BP 160/105/55, HR 58 / 120-130 CVP +12 - +14, CWO ✓ Arthur ✓. Peripherally (R) leg warm, pink pedal & all pulses palpated, sensation & movement ✓ (L) leg – cool, pale pink, pulse obtained on doppler only. Foot & toes are cool rest of leg warm, [illegible] centre of (L) foot. Capillary return ≥ 3 secs. Resp PS (V) PEEP 7.5, PS ↓12, FiO_2 ↓40% RR 20-35 Episode of frequent neg. pressure – PS ↓ to compensate, pt fighting vent – Now better. [illegible] ↓ midlobes, creps coarse [illegible] SA – white obtained, good cough via trachy. O_2 sats 96-97%. GIT BSL, Abdo wound – ooze/pus [illegible], bed saturated. Noted on changing dressing mesh came loose → now bowel contents sticking out [illegible] to be seen this afternoon – Temporarily redressed [illegible]. BO ×3 – large amount [illegible] – [illegible] of [illegible] FCD [illegible] to bottom again. Renal U/O – [illegible] → 120 – 300ml/hr Lasix given as ordered. Pt now on 24/24 urine collection. Integument wound pus & ooze [illegible], redressed – [illegible] noted. PAC ✓ [illegible] not [illegible]. [illegible] 5% Dextrose 100ml/hr. MgSO₄ 20mls in an [illegible] KCL 50mls over 5 hrs. BSL 5-8 – Actrapid – Titrated to sliding scale. T° 38.6. No panadol given today. Admin NGT feed Jevity 150ml/hr – now ceased pending going to OT this afternoon or tonight. Social Worker visited today. [illegible] RN [illegible]

PHYSIOTHERAPY 11/2/00

Remains on PSV

Chest ↓↓ BS both bases

scattered crackles.

Sputum S/A white frothy.

R clapping & vibs N saline + suction

For R/V in AM

[illegible] (physio)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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→ had Diazepam @ 2100hrs ī effect
· not sleeping ; not seeming to respond a (reluctant to pt to word board for communication)
· tachypnoeic

→ given 5mg stat of Midaz @ ~0200hrs ī some effect.

otherwise good : GCS E4 V$_T$ M6 (11) (crossing legs etc)

Plan continue circ obs on LL esp noting any change in (L) pedal pulses
(prev. Fem ✓ Pop ✓ PT ✓ DP (doppler only).

reg PTY

CXR, usual bloods : WR R/V.

11-2-00 1000 hrs ICU WR Dr Leditschke

- cool (L) foot + calf , moving without pain (no compartment syndrome)
- pulses present on Doppler but not on palpation ((R) pulses palpable)
- 3x stool cultures sent
- transaminases coming down
- looks better
- CXR Stable
- ventilation Stable
  PEEP 7.5 F_iO_2 0.40
- neuro → talking quickly, unable to understand
- on diazepam 2mg bd
- agitated
- Temp 38.0's , ~~overnight~~ >39.0°C early this am
- Mg ~~0.6~~ 0.5 → on magnesium
- DNW Dr Carnosty this am for review of wound
  → at Medical School
  → will be here in pm.
- Sputum now white, yesterday's MICB neg.
- K+ 3.4 ; BSL's 10→13, have been 4-5.

CLINICAL EXAMINATION

Rx:- Wean morphine after dressings changed (13mg/hr/day)
- 1 Paracetamol
- 24 hour urinary nitrogen to assess protein needs given uncertain
- Start sodium phosphate once 3rd CL difficile specimen result back.
- Speech therapy assessment of swallow (Harma)
- Sit out
- CVC out
- Peripheral IV

11/2/00 A/V
1030

NUTRITION & DIETETICS

Biochem - Na 143 K3.4 Cr 0.07 Ur 9.6 T Alb 24
AST 74 ALT 106 ALP 103 Bili 15 WCC 21.6 Hb 100
BGL's 4.4 - 12.5 Around 0 - 6U
RO Still large amts lost from wound
Plan 1) Continue Ultrasaf 150ml/hr 20/24
2) To obtain if possible urine N to assess Pt's loss & requirements
3) To weigh if possible
4) A/V requirements Mon
JAN Parsons #684

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

11/2/00.
Wound r/v 9/2/00 - clean, healthy. sutures
today: breakdown of wash from L end. ? 2° to infection
↑ herniation of intestines - look OK: slightly more pale than 9/2/00.
Imp: further wound dehiscence
Rx: r/v by Dr. Carmody this pm. ? re-close tonight/tomorrow
stop feeds

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS
PRIVILEGED AND
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CLINICAL EXAMINATION

Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

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11.02.00 0500 N/ENTRY ICU – Unsettled night, pt restless ++ and anxious ++. also getting very agitated and upset with staff. Difficult to lip read pt. and he most often refuses to give yes/no answers and won't attempt to use the alaphabet/picture system. Thumping legs and violently shaking head at staff. During these frequent episodes Bp ↑ 185–190/–, spontaneously resolves. ? element of confusion / short term memory loss involved. Have given Mr Lindsay full explanations of why he is here in I.C.U / hospital and his treatments and all the devices around him – at times he will settle with reassurance, but is getting increasingly upset.
Obs stable, Febrile 39². Ventilation unchanged SaO_2 >96 on FiO_2 45%. AE R=L coarse bases moderate amounts on suction. IVT as ordered. Morph 2mg/hr. BSL < 5 insulin off at present. UO 80 – 450 ml/hr c̄ regular lasix. BO ō – F.C.D. insitu. TEDS on. Vascular obs – see medical r/v note, (L) foot remains cold, pulses absent. (R) foot warm D.P. absent, P.T. present, sensation present, no movement of toes to request only ankle/leg movement. P.A.C. attended, however pt. will reposition self to back within 20–30 mins. Skin on back good. Oral cares – pt. has vehemently refused swabs. Took midnight dose of nilstat after 10 mins explanation. Feeds 150 ml/hr. Gndrick (Schinkel) (RN)
0630 – more settled with lights on. Is much more aware of environment and happenings around him. Is upset that he can't get up to use the toilet with his drain. Full explanations and reassurance given. Abdo wound edges reinforced, for review today. Gndrick.

11/2/00 Night Shift Summary
0720
O'Donnell (JHO) Day (21) ICU. Adm c̄ Pancreatitis

Main issues
(1.) Cold, pale (L) foot / ankle
– nil change since last pm (1st noted @ 2330hrs)
– pulses palpable and heard on doppler as before

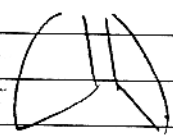
pt denies pain. Clear demarcaⁿ of temp @ ankle

D/W Su Reg @ 0245. he contacted Consultant on call – nil evidence of crit. ischaemic limb. 'no obv. vasc cause' Plan watch; for reg. circ obs

CLINICAL EXAMINATION

2. Resp. status:
reas. stable on FiO_2 0.45 PSV
PS 24
PEEP 10
Rate - spont of ~24
Sats 98%

ABG's	0005 hrs	0625 am
pH	7.48	7.49
pCO_2	49	44
pO_2	114	85
sO_2	98	97


Good AE bilat

3. CNS pulse 140 nil ionotropic support
BP 144/63.
CVP 17

4. Renal Cr 0.08
Ur 11.1
UO: 160 - 400 ml/h.
FB (+) 1-9 l since 1300 hrs.

5. CNS on Morphine 24mg/h.
nil midazolam since yesterday.
→ pt quite agitated this am. (early hrs)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
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NO RELIGION SELF EMPLOYED

SURG Reg
0130
11/7/00

ATSP about cold foot

Background:
. Severe pancreatitis day 20
& Ranson's - 3 necrosectomies
. Long term ventilatory wean
(tracheostomy)
- ? Ab related fever
. no culture growth
. no premorbid history

Tonight noted at nursing
changeover to have cold left foot
not noted previously
. Allegedly warm on morning
shift
. No Hx of femoral arterial
cannulation
. attempted arterial cannulation
of both feet day 3/4 → failed
. Had been on inotropes
Adrenaline, norad, Dobutamine & Dopamine
until 3 days ago

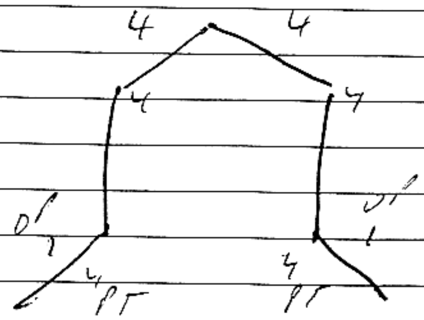
O/E - . PR ~ 120 sinus rhythm
BP 150/70

(PTO)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

NO cardiac murmurs
HS dual - nil added



· Both feet oedematous
· Left foot cold to one hand
Breadth above ankle
· Left foot slightly pale
· patient able to wiggle toes
& ankles of both feet
· no calf signs of DVT (is on 5000 units tds sc heparin)

Imp cold left foot & ankle
embolism is unlikely
? vasospasm ? why

P
I will d/w DR Pyke

→ D/w DR Pyke → nothing else
0230 to add → observe pulses
hourly - shouldn't
be anything serious

[signature]

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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11-2-00 1630hrs Shift Summary

- 42 year old gentleman who is Day 21 ICU admission for acute necrotising pancreatitis

CURRENT PROBLEMS

(1) Ventilation via tracheostomy
- SIMV / PSV
→ dramatically decreased P support from 24 cm H_2O to 12 cm H_2O to stop dyssynchrony TT flow / short sharp spontaneous breaths
→ PEEP decreased to 7.5 cm H_2O from 10 cm H_2O + then down to 5 cm H_2O at 1500hrs
→ Currently F_iO_2 0.40
PEEP 5
P support 12
→ ABG pH 7.47
CO_2 50
O_2 96
HCO_3 36
BE 11.1
O_2 Sats 98%

(2) Mesh repair loose (L) side of wound + needs to be restitched
- reviewed by Surgical Registrar
→ ?OT tonight / tomorrow
→ but hasn't informed of time
→ NBM
- informed Dr Carmody
- wound still oozing mucopurulent discharge, nothing cultured

DATE:

(3) Diarrhoea
- 3x Stool specimens C. difficile → negative
- codeine phosphate commenced.

(4) Cool (L) leg
- intact pulses on Doppler
- tried to contact vascular Reg. several times for review today but no answer

(5) ↓ K+ 3.4
- K+ Supplement today
- K+ 3.7 now.

(6) ↓ Mg 0.5
- supplemented
- now 1.1.

(7) undergoing 24 hour urinary urea to assess nutritional status

(8) Speech Pathology → trial soft diet / thin fluids after OT
- cardiovascularly stable
- obeying commands
- BSL's 4 → 5.
- coping with ↓ sedation

Px:- watch ventilation → will need T P support if tiring
:- watch Mg+ + K+
:- Chase vascular surgical opinion → ? any more action required for (L) leg
:. Surgical opinion regarding OT for mesh (Herman)
:- wean morphine by 3mg/hr per day

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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11/2 Mesh dehiscence on upper surface

Needs to be reclosed - best managed by return to OT

Sheehan.

11/2/00 Nurses Notes 2140hrs.
Ventilation, On PSV at 40% 0² Peep ↓ 5 at 1500hrs Press support of 12. Tolerating well Sats 95%-98% To theatre for resuturing of abdo wound at 1800hrs RT Unit at 1900hrs Commenced on SIMV at rate of 12 O² of 50% Peep of 5 Pressure support of 12. Sats 98-100%. weaned to 60% O². at 2100hrs. sats remain 98%. Blood gases stable.
IV Morphine continues at 18 mg/hr = 10mls/hr 5% Dextrose continues at 100mls/hr. for maintenance. Insulin infusion 50units in 50mls as per sliding scale BSL of 3.7 at 2100. Infusion ceased, pro tem. Haemodynamically stable pre + post op. Now in Sinus rhythm PR 120-92 This shift. BP 130/90 - 110/47. Febrile most of shift 38° - 36.8 (post op) Now 37°
Wound continues to ooze slightly.
Urine output good 50-300mls/hr * on 2hr Urine collect commenced at 1600hrs.
PAC attended to This shift. FCD in situ.
Plan Orders from Dr Stevens Proposal to continue for 4hours post vecuronium. Vecuronium given at 1620 ∴ Proposal to continue till 2220hrs - Then wean over 1hour. NG feeds to recommence at 0400hrs — Olive RN

RMO-GOLIKOV Evening Shift Summary
2320hrs

- pt went to OT at 1800 today for laparostomy, + for insertion of mesh, as it had come away superiorly.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

DATE: Resp

Pt tolerated procedure well.
Returned to ICU on SIMV FiO_2 80%
rate 12, TV 800mls, ē sats 99%.

ABG taken
pH 7.4
PCO_2 58
PO_2 144
HCO_3 34
BE 8.7.
sats 99%.

∴ now weaned to
rate 2
FiO_2 50%.
sats are currently 96%.
→ needs repeat ABG.

CNS.
- Rocuronium given in OT at 1820hrs
- ∴ propofol infusion continued for 4hrs post dose & weaned over next hr
- propofol infusion now ceased & pt is fully awake & pre op state.
- in some ↑ pain post op ∴ given 5mg bolus morph on top of usual 18mg/hr infusion also for Temazepam 20mg nocte.

CVS Stable
BP 132/57
PR 100/min.

Hb 93 post op.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATIOI

V orders - now on PSV
- PEEP 5
- PS 12
- ~~SATS~~ FiO_2 45%

(4) GIT
- having soft diet & thin fluids
- nj feeds continuing 150 mls/hr
- ~~bowels~~ - still diarrhea
∴ x3 c. difficile negative then given codeine phosphate

(5) Temp ↓
in 38's still
↑ WCC 22.1.

Plan: - ↓ FiO_2 gradually then PS
- continue otherwise.

11.2.00 NURSING 2144 hrs. Vent on PSV. (AC-SIMV) Vent unchanged Resp rate 30-40 this shift AE R-L ↑ Creps in both lungs. SaO_2 ≥ 94%. FiO_2 45%. CVS BP 150-210/55-100 ↑ BP when aggitated due to frustration ō communication P in ST @ 135-150 Febrile 39.5 Feeds are tolerated @ 150 ml ate ½ soup + 1/5 of banana this p.m. BSL 7.3 - 13.2 mmol. dressings reinforced ↑ Combine on both sides GCS 15/15 alert & orientated. Visited by family, no changes this shift ——— [signature] (RN) ANTON

13/2/00 Evening shift:
Claydon
D/40 Stable
- watched videos tonight
- mood good

PRIVILEGED AND CONFIDENTIAL
Under Section 61 and Section 141 of the Health Rights Commission Act 1991.

MHPH 45-1 1/92

Chart B

CLINICAL EXAMINATION

DATE: (Cont.)

