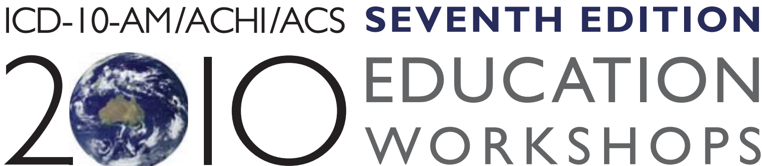

CODING WORKBOOK

ICD-10-AM/ACHI/ACS Seventh Edition
Coding Workbook
© National Centre for Classification in Health, Australia 2010

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Published by the National Centre for Classification in Health (Sydney),
Faculty of Health Sciences, The University of Sydney, NSW 1825 Australia.

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Introduction

The following case scenarios, discharge summaries and clinical records have been designed to provide clinical coders continuing education in ICD-10-AM/ACHI/ACS Seventh Edition. All clinical records have been amended to remove any identifying information.

Since it is not feasible to test every Seventh Edition change, these exercises test issues that were considered to be the main Seventh Edition changes. Topics will focus on:

- diabetes mellitus
- healthcare associated bacteraemia
- leukaemia and lymphoma
- obstetrics
- procedures normally not coded
- sepsis

To obtain the best benefit from the ICD-10-AM/ACHI/ACS Seventh Edition coding workshop attendees must have completed the pre-education material as well as these exercises **before** attending.

Participants are to bring with them on the day of the workshop the following:

- workbook (completed)
- ICD-10-AM/ACHI/ACS Seventh Edition coding books (or eBook on laptop).

CASE SCENARIOS

Case 1

26 year old man was admitted to hospital from home following accidentally cutting his right hand with a broken glass bottle. Examination showed a sensory deficit of the thumb due to an injury to the common digital nerve. Broken glass fragments were also present in the wound.

Procedure:
General anaesthetic via laryngeal mask.
A tourniquet was applied and the wound was explored. Excisional debridement of soft tissue was performed with glass fragments also being removed. The common digital nerve to the thumb was identified and found to be divided. The nerve was repaired using interrupted 9-0 Nylon. The wound was then thoroughly irrigated with saline solution and the skin was closed. A dorsal splint was applied to the thumb and remains in IP flexion at about 30 degrees and slight adduction.

Principal diagnosis: ____

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Additional diagnosis: ____

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Procedures: ____

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Case 2

75 year old lady presented with a five day history of increasing abdominal distension and pain especially on deep inspiration. Last opened bowels today. Diagnosed 12 months ago with an unknown primary cancer with metastases to the peritoneum. Chemotherapy given for 6 months. On examination BP 151/93, P 119, RR 20 and temp 37.

Investigations:
Abdominal x-ray – there are dilated loops of small bowel with fluid levels with very little gas in the large bowel. There is also an increased density in the abdomen suggesting widespread ascites.
FBC and EUC NAD

Under sterile technique, 5ml 1% LA injected and peritoneal tap performed with 14 gauge cannula. Flowing initially well but then slowed. Leave in peritoneal catheter until no further drainage, removed. IV chemotherapy (carboplatin and paclitaxel) administered 3 days later without any problems. At discharge, patient well and mobilising freely.

Final diagnosis: Malignant ascites secondary to metastatic ca. to peritoneum

Principal diagnosis: ____

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Additional diagnosis: ____

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Procedures: ____

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Case 3

58 year old female presented to the Emergency Department for blood transfusion for anaemia (Hb 67). Multiple myeloma diagnosed 18 months ago and is currently on velcade, cyclophosphamide and prednisone. Ex-smoker – stopped twenty years ago. Two units of packed cells administered without incident.

Developed chest pain with associated SOB during the admission. Normal ECG, CXR and cardiac enzymes. CTPA scan showed nil PE but bibasal diffuse ground glass appearance. Patient reviewed by the respiratory physician who recommended a bronchoscopy. Patient underwent a bronchoscopy with biopsy under sedation. Clinician confirmed a diagnosis of cyclophosphamide induced fibrosis from the biopsy results and patient reviewed by the Oncologist regarding her treatment regime. Discharged home on day 5 with a follow-up appointment in OPD in two days time.

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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Case 4

This 35 year old gravida 3, para 1 female was admitted to the delivery suite on 3/9/xx at 41 weeks gestation for IOL for post dates. Abdominal palpation – longitudinal lie, cephalic presentation. ARM and syntocinon induction commenced as per protocol. External CTG monitoring commenced. Epidural was given for pain relief. After 6 hours a liveborn male baby was delivered. Manual removal of retained placenta was performed and the episiotomy repaired. Postpartum course uncomplicated. Patient discharged home with baby on 6/9/xx.

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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Case 5

61 year old man was admitted for investigation of fevers and abdominal pain. He reported a two to three day history of nausea, vomiting and poor oral intake. No dysuria, haematuria or change in urine output. He was found to have a creatinine of ~650 on admission and an E. coli UTI. PMHx hypertension and IgA nephropathy. eGFR on admission 40. Smokes a pack/day.

Investigations:
Hb 111, WCC 18.4, Plt 349
urea 43.0, K 5.0, Na 140.
eGFR (on discharge) 45.
MSU *E. coli* sensitive to ceftriaxone.

