INSTRUCTIONS FOR PAEDIATRIC HOUSE-PHYSICIANS

Northampton & District Hospital Management Committee | **NORTHAMPTON GENERAL HOSPITAL**

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

THE DUTIES OF THE PAEDIATRIC HOUSE PHYSICIAN

1. The day to day care of all the Consultant Paediatrician's patients.

2. The admission of these patients to the wards and the carrying out of treatment and investigations ordered by the Consultant.

3. The collection of the necessary pathological specimens.

4. To report all changes in the patient's condition and progress to the Registrar and to the Consultant and to record these changes in the clinical notes.

5. To keep careful and accurate notes of every case and to record in them the results of all investigations.

6. To have all pathological reports ready for the Consultant on his rounds. If typed reports are not ready it is his duty to approach the Laboratory, before the rounds, for verbal reports.

7. To carry out or order any investigations which he himself may feel necessary in order to arrive at a diagnosis or an assessment of progress.

8. To interview parents of new admissions and to obtain a full history on the lines set out in the example in Section I.

9. To assist the Consultant as required in Out-Patients.

10. To carry out the duties of the Registrar during the latter's absence on holiday etc.

11. To perform the duties of the other Paediatric H.P. during holidays etc., and on such occasions to cover the beds normally cared for by his colleague.

12. To achieve and maintain an atmosphere of harmony with other Firms and Departments in the Hospital.

SECTION I

PAGES 1 –

EXAMPLE OF CASE HISTORY

NORTHAMPTON GENERAL HOSPITAL CHART

NAME Annie BODY AGE 4½ DATE OF ADMISSION 29.2.57

MONTH Feb. March.

DAY	29	1	2	3	4	5	6																
	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.	M. E.
TEMPERATURE 106																							
105																							
104																							
103																							
102																							
101																							
100																							
99																							
98																							
97																R.D. TEMPERATURE							
96																CHART							
95																							
PULSE 160																							
150																							
140																							
130																							
120																							
110																							
100																							
90																							
80																							
70																							
60																							
50																							
RESPIRATIONS	24	22	18	16	12	14	16	12	14														
MOTIONS	1	1	1	1	1	1	1																
VOMIT																							
SLEEP HOURS																							
URINE FL. OZ.																							
SP. GR.	1022																						
REACTION	Nil																						
ALBUMIN	Nil																						
SUGAR	Nil																						
ACETONE	Nil																						
BLOOD	Nil																						
PUS	-																						
BILE	—																						
WEIGHT																							

NORTHAMPTON AND DISTRICT HOSPITAL MANAGEMENT COMMITTEE.

NORTHAMPTON GENERAL HOSPITAL CHART

2

NAME Annie BODY AGE 4½ DATE OF ADMISSION 29.2.57

MONTH

DAY 29

MORN EVE MORN EVE MORN EVE MORN EVE MORN EVE MORN EVE MORN EVE

2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10 2 6 10

TEMPERATURE

106 105 104 103 102 101 100 99 98 97 96 95

4 HOURLY TEMP. CHART.

PULSE

160 150 140 130 120 110 100 90 80 70 60 50

RESPIRATIONS

MOTIONS

VOMIT

SLEEP HOURS

URINE

FL. OZ.
SP. GR.
REACTION
ALBUMIN
SUGAR
ACETONE
BLOOD
PUS
BILE

WEIGHT

PUBLISHED BY THE NORTHAMPTON GENERAL HOSPITAL.

BIRDSALL & SON LTD., NORTHAMPTO

Northampton & District Hospital Management Committee — **NORTHAMPTON GENERAL HOSPITAL** 3

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER
BODY	ANNIE	C 1 4 2 7 1

CHILDREN'S DEPARTMENT **IN-PATIENT** DR. GOSSET

REFERRED BY OWN DR. Dr. Barber

DATE 29.2.57. AGE 4½

(Date of birth: 17.8.52.)

WEIGHT ON ADMISSION

WEIGHT ON DISCHARGE

REASON FOR REFERRING

Convulsions.

HISTORY OBTAINED FROM Mother.

C/o
1. High temperature.
2. Fits.
3. Coughing.

F.H.