- hypertension settled when visitors left.
- Resp PSV
  remains on FiO_2 0·45 as PO_2 borderline (69)

(P) Rpt gas mane wrt ↓ing FiO_2 to 0·40

overall, stable

R Claydon

13 Feb 00 NURSING 0600hr.
Restless night, only slept 1~2hrs despite Temazepam
RESP – tolerated PSV x 12 + 45, thick secretions
O2 sats 93-98%, tachypnoeic most of night
CVS – tachycardic, otherwise haemodynamically stable.
Urine output variable ½ Lasix, Temp 39.5 → 37.3
after large diaphoresis.
GIT – passing flatus ++, loose bowel actions continue
FCD bag 90% effective. BSL'S 5.0 → 10.9 mmol.
CNS – GCS 11 → alert most of night, looking around
++, moving all limbs lower > upper
SKIN/MISC – PAC'S attended, back sl. creased, diaphoretic
++, only minimal ooze from abdo wound.
ADDIT – FCD requires re-application + shave around area. Rapson RN (Oxley)

13·2·00 RMO Kenny
NIGHT SHIFT SUMMARY.

(1) Stable. Relaxed over night ... sleep.
Communicating.
Pain free
(2) CVS - stable. BP 134/57
HR 120 SR

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID----------SEX---UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

12/2
looks good
wants to talk + walk.
weight bearing ok. but no sit ups or crunches!

12/2/00
Consultant WR - Dr Stevens

- pt more alert today.
- stable since return from OT.
- sats 98% on FiO_2 50%, on PSV for 5hrs.
- recommenced feeds at 0400 this morn.
- diarrhea is still a problem - given codeine phosphate.
- renal fn) unchanged; 1st negative balance oedema improved.

Plan: - continue to ↓ morphine to 5mg/hr + boluses as required.
- can get him to wt bear.
- can't PS as tolerated, but 1stly ↓ FiO_2.
- continue 24 hr urinary catheter.
- continue otherwise

meetings.

12.2.00 Nursing 1355HR stable shift.
ventilation: commenced PSV at 0700HR (PS12, FiO_2 45%; Peep 5.0) Mr Lindsay this shift: SaO_2 93-96%. Moderate to large amounts of creamy sputum. Lung fields generally clear on auscultation; occasional crepe bibasally. TV 520-640 RR 26-45. < N > s: Alert, orientated GCS 15/15. Febrile to 39°. Morphine reduced to 14.4mg/hr. < V >: Remains hypertensive 145/49 - monitoring ST HR 120-130. Urine output 70-130 prior to regular basins. CVP 8-~~10~~ mls shift. G & T: Appears to be tolerating moderate amounts of soft diet with thin fluids. Denies nausea. NJ feeds (FS ultracal)

CLINICAL EXAMINATION

DATE:

continue at 150mls/hr. BSL's 8.6 - 11.00 on sliding scale insulin. Diarrhoea ++ (400mls emptied ~? from 12m/day yesterday) Coedine phosphate qNew.
Social: Wife and children visited with Mr Lindsay in the sun. Perfusion: (L) foot cool this shift (same as last shift) however pulse present and ~~Hot~~ pink in colour.
Paul Upp RN Paul Camp

PHYSIOTHERAPY 2/2/00
Remains on PS Ventilation
Alert + co-operative
Deep breathing + wibs
Suction yielding m/d white sputum
for R/V in AM (Murphy Murphy)

6/2/00 RMO - GOLIKOV
1530

DAY SHIFT REPORT.

(1) pt improving each shift
- able to communicate & understand, interacting c family
- listening to music
- went outside for 1st time today & really enjoyed it.
- morph 4.4mg/hr

(2) CVS Stable
BP 173/72 - hypertension started today
HR 144.
peripheral oedema settling.