A renal ultrasound showed no evidence of obstruction. He improved quickly with antibiotic therapy and rehydration. During the admission, the patient was seen by the diabetes educator as he had not been monitoring his blood sugar levels appropriately. Creatinine fell to 530 and he was discharged home on day 5 on a course of cephalexin.

Final diagnosis	Acute on chronic renal failure
Other conditions	UTI
	DM Type 2, on OHA
	Hypertension

Principal diagnosis: ____

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Additional diagnosis: ____

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Procedures: ____

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Case 6

This 32 year old patient was brought to the Emergency Department after a gas leak caused an explosion at his home. He was admitted to the Burns Unit with full thickness burns of the back (20% BSA) and partial thickness burns of both thighs (total of 9%). He was taken to theatre and under general anaesthesia (ASA 1E) a SSG was performed for the burns of the back and dressings applied to the thigh burns.

The patient developed systemic inflammatory response syndrome and acute respiratory failure in the postoperative period. CXR showed consolidation in the right lower lobe and sputum culture grew streptococcus A. He was intubated, via ETT and started on mechanical ventilation. He was extubated 36 hours later and was able to breathe on his own. Discharged home with a followup appointment in the Burns clinic.

Final diagnoses:
Burns
ARF
Pneumonia due to Streptococcus A

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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Case 7

Premature singleton (34 weeks) with a birth weight of 1890 grams, length of 43 cm and head circumference of 33 cm was admitted to the NICU from the labour ward with respiratory distress. Apgars were 9 at 1 minute and 9 at 5 minutes respectively. The arterial cord pH was 7.3 and the base excess -1.

Problems:
<u>Respiratory distress</u>
The chest x-ray and clinical course were consistent with hyaline membrane disease. Received CPAP for 92 hours. He was weaned to air after 62 hours. The maximum oxygen given was 24%.

<u>Cleft palate</u>
Diagnosed with a median submucosal cleft of the soft and hard palate. Initially required TPN for 7 days. At discharge, was being given expressed breast milk through a squeeze bottle and special soft teat. The baby will require surgery at 6 months of age. An appointment for next week has been made at the cleft palate clinic.

<u>Jaundice</u>
Jaundice treated with phototherapy for 32 hours. The maximum SBR was 226 micromol/L. The baby's blood group is A positive and the Coomb's test was negative.

<u>Eye discharge</u>
Baby had eye discharge from the right eye and the swab grew gram positive cocci. Chlormycetin eye drops were commenced to treat the conjunctivitis.

Investigations:
Head ultrasound – showed no evidence of intraventricular haemorrhage.
Haematology – Hb 183; WCC 13.1; platelets 550
Biochemistry – Na 136; K 5.4; Ca 2.74; Creat 67
Discharge SBR – 130 micromol/L

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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Case 8

Diagnoses:
AML – febrile neutropenia post chemotherapy
pancytopenia
SAB

40 year old woman with AML with multilineage dysplasia was admitted to hospital with febrile neutropenia due to chemotherapy administered last week. Complains of feeling unwell, with headaches, rigors and a fever. Diagnosed with AML 2 months ago, underwent induction chemotherapy with Big ICE and achieved remission. First cycle of consolidation chemotherapy (cytarabine, idarubicin, etoposide) started last week. Plan – Urine MC+S, blood cultures, CXR. Hickmans line insitu, 2 lumens accessed for IV antibiotics and TKVO.

On admission Hb 81, wcc 0.2, plt 7
Patient received 3 units of packed cells to treat anaemia and 2 units of platelets to treat thrombocytopenia
On discharge Hb 90, wcc 0.9, neu 0.1 and plt 20.

Micro findings – Staph aureus in blood culture. Commenced on IV penicillin for hospital acquired bacteraemia. Repeat blood cultures negative.
CXR and MSU clear.

Patient afebrile and was discharged home on day 7 and is to continue oral antibiotics.

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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Case 9

59 y.o. male admitted on 5.8.xx for management of right foot diabetic ulcer with bone exposed, MRSA positive. IDDM with peripheral neuropathy, ESRF on haemodialysis → previous right leg fistula/graft. Renal consult sought regarding IV vancomycin dosing. Infectious diseases consult → swab wound, organise blood cultures then commence patient on IV vancomycin 1g Q2nd daily. Patient also to elevate right lower limb and will require daily dressings.

Haemodialysis given via AVF: 6.8.xx, 10.8.xx, 13.8.xx, 17.8.xx, 20.8.xx
Doppler ultrasound of right leg artery and AVF reported no stenosis in CFA, SFA and popliteal artery; patent AVF.
Swab result – MRSA resistant to methicillin, sensitive to vancomycin.
Insertion of PICC, access via left arm basilic vein, performed on the ward on 10.8.xx. IV antibiotics commenced. PICC removed 22.8.xx.
CT scan (non contrast) of R foot/ankle on 12.8.xx no evidence of osteomyelitis of the metatarsals.

Operation report 15.8.xx – debridement of right plantar ulcer involving 4th and 5th metatarsal bones performed under a GA (ASA 2).

Patient was seen by the dietitian during the admission for increased protein requirements in view of ulcer. Recommended a high protein, no added salt, low potassium, diabetic full diet. Diabetes educator provided patient with a new exceed optimal meter with strips on 19.8.xx.