Here fit the child into a family picture, thus:

Father 38 a/w
Mother 36 has sinus trouble
♂ 7 a/w
♀ 4½ patient
♀ 18/12 a/w.

indicating that the patient is a girl aged 4½ the middle of 3 children.

PROVISIONAL DIAGNOSIS

1. Febrile convulsions secondary to upper respiratory tract infection

FINAL DIAGNOSIS

1. Febrile convulsion
2. Acute Tonsillitis.
3. Anaemia (Iron deficiency)
4.

CONVULSIONS OR FITS ? Yes / No
IN FAMILY ? Yes / No
IN THIS ILLNESS ? Yes / No
PREVIOUSLY ? Yes / No

} must be enquired every time.

State here whether any family history of chronic illness, T.B., Allergy (including migraine), upper respiratory infections, diabetes, etc. Family includes close relatives and forebears.

Birth History: Where born, whether normal or instrumental delivery, birth weight and condition at birth.

* **Example:** "F.T.N.D. Barratt Maternity Home. B. wt. 6 lbs. 7 ozs. Slight cyanosis for ½ hour.

Progress and Development: Method of feeding, whether any difficulty or problems, comment on weight again.

* **Example:** "Breast fed for three months then Nat. Dried Milk ½ cream. No feeding problem. Gained weight normally."

Northampton & District Hospital Management Committee — NORTHAMPTON GENERAL HOSPITAL 4

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER

Date

CONTINUATION SHEET

Milestones (of Development) i.e. age when she smiled, sat, stood alone, walked, talked, became dry at night.

Immunisations: whether inoculated and/or vaccinated with common antigens, i.e. Diphtheria, Whooping cough, smallpox, tuberculosis, poliomyelitis, Typhoid etc.

Social

To complete the mental picture of the child in its family environment, comment on type of home, standard of living etc. Note where milk coming from and in older children include note on school progress.

Example

Damp, condemned semidetached cottage in country. Shares room with older brother. Outside lavatory. Father long-distance lorry driver away from home much of time. Finances difficult. Milk from Co-op. (pasteurised)

Past Illnesses:

Include history of allergy, i.e. infantile eczema, tendency to colds etc., infectious diseases, operations, accidents.

History of present condition:

Describing events in chronological order.

Example:

10 days ago: seemed off colour. Temperature 100. Runny nose. In bed for two days.

8 days ago: Better. Allowed up. No temperature but still had a slight cough.

2 days ago: Hot and flushed.

Last night: Coughing, vomited twice and shortly afterwards rolled eyes, went pale and stopped breathing.

There should follow then an inquiry into the special systems.

Respiratory System: earache, sore throat, running nose, cough, sputum, dyspnoea?

Alimentary System: Appetite, vomiting, abdominal pain, bowels, appearance of stools, diarrhoea?

Cardiovascular System: distress, fainting, squatting, cyanosis etc?

Central Nervous System: headache, sleep, special senses etc.? Enquiry into behaviour and development.

Urinary System: Frequency, dysuria, haematuria, enuresis, oliguria etc.?

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

On examination: Whilst a systematic examination is desirable and less likely to miss any important details, it is difficult to secure the full co-operation of the child. It may be necessary to examine the 'presenting' part first leaving unpleasant procedures such as examination of the throat, until last. The findings should be set down systematically. Notes should include, facial appearance, condition of skin and upper respiratory passages, heart, lungs, blood pressure etc.

* Example: "Temp. 102. P. 100, Respirations 24.
Flushed with circum-oral pallor. No rash.
Noisy snoring respirations.

Nose: Profuse mucopurulent nasal discharge. Turbinates red.
Poor airway.

Ears: Passages clear. Drums normal.
Hearing normal.

Mouth: Teeth good.
Tongue, lightly coated.
Fauces, red, tonsils enlarged +++ and very inflamed.
Some post-nasal discharge.

Neck: Tonsillar lymph-glands enlarged and tender.

Chest: Axillary glands normal.
Lungs: ...etc.
Heart: ...etc (including position of apex and record of blood pressure)
and so forth.

The account of examination should be rounded off with a diagnosis - even if only tentative.

Written in the margin should be the list of necessary investigations - a tick will indicate that a request form has been written. Results of investigations should be written alongside them

Diagnosis: 1. Febrile Convulsion
2. Tonsillitis.