(3) Resp :-
PSV - FiO_2 45%. PO_2 (57).
pH 7.47. HCO_3 33
PCO_2 44, Sats 94%.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION             SELF EMPLOYED
```

(Renal) UO >50 mls post op
-observe, now that propofol is
off likely ↑BP & ↑UO.
- Cr 0.07, K 3.7

(L foot) - has become warmer
+ DP pulse palpable.

(GIT) feeds to commence 0400hrs.

Plan:- repeat ABG
- continue ↓ wean
- observe + R/V UO
- observe K⁺.

[signature].

12.2.00 : Nursing : 0630
pt condition unchanged and stable. Continue on ventilation SIMV x FiO2 .50
x Resp 8 x PS 12 x Peep 5. SO2 97-95%. ET suction Large-moderate
thick, white secretion. breath sound crackly and noisey. haemodynamically
Tachy and BP stable. 100-120. Neurologically pt slept for a short
time with help of 5mg morphine bolus and IT Temazepam and awake
but comfortable the rest of the night. morphine infusion continue
18mg/hr. Metabolism: BSL 4.8-11.0 and insuline sliding scale
runned 0-7 units/hr. feed via NJ recommenced 150 mls/hr and
maintenance 5% Dex 100mls/hr. U/O good 65-250 mls. remained
febrile over night 37.8-38.5

[signature] RN NFAMOVC

PHYSIOTHERAPY 13/2/00
Remains on PS Ventilation
Chest ↓ BS coarse creps
Transmitted sounds throughout
R clapping + vibes NaCl + suction
yielding SM/A creamy secretions
for R/V in AM [signature] (Physio)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

12/2/00 Night Shift Summary
0700 hrs
O'Donnell Day 22 ICU Acute severe necrotising pancreatitis
(JHO)

pt slowly improving each day!

communicating more appropriately & effectively

slept better this shift

since return from OT yesterday pm, pt has been stable

had been on SIMV FiO_2 50%
Rate 2 → Spont breaths to 30.
PS 12 cm
PEEP 5cm
TVol 800ml.

ABG's @ 0600 pO_2 114 Sats 98%
pCO_2 47

↓ V to PSV FiO_2 0.45
PS and PEEP same

Good UO 70 - 120ml/h.

Propofol ceased @ 0000 hrs

Feeds restarted @ 0400 hrs Maint 100ml/h.

haemodyn. stable

Morph @ 21mg/h.

Plan continue to slowly wean V as tolerated

PTY etc

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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13/02/00
WR 1x BC bottle on 9/02:
addit: scant growth of Candida (micro. phoned)
(also in sputum, mouth ++)

→ given risks of systemic antifungals
won't commence as only scant growth (may be contaminant)
→ need to re-culture specifically to search for Candida.

Nursing Entry 1350hrs RClaydon
13/2/00. Pt remains ventilated TV 450-500. PEEP 5. FiO2 ↓ 45-40% pressure support weaned from 12-11. resps 32-44 O2 Sats 93-96%. 500g at 1200 midday for 2hrs ↑ resps 50. ↓ O2 sats 93% T. 39°c given panadol pg orally (Blood cultures taken). CVL dressing attended. IDC - hourly measures adequate. Actrapid infusion as per sliding scale. morphine 2mg/hr. maintenance 100mls/hr. NG fed at 150mls/hr. BO x1 loose - codeine phosphate given. faecal appliance applied (L) hand oedematous. BP 120-160 copious amounts of sputum suctioned. 10mmol Mg 50% given over 1 hour. Abdo wound: cannules changed, duoderm and dressing redone. Visited by family — J Fitzgerald RN (Christchurch)

13/02/00
1610hr Day shift Issues -
RMO Claydon.

① Resp. - aim today was to
- wean PS 8 to 10
to aim for T-piece tomorrow
(as per WR notes)

CLINICAL EXAMINATION

→ PS ↓ to 11 ✓ 10.30 am
& then sat out in chair ~1/2 hour
→ gradual ↑ in RR (high 40's)
sats ↓ to 92-93%
PO_2 5.9 – (On FiO_2 0.40)

→ back into bed
& PS taken back up to 12.
& FiO_2 ↑d to 45 (sats 95-96%)
Chest – widespread harsh insp. crackles
freq↑ esp. wheeze.

→ remained tachypneic: (likely 2° Fluid + sitting out of bed – also. prostic)
given frusemide dose (40mg) early
at 1530h
c 270, 300 ml diuresis so far.

clinically – RR ↓d. ~30's.
Sats 96% now & stable.

(P) – R/t ABG please Masha.
see clinical response
post-diuresis
– if stable again → re-attempt
to ↓ PS as per WR
plan.
& ↓ FiO_2 to 0.40.
(consider stat lasix doses o/n if needed)
(2) BP stable – hypertensive at times
(160 s.)
– tachycardic c SOB ~140-150
(ECG – sinus tachy.)
o'wise stable.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION	SELF EMPLOYED	

(3) TFT's (N) other bloods stable
-Euthyroid k+3.8, mg 0.8

(4) Febrile this shift to 39°
- Further BC's taken
(specifically re. Candida)

(P) - as per am WR + notes above.

R Claydon.

13/2/00 2220hrs NURSING. Pt alert. G.C.S. 15. PEARL=5mm Able to move limbs with mild weakness. Tachycardic + pt ventilated on PSV at 45% FIO2, RR 35, PRESS. SUPPORT 12cmH2O. Clin entry both sides but ↓ on (R) side. Frequent suctioning reqm. with mod thick sputum. N/G feeds continue (tube blocked x1 time which cleared with Coke™ flushes) with very loose green bowel motions. Skin integrety good. F.C.D. applied to contain noxious waste. Haemodynamically pt still tachycardic + hypertensive at times, peripheries, O.K. (R) foot remains cool with fair cap. refil, pulses present & sensation + movement. Pt quite anxious + shifting around in bed, 2x large diaphoresis + quite "shaky". Settled with normal diazepam dose but may require more. ~~S.D.A.~~ R.N. Hodson —

13/2/00 2300hrs R Dsso - Golikov.

Evening Shift summary -

Pt is stable improving overall.

(1) Resp: apparently pt is PS was ↓ to 8 today from 12 but didn't tolerate it well & sitting up etc ∴ turned back to 12 again.

CLINICAL EXAMINATION

• ABG repeated at 1750 hrs on FiO2 45%.
pH 7.58 ↑ ∴ metabolic alkalosis
PCO_2 39
PO_2 93
HCO_3 37
BE 13.3 ↑
SATS 98%.
∴ discussed c Dr Stevens –
2200 hr dose of frusemide was replaced by acetazolamide 250mg IV.
Repeat ABG at 2230 hrs
• pH 7.45 ∴ much improved
pCO_2 53
PO_2 111
HCO_3 36
BE 11.1
98%.

– ∴ FiO2 ↓ to 0.40
– plan is to try to wean some PS tonight if tolerated

(2) CVS stable
• BP 128/60 MAP 81
PR 87. 127.

pulm oedema earlier today. seems improved.
∵ ↑ gas exchange
↓ tachypnea
improvement in lungs.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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③ PS/ PSV FiO_2 45% Sats 99%.

ABG 0620 ph 7.47 HCO_3 38
pCO_2 53 BXS 12.9.
pO_2 84

PEEP 5
PS 12

④ GIT Continued ↑ NG heads
x2 diahorrea → no cultures grown
→ cont. sodene phosphate

⑤ Renal U.O. > 80ml/hr.

⑥ Temp shift in 38.5 - 38.4°
WCC 21.4
Neut 19.8

Man/ Cont mtn BV keep FiO_2 45% mtd
PaO_2 improved. (84).

Add magnesium 10mmol (Mg 0.6)
Add 40mmol KCl to IVF (K 3.5).
↓ morphine as tolerated.

Kenny

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

13/2/00 DR STEPHENS WR.
0945am.

- gas XC good (PO_2 84)
  FiO_2 ↓d to 0.40 this am

Plan - ↓PS to 10 later today
(aim T-piece tomorrow)
- continue weaning morphine

other - Mg 0.6
K^+ 3.5 } - nursing replacement
Hb 97

CO_2 ↑ng slightly (53)
- clinically not tired
∴ observe for now

T°: observe - no Rx unless frankly septic

given ↑ HR, sweaty => check TFTs

continue ± outside trips

- uncertain re. overall surgical plan at present -> to clarify ± Dr Carmody this week.

R Claydon
(SHO)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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SELF EMPLOYED

(3) Renal.
- 1600 hr dose of lasix given earlier ∵ of wet lungs → c̄ good effect, >500 mls in next hr.
- UO mostly >100 mls/hr.
- Cr 0.07
- Urea 6.5
Looks less oedematous peripherally
- still in ⊕ balance ~ 1L.

(4) GIT
- diarrhea continues despite codeine phosphate.
- is now eating reasonably well, nurse estimates that he at ~ 1/3 of his beef stew today.
∴ ? will need to look at ↓ feeds accordingly over next few days.
Currently feeds 150 mls/hr.

(5). CNS - alert + responsive
- morphine now on 12mg/hr.
- somewhat agitated later in the evening improved after nocte diazepam was given.
↳ likely also benzo withdrawal
- due for Temazepam tonight.

(6) electrolytes
↓ Cl to 92.
∴ change maintenance fluids to ~~NaCl~~ saline 60 mls for time being. (↓ from 80 → 60 mls).
- watch K+ at 3.4.

Plan:- Continue to wean V.
- watch ↑pH due to diarrhea + frusemide.
- R/V fluids + feed vol mane.
- watch WCC (has ↑ to 25.0) + repeat cultures if >38.5.

14/2/00 ICU NURSING ENTRY:
pt settled and slept for short periods throughout night.
pt alert and co-operative when awake GCS 14/15.
T 38.5 HR 120 ST ↑ SO BP 140/60 peripherally warm and sweaty at times. (↓) foot now warm.
FiO_2 weaned to 40% + PS + 11 during night. m/+ thick creamy sputum suctioned frequently overnight.
IVT cont as ordered Insulin infusion cont as per sliding scale.
U/O 160 - 250mls/hr BNO. NG feeds 150mls/hr
wound dressing remains intact. but continues to ooze from dressing (x1/24)

14.2.00 RMO Lenny
Night shift report.

Stable throughout shift. Slept well. Alert. Cooperative. No distress th' night.

CVS - Stable BP 140/70 HR 70

② RS - PSV 40% PS reduced to 11. Sats 98%.
ABG 0620 Ph 7.43 HCO_3 32
pCO_2 49 BXS 7.6
pO_2 26.9

- Weaned & PS well further & to 10.

③ Renal. - dieresis ++ >150ml/hr th' night.
K 3.4+
Cr 94 - improved.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATIOI

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14/02 - ~~24 h urine~~ Result -
~~Vol 2918 ml~~
Cr 5.3 ~~5.3~~ mmol/L
Cr excretn 15.5 mmol/d (10-22)
Urea 187.3 mmol/L (100 - 1400)
Urine Urea excretn 547 mmol/d (400-700)

RC.

ICU WARD ROUND **Monday, 14 February 2000** **DR A LEDITSCHKE**
Name: Terence Lindsay UR No: 778512

He is awake and appears comfortable on his weaned Morphine, now on 9.75 mgs/hr of Morphine. Still on the 2 mgs bd of oral Diazepam. He is haemodynamically stable. Heart rate is around 110. He is still febrile to nearly 40 and note that there was a positive blood culture with a candida yesterday in the context of candida in the sputum, which was an albicans. Gas exchange has improved with PO2 of 126 on 40%. Still hypercaponaeic with PCO2 of 49, but he has a metabolic alkalosis with a pH of 7.43 in the context of Frusemide. However, he is pruning up well. The plan is to remove all his lines, to insert a peripheral line, to take some more blood cultures, for IV Fluconazole and he can change to oral in a few days and urinary catheter out also. For nil by mouth and a speech therapy review as there is some concern about how well he is going with oral fluids. Try and tighten up his Insulin infusion. Note that he is complaining of decreased hearing and has bi-lateral effusions on auroscopic examination. Could the ENT doctors see and advise re further investigation? Note that he has persistent left lower lobe collapse with copious sputum and needs aggressive physio. Stop Omeprazole and reduce Diazepam to 2 mgs/daily.

14.2.00 SPEECH PATHOLOGY 1230 hrs.
R/V as Pt apparently having difficulty c Thin fluids - No mention in chart.
R/V Thin only. No change from 11.2.00.
Pt needs to be as upright as possible, given mild delay in pharyngeal phase.
Nil colour on ~~post~~ trial suctioning.
Plan: Please monitor suctioned secretions ~~over~~ next 3-4 hours.
If Nil colour, Pt appropriate to continue c Thin fluids & Soft diet.
Kathy Speech

14.2.00 AM NURSING ENTRY
Resp; Ventilated 2 hours off ventilator on T piece. Pt became sweaty agitated RR 40 HR 140 Sats ↓ 85% returned to ventilation mode PSV + 5 PEEP Fio2 .4. TV good 500-600mls. PS set 10. Chest crackles throughout Wheezy (R) mid zone. Secretions ~~+++~~ creamy in colour. Plan to take off vent 1 hour at a time. Tommorow 1hour off 2 hours on.
CVS; HR up to 140 when agitated. Normally 110 bpm. Bradycardiac episode 36bpm when suctioning, self-resolving. Fundial in blood cultures

CLINICAL EXAMINATION

commenced on fluconazole. All lines to be removed and sent for MC+S
IVI to be discontinued. Temp 39.3. Peripherally pink. leg ~~P~~ intermittantly cool, but all pulses present. BSL controlled on sliding scale, currently at 3mls/hr BL 5.7. Morphine reduced to 10mls/hr (10mg/hr) Wound oozing serous fluid at ~~of~~ sides of dressing.
GI; BI/Sr bowels opened soft formed green stool. Anal bag removed on moving patient. ? aspiration Food + thin fluids, ~~Dietician~~ speech therapist review, happy but to remain NBM for 3-4hrs then suction, if not blue dye recommence ~~PO~~ Free fluids + diet. Ultracal contains 1 cal/ml. NG tube not blocking.
GU; Output good. MC+S taken. Catheter to be removed today.
CNS; PEARL + 3 moving all limbs. Orientated. Appears withdrawn at times.
Skin; Anal cleft reddened, Skin intacted. Skin under arms thrush ++. Needs skin specimens taking today.
VIB Parents, sat out of bed today. ~~A~~ Shilling (SKELDING) QST

14/2/00 **PHYSIOTHERAPY** 1500hrs
- patient remains intubated PSV 36 x 540 ↓40%. SpO2 94%.
PEEP 5, period on T-piece above noted
Assess - ↓BS bilaterally ↓L > R, transmitted sounds throughout
Rx - MHT + esp ribs
- suction + NaCl p/o m/a creamy sputum
Plan - continue to tx/

S Rickers (VICKERS) PT

~~14/2/00~~

14/2/00
17/0hr
RMO Claydon

Day Shift Summary:

Stable shift

Resp → T piece trial this ~~E~~ am.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bilirubin	Blood	Urobilinogen	Remarks

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NO RELIGION
SELF EMPLOYED

CLINICAL EXAMINATION

Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

(3) Renal:
- 1600 hr dose of Lasix given earlier ↓'d wet lungs → ☺ good effect, >500 mls in next hr.
- UO mostly >100 mls/hr.
- Cr 0.07
- Urea 6.5

looks less oedematous peripherally
- still in ⊕ balance ~ 1L

(4) GIT
- diarrhea continues despite codeine phosphate.
- is now eating reasonably well, nurse estimates he ate at ~ ½ of his beef stew today.
∴ ? will need to look at ↓ feeds accordingly over next few days.

Currently feeds 150 mls/hr.

(5) CNS - alert + responsive
- morphine now on 12 mg/hr.
- somewhat agitated later in the evening, improved after nocte diazepam was given.
→ likely also benzo withdrawal
- due for Temazepam tonight.

(6) electrolytes
↓Cl to 92.
∴ change maintenance fluids to ~~NaCl~~ Saline 60 mls for time being. (↓ from 80→60 mls).
- watch K+ at 3.4.

CLINICAL EXAMINATION

DATE:

Plan:- Continue to wean V.
- watch ↑pH due to diarrhea + frusemide
- R/V fluids + feed vol mane.
- watch WCC (has ↑ to 25.0) + repeat cultures if >38.5.

14/2/00 ICU NURSING ENTRY:
pt settled and slept for short periods throughout night.
pt alert and co-operative when awake GCS 14/15.
T38.5 Hr 120 ST ↑30 B/P 140/60 peripherally warm and sweaty at times. (L) foot now warm.
FiO_2 weaned to 40% + PS + 11 during night. m/a thick creamy sputum suctioned frequently overnight.
IVT cont as ordered Insulin infusion cont as per sliding scale.
U/O 160 - 250mls/hr BxO. NG feeds 150mls/hr
wound dressing remains intact but continues to ooze from dressing.. (ox/sy)

14.2.00 RMO Kenny
Night shift report.
Stable throughout shift.
Slept well.
Alert. Cooperative. No distress th' night.

CVS - Stable BP 140/70 HR 70

② Rs - PSV 40% PS reduced to 11. Sats 98%.
ABG 0620 Ph 7.43 HCO_3 32
pCO_2 49 BXS 7.6
PO_2 126 ↑

- Aerated + PS well further ↓ to 10.

③ Renal. - diuresis ++ 2150ml/hr th' night.
K 3.4+
Cr 94 - improved.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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CLINICAL EXAMINATION