BSLs stable throughout the admission. Seen by physiotherapist on 21.8.xx where a total contact cast was fitted to the right leg, suture line dressed and comfeel applied to ulcer site. Patient discharged home on 22.8.xx to be followed up by the community nurses.

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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Case 10

84 year old female admitted with ↓LOC and acute respiratory failure secondary to severe sepsis. Two months ago suffered a left subcapital # treated with arthroplasty and is currently undergoing rehabilitation. PHx IHD, CABG, MVR – on warfarin, hypertension, CCF. For septic workup. IV antibiotics, inotropes and fluids commenced.

Admitted to ICU with the following problems:
1. Septic shock with hypoxic encephalopathy. Intubated via ETT (SIMV on 60% O2; PEEP 10, PS 15).
2. acute multi-organ failure (liver, respiratory and renal). Continuous veno-venous haemodiafiltration (CVVHDF) administered.
3. coagulopathy secondary to warfarin (INR 9.6) treated with vitamin K, prothrombin and 2 units of FFP.

Results:
CT brain – NAD
Chest x-ray – cardiomegaly. Support tubes in satisfactory position. There is a right basal shadowing consistent with pleural effusion and atelectasis and/or consolidation. Lungs are otherwise clear.
Renal ultrasound – no evidence of hydronephrosis, bilateral simple cortical renal cysts.
Ultrasound hip/groin – NAD
No VRE or MRSA detected by PCR
MSU – clear

Seen by the dietitian re NG feeds and the physiotherapist for suctioning via ETT. Ventilation weaned and patient extubated on day 7. Sepsis resolved and patient transferred back to the Rehab Hospital.

Final diagnosis: Severe sepsis

Principal diagnosis: ______________________________

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Additional diagnosis: ______________________________

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Procedures: ______________________________

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DISCHARGE SUMMARIES

DISCHARGE SUMMARY 1

Principal diagnosis: ______________________________

Additional diagnosis: ______________________________

Procedures: ______________________________

HEALTH

Discharge Summary

Hospital		MRN
Family Name		
Given Names		
DOB	Sex Female	Consultant

Discharged From Ward/Unit:
Consultant at discharge:
Admission date: 25/05/20 Discharge date: 30/05/20
Previous BMT Type:

Haematological diagnosis:

Acute Myeloid Leukaemia
Aml With Myelomonocytic (m4)

Reason For Admission:
40 year old lady with AML admitted for consolidation chemotherapy on Arm 2 of the M12 trial.

BG:
- AML- Dx in April 09. Induction chemotherapy with Big ICE, achieved remission. For first cycle of consolidation chemotherapy.

Procedures:
Consolidation Chemotherapy

Management_Investigations:
Admission Bloods: Hb 94, WCC 9.8, Plt 536, neutrophils 6.4.

Course: uncomplicated.

Discharge bloods: Hb 84 , WCC 5.8 , Plt 210.

Results pending:
Nil

Disease Status:
Complete Remission-First C.R.

Opinions and recommendations:

Medications on Discharge	Dose	Frequency	Duration
Fluconazole	400mg	daily	while neutropenic
Somac	40mg	daily	
Sodium Bicarbonate Mouthwash	1 cup	qid	while neutropenic
Norethisterone	5 mg	bd	while neutropenic
Pegfilgrastim	6mg SC	once	24 hrs post last cy

Pathology:

Last Blood Date:

Discharged to	Home	**Other/Specify:**		
F/Up appointment		FU AT CANCER CARE TWICE WEEKLY INCLUDING BLOOD TESTS.	Date:	2/06/20

Name. Signature Designation [illegible] Date 01/06/

DISCHARGE SUMMARY 2

Principal diagnosis: ____

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Additional diagnosis: ____

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Procedures: ____

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ADMISSION REGISTRATION FORM

Binding Margin – No Writing

FAMILY NAME:	GIVEN NAMES:	TITLE: Mrs	AUID:
SEX: Female	DATE OF BIRTH:	AGE: 40 years	MARITAL STATUS: Married or De facto
OVERSEAS VISITOR: No			
ADDRESS:	POSTCODE:	FINANCIAL CLASSIFICATION: D3P - Same Day Private	
TELEPHONE:	Work: :	MEDICARE NUMBER:	
INTERPRETER REQUIRED (IF YES PLACE STICKER HERE)	INDIGENOUS STATUS: Neither Aboriginal/Torres Strait Is	FUNDING AUTHORITY:	
	READMISSION WITHIN 28 DAYS: 1 - Not Applicable	PLAN TYPE: 1 - Full Hospital Cover - Private Patient	
LANGUAGE USED AT HOME: English	COUNTRY OF BIRTH: Australia	PLANNED LOS: Same Day	ADMISSION DATE: Monday 25th May 20
LEGAL STATUS ON ADMISSION: No Act Applies	RELIGION: Catholic, nec	ADMISSION TIME: 13:06	
NEXT OF KIN:			
RELATIONSHIP: Husband	TELEPHONE No:		
ADDRESS:		DISCHARGE DATE: 30/5/	
EMERGENCY CONTACT:	RELATIONSHIP:	TELEPHONE No:	DISCHARGE TIME: 1500
ADDRESS:		AUTOPSY:	
GP NAME:	TELEPHONE No:	GP CONSENT:	
ADDRESS:			
AMO 1: Haematology	ADMISSION SPECIALTY: Clinical	AMO 2 :	ADMISSION SPECIALTY:
EMPLOYER'S NAME:	TELEPHONE No:	SOURCE OF REFERRAL: 7 - Other Medical Practitioner other than Number 10.	
ADDRESS:		SERVICE CATEGORY: 1 - Acute Care	
PRESENTING PROBLEM: Chemotherapy		ADMISSION STATUS: 2 - Elective	