Treatment: Must be written on prescription sheet
* Example but must be repated here also.
Argotone nasal drops q.d.s.
Penicillin I.M. 500,000 units b.d.
Phenobarbitone grs. ½ b.d.

Progress Notes: should be written daily and include all observations, investigations, changes of treatment, etc., thus:

* 1.3.57. Lumbar Puncture: Crystal clear C.S.F.
Pressure 100 mms./C.S.F.
Free rise and fall.
Temperature down. Seems better.

Investigations:

Throat swab.	
Hb.	72%
Film	hypochromic.
W.B.C.	14,000
Diff.	Poly 74%
	Lymph 16%
	Eosin. 10%
E.S.R.	34 mms/hr.
Lumbar puncture	
Cells	no increase
Protein	20 mgms.
Glob.	no increase
Chlorides	700
Sugar	normal.

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date	CONTINUATION SHEET
* 2.3.57.	Much improved. Chest clear. No further convulsion. Mist. Ferri. Sulph. Pro. Inf. grs. 2 t.d.s.
* 3.3.57.	Nose much cleaner. Tonsils not so big. Temperature normal.
* 4.3.57.	Very active. Chest clear. Throat looking clean.
* 5.3.57.	Quite well now. May go home. to have: Mist. Ferri. Sulph. Pro. Inf. grs. 1 t.d.s.routinely Phenobarbitone grs. ½ bd. if when febrile. to be seen in Out-patients in one month. ~~Substantial space between next paragraph and preceding one (about "may go home" etc.)~~ Path. investigations and X-rays are reported on gummed forms which are fixed to the sheets provided (See examples following) Doctors letters and a carbon copy of the discharge letter which must be sent out with every patient, also have a special sheet. The notes are summarised on a pink sheet by the Registrar, after discharge and copies sent to Dr. Cosset and the General Practitioner.

7 (3)

NORTHAMPTON AND DISTRICT HOSPITAL MANAGEMENT COMMITTEE

NORTHAMPTON GENERAL HOSPITAL

FOLDER NO.: E 14271

Ward: Children

Treatment and Prescription

Surname BODY Christian Names Annie Age 4½

THIS SHEET MUST NOT BE TAKEN AWAY

Date	Treatment and Prescription	Department or Ward	Date of next attendance	Initial of Prescriber
29.2.57	℞ Argotan nasal drop gtt 3. ℞ Crystalline Penicillin (I.M.) 500,000 units bd ℞ Phenobarbitone tablet gr ¼ b.d.			
2.3.57	℞ Mist Ferri Sulphat. pro Infant. (N.F.) gr ii 6ds			
5.3.57	℞ Mist. Ferri. Sulphat pro Infants (N.F.) gr ii 6ds mitte 3 XII t.t.o. ℞ Phenobarbitone tablets gr ¼ mitte (20) t.t.o. Sig as directed.			

Northampton & District Hospital Management Committee — NORTHAMPTON GENERAL HOSPITAL 8

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	WARD/DEPT.	UNIT NUMBER
BODY	Annie	Childrens	C 1 4 2 7 1

PATHOLOGY REPORTS

NORTHAMPTON AND DISTRICT HOSPITAL MANAGEMENT COMMITTEE

NORTHAMPTON GENERAL HOSPITAL

DEPARTMENT OF PATHOLOGY

JS

Drs. R. M. Heggie, W. E. Bryan, D. Philpott and R. A. Sladden

Pathological, Bacteriological or Biochemical Report

Lab. No. 3427121

Name of Patient Annie Body *Reg. No.* C14271

Physician or Surgeon Dr. Gosset *Ward* Childrens

Specimen C.S.F. *Dated* 19.2.57.

REPORT

Crystalline colourless fluid.

Cells: No increase.
Protein: 20 mgms %
Globulin: No excess.
Chlorides: 700 mgms %
Sugar: Normal.

Date of Report 1.3.57.