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NO RELIGION	SELF EMPLOYED	

(E) GIT - shld some diahorrea → anxiety with T codeine
Managed breakfast well.

(I) Temp - shld pyrexial 38.5°
awaiting cultures re candida

Plan/ watch to see if tolerates PS 10.
K+ 3.4 - add 40mmol KCl to
Amount repeat cultures re temp
Cont to wean morphine as tolerated.

14/02/00

DR Leditschke WR:

- overall improving. (PO_2 126 on 40%)
- at present on T-piece doing well - Sats 96%
  —: Plan - leave on T-piece
  until tires, tachy.,
  hyperT, hypercap.
  => onto ventilator
  + onto ventilator o/n.

- Ongoing Temps - Candida sparse growth 1x BC. (Phoned yday by MICRO, → need to clarify species (re. Fluconazole sensitivity)
  • remove all lines (wean ↑ing) Febrile to nearly 40°C.

- haemodynamically stable.

- TFTs (N)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (CONT.)
DATE:

- ongoing metab. alkalosis.
- take Further 2 x BC's
- peripheral lines. please.
- tolerating feeds.
  → concern re. Fluids:
  ∴ speech therapy R/v #258
- tighten Insulin
- c/o ↓ hearing.
  - bilat. effusions likely cause
  - ask ENT please to R/v & advise re. need for Further Ty.
- chase 24 h ur. nitrogen. (Dr Que Hee #169)
- ongoing diarrhoea (3 x C diff. (-))
- continue weaning morphine

RClayden
(RMO)

14/2/00 **PHYSIOTHERAPY** 1115 hrs
Tx at 0830 hrs, Tx on 13/02/00 addit patient SOOB at 1130 hrs.
Patient ventilated
o/e - ausc^ - ↓ BS bibasally, transmitted sound throughout.
Tx - MHI T exp ribs
- suction T NAsal, productive l/a thick creamy sputum
- Patient SOB ~ 3½ hrs
Plan - continue to T/V.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

~2h duration
→ went well
maintained sats no ↑ RR.
back onto ventilator when felt tired.
-Plan was for another hour this a'noon never sats only 93% at present ∴ will check ABG, if PO_2 poor / ↓ d ⇒ leave until tomorrow.

GIT - Speech therapy R/V today - thankyou.
→ no evidence of aspiration (no dye suctioned immed. or 5h post)

∴ → as NJ tube blocked
→ remove.
& continue c ō diet & ō fluids.
+ iv Fluids ceased given ō intake.

other meds. - commenced on fluconazole

- lines removed (not for art. line -sent for culture. rplct at this stage)

- peripheral cultures sent ✓

uo - IDC also removed (given Candida)
Please ctue lasix & continue Fluid Balance

-also d/w ENT Reg (Dr Que Hee) re. ↓ hearing →

CLINICAL EXAMINATION

DATE:

likely 2° to ETT, high P.V. ē Exst. Tube trauma
- will resolve ē time.
any further concerns he will R/V.

RClayden.

14/2/00 2150hrs NURSING. All lines removed + sent for culture. Skin + wound swabs taken + sent, pt appears agitated at times as last p.m. shift denies being agitated or jumpy + sensory delusions. At times when questioned appears to lose concentration + looks dazed, if question repeated pt seems to respond. Appears to be orientated to person + place but unsure of what day it is. PERRL=3mm. Pt able to move all limbs well with mild weakness. Resp. wise pt remains tachypneair with RR 37-43/min. RMO advised against T-piece trial tonight as PaO2 6.0mmHg, SaO2 91-93% on FIO2 .40, pt currently on 10cm H2O press support. Still requiring frequent suctioning for thin creamy sputum. Physio x2 this shift ē good result. Pt encouraged to try + cough up sputum ē some effect. N/G tube blocked on previous shift + unable to be cleared ∴ tube removed. Pt able to tolerate diet with nil sign of distress or aspiration. Need to push oral intake though. Wound redressed, looks well perfused nil sign of infection exudate or necrosis nil significant odour. BOX2 with very soft formed green faeces. Pt now voiding urethrally into bottle with respectable amounts so far. Pt left lower leg still ~~to~~ S/H. cool to touch but otherwise (c sm) C.V., + pulses DP, PT, + POP. present. Pt remains ~~dry~~ S/H diaphoretic + hygiene cares attended to. Pt educated to importance of PAC + appears to understand. R.N. Hudson

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

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CLINICAL EXAMINATION

Under Section 91 of the Health Rights Commission Act 1991.

ICU WARD ROUND Tuesday, 15 February 2000 DR A LEDITSCHKE

Name: Terence Lindsay UR No: 778512

Continues to improve. Chest x-ray possibly clearing, but copious white sputum. Gas exchange was stable, but no blood gas this morning due to problems obtaining a specimen. He is alert and interactive. Still on daily Diazepam at night. Slept well from 2.00 a.m. after Temazepam. Continue to wean Morphine as appears to be comfortable. Cardiovascularly stable. Nasal jejunal tube was blocked, so is having a trial of oral diet. So far successfully, but needs a low fat diet. He still has diarrhoea, but more formed this morning. This may improve as he starts to eat normal food. The plan is to start a T-piece wean, trying an hour off the ventilator and then 3 hours on for a rest and we will do that 3 times today if he tolerates it. He was exhausted after 2 hours on a T-piece yesterday. He can have daily blood gas and second daily x-rays unless there is a deterioration. Remains persistently febrile. Still on IV Fluconazole in view of the candida in his blood over the weekend.

NURSING 15·2·2000 1510 hrs:- Stable shift:- NEURO. GCS 15/15, although pt has tracheo. Continues on Morphine infusion. ↓ from 10mg/hr to 5mg/hr today. RESP:- Ventilation remains PSV. PS 12. FiO^2 40%. PEEP 5. RR up to 36 bpm. TV 400-550. Chest X-Ray appears improved. Copious amts of white secretions evident on suctioning. Regular suctioning necessary. chest - A/E = bibasally. CVS - Haemodynamically stable. Remains in Sinus tachy. Remains afebrile. Normotensive. BSL WNL - actrapid sliding scale titrated accordingly. GIT:- Tolerating oral diet very well. Managing thin fluids. Diarrhoea continues BO x 3 today. Appears to have more formed semi motions in comparison to previous days. c/o- adequate. IV Lasix continues. Using bottle well. * NB:- Trial on T-Piece today. 1 hour on T-piece this am. Tolerated it very well. For another trial this pm. For 1 hr off ventilator only. Visited by Mother & father. Dressing on stomach left insitu. No leakage until 1430. Will need re-dressing this pm. Tracheo dressing changed. IVC resited in (L) arm. ——— Majord (RN Cadzow)

15/2/06 **PHYSIOTHERAPY** 1520 hrs Rx x 3

o/e - Patient remains ventilated, T-piece wean daily.
- ausc^n - ↓BS (L) LL, °added sounds.
I - cough - strong & effective - able to clear secretn, then remove T section from tracheo
Tx - MHI techniques
- suction T-Nabl - p/o 1/a thick creamy sputum

DATE:

- Patient SOOB x 1½ hrs.
- Mobility - fairly sm amt of wt thru legs, ¾ x assist required to transfer to chair

Plan - continue to R/V + encourage mobility
- R/V by night physio.

Mickers (VICKERS) PT

2200 hrs 15/2/00 NURSING. Pt alert + more orientated this shift, also appears more relaxed. GCS 15 with tracky insitu. PEARL = 4mm. Able to move limbs with severe weakness. Airway clear + both lungs equal i multiple crackles. Still large amounts of thin white/cream sputum being suctioned + pt assisting by coughing to clear chest. On PSV ↑ to .45/. FiO2 for rest & night + press support ↑ to 13 cm H2O as well. Successful with 1 hour on T-piece this p.m. Oral intake of fluids continues well though pt. c/o nausea during dinner (could be the sweet + sour pork). Still managed some food + settled with maxalon. Bowel sounds present, + B.O. continues still very soft + green but formed. Wound reinforced again tonight + ? if wound nurse is still reviewing - Haemodynamically stable remains tachycardic but B.P. better this shift. Temp was down to 36.7°C for a short period but now 38.3°C - Skin integrity very good considering pt's ordeal some thrush noted on both axillas, now being treated with micanyole cream. Otherwise skin intact. Needs to be re-inforced why pt needs PAC (TO PATIENT) as pt tends to roll onto his back after turns. All in all pt appears much more settled + of a positive aspect. Pt.'s relatives may also need to restrict their visits somewhat as this seems to cause agitation to Terry. R.N. HUDSON

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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Nursing Report Contd.

improved o-night - at R/T - SpO_2 - 94-96% Resp - 26-30 bpm STV 450-500mls - Suctioned for copious amt pretty creamy secretions - good cough reflex. Air entry equal. C.V.S:- Monitoring in S. Tachy. 140 ↓ 110 this am. Normotensive - Temp 39.4°C ↓ 37.9 at R/T - Tepid sponge & fan in progress o'night.

Intake:- Morphine inf. contd at 10ml/hr Insulin inf. 1 unit/ml as per S scale - 3ss BG - 7.2 mmol - Oral juice & (PRN) meds. APC -

Output:- Small dark green formed BO early morn incontinent of approx 500mls - urine this am:- aware after he had BO. -

General: PAC oral eye care attended: Pt slept on his back on his request - but rolled. 3 hrly GCS 15. - moving all limbs - mild weakness - persists obeys commands - but looks vague at times

Endorsed by RN - Exley.

15.2.00 Night Shift Summary RMO Kenny

Stable th' out shift.

(1) CVS - haemodynamically stable
Sinus tachycardia th' out night ~140 bpm, this am now 110 bpm.
BP stable 140-120
50-60

(2) RS PSV 50% 40 PEEP 5 PS 12
Post T-tube - tachypnoeic 40-45 RR
- desats - 91%
Th' out night - Sats improved 94-96%
RR & bo 26-30/min

→ no further reduction in PSV attempted.

(3) Renal - voiding both well yesterday
U.O. adequate
Incident of urine this am → above

@ GP - hard breakfast this am.
- B.O. + diahorrea

3) CNS - alert/ communicating
Some distress last night energy
Not settled ? temazepam → slept well.

6) Temp - Still episodes of pyrexia upto 39.4°.
→ started on ? ceftriaxone

5/2/00 NUTRITION & DIETETICS A/V

Biochem: Hb 108 WCC 28.5 Alb 23 AST 63 ALT 87
ALP 107 Na 137 K 4.1 Cl 94 Cr 0.07 Ur 7.4
Febrile up to 39° o/n Currently 37°
Still awaiting urine N results to ax N requirements
Feeds NJ feeds ceased due to blocked tube.
Pt commenced on a normal diet + thin fluids
Pt eating well.
Plan 1) To provide low fat diet / High Pro
2) To provide supplements so that pt can meet high energy requirements
3 x SHP / day
3) To ax oral intake tomorrow to determine if further supplements required
Assessment #684

5.2.00 SPEECH PATHOLOGY 1145hrs
Nil colour SH post trial yesterday, indicating no aspiration on thin.
Pt safe for normal diet, Thin fluids. Dietitians are monitoring intake re: ↓ NG feeds.
Plan: RIV on request.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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@ Rectangles -Lt 3.8 much improved.

Man needs ABG taken heated this am.
for T-tube again today
CSI advised further ✓

ICU WARD ROUND **Wednesday, 16 February 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No: 778512

This man is still slowly improving. The issues are nutrition. With his naso-jejunal tube out he ate relatively well yesterday, but was not very interested in breakfast this morning. He appears to be a bit more depressed. He is still on 2 mgs of Diazepam at night plus some PRN Temazepam. He is now down to 5 mgs/hr of Morphine, so we will wean this down to 2½ today, provided that he is comfortable. He has a coagulase negative Staph. in a blood culture and a coagulase positive Staph. on one of his line tips. The plan at the moment is to do nothing about that because the coagulase negative Staph. probably skin contaminant. He is still on Fluconazole for the Candida that he had in his blood on the weekend and his AST has gone up from 66 to 109, so we will need to keep a close on eye on that. He could change to oral Fluconazole after today's intravenous dose. The ventilatory weaning is progressing. The plan today is for an 1½ hours off and then 2½ hours on and see how he goes with that.

NURSING 16·2·2000 1330:- Stable today. Orientated. Morphine infusion ↓ to 2.5mgs/hr. Pt appears comfortable on that amt. strength in limbs appears a little improved. GCS 15/15.
RESP:- Trial of T. Piece today - managing very well. 1½ hrs off ventilator 2½ hrs on ventilator. Continue this into this morning. Ventilation orders remain unchanged. PSV. PS 13; Peep 5; F_iO^2 ↓ 40%. without significant change in O^2 saturations. SaO^2 on T-piece 97%. Chest remains poor. crops both ⓐ + ⓑ. Slight exp wheeze evident on ⓛ T lobe. Moderate amts of white secretions still evident via the tracheal tube. Frequent suctioning necessary. CVS:- Stable. Monitored in ST ♩ 110 bpm. Normotensive. Remains febrile.
GIT:- Bowel motions x 2 today. Reluctant in oral diet today. BSL - WNL. Actrapid infusion titrated as per S/S.
U/O:- Adequate. Continues on IV frusemide.
WOUND:- Wound completely redressed. Comfeel changed. See back of Obs chart (16·2·2000) for instructions, & dressings used. Kim Chua contacted & suggested this regime.
SOCIAL:- Family into visit.

Cadzow (EN cadzow)

DATE:

16·2·00 PHYSIOTHERAPY.

Remains ventilated. Trialling T-piece 1·5 hrs.
Chest: ausc: ↓ BS (L) LL. Coarse crps b. basally
cough: effective / prod thick creamy.
Rx: Bagging + likes, N/saline + Sx
SOOB - 4× assist. Stand T/F. Hoist back to bed
Suctioned for thick creamy
Plan: For evening PT

Meel (mees)

16/02/00 DAY SHIFT SUMMARY
1430

42yo ♂ admitted initially with pancreatitis / gastrografin aspiration

Continuing to improve slowly.

① CVS - BP 110 - 150
45 - 75
PR ≈120

② Resp RR 22 - 30
Sats 97-98 %
PSV Resp 5 PS 13
Trial TP 1½ HR Then ventilator 2½ HR (doing well)

③ CNS GCS 15
PERRL

④ Renal UO 130 ml/HR. Naught → Noon.
urea 7.4
creat 0.06.

⑤ Endocrine: still BSL 3·2 (0000 hr)
Sliding scale adjusted ✓ by night RMO.
Monitor BSL.

⑥ Infection: Yeast on Blood cultures 13/02/00
On IV fluconazole
LFT abnormality on ? fluconazole

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

watch LFT
Δ IV fluconazole → po tomorrow
Coagulase -ve staph on blood cultures 14/02/00
Imp: slowly improving
Plan: Continue as planned.
Δ to po fluconazole tomorrow.

VG
TKAN

16.2.00 Nursing 2200. CNS Comfortable on 2.5 mg Morph hr.
Awake all evening, went downstairs & watched video tonight
Valium to settle. No temazepam offered as yet.
CVS - Tachycardic, normotensive, well perfused. T 37.6 Paced quite
Resp - Coping well when on T-piece. Denies fatigue, sats
remain in mid 90's, RR & HR unchanged. On PSV overnight.
Copious white sputum. Good cough. s/b Physio tonight.
GIT - Poor appetite. Well takes fluids well. BO - Small loose
Renal - Voiding well, 400 + mls at a time. Urine clear.
General - BSL's labile - 12.7 → 7.5. Insulin infusion continues.
No problems with wound dressing leakage. Buttocks slightly red
Family visiting all p.m. — Cerebellar WEHRAN [illegible]

16/2/00 RMO - GOLIKOV
2300 hrs. EVENING SHIFT SUMMARY

pt v stable this shift.

(1) Resp :- ventilator orders unchanged
· FiO_2 40% Resprate 25
· PS 12.
has tolerated trial of T piece
(1½ hrs on & 2½ hrs off)

(2) CNS : stable
BP 120/60, -