	CODE:	CODE:
PRINCIPAL DIAGNOSIS: the diagnosis which after study was the principal reason for admission		
SECONDARY DIAGNOSIS AND CO-MORBIDITIES: Other diagnoses, complications, active and inactive medical problems encountered during hospital stay.		
EXTERNAL CAUSES OF ACCIDENT, POISONING OR INJURY: (if applicable)	E1	E2
PRINCIPAL PROCEDURE: Diagnostic, therapeutic, operative and non-operative.	**DATE PRINCIPAL PROCEDURE PERFORMED:**	
OTHER PROCEDURES:		

MEDICAL OFFICER: (print name)	SIGNATURE:	DATE:
PATIENT ALERTS:		

INTENTION TO RE-ADMIT WITHIN 28 DAYS *(Please tick appropriate box)*

☐ 9 = No intention to readmit to any Hospital/Healthcare Facility

☒ 1 = Re-admission to this Hospital planned and booked

☐ 3 = Re-admission to other Hospital/Healthcare Facility planned and booked

☐ 0 = Direct transfer to another Hospital/Healthcare Facility or Death

☐ 2 = Re-admission to this Hospital planned but NOT booked

☐ 4 = Re-admission to other Hospital/Healthcare Facility planned but NOT booked

NOMINATED GENERAL PRACTITIONER DETAILS

Name

Address

Telephone Number

Facsimile Number

NOMINATED SPECIALIST DETAILS

Name

Address

Telephone Number

Facsimile Number

FACSIMILE TRANSMISSION RECORD *(desk clerk to complete)*

Date and Time of Facsimile Transmission 7/-8/

Recipient Notified (Please tick) ☐ N = No ☐ Y = Yes

If facsimile transmission is not possible, please complete the following:

By Whom (Please print name)

Copy of Prescription Included (Please tick) ☐ N = No ☐ Y = Yes

Date and Time of Postage

PRINCIPAL DIAGNOSIS *(after study, the condition chiefly responsible for this admission). Record an uncertain diagnosis as "probable" if treatment was initiated.*

Mediastinal Large B-cell lymphoma Stage IV

OTHER DIAGNOSES

(a) list all other conditions (pre-existing or current) **either** investigated or treated during this admission **or** which affected length of stay

Large B-cell Lymphoma
Dx March 20
Stage IV
Possible T2/T3 vertebral disease
CD20+ve
R-CHOP x6 residual activity on PET

(b) list other significant conditions (pre-existing or current) **not** included above

COMPLICATIONS *(arising during this admission)*

INJURY OR POISONING

Place of occurrence of any injury or poisoning

Activity at the time of injury or poisoning eg working, playing sport etc

KNOWN ADVERSE DRUG REACTIONS

NEW ADVERSE DRUG REACTIONS

GIVEN NAME	DOB	SEX
ADDRESS		
SUBURB POSTCODE	TELEPHONE	

OPERATIONS AND PROCEDURES

Insertion of R CVC

CLINICAL SUMMARY / LETTER TO GENERAL PRACTITIONER AND / OR OTHER HEALTH CARE PROVIDER
(include SIGNIFICANT details of the history, examination, investigations, opinions, procedures and treatments during this admission)

was admitted electively for salvage chemotherapy for residual lymphoma on PET. A right CVC was inserted and R-ICE chemotherapy was commenced. His admission was uneventful and his chemotherapy was tolerated well.

PLEASE NOTE: Medications on discharge are detailed on a separate prescription sheet

KEY ISSUES FOR FUTURE MANAGEMENT

) Significant alterations to management and / or medication during this admission

Reduce Clexane dose when Platelets <50

(b) Future Management Plan *(include outstanding issues to be addressed by General Practitioner or in Outpatients, and advice given to patient)*

For review in day centre next week
Insertion of Hickman line

ADDITIONAL COPIES OF DISCHARGE SUMMARY TO *(eg rehabilitation/palliative care centres, nursing homes, other carers)*

Name .... Name ....

Address .... Address ....

COPY OF PRESCRIPTION ATTACHED?: ☐ N = No ☐ Y = Yes

DISCHARGE SUMMARY

Date 5/8/

DISCHARGE SUMMARY 3

Principal diagnosis: ____

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Additional diagnosis: ____

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Procedures: ____

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Haematology Discharge Summary

1/3

Re:
DOB:
MRN:

Telephone:
Admitted: 05/01/
Discharged: 07/01/

Specialist:
Registrar:
Resident:

DIAGNOSIS:

1. Autoimmune haemolytic anaemia ?cold agglutinin disease related to NHL
2. UTI – E. coli

PAST MEDICAL HISTORY

1. NHL (Marginal zone)
2. Autoimmune haemolytic anaemia
   - Feb 2008
   - likely cold agglutinin disease associated with NHL
3. Steroid induced diabetes

PROGRESS:

Haematological issues

Mrs was admitted for chemotherapy and further investigation of haemolytic anaemia.