Northampton & District Hospital Management Committee

NORTHAMPTON GENERAL HOSPITAL 9

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	WARD/DEPT.	UNIT NUMBER
BODY	Annie	Children	C 1 4 2 7 1

X-RAY REPORTS

Stick slips on as received, starting from the bottom

Northampton & District Hospital Management Committee — NORTHAMPTON GENERAL HOSPITAL

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	WARD/DEPT.	UNIT NUMBER
BODY	Annie	Children	C 1 4 2 7 1

CONSENT FOR OPERATION, POST MORTEM ETC.

Stick slips on as received, starting from the bottom

Northampton & District Hospital Management Committee

NORTHAMPTON GENERAL HOSPITAL

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER
BODY	Annie	C 1 4 2 7 1

Date	Copies of Doctors' Letters

Northampton & District Hospital Management Committee

NORTHAMPTON GENERAL HOSPITAL

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER

SUMMARY SHEET

SECTION II

PAGES 16-

INFORMATION ABOUT
PATH. INVESTIGATIONS DEPT.
PATH. PROCEDURES
TRANSFUSIONS ETC
XRAYS.

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date

CONTINUATION SHEET

AGE LIMITS

Childrens Ward	12 years
Premature Baby Unit	12 hours

NOTE TAKING AND RECORDING

It is of the utmost importance to take a full, careful and detailed history in every case. The recording of negative findings, such as the Mantoux Reactions, might be of the greatest importance should the patient be re-admitted later.

DIAGNOSIS

Cases should be diagnosed as soon as possible after admission, using all available resources of the auxiliary departments. Any difficulties should be discussed with the Registrar or Consultant as quickly as possible. Every admission must be regarded as an emergency and no chances can be taken.

ADMISSIONS

No child should be admitted to the Childrens Ward unless he or she has been seen and examined in the Casualty Department. Patients sent to the hospital 'For admission' may only be sent home or denied admission by a Registrar or Consultant.

INFECTIOUS CASES

Should normally be admitted direct to Harborough Road Hospital, informing the Matron by telephone. There is no age limit in the Isolation Ward.

WARD ACCOMODATION

Childrens Ward (N.G.H.) Puerperal Sepsis Ward (N.G.H.)
Premature Baby Unit (B.M.H.) Convalescent Unit (H.R.H.)
Isolation Ward (H.R.H.)

(Details of each ward follow)

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

PREMATURE BABY UNIT (Barratt Maternity Home.)

For the care of immature babies (birthweight under 5½ lbs) born in the Barratt Maternity Home, in other maternity homes, and in their own homes. Certain mature but shocked or anoxic babies born in the Barratt may also be cared for or resusitated in the Prem. Unit if they require the highly trained and specialised nursing care available in this unit. Mature babies from outside the Barratt may never be admitted to the Unit for fear of introducing infection.

16-20 infants are accomodated in cots and incubators.

Premature babies from outside are collected by the Prem. Unit Sister with a heated portable incubator in a heated ambulance.

Exchange transfusions are always carried out in the department.

CHILDRENS WARD

Dr. Gosset has 16 beds and cots, including 2 (single) isolation wards. The age limit for this ward is the 12th birthday. Surgical cases are not attended by the Paediatric Department.

PUERPERAL SEPSIS WARD

These beds and cots are administered by the Obstericians and their consent is required before a case is admitted. The ward is intended for newly delivered mothers who have infections, abortions etc. However new-born babies may be admitted in certain circumstances, particularly if it is desirable to admit the mother as well.

CONVALESCENT UNIT (Harborough Road Hospital)

22 Beds are available in this ward and there are two side-rooms for semi-isolation. As a rule patients are admitted to this ward from the childrens ward at the General Hospital. A few patients, including cases of nocturnal enuresis, are admitted from Out-Patients or the waiting list. No acute or infectious case may be admitted, and all admissions should have negative throat swabs etc.

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

ISOLATION WARD (Harborough Road Hospital)

22 beds and cots, each in a separate cubicle. No age limit. These cubicles are for the treatment of notifiable infections only. General Practitioners usually arrange for the admission of their patients direct with the Harborough Road Hospital. Un-diagnosed cases are frequently sent in to the Casualty Department of the General Hospital. Their proposed transfer to the isolation hospital should be notified to the Matron by telephone before transport is arranged.