PR 120.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE:

(3) CNS
- alert
- watched video & enjoyed it.
- on 2.5 mg morph / hr

(4) - GIT not v much appetite today.
- bo - this shift, small vol & loose.

(5) Still having some hypoglycemia earlier today but BSL's have been (N) (-) adjustment of sliding scale.

(6) Renal
- UO good
- Cr 0.07
- U 6.8

(7) Bloods.
- Hb 93
- WCC 23.9
- LFT's stable but ↑ of few days a
  - ALT 153
  - ALP 194
  - AST 68
- K^+ 3.5 ∴ for 1x spank mane
  ∵ required x3 chlorvescent yesterday & oral intake poor.
- Cl^- 89 will need 4 NaCl on food.

Plan:- Continue V wean.
- observe nutritional req c ↓ appetite.
- observe BSL.

Markers.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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15/2/00 RMO - Golikov
2325hrs Evening Shift Summary.

pt stable this shift.

(1) Resp:- Pt tolerated ~ 1/hr on T piece a few times during day. Again for 1hr this evening.
- beginning of shift seemed somewhat tired RR 41 + sats 91%.
∴ ↑ FiO_2 to 45%. + PS to 18 (from 12)
+ RR has ↓ + sats have improved.
- Aim is to keep pt well rested so that he can continue c the T piece tomorrow.
- ABG = pH 7.48
(on 45%) pCO_2 50
pO_2 82
SO_2 96%
HCO_3 36.

(pO2 is ↓ from this morn

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(2) CVS :- BP 136/67
HR 125.

(3) GIT :- eating well, some nausea that resolved c maxalon
- BO at 1700 more formed
- probably needs RV by RN Chief re wound again.

(4) BSL's - Some hypo's continue even c yesterdays adjustment of SI scal
- BSL 3.0 - given Apple juice + insulin off.

CLINICAL EXAMINATION

DATE:

Plan:- continue c̄ T piece tomorrow.
- continue c̄ morphine wean, currently 5mg/hr.
- K 3.0 ∴ for replacement.

[signature]

16/2/00 0630 // General condition unchanged overnight. Haemodynamically
NURSING stable but still febrile to 38.4, tachycardic to 135, and tachypnoeic
to 35. $SaO_2 \geq 96\%$ on 45% PSV 5PEEP 13PS. Frequent moderate
amounts of creamy sputum ½-1¼. Fluid balance ~1700 ml negative.
Morphine continues at 5mg/hr. BSL's 3.0 at 2330, 8.4 at 0200, and 3.2
at 0600; ?? Insulin sliding scale too "heavy handed". BO x1 overnight
small amount of semiformed stool. Patient slept for 2-3 hours
[signature] RN

15/2/00 Night shift report RMO Kenny

Stable. No problems.

① CVS - stable. still tachycardic ~120bpm
BP 130-140 / 60-70.

② RS PSV FiO_2 increased to 45% in evening and PS14
[illegible] 2° tachypnea
↓ sats.
No ↓ in FiO_2 overnight sats ~96%

PS 14 PEEP 5 FiO_2 45.
RR ↓

GIT - B.O. x1 - more formed. Eating well.
Renal - using bottle 1000ml -ve FB.
Temp - still pyrexial upto 38.4°C
[illegible] still some low BSL 3.0/3.2 needs further
adjustment of SSI.

...NATION

...INATION ON ADMISSION/OUTPATIENTS

...e	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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DIETITIAN cont.
@ target rate of 150ml/hr
Commence @ 90ml/hr 2/24, ↑ to 120ml/hr 2/24
then ↑ to target of 150ml/hr.
Add water to feed & provide fluid boluses as required depending on 24 hrs fluid intake
4) Add ½ salt/water to 1st feed
5) To RV tomorrow am
J ANDERSON RD #684

ICU WARD ROUND **Thursday, 17 February 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No: 778512

This man continues to improve. He is continuing to wean well, apparently 1½ hours off the ventilator and 2 hours on. He has still got copious thick secretions. He is weaning well from his Morphine. He is haemodynamically stable. He is running a negative balance, but still has some oedema, although he is pruning well. His nutrition is an issue. He is not eating all that well since his naso-jejunal tube came out. The plan today is to continue with the weaning, increasing his time off the ventilator and then giving him a decent rest in between. We will try for 3 periods of at least 2 hours off, if possible, with a decent rest time in between of greater than 2 hours. Change his Fluconazole from IV to oral and I would give him a course of 2 weeks of Fluconazole. His liver function tests appear to be stable at the moment. We will place a fine bore enteral feeding tube and feed him enterally overnight and then encourage normal diet during the day. His magnesium is 0.6, so we will give him some magnesium aspartate down the naso-gastric tube and he will need some extra supplemental potassium as well. This is because his potassium is 3.2. Encourage mobilisation as much as possible.

17.2.00. 14¹⁵ hrs. NURSING ENTRY
Resp:- Weaning well, 2 hours off the ventilator this am. Ord not tire. Sats remained 99%. on 40% O_2 via concha. Returned onto the ventilator 45% O_2, PS12, PEEP 5, good tidal volumes ranging from 350 to 500mls. Sats > 93%. Copious amounts of thick creamy sputum, appear to be looser this afternoon, good cough only on suctioning. Bilateral breath sounds, noise from secretions - sounds clearer this afternoon.
CVS:- Low grade fever 37°, CVS obs stable, peripherally warm, peripherally oedematous. ST. no dysrhythmias. Fluconazole changed to oral - waiting for it from pharmacy.
CNS:- Morphine stopped, appears comfortable, Pupils size 3 brisk, weakness in arms and legs.
U/O:- IV frusemide BD 80mg - good urine output
Drinking good amounts of oral fluid.
GIT:- Not eating good amounts. Need clinifeed tube inserted see dietician review. BSLs stable on Slading scale insulin. RNO this morning

CLINICAL EXAMINATION

DATE:

Cubs: pressure areas intact. additional dressing done – surgeons will want to [illegible] the wound, they might tighten the mesh tomorrow. Outside for 1½ hour. Family visited for most of the morning. All cares attended to. Sat out of bed for 2½ hours. Standing transfer with 2 wardsmen. [illegible] S.E. PETER (RS)

PHYSIOTHERAPY 17/2/00
nil complaints
Trialling T piece for short periods – managing well
Chest widespread crackles
[illegible] clapping + vibs N saline + suction yielding M/A creamy secretions
Sat out of bed – maximal assistance required with standing transfer
For R/V in AM [illegible] ([illegible])

17/02/00 DAY SUMMARY

STABLE this shift.
continues to improve. (weaning off ventilatory support well.)

① CVS → stable
BP $\frac{110-140}{50-70}$
K 3.2 → Chlorvescent + monitor rpt tonight.

② Resp → weaning off vent. support well
tolerated 1½HR on T piece well. – ↑ to 2HR × 3 episodes.
RR ≈ 30
Sats 96–99%. PSA Now 45%

③ CNS → stable 14–15 GCS.

④ Renal → urea. 6.2
creat 0.06.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

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NO RELIGION	SELF EMPLOYED	

24/24 NIS - Nursing Report. 16/2. - Neuro - Grossly intact PEARL size. 3.5mm + brisk in action, morphine @ 2.5mgs/hr ÷ slight weakness in Both upper + lower extremities. GCS 14/15 opens eyes to speech but mostly spont. eye opening. Resp - pt ventilated via Tracky on PSV - of 12cm H_2O PEEP 5cm H_2O FIO_2 40, pt well saturated 95% → 97%. VT 350 → 600mls A+E good to bases, RR 26 → 34 b/min, thick yellow green sputum on suctioning via Tracky - pt has good cough + swallow. CVS - Atlanta + stable BP via NIBP cuff 125/53 MAP 78mmHg HR 110 → 120 b/min ST. Chloride + K+ on harsh side - commenced on Spark. given this evening as charted. Peripherally warm, feet slight amount of oedema nil elsewhere noted. pulses palpable x 4 IVC (R) lower arm, nil signs of infiltration. GIT - abdo dressing intact nil leakage from dressings. B/sounds - audible, hyperactive + pt passing flatus - BO x1 this shift small non formed dark green faeces ~ 50mls. insulin infusion as per SS scale encouraging diet + fluids when pt awake. Urine - has not Piled this shift (7pm 12st micturition.) nil sign of discomfort from pt. - Other PA intact pt sleeping (appeared) at beginning of shift, continue to assess pt's nocturnal sleep pattern

OXLEY NA / RN C. Cameron.

0200 Nursing 17/2 - x2 PO Temazepam given due to pt not sleeping.
0700 Nursing 17/2 - BO x 3 - soft non formed faeces mod → large amounts. Pt slept intermittent throughout this shift. Insulin @ 1 → 0 units/hr. + BSL's 6.2 → 8.0 mmols. tracky dressing attended nil oozing from abdo dressing. NE changes

OXLEY N.A.

C. Cameron. RN

18/2/06 Penny RMO Night shift report

Uneventful night.

① CVS - stable HR 110-120 BP 130/50-60

② RS PSV PEEP 5 PS 12 FiO_2 40% RR 26-34

ABG ph 7.49
PCO_2 52 ↑ HCO_3 39
PO_2 65 ↓ BXS 13.7

③ GIT - B.O. x1 unformed

④ Renal - U.O. adequate

⑤ CNS - alert / orientated

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

(6) BLOODS LFT - Stable
K 3.2
Mg 0.6.
Cl 90

(7) BSL - well controlled
~7

Plan / Cont to replace K+ - span K
Mg } dietary.
Cl }

PhO2 45%

FREEDOM OF INFORMATION / CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

17/2/00
1200

NUTRITION & DIETETICS

* Biochem: Hb 92 WCC 23.9 Na 135 K 3.2 Cl 90 Mg 0.6 Cr 0.06 Ur 6.2 Bili 13 AST 56 ALT 135 Alk P 186 BSL's 6.2-9.8 Actrapid 1-2 Units
* BO yesterday UO good Temp 37.5
* O intake - pt has poor appetite. Consuming little of supplements provided & very little food. Spoke to parents last night. They asked if they could bring food in if he has a preference for foods not provided by the hospital. Discussed suitable options to them.
* Est intake ~2MJ + 10-15g ptn only
* Est Requirements 8.2 x 1.2 x 1.3 = ~12.8MJ
Ptn Requirements ~125-140g/d
Fluid " 2-2.5L/d

Plan
1) Continue to encourage oral intake including supplements
2) To supply 2 x SH+ /d Please encourage intake
3) To commence NG feeds @ night

Feeding Regime
NG Continuous feed to Ultracal 1800 - 0600

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID---------------SEX---UR NO--
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

18/02/00 EVENING SUMMARY
* Doing well this shift.

① CNS → stable

② Resp → RR 40
Sats = 97% PSV.
T piece trial 2HR / 1 HR ventilator → tolerating well.
ABG still resp alkalosis PH 7.52
PCO2 47

③ CVS → GCS 15/15
stable.

④ Infection → restarted IV fluconazole (alt concern c̄ absorption)
WCC today 29.4

⑤ GIT → nocturnal diarrhoea

PRIVILEGED AND CONFIDENTIAL
Under Section 62 and Section 141 of the Health Rights Commission Act 1991.

⑥ Electrolytes → ↓K+
last K+ 3.3
Have ceased lasix
currently on chlorvescence ii OD.

Imp: Improving.

Plan: Monitor electrolytes
IV fluconazole.
continue as planned

19-2-00 N/ENTRY 0605
Stable shift T° 38.4 pa P 120-132 BP 140/84 130/60
R 32-44 Sputum large in amount, white & thin
O2 sats 91-98%, PS Ventilation overnight on to concha 40% at 0600, Nil distress. BSL 8.7 mmol
Insulin as per sliding scale. Faecal containment device insitu gas +++. Uridome 500 mls + wet bed. Dressing reinforced x 1. Ultrafil 120 mls/hour achieved. Mouth & pressure care given —— [signature] RN

CLINICAL EXAMINATION (Cont.)
DATE:

RADIOLOGY
PROCEDURE CT CHEST PA
CONTRAST ULTRAVIST 300X 120ml
TIME 12:45 DATE 19.2.2000
DOCTOR DEMETRIADES

19/2/00 LEDITSCHKE 1330 · Sudden deterioration this am.
Tachycardic, Tachypnoeic → full dose IV heparin
CTPA - negative.
CXR ? ↑ collapse ē Chest : mucous plug ++; ? mild on probing
Otherwise stable, although WCC 28 which is up a bit from ~ 23.
generally less febrile.
diarrhoea settling.
appear has staph ē BC from A.Ht.
- id not yet clear.
this is in context of staph coag neg from 14th + staph aureus from (wip art) from 14th.

Mg 0.7.
no phosphate for 2/7.

Plan : Bronchoscopy
· Continue IV fluconazole
· Cease IV heparin, Continue TDS S/c heparin
Stop amoxycillin (restarted : antireq ?). (7500 units).
· Add anti staph cover
cease id of recent isolates.
· Restart diuretics (ceased yesterday)
single dose acetazolamide.

[signature]

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION	SELF EMPLOYED	

DIETITIAN cont.
- Continue using Ultracal feeds
- To NV Mon
Thompson RD #684

ICU WARD ROUND Friday, 18 February 2000 **DR A LEDITSCHKE**

Name: Terence Lindsay UR No: 778512

This man continues to improve. He's weaning well from the ventilator and the plan today is for alternating 2 hours off and then 1 hour back on the ventilator with a longer rest period over lunch and then a rest period overnight on the ventilator. The main issue is nocturnal diarrhoea related to the reintroduction of nocturnal naso-gastric feeds. The plan currently is to reduce the feeding rate and see what happens. He is a bit hyponatraemic, hypochloraemic and hypokalaemic, but we will stop his Frusemide and observe these at present. We will need to replace his magnesium in case that is contributing to his diarrhoea. His white cell count is 29.4. Observe this at the moment. Because of concern about the absorption of his Fluconazole, change it to intravenous.

18.2.00. Nurses notes 1400 hrs.
Improving steadily.
On no analgesic at all! Codeine phosphate for diarrhoea 30mg QID for diarrhoea though CNS- mentally alert does not seem overtly depressed to me
Stood out on tilt table with postural hypotension on outward effects.
CVS- Stable. Profuse sweating continues
T° 37'-37.8. HR up to 130 today BP to 153/60
Resp- creeps + bilaterally. Copious amounts creamy sputum aspirated via yacht.
GIT- no diarrhoea or bowel activity today. Bowel sounds active +. Taking oral fluids (sustagen hospital plus) well but poor on solids.
Renal- Urine clear. Voided x 1
Endocrine- continues on sliding scale insulin as per medic chart.
General- family to visit
Tilt table
IV cannula resited
Recommenced IV ~~fluconazole~~ fluconazole in light of diarrhoea D/W (Hudghton) Caitlin

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

PHYSIOTHERAPY 18/2/00

~~Remains~~ Trialling T piece 2 hours on
1 hour on ventilation.
Chest widespread transmitted sounds
Crackles (L) [illegible]
L/A sputum
[illegible] clapping + vibs N saline + suction
Stood on tilt table managed very well
For R/V in AM [signature] (Murphy)

18-2-00 1900hrs Shift Summary ICU Reg

- uneventful day, ↓ feeds for diarrhoea, IV fluconazole, IV changed
Px :- Continue monitoring K+ + mg+
: Continue T tube trial - tolerating well [signature]
(Harris)

18/2/00 2220hrs.
NURSING ENTRY: RESP/ A/E EQUAL - AU FIELDS EXPIRATORY CRACKLES MODERATE AMOUNTS OF SPUTUM REMOVED [illegible] WITH SUCTION CREAMY TAN. SATS 97% - 99% PSV .45 FiO2 AT WITH CONCHA PACK .4 FiO2 (2HRS : 1HR) RESP RATE 36 - 44.
CVS/ (S) BP 140 - 160 (D) 60 - 80 ST - 130 - 150
T 38' - 38⁷ MOB/ PAC 2-3HRLY TURNING SELF WITH HELP X1 OUTPUT/ 60 PH THROUGHOUT SHIFT GIVEN FCD FOR CONSTANT BOWEL MOTIONS AS WELL AS CODEINE PHOSPHATE - NIL FURTHER BM'S - URIDOME ALSO FITTED FOR OVERNIGHT. WOUNDS/. REINFORCED ABDO WOUND X1 MODERATE AMT OF OOZE INTAKE/ MODERATE O INTAKE SUPPLEMENTED BY ULTRACAL 40ml/HR SINCE 6pm. VISITED BY FAMILY THIS P.M. [signature] CHARGE RN.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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chest - widespread harsh insp. creps.
esp. LL zones

sputum ++ on suctioning

→ also febrile o/n 738 (concurrent
(on Fluconazole) c tachypnea)

ABG - FiO2 0.4
pH 7.52
pCO2 47 - ongoing metab.
PO2 97 alkalosis.
HCO3 38
BE 13.3.

- awaiting k+, mg. results