Repeat cold agglutinin studies were performed due to inconsistencies in previous studies to detect cold autoantibodies. Cold auto-Ab not detected on G+H, awaiting formal cold autoantibody screen

Repeat urinalysis for quantitative IEPG/EPG + creatinine clearance was also performed.

Mrs underwent chemotherapy with Rituximab 375mg/m2 (600)g on 6/1/ IV without complication.

For further weekly courses of rituximab – next course as inpatient, then to decide if further courses suitable as outpatient.

UTI

Incidentally, Mrs was also found to have a UTI with E. Coli grown in MSU, thus commenced 5/7 course of trimethoprim on 6/1. Mrs was asymptomatic although had recently been treated as an outpatient (Dec) with a UTI.

For repeat MSU on readmission

Haematology Discharge Summary

BLOODS ON DISCHARGE:

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ELECTROPHORESIS                Cum EPG                    Immunology No :
EPG:
Total Protein          59      g/L  (59 - 78)
Albumin              35.3 L    g/L  (35.7 - 53.4)
Alpha-1 globulins     2.8      g/L  (1.1 - 3.2)
Alpha-2 globulins     7.1      g/L  (5.3 - 11.2)
Beta globulins        7.4      g/L  (5.0 - 10.0)
Gamma globulins       6.3      g/L  (5.3 - 13.7)
EPG comment: Refer to IFE.

IFE(IEPG): Trace IgM Kappa monoclonal protein detected in the gamma region.
           The band is too faint to be seen on the EPG.
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FREE LIGHT CHAINS                                        Immunology N

Free Kappa                17.4              mg/L  (3.3 - 19.4)
Free Lambda               18.6              mg/L  (5.7 - 26.3)
Kappa/Lambda Ratio        0.94                    (0.26 - 1.65)
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 Iron                    9    umol/L
TIBC                    32 L umol/L
Ferritin               397   ug/L

Fe saturation           28    %
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General Biochemistry                                                 Fasting: no
 NA        147 H mmol/L        PROT      53 L g/L       CRP        9 H mg/L
 K         5.1 H mmol/L        ALB       30 L g/L       LD       434 H U/L
 CL        110 H mmol/L        ALP       54   U/L       CA      2.16 L mmol/L
 HCO3       30   mmol/L        AST       27   U/L       CCA     2.36   mmol/L
 AGAP       12   mmol/L        ALT       15   U/L       PHOS    1.27   mmol/L
 UREA      5.7   mmol/L        GGT       17   U/L       MG      0.86   mmol/L
 CRENEW     80   umol/L        TBIL      25 H umol/L
 EGFR       59   mL/min/1.73m2
 URAT     0.31   mmol/L
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Haematology Discharge Summary

Full Blood Count   Report Status - Final   Specimen Received Time - 07:36

WBC	6.9	NEUT	44	%	3.0	Smudge	%
RBC	1.74 L	BAND		%		Atyp.Mono	%
HGB	67 C	LYMPH	46	%	3.2	Atyp.Lym	%
HCT	0.20 L	MONO	8	%	0.5	OTHER	%
MCV	116 H	EOSIN	1	%	0.1	NRC	/100 WBC
MCH	38 H	BASO	1	%	0.1		
MCHC	330	MET		%			
RDW	18.0 H	MYE		%			
PLT	479 H	PRO		%			
MPV	6.5 L	BLA		%			

SMM

MEDICATIONS ON DISCHARGE:

1. Pariet 20mg daily
2. Ferrograd C 1tab BD
3. Cholecalciferol 1000units daily
4. Caltrate 600mg BD
5. Folic acid 5mg mane
6. Xalatan eye drops 1drop BE nocte
7. Trimethoprim 300mg daily for 7days from 6/1/10

FOLLOW-UP:

1. Readmit 13/01/ for next course Rituximab
   - if nil problems, then to decide if can continue weekly courses in 12A as OP
   - repeat urine MC+S on readmission
2. Investigations still pending
   - cold antibody screen 6/1
   - 24hr urinary electrophoresis 5/1
3. Return with problems

Haematology RMO

cc. Clinical Haematologist
Medical Records

CLINICAL RECORD 1

Principal diagnosis: ____

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Additional diagnosis: ____

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Procedures: ____

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DISCHARGE SUMMARY

INTENTION TO RE-ADMIT WITHIN 28 DAYS *(Please tick appropriate box)*

- ☐ 9 = No intention to readmit to any Hospital/Healthcare Facility
- ☐ 1 = Re-admission to this Hospital planned and booked
- ☐ 3 = Re-admission to other Hospital/Healthcare Facility planned and booked
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NOMINATED GENERAL PRACTITIONER DETAILS

Name

Address

Telephone Number

Facsimile Number

NOMINATED SPECIALIST DETAILS

Name

Address

Telephone Number

Facsimile Number

FACSIMILE TRANSMISSION RECORD *(desk clerk to complete)*

Date and Time of Facsimile Transmission 27/8/ 9.00

Recipient Notified (Please tick) ☐ N = No ☐ Y = Yes

If facsimile transmission is not possible, please complete the following:

By Whom (Please print name)

Copy of Prescription Included(Please tick) ☐ N = No ☑ Y = Yes

Date and Time of Postage

PRINCIPAL DIAGNOSIS *(after study, the condition chiefly responsible for this admission). Record an uncertain diagnosis as "probable" if treatment was initiated.*

Left MCA subcortical infarct

OTHER DIAGNOSES

(a) list all other conditions (pre-existing or current) **either** investigated or treated during this admission **or** which affected length of stay

1. Left MCA infarct 04/2009: Multiple IC stenoses, vertebral artery stenosis, basilar angioplasty
2. NSTEMI 08/2009
3. T2DM – OHG
4. Dyslipidaemia
5. HTN

(b) list other significant conditions (pre-existing or current) **not** included above

1. Ex-smoker

COMPLICATIONS *(arising during this admission)*

INJURY OR POISONING

Place of occurrence of any injury or poisoning

Nil

Activity at the time of injury or poisoning eg working, playing sport etc

Nil

KNOWN ADVERSE DRUG REACTIONS

NEW ADVERSE DRUG REACTIONS

Nil

OPERATIONS AND PROCEDURES

CLINICAL SUMMARY / LETTER TO GENERAL PRACTITIONER AND / OR OTHER HEALTH CARE PROVIDER

(include SIGNIFICANT details of the history. examination, investigations, opinions, procedures and treatments during this admission)

61 year old woman presented with right hand clumsiness.

[Ex]amination: BP 155/80, right facial droop, right UL pyramidal weakness and drift, right LL pyramidal weakness.

Investigations:

CT-B: No evidence of acute ischaemia. Severe chronic small vessel ischaemia.

MRI: New focal infarcts in the left corona radiata / centrum semiovale on the background of multiple previous infarcts.

Lipids: Chol 4.4, LDL 2.6, Tri 1.5.

HbA1c 6.6

UEC, LFT, FBE normal

Progress: Ongoing symptoms (particularly left upper limb weakness). Experienced ongoing dizziness, likely secondary hypotension. Cardiothoracics team informed of current admission (planned for outpatient CTS clinic in 4/52). Transferred to .... for ongoing rehab.

PLEASE NOTE: Medications on discharge are detailed on a separate prescription sheet

[K]EY ISSUES FOR FUTURE MANAGEMENT

(a) Significant alterations to management and / or medication during this admission

Commence aspirin and clopidogrel

Decrease irbesartan to 150mg, cease frusemide (mild hypotension)

(b) Future Management Plan *(include outstanding issues to be addressed by General Practitioner or in Outpatients, and advice given to patient)*

T/f .... for ongoing rehab

Cerebrovascular Clinic in 3 months

ADDITIONAL COPIES OF DISCHARGE SUMMARY TO *(eg rehabilitation/palliative care centres, nursing homes, other carers)*

Name .... Name ....

Address .... Address ....

COPY OF PRESCRIPTION ATTACHED?: ☐ N = No ☐ Y = Yes

DISCHARGE SUMMARY

Date 27/08/

Pharmaceutical benefits entitlement or DVA number

☐☐☐☐☐☐☐☐☐☐☐☐☐

Print patient's name ______________________

Tick appropriate box (one scheme only per form)

☐ Safety Net entitlement card holder ☐ Concessional or dependant, RPBS beneficiary or Safety Net concession card holder ☐ PBS ☐ RPBS ☐ Chemo Access

Drug name and form	Strength	Dose, route and frequency	Quantity	Rpts	Supply Y/N	☎ Approval number if required
ESOMEPRAZOLE	20mg	po mane			N	
METFORMIN	1g	po BD				
CLOPIDOGREL	75mg	po mane				
TERBINAFINE	250mg	po mane				
ATORVASTATIN	80mg	po nocte				
ASPIRIN	100mg	po mane				
GLIPIZIDE	30mg	po mane				
METOPROLOL	12.5mg	po BD				
IRBESARTAN	75mg	po mane				
					↓	

Drug hypersensitivities

DO NOT LEAVE BOX BLANK
If patient has no allergies enter N/A in box.

N/A

Prescriber's name:

Signature:

Pager number:

Prescriber number:

Date: 26/8/

Clinical unit: Stroke

I certify that I have received this medication and the information relating to any entitlement to free or concessional pharmaceutical benefits is not false or misleading.

___/___/___ Date of supply

Patient or agent's signature

Agent's address

Authority required items ONLY (refer to approved authority indications in *Schedule of Pharmaceutical Benefits*)
(Authority prescription applications 24 hour service PBS 1800 888 333 RPBS 1800 552 580)

Disease or purpose(s) for which benefit required or clinical justification for use of item ______________________

Next visit: GP/outpatients in ______________ days/weeks/months

Patient's weight (paediatric): ________ kg

Patient's age if child ________

Did an ADR occur during hospitalisation? ________

If YES, drug ________

Details ________

Pharmacy recommendation: liaised with Rehab.