ADMISSION OF PATIENTS---Northampton General Hospital

All children must be examined in Casualty unless:
1. They are very seriously ill
2. They have been sent in by the Consultant Paediatrician
3. They are new-born babies.

History and examination:
A full history and examination should be recorded in Casualty on the lines of the example in Section 2 of this handbook. Infectious cases must be admitted to the Harborough Road Isolation Ward unless specialist care (e.g. Surgery) of a type available only at the General Hospital is required.

Diagnosis:
A provisional diagnosis should be made and the child admitted as quickly as possible.

X-Rays:
It very often saves time and saves disturbing a child recently installed and settled in the Ward if diagnostic X-rays are taken on the way to the Ward. The Casualty staff should then be asked to admit "via X-Ray Dept", and be provided with the necessary Request Form completed.
There may be some delay in the X-Ray Dept during busy periods, so this method should not be used for seriously ill cases.

Investigations:
Should be carried out as soon as possible after admission. In order that treatment may be started as soon as possible, aids to diagnosis and other investigations must be carried out as soon as possible. Only in most exceptional circumstances is it permissible to delay overnight.
Abnormal tests, X-rays etc., must be repeated at least weekly until the values return to normal. A child will not be discharged home until all path. investigations, blood, biochemical and bacteriological investigations are normal.

NORTHAMPTON & DISTRICT HOSPITAL MANAGEMENT COMMITTEE

Request for X-Ray Examination

Previous Dept. No.

Dept No.

Name Anne Body Age 6 1/2 Reg. No. C1627

Address Peabody Buildings Ramsey Consultant Dr Grant Ward O.P. Children

Further Out Patient Appointment - None : Already made : Make after X-Ray

Stretcher Case : Chair Case : Walking : Portable :

Underline which is applicable

Short History, stating requirements : Chest plain, PA + both lateral.

Pyrexia + cough

Signed [signature] Date 24-2-57

X-Ray Report :—Date :

Lab. No. .....

Date rec'd .....

NORTHAMPTON GENERAL HOSPITAL

DEPARTMENT OF PATHOLOGY

REQUEST for PATHOLOGICAL, BACTERIOLOGICAL or BIOCHEMICAL EXAMINATION

Hospital Registration No. C14271

Patient's Name (BLOCK LETTERS) BODY Sex F Age 4½ Ward Child

Christian Name Anne Cons. Physician or Surgeon Dr Gosset

Address Peabody Buildings, Raund. Occupation .....

Specimen Blood Date and **Hour** of Collection .....

Examination Required ESR, Ht, film, WBC, Differential Count

CLINICAL HISTORY	FOR TECHNICAL USE ONLY
Convulsions Pyrexia	

House Physician/Surgeon AMP Technician .....

Date 29.2.57 Phoned at .....

No examination will be undertaken unless the specimen is accompanied by this form duly completed and signed

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

NOTES ON INVESTIGATIONS AND PROCEDURES

X-RAYS

Request forms should contain all the information necessary to the Radiologist to assist him in:

1. Obtaining the most suitable 'views'
2. Arriving at an accurate diagnosis.

Chest films in children are useless unless Postero-Anterior and both lateral views are taken. Requuest forms must be clearly worded to this effect.

Abdominal X-rays for evidence of obstruction should be taken "Erect for fluid levels" and in cases of imperforate anus etc in infants should be taken "inverted with anal marker" so that gas distends the lowest limit of the rectum.

URINE

Microscopy of the urine should be carried out on every patient admitted. Normally a clean specimen of urine is suitable for diagnostic purposes- but with female infants a catheter specimen may be required. The investigation is, therefore, waived in this case unless it is absolutely necessary.

Request forms should require: "Routine testing, centrifuged deposit, culture and sensitivity". (Note that the Laboratory does not test for reducing substances unless asked specifically to do so.)

Addis Counts require 12-hour specimens.

17-Ketosteroids require 24-hour specimens

BLOOD PRESSURE

Smaller cuffs are used in children. For an infant a 1" or 1½" cuff will be required, and the Systolic pressure recorded by palpation of the pulse.
B.P. must be recorded daily in all cases of Nephritis and in all cases undergoing treatment with steroids.
The size of the cuff used should be recorded alongside the blood pressure (e.g. B.P. 100/68 (2" cuff))

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

INTRA-VENOUS TRANSFUSIONS

Particular care must be taken with children owing to the relatively small blood volume and the danger of overloading.