③ CVS stable

④ mood - low this am
very flat affect
no particular concern - everything
overall making him
depressed.

Plan - ① ?? need to Δ type of ng feed
to ↓ diarrhoea
WR discuss": ② ? consider anti-dept Rx.
- trips outside etc.

③ as per evening shift
Cl dropping c Na
→ should we add
to feeds?

RClaydon.

- addit K+ 3.1 Mg 0.6
- d/w Reg (Dr Harmon) -
will add to ng Rx.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

18-2-00 1030hrs ICU WR Dr Ledtschke

- Diarrhoea
  - already on fibre in feeds
- Temp ↓ ↓Na, ↓K, ↓Mg
- Flat affect WCC 25.4
- off morphine + comfortable
Rx:- Slow rate of NGT feeds
  :- Restart IV fluconazole (? 5 being absorbed)
  :- monitor K+
  :- Frusemide ceased
  :- 2hrs off + then on vent whilst asleep until (Hermes)
  approx 2 x 2 hrs, bigger rest break lunch.

18/2/00 1045 **NUTRITION & DIETETICS** A/V

* Biochem: Hb 90 WCC 29.4 Plt 516 Na 133 K 3.1 Cl 88↓ Cr 0.06 Mg 0.6 Bili 10 AST 44 ALT 19 ALK 178
* Temp up to 38.9 o/n 37.5 now
* Feeds o/n NG feeds up to 150ml/hr, - x6 diarrhoea +++ - disrupted pt sleep
* ō Intake slowly improving - good intake of fluids

Plan 1) Encourage ō intake particularly intake of supplements
2) Continue to provide 2-3 SH+ day - please ensure he tries these
3) O/N NG feeds. ↓ feed rate to see if pt tolerates better ē diarrhoea ↓
- Commence feeds after pt had time to have any supper he desires orally
- Commence feeds @ 40ml/hr for 3/24. If tolerating ē no excessive diarrhoea ↑ feed to 60ml/hr for 3/24. Continue to ↑ rate by 20ml/hr every 3 hrs to a target of 120ml/hr. Only ↑ rate if pt tolerating feed and no excessive diarrhoea.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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NO RELIGION
14-06-1957
M
SELF EMPLOYED
... LABEL HERE

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

19.02.00 Bronchoscopy
/Dr [illegible].
[illegible]
Copious [illegible] sputum.
No plugging.
airways mildly erythematous

Sputum - urgent gram stain.
C+S.
[illegible] [illegible] 3.1gm qid
If [illegible] many gram +ve cocci, add
Vancomycin

19/02/00 NURSING (ICU) 1520hrs. Eventful shift! Prior to taking pt outside on t-piece @ ~0900hrs, pt ↓SpO_2 to as low as 64% (Free flow breaths) → Returned to PSV & attended CTPA & Broncoscopy.
CNS: GCS 11/15. PEARL. Alert & orientated. Given Propofol @ 10mls/hr during broncoscopy for ~30mins c̄ 2x5ml boluses.
CVS: Monitored in ST. HR 110-125. BP 130/60 - 155/78. Afebrile
RESP: PSV. ↑FiO_2 from 0.4-0.5; PS from 14-20; PEEP 5. V_T 380-530
SpO_2 93-100%. Thick creamy sputum suctioned.
GIT: Tolerating mod amt. c̄ intake. BS present. FCD insitu.
RENAL: IDC inserted (#14). U.O 70-200mls/hr. Lasix 40mg given x2 this shift.
Settled c̄ family @ present. Cont to observe. [illegible] RN (MCKNIGHT)

19.02.00 Gram +ve cocci in blood culture - coag neg to date - awaiting confirmation
Coag neg staph on catheter tip 14.02.00.
Add Vancomycin 1gm bd.
Awaiting sputum gram stain
[signature]

19/02/00 DAY SHIFT SUMMARY
+ No major problems this shift.

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

① CVS → stable

② Resp → Episode of acute desaturation this morn.
Now stabilized
Had CTPA → -ve for PE (Reported by Radiology Reg Tm)
ABG - pH 7.54 → given acetazolamide attempt to correct alkalosis.
SO_2 62 PO_2 69
Sats 96%
PCO ...

CLINICAL EXAMINATION (Cont.)
DATE:

Had bronchoscopy this morning
- copious sputum
- sent for urgent stain. → check
- No plugging. my review
Restarted Lasix 40mg bd today
③ CNS → STABLE
GCS 15/15

④ Electrolytes → K+ 3.5 - watch in view of reintroduction of Lasix
Ca 1.3
Mg 0.7

⑤ Infection → H/v of blood cultures. catheter line Arterial.
14/02/00 previously report S. aureus
Now → coagulase -ve staph.
Candida.
Blood culture 14/02 coagulase -ve staph.
Blood culture 17/02 ? coagulase -ve. sensitive to vanco.
Plan: started [illegible] IV
started vancomycin IV
continue fluconazole IV.

Plan: as above.

19/2 Bronchoscopy sputum
→ MCS
Leucocytes ++
+ve cocci ? strep numerous
+ve cocci ? staph few
-ve bacilli moderate

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

Act 1991.

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19/2/00 Nurses Notes 2235hrs.
Disruptive shift this shift. diarrhoea continues BO x 3 this shift. unsuccessful application of FCD → Removed. Ventilation FiO2 50% PSV Pressure support 20 Peep 5 ~~Dyspnoeic~~ tachypnoeic most of shift. Volumes 460-700 Airway pressure 23-31 R/V at 2230 Commenced on SIMV rate of 18 TV of 600 Pressure support of 12. Continues to be tachypnoeic. To be R/V in 1hr. Good urine output this shift. Most drugs given late as IVT resited this shift. Ultracal feeds recommenced at 2130 @ 30mls/hr. —— RN (Ollive)

19/2/00 Evening shift summary RMO Kerry

① CVS haemodynamically stable

② RS FiO2 tachypnoea most of shift ~40 RR
ventilation orders changed
FiO2 50% SIMV Rate 18 PEEP 5 PS
ABG; afterwards;
pH 7.45
pCO2 51 ∴ Met ~~acidosis~~ alkalosis 2° diarr
pO2 97 → with resp compensation
HCO3 34
BXS 9.9
→ cont ventilation orders.

③ GIT Poor oral intake. Diarrhoea ++. For NG feeding

④ Renal U.O. good. K+ 3.4 → ? replacement

⑤ Temp still pyrexial ~38.5 - commenced on Ab regime

⑥ Mood → low

Plan/ watch K+ more.
Check Mg2+ more ? needs replaced.
Cl- 88 → add x3 salt sachets to NG feed.
Monitor RR.

MHPH 45-1 1/92 Chart B

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE:

20/2/2000 Nursing Entry: 0645hrs -
CNS: Opens eyes spontaneously, obeys commands - appears orientated. communicates well c/c mouthing words. PEARL size 3.
T - 39° → 37.5. ii Soluble Panadol given at 0200 when T 39°.
CVS: HR 120 → 135 (ST), NBP - 100/40 → 135/55, warm + well perfused.
RESP: SIMV - 18 × 600 c/c 50% PEEP - 5, P/S - 12.
VTs delivered - Machine 600's → 700's. Own 200's → 500's.
AE - L=R c/c good [illegible] in bases + noisy throughout. Suctioned [illegible] - small to large thick creamy sputum. ABGs done this am.
GIT: N/G feeds 40 → 120 mls/hr (increased as tolerated) → 0600hrs. Passed small amounts (continued leak) of thin greyish faecal matter. BSL's 9.6 → 10.2 Insulin [illegible] to BSL.
Renal: IDC. 35 → 360 mls/hr. lasix 60mg IV at 0000.
Wound: leaking moderate amounts from both lower corners of dressing - reinforced x1.
IVT: N/saline for drugs.
K Owens RN

20/02/00
Claydon
RMO.
Night Shift Summary -
stable.
tachypnea settled o/n.
on SIMV.
main issues this am -
K+ 3.1 ∴ Chlorvescent ↑d to ii BD.
Mg 0.6 - will replace.
* Na 158 - had 3x NaCl sachets in ng feeds o/n.
osmol ↑ (313)
good UO.
asymptomatic

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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as => d/w Dr Hoare:
Δ iv fluids to 5% Dextrose
+ give another 500ml 5% Dex. over 12hr.
lasix should help "off-load" Na.
NO more NACl into feeds this am.

RLL

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

addit. Hb 76
no clin. evidence bleeding
APTT only mild ↑.
will recheck Hb later

20/02/00 KEDITSCHKE 1130.
· Haemodynamically relatively stable HR 120 BP 126/52.
· Fair gas exchange pO_2 88 on 50% ~~RA~~ PEEP 18 x 650.
Spont Vt ~ 400ml RR 12
· Looks Tired.
· Chest - crackles ++ as before.
LHS 2 mil added sound but difficult ∴ lung sounds.
CXR not done (was 2nd Daily).
Diarrhoea settling
Mild fluid Deficit.
Note Na 158, Hb 76 K 3.1. Mg 0.6. Phosphate low
Bicarbonate 26 on after acetozolamide.

Plan - Continue A/B's - Timentin
Vanco
Fluconazole.
- Check sensitivity of candida to fluconazole
- Recheck Hb.
- extra free water stop added salt.
Supplement Mg, Phosphate, K.
- Lines rem'd today, for CXR
- Recommend surgeon, ~~&~~ Repeat CT Abdo.
- Back to full NG feeds please.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)

DATE:

Nurses note. 14^{30} 20/2/00

- Fully alert & co-operative, tired, slept a lot.
- Vent - SIMV 50% x 600 x 18 peep 5 PS 12.
  Air entry crackles O2 sat 96% [illegible] thick creamy sputum
- Obs: T 38.4 BP 120/70 HR 134. ST.
- lasix 40mg IV BD good diuresis, urine sent for C+ST.
- Na+ ↑ was on 5% D 80ml/hr till 12^{00} Na ↓136
  IV back to N.S.
- Eating fairly well drinking well. back to N/G feeding 6pm to 8AM ultracare 120ml/h please
- Abdo wound not done am. oozing +++. please take swab x C+ST if no dressing pm
- BSL 8.4 – 11.3. insulin to sliding scale.
- BO x 2 [illegible] loose paste.
- visited by parents.

RN. W.P. Ba[illegible]

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

20.02.00 PHYSIOTHERAPY 0730hrs; 1030hrs; 1400hrs

pt remains ventilated
chest - widespread transmitted sounds
large amount thick cream sputum.
Rx: bagging & vibs
SX.
Plan: R/V in am.

K A Stewart
(STEWART) PT.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

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MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

20/02/00 DAY SHIFT SUMMARY

① CVS → relatively stable

② Resp → looks tired this morn. but settled this pm
CXR – slightly improved (delay consultants
CXR daily please ē surgeon + CT
RR 30. aside for now)
Sats 95–96% on SIMV 600 x 18. 0.50%.

③ Electrolytes Na 134
K 3.8
Mg 0.6 → gave IV $MgSO_4$ 10mmol today.
PO_4 1.0
liver enz okay.

④ CNS → stable
GCS 15/15

⑤ Infection → On IV fluconazole / Timentin / Vancomycin.
Trough level 7.1
Continue.
Blood cultures staph coagulase -ve.
Candida albicans
→ requested sensitivity
Will be ready MON.
Febrile today → Blood cultures sent

Plan: continue ventilatory support.
continue IV AB's

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

TRAN

20/2/00 PHYSIOTHERAPY - Evening 22.20
ATSP by RMO re: rattly chest
O/E tachycardic to 150.
chest ↓ UATS AE quite good
Rx ① manual hyperinflation ē insp. vibes
② NaCl lavage / + S/O IM/A thick creamy secretions
Clamblay (CAMBLEY) PT

MHPH 45-1 1/92

Chart B

20/2/2000 Nursing 2235 hrs: Ventilation SIMV FIO2 .5 PS 12 Peep 5. TV 400-500 RR up to 40. Sats 96-99% Chest widespread crackles - S/B physio. Secretions m/A CR sputum. Temp 38.6 - B/C taken. HR - ST increasing rate @ 2200 up to 155 bpm. ecg taken, ST. BP elevated to 169 systolic. RR 38. Pt has no chest pain. GCS 15, pt mood somewhat flat. Co operative but distant in communication. NGF restarted, currently 60ml/hr pt tolerating these. BO x 3 small/mod. amt green fluid. Fluid status ++. Oral intake fair fluids encouraged. Skin: dressing changed, duoderm replaced, serous leakage ++ at edges. ——— J Bayley (Nurse)

20/2/00 Evening Shift summary RMO Kenny

Stable most of shift.

① CVS - Stable until ~10pm
→ tachycardia 140-150 bpm
ECG - SR sinus tachycardia
denies pain.
No evidence blood loss / fluid

② RS - SIMV FiO2 50 PS 12 Peep 5
TV 400-500 RR upto 40
Sats 96-99%
Chest widespread crackles → improved after physiotherapy

③ CNS alert/orientated. flat mood.

④ GIT back on NG feeds.
Small diahorrea x3.

⑤ Renal uo adequate

⑥ Temp small pyrexial upto 38.5°C
→ ? why also tachycardia

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

NAME LINDSAY Terence
U.R. NO. 770512
ADDRESS
D.O.B. 14/06/57
SEX (M)

AFFIX PATIENT IDENTIFICATION LABEL HERE

21/2/00 SPUTUM - CYTO

21/2
* - d/w Dr Tilse re. sensitivities of Candida
→ needs to be sent to Adelaide
∴ will take some time for result
→ should be sent to Flucon.
addit 13/2 C. Albicans (S) to Fluconazole. PO.

20/2/00 MSU - leucs 0
RBC 6
no bact.

20/2 - BCS -(-)

23/2 SPUTUM -
Cult
① Acinetobacter heavy
② ? Haemophilus (GNB) heavy
③ Candida ~~spare~~ scanty
Sens ~~Z~~ Amikacin only
(Aug Ceph Amox N. + Gen) R.

28/2 SPUTUM:
few g- bacilli on micro
no growth on Culture

28/2 MRSA screen;	MRSA	ESBL	VRE
Tracheostomy	-ve	-	-
Nose	-ve	- ve	- ve
Groin	-ve	-	-
Perianal	+ve	-	-
Wound	+ve	-ve	-ve

CLINICAL EXAMINATION

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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21/2/00 Evening summary RMO Kerry

Stable night. Watched video.

① RS SIMV RR 14 FiO_2 0.5 PS 12 PEEP 5
Sats stable.

② CVS - haemodynamically stable
Sinus tachy ~ 120 resolved spontaneous.

③ Renal - U.O. adequate

④ GIT - restarted on NG feed as suggested by dietician. Nacl added.

⑤ Temp - improved
- no temp spikes T max 37°.

⑥ CNS alert. Head seems better.

⑦ BSL - hyper in' aut night despite SSI
BSL 9.9 → 17.4.
Given start dose of IV actrapid and SSI changed.

Plan/ watch BSL may need further change in SSI
Routine bloods done.
CXR done.
Awaiting CT abdo and TOE (recurrent sepsis)
Candida → sensitive to fluconazole.

Kerry

22/2/00 Slept reasonably well this evening, condition stable
Neuro Alert & obeying commands moves all limbs do commence
Resp Size 7.5 P/C Trachy, cuff 28cm H2O, SIMV 14 x 600 @ 50%
Resp 5 P/S 12cm P/S 50 Flow trigger 1 lm secs, 2/24
r Pulmonary toilet c meal - Remains creamy sputum

CLINICAL EXAMINATION

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

LINDSAY	M	778512
TERENCE		
27-29 CULGOA CRES		14-06-1957
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NO RELIGION	SELF EMPLOYED	

Temp up to 38.5 O/N.
WCC 26.9 ↑ stable.
continues on Vanc, Timentin, Ciprofl.

coags (N)
PT 13.5
INR 1.0.
39.9.

mood :- improved mane + response + reaching
Plans- need to chase candida sensitivities.
- probably needs further surg R/V
- ? is pt for TOE.

PREVENTION AND CONTROL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

21/2/00
1000h DR LEDITSCHKE WR

→ events over WE → resp.-wise more tired
- WCC ↑.
- spiked T°s
- sudden desat Sat am ē tachycardia (CTPA (-))
- Bronch - bilat pus more on (R) in context of staph. epi. in blood & Candida => sens. to Flucon. should be avail today.
- should proceed to ECHO given ongoing Sepsis (TOE)
- NOW Hypo Na+ (130) ∴ need to add salt again to ng (+sachet tds)
- metab. alkalosis slowly improved
- less tired resp. wise gas xc improved on FiO2 50 at present fully v/d on a rate of 18-
=> if tolerates : wean rate back so on PSV.
- continue ē Ab's

CLINICAL EXAMINATION

Chart B

-GIT- feeds at 120 ml/h
Still only small ō intake ∴ ctue full feeds.
✓ dietician R/v please.

PLAN OVERALL:
∴ ① ctue abs
② Chase sens of Candida & other cults
③ wean ↓ as able (try rate at 14 1st)
④ ctue full feeds ↳(diet. R/v please)
⑤ add NaCl 1sachet tds to feeds
⑥ Liase ē surgeons re. return to OT & if no further impvt => ? Rpt CT ✓ RClaydon

21/2/00
1130 d/w Dr Tilse (microbiologist) re Candida sensitivities;
→ needs to be sent to Adelaide
∴ will take week or so for result
→ should be sens. to Fluconazole.
suggested exclude collection.
addit - Specimen on 13/2 (S) to Fluconazole.
RClaydon.

21/2/00 **NUTRITION & DIETETICS** ATSP re weaning from full NG feeds to oral nutrition. PO currently on 120mls/hr Ultracal x 20/24. Having diarrhoea ++. Small oral intake.
• Recommend provide ± 60% of nutritional requirements NG is 85mls/hr Ultracal x 20/24.
• 4 hrs without feed 1000hrs → 1400hrs to improve appetite during day
Will provide soft diets pots 3 x SHT daily.
@ Vitamin #187

21/2/00 **PHYSIOTHERAPY** 1440hrs
Patient remains ventilated SIMV 14/31 x 610/580 PEEP 5, Sats 98%.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