Medication chart done: Y / N

Medication counselling by: ________

Profile checked by: ________

Dispensed by: 1. ________ 2. ________

Handed out by: ________

4062A (01/09)

Triage Classification: 3

Interpreter Required:

Current Location: 10

Arrival Date/Time: 17 AUG 20 17:28

Accompanying Person:

Presenting Problem:

PAIN - HEADACHE FOR PAST 3/7 NOW NOT ABLE TO STAND AND NUMBNESS TO R HAND HX DIABETIES CVA ANGINA PEARL 3+ R SIDE DEFICIT GCS 14/15 SPEAKING IN FULL SENTENCES P 60 REG RR 16

Triage Nurse:

Time Triaged: 17:28

Treating Doctor:

Time Seen: 23:02

EMERGENCY RECORD

B

- ☐ iv infusion
- ☐ iv anaesthesia
- ☐ LP
- ☐ laryngoscopy
- ☐ PEG
- ☐ defibrillation
- ☐ blood transfusion
- ☐ suture >7cm
- ☐ debride deep wound
- ☐ R/O subcut FB
- ☐ I&D abscess / h'toma
- ☐ tendon repair
- ☐ repair nail bed
- ☐ pack epistaxis, obs >4h

E

- ☐ 4h observation & treatment
- ☐ 1/2hrly obs on chart / cardiac monitor
- ☐ mental health management (req. ECATT)

O

- ☐ critically ill pt prior to transfer to other hosp
- ☐ IP admits that are cancelled / absconded
- ☐ intent to keep overnight with 1/2 hrly obs x4h
- ☐ died in ED after resuscitation

For General Clinic use only.

Time Ordered	Drug / Procedure	Volume ml / Dose	Route	Time	Dr. Signature	Time Given	Nurse Signature

This information must be completed prior to discharge of patient

PRINCIPAL DIAGNOSIS:

SECONDARY DIAGNOSES:

PROCEDURES:

Is there an intention to re-admit the patient within 28 days? YES ☐ NO ☐

EMERGENCY DEPARTMENT ADMISSION TYPE (Dr. PLEASE ✓)

- ☐ Type **O** Planned overnight admission
- ☐ Type **B** Banded procedure or intervention (see guidelines)
- ☐ Type **E** Extended ED care >4 hours observation or intervention
- ☐ Type **C** General Care, unable to discharge due to general or care coordination requirements

This patient meets the general criteria for an emergency department admission of the type specified above.

Signed...