All intra-venous fluids are ~~xxxxxxxx~~ potentially dangerous, Normal Saline is particularly so in infants.

Infusions must be very slow indeed

Normally ante-cubital, scalp and saphenous veins are used. If a 'cut-down' is necessary (rarely), the ankle is the first choice.

Useful figures: 4 drops per minute is approx ½ ounce per hour.
40ccs blood produce rise in Hb. of 10% in a 7 lb. baby.
Approximate blood vol of infant is 40ccs/lb.

Transfusions in infants:
Fluid given must be carefully measured, and therefore should be given using either a Fletcher Drip- or a graduated syringe. In either case most careful supervision is required.

Exchange Transfusions:
Carried out in cases of Jaundice of Prematurity and Rhesus or other Blood Group Incompatibilities.
Fresh donor blood must be used and is cross-matched with mother's blood. Therefore a specimen of the mother's serum must be collected by the Obstetric House Officer. Donors will be bled by the Consultant or Registrar, but the Paediatric House Physician should arrange for donors of the appropriate Rh. Negative group to be sent for. (A list is kept in Miss Pearson's office in the Path. Lab.)
If a baby weighs more than 6 lbs, two donors will be required.

Blood Donors:
Must at all times be treated with the utmost courtesy and consideration. They must not be allowed to leave the hospital until they have rested and had a hot drink. If necessary transport should be arranged to collect them and take them hxome.

Northampton & District Hospital Management Committee — **NORTHAMPTON GENERAL HOSPITAL** 29

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER

Date — CONTINUATION SHEET

LUMBAR PUNCTURE

Must be performed on any child admitted (1) with real or suspicious signs in the C.N.S. (2) with convulsions (epileptic children already known to the department need not necessarily have an L.P. each time they are admitted provided they have had an L.P. once). It is most important to position the child acurately with the spine flexed as much as possible in the saggital plane, yet absolutely untwisted. The joint of entry must be lower in an infant as the cord is relatively longer. (In a new born a level as low as S1 - S2 may be used).

The "request form" must always ask for "Number and type of cells, Biochemistry, Culture and Sensitivity". The first Lumbar Puncture on any child should also be checked for W.R. (whatever the suspected diagnosis) and when the fluid is not crystal clear or T.B. is suspected a stained film should be asked for.

Always measure the pressure, check that rise and fall is free and record these findings in the notes.

The fluid must be examined for cells immediately: these lyse within a few hours. At night the duty pathologist must therefore be notified.

In the treatment of Meningitis an anti-biotic usually Penicillin is administered intra-thecally. It is wise, therefore, to have Penicillin made up ready at the first 'diagnostic' L.P. It should be made up in Normal Saline, not water.

A special dry Penicillin Salt is kept for the purpose in 100,000 cc vials. 5 cc's of Normal Saline are injected into a vial, and 1 cc (20,000 units) withdrawn after thorough mixing. A further 3 cc's of Normal Saline are taken up into the same syringe and shaken up. The resulting solution contains 5,000 units per cc - and normally only 1 cc of this solution would be put into the theca in an infant or up to a maximum of 4 cc in an older child.

It would be better to dilute the solution further since Sir Hugh Cairns laid down that (1) not more than 20,000 units may be given intrathecally at one dose in adults, (up to 15,000 units in children) (2) the solution must not be stronger than 2,000 units per cc.

However the above routine works well in practice and provided the pure Penicillin for intra-thecal use is given, there does not appear to be any danger.

Venipuncture (for pathological specimen).

Always ask a nurse to assist if the child is difficult.

A soft rubber tube tied around the upper arm is a more easily and firmly adjusted tourniquet than a ~~rubber band~~ nurse's hand.

Do not attempt venipuncture unless you are quite sure that no air will leak into the syringe around the piston as you withdraw it.

continued

Use a large enough syringe to get all the blood you need in one operation.

Sites: the anti-cubital vein is always present but may be small and buried in fat.

The saphenous is constant at the ankle but difficult to enter with a needle.

The femoral vein, internal jugula and external jugula may be used in infants.