--ID---------- SEX--- UR NO
LINDSAY M 778512
TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

∴ ↓ FiO2 to 45%.
maintained sats
∴ ↓ rate to 12 at 0730 hrs

(3) ↑ Renal UO adequate.

(4) BSL's have ↓ & become more stable

(5) GIT - feeds at rate 85/min.
- BO o/N
- LFT's ALT 109
AST 180
ALK 274.

(6) Temp ~~Sorope~~ Low grade temp still 38°
candida sensitive to fluconazole.

Plan:- - ↓ Terry for further ↓ wean at this stage?
- observe BSL's with recommencing (n) diet

MAdkins

22/2/00 DR Leditschke WR
- gas XC improved PO2 7100 on 50%
saturating well on 45%
∴ ↓ FiO2 to 40%
- looks less tired
- needs Cannula changed ev. 4h
(this am cannula looked purulent)
- Temp. coming ↓ though spiked 38° last pm
- coping on rate 12

Plan - Nando level
- wean rate ↓ FiO2 to 40%.
- TOE this am. (Clinifeeds stopped)
(verbal consent obtained yesterday by DrHoare & myself).

CLINICAL EXAMINATION

CONTINUATION (Cont.)

D

22/2/00 TOE done
- ½ propofol 90mg, ½ midazolam 2.5mg
- probe swallowed without difficulty
- good images.
- everything normal trivial MR only.
- No evidence of vegetations.

G Chia

ICU WARD ROUND **Tuesday, 22 February 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay UR No. 778512

This man's gas exchange and clinical state has improved. He is less febrile, although he spiked to 38.1 last night. He has a PO2 of 128 on 50% this morning and sats of 98% on 45% now. Reduce his FIO_2 to 40%. He is for transoesophageal echo this morning and we will wean his ventilation as able after that. The plan is for a rapid wean back to C-PAP with pressure support and then, depending on how he goes, we will continue T-piece weaning again towards the end of the week.

22/02/00 1300hr
NURSING
CVS & Resp stable, required 150mls N/saline bolus IV following propofol sedation for TOE → results not yet available. Now normotensive ST, afebrile, warm + well perfused. Somewhat diaphoretic. CNS :- GCS 11T/15 E4 V(T)4 M6, mild weakness arms + legs bilaterally R=L. Encouraged + self cares etc and limb movements. RESP :- FIO_2 ↓ to 4. Plan 12 - plan to further wean later today. Suction 2-4/24 2/24. SaO_2 97-99%. Secretions loose / white small-mod volumes. AE R=L occasional coarse crackles + transmitted sounds. GIT :- NBM for TOE - intake good earlier → see food chart. BO x1 this shift, semi formed. Perianal area only slightly excoriated for specimens x 3 please. RENAL :- UO 150-200/hr dark straw clear urine. INTEGUMENT :- intact, mucosa clean + moist. IV resited to (R) forearm. Old cannula sent for m/c/s. Abdo wound dressing reinforced with tegaderm → dve

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

CLINICAL EXAMINATION (Cont.)

DATE:

22/2/00 CVS. Monitored in S/T haemodynamically. Obs
Warm & well perfused B/P satisfactory. ON
Input 85 mls/hr Isocal into NGT tolerated OK
+ IV fluids as charted for drugs, S/S insulin
infusion 1-3 u/hr (2·6 u/hr as charted)
Output Good U/O via IDC. c good response to lasix
@ 0600. Bowels open x 1 very large early in
night, fine since
Gen/general Temp ↑ 38 O/N ⇒ given ii Panadol @ 0410
c rapid diaphoretic response c consequent ↓ in temp
All drugs as charted c prn neuro sedation (ii TZ
assisting c 4-5 hrs sleep O/N. Blood drawn for FBC
U/E coags & ABG @ 0530. [signature] D SAULL CCRN

22/2/00. RMO - GOLIKOV
0815hrs NIGHT SHIFT SUMMARY.

Terry was stable O/N
+ seemed to have a reasonable sleep.

(1) CVS

BP 106/52
PR 111/min.

(2) Resp. seems to have rested well
on SIMV 14
FiO_2 50%.
today ABG.
pH 7·49
PCO_2 48
PO_2 128 ↑
HCO_3 36
BE 11.7
sats 99%.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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Ph(B) 0419655702		
NO RELIGION		SELF EMPLOYED

For renewal 23/02/00. Nbound care CNC NSW R/V FRI 25/2. Psych/social: Fully interactive though says is very bored. Encouraged to be more self sufficient e.g. feeds etc as Tx becoming very dependant, especially on parents gentle encouragement needed with mum Rita to allow Terry to do things for himself. also, ENDOCRINE: BSL's essentially stable - actrapid currently off due to NBM status.

22/2/00 **PHYSIOTHERAPY** Rx x 3

RE Patient appears more alert today, remains ventilated SIMV 12/20 x 640/410, PEEP 5 Spo2 99% on 40% O2. ausc - harsh BS throughout.

Rx - bagging + ongo vibes
- suction + NaCl. productive m/a thin creamy sputum

Plan - Continue to R/V - attempt tilt tomorrow if able.

M Rickers (RICKERS) PT

22/02/00 Day Shift
1715

- stable
- tolerating SMV rate ↓ to 10
good NS
Sats stable
- ECHO this am -
NO VEGETATIONS
Normal echo.
- R/v'd by maxillo-facial Reg (thankyou Dr Erzetic)
- teeth appear good condition
no obvious abscesses/caries
(would need XR when able)
Currently no Rx needed.

RC

PRIVILEGED AND CONFIDENTIAL

Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

2-2-00 NURSING ENTRY
2130 Stable evening.
SIMV rate weaning - minutely ↓, Total rate unchanged at 24-30
Mod amts creamy sputum aspirated from trache
Air entry equal - scattered coarse crackles.
Low grade fever 37.4
Haemodynamically stable.
Monitor: ST
Clinifeed tube inserted at 1600hrs. Feeds recommenced after XR confirmation of site.
Insulin infusion cont as per sliding scale.
UO good.
Wound dressing reinforced x2 - ? needs dressing daily in light of amt of ooze.
[signature] EN (AD/AM)
addit: 2200hrs. Now on PSV - total rate unchanged.
[signature]

22/2/00 Evening Shift Summary
2315hrs
O'Donnell (JHO) Day 32 ICU

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

· pt v. stable this shift

· alert, oriented, communicating appropriately when awake

· continues on PSV (rate completely weaned this shift)
- FiO_2 0.4
- ~~Bed~~ PS 12 cm H_2O
- PEEP 5cm H_2O
- Rate up to 31/min V_{To} 450 - 500ml
- Sats 97%

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATIO

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(6) electrolytes.
K+ 4.6
∴ chlorvesc withheld for 0800
+ due for mane frusemide.

Plan:- continue ↓ wean.

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Human Rights Commission Act 1991.

mGoulnos.

23/2/00 DR Leditschke WR.
1010 am

→ improving mood better.
→ now on PSV c PS12
⇨ trial 1 hour on T-piece this afternoon (≈1600hr) unless obviously too tired.
- WCC okay but needs to stay on abs currently.
- daily bloods
- 2nd daily XRs
- turn feeds off & leave off until after dinner to encourage appetite.
- mild hypoNa 24 - stop frusemide. cont NaCl sachets.
- mobilise +++.

R Clayden

23/2/00 **NUTRITION & DIETETICS**
1120hr Ongoing r/v re. enteral feeds.
Currently: 85ml/hr Ultracal x 20/24 → provides ≈60% of est req.
BGV BG's 10-9 today - on sliding scale insulin.
(P)/for trial O/N feeds only - goal 85ml/hr SUSTAGEN 10/24 (1000 cals)
This provides ~50% of est req.
• Cont. LF diet w/ additional HP, LF hyps as per preferences.
• For food & fluid record please.
• Will cont to r/v.

J. Mc Kay (AHSA)

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

ICU WARD ROUND — Wednesday, 23 February 2000 — DR A LEDITSCHKE
Name: Terence Lindsay — UR No: 778512

This man continues to improve. His gas exchange is better on 40% with a PO2 of 88 and he is now on pressure support ventilation with a pressure support of 12. He walked and stood with a tilt table this morning. He is going out in the sun this afternoon. Note that he has mild hyponatraemia with a sodium of 133 and chloride of 95 on added salt to his diet. Stop his Frusemide, which may help his metabolic alkalosis also. He continues on Vancomycin, Timentin and Fluconazole. His Vancomycin trough level yesterday was acceptable at 6.5. Need to watch his transaminases, which are trending upwards at the moment. Transoesophageal echo yesterday was normal. The plan is to stop his feeds to encourage oral intake, to mobilise him as much as possible and give him a T-piece trial this afternoon if he is not too tired.

23.2.00 SPEECH PATHOLOGY 1400hrs
- Pt not in bay.
- ? Difficulty swallowing or dry food.
Plan: R/V this pm as able c̄ view to upgrade
— diet giving c̄ meals.
[signature]

PHYSIOTHERAPY 23.2.00.
Remains ventilated.
PSV pressure support 12
Chest ↓ BS both bases
Sputum M/A cream.
℞ clapping + vibs N saline + suction
Stood on tilt table 10 mins – managed well.
[signature]

23/2/00 Nursing Notes
Patients condition improving. Vent. PSV 40% O2, peep 5. Resp. rate 28-30. Sputum clear-cream moderate amount. B/P 132/63. Monitor sinus tachycardia rate 105-115. T° 37¹-37². Sliding scale insulin 2-4 units hour. glucometer 7.1- 10.9.
Diet patient tolerating fluids / yoghurt. Some difficulty with eating /swallowing solid foods - coughing. ++. Suction post eating nil return. Medical staff informed for speech /swallow review by speech therapy this evening. Diction - for. hospital strength sustagen 1800 - 0600. Encourage diet NB minimal lunch today 4-6 mouthfuls managed. 500ml milkshake this afternoon. cont.
T.O'Neill T.O'Neill RN

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION SELF EMPLOYED

temp to 37^5 this pm.

peripherally warm.

CVS stable BP 113/66
pulse 112.

Continues on 85ml/h.
Good UO

Plan aiming for wean off V to T-piece by end of week

continue P++ / mobilisaⁿ

routine bloods mane

Actrapid as per slid. scale.

[signature]

23/2/2000 Nursing Entry: 0645hrs
CNS: T- 39.6 → 37.5. Moves all limbs, obeys commands. appears lucid. communicates reasonably well by hands + mouthing words. slept ~4hrs overnight. moves self in bed.
CVS: HR 110 → 120. (ST). BP. 110/60 → 117/67.
peripheries warm + well perfused.
RESP: Ventilated on PSV - no rate. RR - 24 → 32
TVs 400's mostly. FiO_2 40%. Sats 96 → 99%.
PEEP - 5, PS - 12, AE (noisy) - air ℅ (L) bases.
suctioned prn - mod → large amounts of thick creamy sputum.
GIT - NG feeds 85mls/hr + UO for drugs. passing copious flatus but no BO this shift.
Renal. 260 → 95 mls/hr.
IVT. N/Saline for drugs. Insulin infusion titrated to BSLs
BSLs 4.6 → 9.1.
Hygiene: all cares attended.

[signature]

PRIVILEGED AND CONFIDENTIAL

Under Section 91 and Section 141 of the Health Rights Commission Act 1991

MHPH 45-1 1/92 Chart B

CLINICAL EXAMINATION (Cont.)

DATE: 23/2/00 RMO- GOLIKON

0730hrs NIGHT SHIFT SUMMARY

Stable shift.

(1) CVS: Stable.
BP 110/65
PR 115

(2) Resp:- on PSV 40%.
PS 12.
~~no rate~~
Peep 5

ABG. pH 7.44
PCO_2 46
PO_2 88
HCO_3 31
BE 6.6
Sats 97%.

(3) BSL's:- Improved
<10 O/N
continues on actrapid infus-

(4) GIT:- No bowel motn O/N.
LFT's Continue to ↓
↑ AST 103
↑ ALT 237
↑ ALKP 369.

(5) Temp:- Improved
<37° O/N

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

--ID---------- SEX--- UR NO--
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NO RELIGION SELF EMPLOYED

CLINICAL EXAMINATIO

23/2/00

Nursing Notes 1500
IDC D removed 1130 am has not passed urine yet. Patient on tilt table 10 min. Outside 30 min. now tired.++ Trial T-piece. ½4 this evening for abdo draining this pm please. Visited by parents. Patient D continues to sweat +++. All cares given.
TO'Neill (T.O'Neill)

23.2.00 SPEECH PATHOLOGY 1545 HRS
RIV of pt's swallowing requested.
RIV puree + sandwich.
No oral phase or pharyngeal phase difficulties noted.
Strong swallow reflex elicited
Nil wet voice on post trial suctioning / nil choking or signs of difficulty.
May be related to fatigue?
Plan: Continue normal diet with extra gravy.
Please ensure pt upright / small amounts.
Notify if further difficulties.

23/2/00 1700 Day Shift:
- SEE WR NOTES -
v. stable
- now on PSV - well tolerated
→ will probably have T piece trial this a'noon.

Other issues - stable

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

23/2/00 NURSING ENTRY: 2215hrs. RESP/ PSV +12 UNCHANGED THIS SHIFT. ON CONCHA PACK FOR 1hr - DID WELL, ~~[illegible]~~ DOCUMENTED. A/E EQUAL + APPARENT IN ALL FIELDS INSP + EXP NOISE. MODERATE AMOUNTS OF THICK SECRETIONS REMOVED SpO_2 97-100% NIL DISTRESS RR 20-30. CVS/ ST 110-125 BP STABLE (2/24) T° 37² MOD/ PAC 3/24 NIL SIGNS OF PA'S INPUT/ ATTEMPT TO ~~EAT~~ FOOD FOR DINNER BUT DISLIKED TASTE. ASKED FAMILY TO BRING MORE APPETISING MEALS IN. OUTPUT/ GOOD DIURESIS - PT ALARMING STAFF TO WHEN HE'S ABOUT TO PASS URINE. 80 x1 hourly/ WOUNDS/ DRESSED ABDO WOUND - LOOKS HEALTHY - DONE TO PROTOCOL NIL DISCOMFORT FROM PT. HYG/ MOUTH CARE 3/24 WASHED AT 2100hrs 2° TO ⊞ DIAPHORESIS. [signature] CHARMAN RN

23/02/00 2345hrs — Evening Shift Summary

O'Donnell (VHO)

- pt was a model pt this shift!
- he coped easily c̄ the T piece for ~ 1hr on 40% F_iO_2
- tolerating small vol. of ō diet (Not hospital food - surprise, surprise)

Haemodyn stable

Sats 97% comfortable RR ~ 20

warm peripheries

Plan enteral feeds 12/24

continue to s.c.o.b, mobilise, PTY.
more videos!
routine bloods mane.

[signature]

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION		SELF EMPLOYED

24·2·00 Nursing Observe. Pt slept most of night. Sponged Comfortable, pain free, abdo dressing intact.
Vent PSV RR=30bpm FiO_2 ·40 PS 14 TV = 360-400 ml peep 5
Suctioned large amounts of thick creamy sputum
NJT feeds ceased @ 85ml. patent. Tolerating oral fluids, small formed bowel motion thus ordered by in-charge nurse to withhold am codeine phosphate. IV actrapid @ 8units/hr BSL 7-8mmol/l
AE equal & creps throughout Sats 96-99%. Normotensive & Temp 37°. Dr aware. Nil pressure areas observed.
Teds in situ. PEARL GCS-15. Co-operative. Vending well.
(R) IVC patent and pain free. N Patton RN (PATTISON) OXLEY

24/2/00 RMO-GOLIKOV
0800hrs NIGHT SHIFT SUMMARY.

Pt very stable O/N.

① Resp:-
- some ↑ RR to ~35/min O/N
∴ ↑ PS to 14 for a few hours, now back to 12.
- maintained sats >97% all night
↑ RR ↓ to ~27

- ABG taken am: appears to be mixed sample ∴ needs to be repeated.

② CVS stable
BP 120/60
PR 110

③ Temp max T O/N was 37°.
WCC 26·3 (↑ from 22·7).

④ BSL's. stable but down to 4·7 prior to bfast this am.
∴ may need to observe & adjust sliding scale agen.

CLINICAL EXAMINATION (Cont.)
DATE:

(5) Renal :- UO good.
- electrolytes pending.
K 4.6, Na 132, Cl 95

(6) GIT :- LFT's ↑ Alkphos 510, ALT 257, AST 96.

Plan:- continue T piece today
- pt to be mobilised for theo.
- LFT's have ↑ - note + observe.
- needs NaCl replacement.
Mopalhot.

24-2-00 1000 hrs ICU WR Dr Leditschke

- Tolerated T piece for 1 hr yesterday
- Na 132
- Formed Bo.
- Transaminases Stable

Rx :- Cease added water to NGT feeds
:- Rpt ABG.
:- Cease cefaxone phosphate
:- Continue timentin + vancomycin (intl) middle of next week
Continue fluconazole until beginning next week as Th
(Hormal

ICU WARD ROUND **Thursday, 24 February 2000** **DR A LEDITSCHKE**

Name: Terence Lindsay
UR No: 778512

This man tolerated his T-piece trial well last night, so he is to recommence T-piece weaning this morning. He is still mildly hyponatraemic, with a Sodium of 132 and hypochloraemic at 95. We will therefore reduce the amount of water in his feeds. Diarrhoea has settled. The plan is to continue his Fluconazole, at least until the beginning of next week and his Timentin and Vancomycin at least until the middle of next week at this stage. Transaminases are fluctuating but appear stable.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

ID SEX UR NO
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NO RELIGION
SELF EMPLOYED

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

24/2/00 **NUTRITION & DIETETICS** Ongoing r/v
1250hr
Cont. on goal feeds @ 85mL/hr SUSHY x12/24 (1800-0600hr) overnight. Also managing small amts of oral diet w/ additional HP fluids to midmeals. N/G feeds currently meet ~50% of total est. req. BSL's noted. Diarrhoea settled.
(P) • Cont O/N n/g feeds @ 85mL/hr SUSHY x 12/24 (1800-0600)
• Cont. enc. w/ oral diet & enc. HP fluids as much as possible.
• Will cont. to r/v.
J. Milling (4068)

24/2/00 Nursing ICU 1330hrs
on T-piece for 2½ hours → RR 20-28, 40% O2; O2 Sat's 99-100%
↓ air entry bibasally, suctioning mod amts thick creamy secretions from trache. BP 121/65, HR 125 SR
Terry put back on vent at 12MD for rest period & going outside at 2pm.
Vent c PSV 40%, TV's 410-500mls, RR 30. PS 12; Peep 5
O2 Sats on vent 96-97%.
T 37.6 sweating +++.
BO x1 mod amt, formed faeces. voiding in bottle.
used tilt - table with physio this am
pt c/o tired today; sat in chair for 3hrs this am.
BSL'S 10.2-4.4 mmol - actrapid per sliding scale.
visited by family
tolerating diet & fluids well. — M. [illegible] (RIES)

PHYSIOTHERAPY 24/2/00
- Remains on PSV.
Trialling T piece tolerating well.
Chest ↓ BS clears
Sputum M/H cream.
R bagging & with Narlene & suction
Quads & ↓ leg ex's
stood on Tilt table full tilt - managed well
To R/V in AM Murphy (MK[illegible])

PRIVILEGED AND CONFIDENTIAL
Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

DATE:

24/2/00 Day Shift
Claydon

· tolerated T piece until ~ 12.
→ having more T piece this a'noon.

ABG 1240: (post T piece)
pH 7.48
PCO_2 40
PO_2 95
HCO_3 29
BE 5.5
Sats 98%.

BSL's more stable today

Vanco trough 4.7
∴ dose ↑d to 1500mg bd.

[signature]

24/2/00 ICU 2100.
Stable evening. Abdo dressing done @ 1600. Serous ooze saturated dressing, surrounding skin intact. SOOB for 2 hrs on t-piece FIO_2 40%. Sats 99%, sweating profusely but not diaphoretic. Returned to PSV/CPAP overnight. FIO_2 ↓ 35%. m/a thick creamy sputum expectorated, coarse crackles. Obs unchanged, afebrile. Eating most of diet, BNO, voided 600mls. BSL's stable @ 8mmols, on 4 units of insulin/hr. N seated @ am. U/S family.
[signature] RN.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

25/02/00 Evening shift Summary.
2305 hrs
O'Donnell v. good evening!
(JHo)

watched a video (v. depressing, but entertainment none the less)

main issues:

1. ceased Actrapid infusion @ 2130 hrs.
had been on ~ 4u/h
BSL's stable 6-7 this shift

now tolerating diet ✓ (had tasty hospital dinner)

D/w Med Reg this pm re Insulin req'ments
he advised:
- cease Actrapid
- await response; meas q2hrly BSLs

if BSL > 12, give 6 units Actrapid s/cut

otherwise, continue q2h meas'ments
and if persistently high in am, start Actrapid
as per Med sheet. (Adjust pm)

currently written as Actrapid 15u tds (pre-meals)
Protophane 20u nocte

2. on PSV: Sats 97-98% on FiO_2 30%

PS 12cm
PEEP 5cm
Rate ~ 4005
Tvols ~ 400 ml/s.

Good AE
(N) vesic BS.

CONFIDENTIAL
Under Section 91 and Section 141
of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

CLINICAL EXAMINATION (Cont.)
DATE:

3. haemodyn. stable

good i/o
BO
alert, in reasonable spirits   Keen for extubation!

Plan for T piece V mane for the day

watch BSL's as prev

routine bloods, CXR mane

NURSING NOTES. NIGHT DUTY. 6[30] AM 26.2.90

C.N.S. Conscious + Alert. Moving all limbs to command. Pupils equal + reacting to light.
C.V.S. Tachypnoeic + Normotensive Clammy + febrile overnight
Resp. Pressure support mode Coughing + expectorating scant sputum (clear) Sats 95-97%
Renal Voiding into a bottle reasonable amounts
Drugs Review oral sodium + magnesium.
General Drinking fluids well Bowels opened x1 Mod. amount of soft formed stool
BMs 2 hly 7.2-9.7 mmols overnight ∴ no insulin given as per Dr order. Low fat diet
Plan today To T Piece.

[signature] Oxley

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

--ID--------------	SEX--	UR NO--
LINDSAY	M	778512
TERENCE		
27-29 CULGOA CRES		14-06-1957
LOGAN VILLAGE 4207		M
Ph(H) 0755 468256		
Ph(B) 0419655702		
NO RELIGION	SELF EMPLOYED	

addit Na 132
⇒ please add salt to meals
- Terry is happy c this

RLL.

26/2/00 Nursing Notes: 2300: Pt Stable Remains on T-Peice 35% O_2 O_2 sats 98-100%. minimal amounts of white Sputum Suctioned Air Entry decreased to bases Deep Breathing + coughing encouraged. Eating and drinking mod amounts passing good amounts urine passing Frequent Flatus bowels ~~not~~ opened this Shift. BSL 11.5 - 7.6 mmol. Temp 37.4 at 2000 Pt Sweaty at times Pt participating in cares did not sit Out of bed this shift Pt visited by Frends and relatives
Brenda RN (SHANAHAN) N NA

~~26~~/27/1/00 RMO - GOLIKOV
0140 hrs Evening Shift summary.

pt v stable this shift.

(1) Resp on T piece still & sleeping.
ABG not repeated
sats 100 %
RR 28/min

(2) CVS
BP. 120/80
PR 120/min.

(3) GIT :-
BNO this shift
ate dinner

(4) BSLs stable on SC insulin
↘ 7.6.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

CLINICAL EXAMINATION

Plan:- IV needs to be resited
- vancolevel mane
- continue T piece wean

[signature]

27·2·00 · 0630
nursing: stable and satisfactory, slept well overnight. Tolerating T-piece on 0·35 FiO2 and SO2 100%. coughing up sputum. ↑T, but stable haemodynamically. IV cannula resited on L) arm. [signature] RN

26/2/00 nyht summary

Stable o/N.
Slept well. Good mood.

1) (RS) Stable Sats stable
2) CVS - stable

3) BSL - stable.

Plan) Cont diet/fluids.
Needs vancomycin levels + bloods done
Cont on T-piece

[signature]

PHYSIOTHERAPY 27/2/00.
Remains on T piece - managing well
Chest ↓ BS both bases
Transmitted sounds throughout.
Sputum M/A creamy huffing well
Standing transfer to chair with 2 people assist
for R/V in AM [signature]

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

CLINICAL EXAMINATION (Cont.)
DATE:

Plan:- IV needs to be resited
- vancolevel mane
- continue T piece wean

Mgouin

27·2·00 · 0630
nursing: stable and satisfactory, slept well overnight. Tolerating T-piece on 0·35 FiO2 and SO2 100%. coughing up sputum. ST, but stable haemodynamically. IV cannula resited on L) arm. ——— Ifamon RN

26/2/00 Nyrd summary

Stable O/N.
Slept well. Good mood.

1) (RS) Stable Sats Stable
2) CVS - Stable
3) BSL - Stable

PRIVILEGED AND CONFIDENTIAL
Under Section 51 and Section 141 of the Health Rights Commission Act 1991.

Plan) Cont diet/fluids.
Needs vancomycin levels + bloods done
Cont on T-piece

Kenny

PHYSIOTHERAPY 27/2/00.
Remains on T piece - managing well
Chest ↓ BS clo th bases
Transmitted sounds throughout
Sputum m/A creamy huffing well
Standing transfer to chair with 2 people assist
For R/V in AM

Jrafly (MCRPHY)

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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TERENCE
27-29 CULGOA CRES 14-06-1957
LOGAN VILLAGE 4207 M
Ph(H) 0755 468256
Ph(B) 0419655702
NO RELIGION SELF EMPLOYED

26/2/00 Night summary

Stable uneventful night.

(1) CVS - stable
(2) RS PSV . Sats stable
(3) Renal - U.O. adequate
(4) GIT tolerates fluids well.

Plan/ Please take routine bloods [illegible] earlier → then renal need for renal replacement.
Monitor BSL → as per med. reg advice.

PRIVILEGED AND CONFIDENTIAL
Under Section [illegible] of the [illegible] Rights Commission Act 1991.

[illegible signature] Kenny

PHYSIOTHERAPY 26/2/00
On T-piece managing well
Chest ↓ BS [illegible] clear
Rx deep breathing + [illegible]
arm + leg ex
suction yielding N/A cream secretions
For R/V in AM Murphy (MURP44)

26/2/2000 Nursing Stable day on [illegible]
c 0730 has been on all day
c no apparent distress
Tolerating diet + fluids well nutritional fluids encouraged
ABGs. [illegible] clearing of excessive slough on (L) side otherwise unchanged
out side & entire family enjoyed the outing [illegible signature]

CLINICAL EXAMINATION

CLINICAL EXAMINATION (cont.)
DATE:

26/2/00
Claydon Day Shift Notes

* tolerated T piece well today
→ on since WR this am
sats maintained
no subjective concerns

ABG at 1000h -
PO_2 lower at 70
PCO_2 41
pH 7.44
Sats 94%
N'ever remainder of day sats 98-100%. ∴ not repeated

* eating well & actually enjoying meals!!
- has started s/c tds Actrapid as per med reg.

BSLs remain ~9-10 today
→ may need s/c I. re-adjusted tomorrow.

good uo. ✓

haemodynamically stable ✓

* needs a VANCO level mane please (thanks Clare) & recheck LFTs - still ↑.

IVL re-sited due to inflamed site on (L)

R Claydon.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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28/2/00 DR Ulyatt WR
see printed notes.
R Claydon.

28/2/00 **NUTRITION & DIETETICS**
1210hr. Ongoing CW
Previously KOL. N/G feeds O/N - was removed Fri pm (3/7 ago)
Now on full diet - receiving CF diet w/ additional CF HP drinks between meals. Alb 24g/L
(P) • Cont CF menu - add SP
• Cont HP (CF) SPS as per preferences.
• Keep food & fluid records please to assess KJ & protein intake
• Will cont. to f/u.
S McKay (#689)

ICU WARD ROUND Monday, 28 February 2000 **DR D ULYATT**
Name: Terence Lindsay UR No: 778512

Weaning well on the T-piece today having been managed on pressure support overnight, although his cultures from the 23 February remain positive for Candida and also heavy growth of Acinetobacter and possibly Haemophilus. He is afebrile, with a falling white cell count. Generally well and mobilising with a good cough and his sputum suctioned is creamy and not voluminous. I suggest we stop all his antibiotics, including the Fluconazole as his liver function tests are deteriorating rapidly with his alkaline phosphatase now reached 648. Note that a previous ECHO during the time of his Candidaemia was negative for endocarditis.

1415 28/2/00 NURSING RN WONG
Had a shower, abdo wound seen by stoma care sister. dress wound daily with EXU-DRY and op-site. tracheostomy redressed. T° 37.4 HR 115 ST BP 130/60 RR 24 on T-piece 35% O2 Sat 100% moderate creamy trache asp. eating and drinking well, please record food chart. had passed urine 80 x 10. went outside for 45 minutes
T P Wong

28/2/00 **PHYSIOTHERAPY** 1530hrs
Continues to tolerate T-piece well. 35% O2 SpO2 100%.
ausc ~ ↓BS both bases, transmitted sounds throughout
Rx - deep breathing c̄ exp vib's

DATE:

Huffing & coughing well, suction + NaCl p/o moderate amount creamy sputum
- standing transfer to shower chair, tolerated well & was able to take 2 small steps & good knee control
Plan - cont to RFV + progress mobility as able.
Vickers (UCKEES) PT

28/2/00
Claydon V. stable day shift

Sats 100% on T-piece & doing well.
BSLs improving
eating well
mood happier.

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Under Section 91 and Section 141 of the Health Rights Commission Act 1991.

R Claydon.

28/2/00 Nursing 2215hrs
Stable shift. Remains on t-piece throughout this shift. O_2 sats >95%. Air entry equal, ↓ in bases - encouraged to deep breathe. Has not required suctioning - able to cough sputum into t-piece.
Eating & drinking well. BSL's 5-9 mmol. Good urine output. BO - mod amt, soft, formed
Wound required reinforcement x 2 - leaking clear serous fluid.
Visited by parents & wife this shift. - ~~BD - often~~ -

28/2/00 RMO Goulkov
2300hrs EVENING SUMMARY

- Terry continues to do well.
- Remains comfortable on T piece Sats 100% still
- cardiovasc. stable also.

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks

MATER PUBLIC HOSPITALS

CLINICAL EXAMINATION

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NO RELIGION SELF EMPLOYED

25/2/00 **NUTRITION & DIETETICS** Ongoing r/v.
1200hr.
Cont. to receive CF, partially SF oral diet (Soft) with additional HPCF sips @ meals. Food + fluid records indicate eating ~3/4 of L+D; all of BF. Pt reports feeling a bit sick/nauseous the past 2/7 + ∴ ↓ intake.
S/T r/v noted. alb. 25g/l.
(P) - Cont. current diet
- Cont. HP sips between meals. Cont. to ~~keep~~ keep food + fluid record pl.
- Will cont. to r/v.
J. McVey (#1654)

ICU WARD ROUND **Tuesday, 29 February 2000** **DR D ULYATT**
Name: Terence Lindsay UR No: 778512
Weaning well on a T-piece with 35% oxygen. Is eating well. Biochemistry and haematology are all satisfactory. Plan to let the cuff down of his tracheostomy tube and observe how he manages with oral intake. He is going to theatre tomorrow for attempted closure of his laparostomy. Plan to keep him in Intensive Care until at least that is completed. In many respects he is ready for the ward. Cease his magnesium supplements.

29/2/00 1445hr - nursing Entry. CNS Very pleased with his progress today. Looking forward to theatre/ward transfer this week as planned. Tired after sitting out in chair for several hours. CNS normotensive, afebrile. 1x large diaphoresis. RESP - Trachy cuff deflated mid morning. Has tolerated this very well - nil stained fluid / food aspirated on swallowing. Encouraged to take time & meals/swallows. No swallow delay noted. Terry expectorating white/cream secretions. Have explained to Terry he must inform staff if he becomes tired & swallowing / delayed swallowing, coughing & fluids etc. Cuff must be reinflated in these cases. GIT - Eating well. Renal - Output adequate. Social S/B family. PLAN cont as per nursing plan. for NBM 2400hr - for OT 1000hr - 1100hr 1/3/00.
D Ferguson (Registrar)

29/2/00 PHYSIOTHERAPY
c/o - nil new, continuing to improve, clearing secretions + cough
o/e - remains on T-piece 35% O_2 SpO_2 99%. SOB large portion of day
- ausc^n - ↓BS bibasally ↓ L > R.
- calves - soft/non tender

Rx - staged basal expan + insp hold
- Uc demand ventilat, LL circulatn exs + limb maintenance
- ACBT ē exp vibs p/o small - moderate amt thick creamy sputum
Plan - cont to RV - progress mobility
Vickers (VICKERS) PT

29-2-00 NURSING ENTRY
2200 condition remains stable.
Low grade fever T 37·6-8
Tachycardic normotensive.
SpO_2 98-100% on FiO_2 0·35 via T-piece
Trache cuff remains deflated - no problems.
IV cannula fell out this PM - to stay out pro tem
Eating & drinking well.
- continues to expectorate all sputum - creamy / white.
Visited by parents.
[signature] - RN (ADAM)
addit: Given mylanta 20ml on request
[signature]

29.2.00 Evening summary

Stable. Feels well. Mood good.

- Haemodynamically stable
- Sats stable 98-100% on T-piece FiO_2 0·35
→ tracheostomy deflated tolerated well.

- Eating/drinking well.

Plan/ For theatre morn consented ✓
Will need - grp/hold on bloods morn.
Routine bloods morn.
CXR now every other day
Post-op morn ? tracheostomy out → ward?
[signature]

URINE EXAMINATION ON ADMISSION/OUTPATIENTS

Date	Time	Amount	Amount for 24 hours	Colour	S.G.	pH.	Protein	Glucose	Ketones	Bili-rubin	Blood	Uro-bili-nogen	Remarks