Intra-cranial Sinus should only be used as the last possible resort, and only after obtaining permission from the Consultant.

SURNAME (Block Letters) | FIRST NAMES (Block Letters) | UNIT NUMBER

Date | CONTINUATION SHEET

CULTURE OF FAECES

Infants Gastro-enteritis is often caused by B.Coli organisms of pathogenic types. Staphylococci are rapidly becoming of major importance in Hospital infections. Therefore all faeces sent for examination must be cultured for Pathogenic B.Coli and Staphylococci, these organisms MUST be Phage Typed, and their sesitivities to antibiotics MUST be determined.

TUBERCULIN JELLY TEST ('Patch Test')

This must be carried out on all children admitted. It is performed as a routine by the Ward Sister who records the result in a book. However it is the duty of the H.P. to observe the result for himself and to record this in the patients notes.

DISCHARGE FROM THE WARDS.

Cases may not be discharged by the House Physician. A 'Doctor's Letter' must accompany each discharge.

TRANSFER TO CONVALESCENT UNIT

House Physician or Registrar should notify the Convalescent Unit of any proposed transfer. Childrens' Ward Sister will arrange transport and notify parents.

Lab. No. .....

Date rec'd .....

NORTHAMPTON GENERAL HOSPITAL

DEPARTMENT OF PATHOLOGY

REQUEST for PATHOLOGICAL, BACTERIOLOGICAL or BIOCHEMICAL EXAMINATION

Hospital Registration No. .....

Patient's Name (BLOCK LETTERS) ..... Sex ..... Age ..... Ward .....

Christian Name ..... Cons. Physician or Surgeon .....

Address ..... Occupation .....

Specimen ..... Date and **Hour** of Collection .....

Examination Required .....

CLINICAL HISTORY

FOR TECHNICAL USE ONLY

House Physician/Surgeon .....

Technician .....

Date .....

Phoned at .....

No examination will be undertaken unless the specimen is accompanied by this form duly completed and signed

Northampton & District Hospital Management Committee — **NORTHAMPTON GENERAL HOSPITAL** 23

SURNAME (Block Letters)	FIRST NAMES (Block Letters)	UNIT NUMBER

Date

CONTINUATION SHEET

PATHOLOGICAL INVESTIGATION REQUEST FORM (Example opposite)

Must be completed fully for each investigation. Where investigations can be carried out on a drop of blood from finger or ear prick, specimens will be collected by the Lab staff. However the following investigations require veni-puncture specimens:-

TEST	SPECIMEN	CORRECT BOTTLE (Labell thus)
E.S.R. (F.B.C can be done on same spec)	2cc	FOR E.S.R. and BLOOD COUN Name Ward Date Add 2 to 5 ml. of blood and shake w
BLOOD UREA	2cc	OXALATE TUBE — For BLOOD CHEMISTRY ONLY — Add 2-5 c.cs. blood — MIX WELL — Name / Ward / Date
PLASMA PROTEINS	2cc	
BLOOD CHEMISTRY ELECTROLYTES	5-10ccs	HEPARIN TUBE — for ELECTROLYTES only — ADD 10 ml BLOOD — MIX WELL — Name / Ward / Date
C.S.F. CHEMISTRY	8ccs	C.S.F. TUBE — for CHEMISTRY ONLY — NON-STERILE — Name / Ward / Date
CELLS	½cc	
CULTURE	1cc	
PROTHROMBIN	2cc(exact)	For PROTHROMBIN ESTIMATION Name ..... ADD EXACTLY 2 c.cs. BLOOD
BLOOD SUGAR	1cc (Can be done by finger prick)	FLUORIDE TUBE — For BLOOD SUGAR ONLY — Add 1 c.c. blood — MIX WELL — Name / Ward / Date
CROSS MATCHING	10ccs Serum	10 ml Blood GROUP AND X—MATCH Surname ..... Other names ..... Date of birth — day / month / year Ward ..... Date ...../...../..... (Initials)
BLOOD CULTURE	5-10ccs.	Special sealed and air-tight bottle containing broth.
AGGLUTINATIONS WIDAL REACTIONS W.R. and KAHN	8-10ccs Serum	STERILE NAME WARD