MEDICAL CERTIFICATE (Circle) **TAC** **W / C** **ORDINARY**

DURATION ____________________

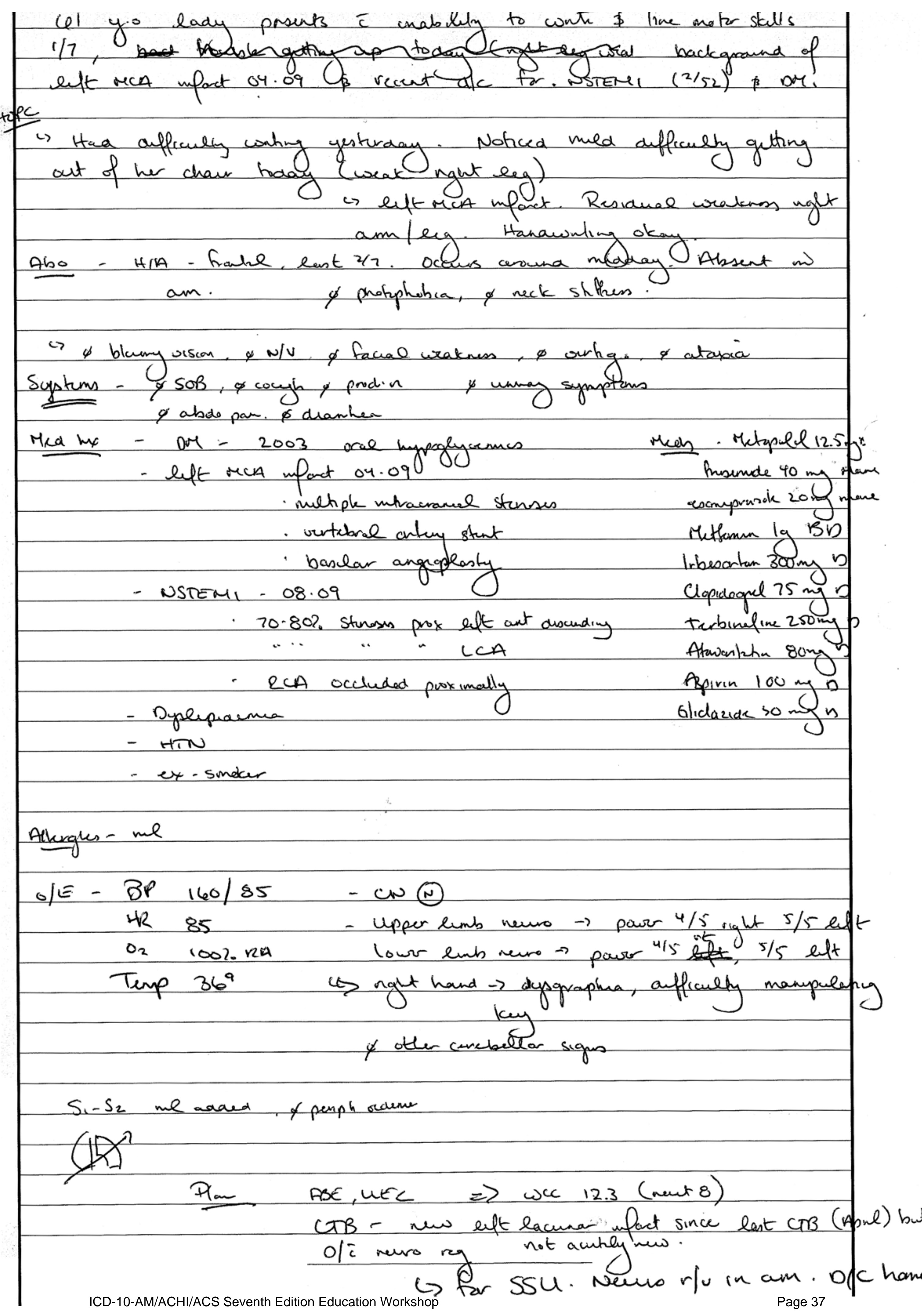
DEPARTURE DETAILS | DOCTOR CODE

DEPARTURE TIME

CODE ____________________

OP CLINIC / UNIT ____________ WARD ____________

ED1



61 y.o lady presents c̄ inability to write & fine motor skills 1/7, ~~back~~ trouble getting up today (right leg) with background of left MCA infarct 04.09 & recent a/c for NSTEMI (2/52) & DM.

HOPC

↳ Had difficulty writing yesterday. Noticed mild difficulty getting out of her chair today (weak right leg)

↳ left MCA infarct. Residual weakness right arm/leg. Handwriting okay.

Also - H/A - frontal, last 2/7. Occurs around midday. Absent in am. ∅ photophobia, ∅ neck stiffness.

↳ ∅ blurry vision, ∅ N/V, ∅ facial weakness, ∅ vertigo, ∅ ataxia

Systems - ∅ SOB, ∅ cough, ∅ prod'n, ∅ urinary symptoms
∅ abdo pain, ∅ diarrhea

Med hx - DM - 2003 oral hypoglycaemics
- left MCA infarct 04.09
  · multiple intracranial stenoses
  · vertebral artery stent
  · basilar angioplasty
- NSTEMI - 08.09
  · 70-80% stenosis prox left ant descending
  · " " " LCA
  · RCA occluded proximally
- Dyslipidaemia
- HTN
- ex-smoker

Meds · Metoprolol 12.5mg
Frusemide 40 mg mane
Esomeprazole 20mg mane
Metformin 1g BD
Irbesartan 300mg D
Clopidogrel 75 mg D
Terbinafine 250mg D
Atorvastatin 80mg D
Aspirin 100 mg D
Gliclazide 30 mg N

Allergies - nil

O/E - BP 160/85
HR 85
O2 100% RA
Temp 36.9

- CN (N)
- Upper limbs neuro → power 4/5 right 5/5 left
  Lower limbs neuro → power 4/5 ~~left~~ rt, 5/5 left
  ↳ right hand → dysgraphia, difficulty manipulating key
  ∅ other cerebellar signs

S1-S2 nil added, ∅ periph oedema

Plan FBE, UEC ⇒ WCC 12.3 (neut 8)
CTB - new left lacunar infarct since last CTB (April) but not acutely new.
O/E neuro reg
↳ for SSU. Neuro r/v in am. D/C home

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
18/8/	SCU WR
	61 yo ♀ p/w Ⓡ hand clumsiness 1/7.
	PMHx
	Ⓛ MCA infarct 04/09
	- multiple IC stenoses, vert art stent, basilar angioplasty
	NSTEMI 08/09.
	TIIDM - OHA
	Dyslipidaemia
	HT, ex-smoker
	O/E BP 155/80
	Ⓡ facial droop.
	RUL proximal weakness
	drift, pyramidal weakness
	LUL ø drift.
	RLL pyramidal weakness
	ECG NSR rate 84.
	Admit SCU
	Ⓟ 1. MRI/MRA ? b-stem stroke
	2. Asp + clopidogrel
18/8/09	SCU Intern
	- ECG please (12 lead).
	- To have sedation pre-MRI.

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
19/8/	Nursing ND: Pt GCS15, PEARL, FP of Lt) side, mild weakness of Rt) side. v/s WNL, afebrile. Continent of urine in toilet. Transfer x1 to commode. BNO. Pt is for MRI in am, Alprazolam 0.25 mg has been charted for pre-med before MRI. Pt sleep well overnight. Nil c/o voiced. Nil other issues (RM)
19/8/ 9.30am.	**SOCIAL WORK** Referral received requesting S/W to facilitate New ACCR paperwork for this lady who is reportedly on TCP program via ______ TCP program.
	S/W has made contact ̄c:
	• TCP – ______ & case manager
	• Awaiting: fax of OLD ACCR + email of TCP referral form template
	Will Require TRAC referral by Doctors to ensure that TRAC r/v – ~~but~~ ̄c and to ensure they Ax whether TCP still relevant.
	TCP report that ______ gets:
	: Daily visits (P care 3x pw + ? (A) ̄c Dressing other days) + meal set up, set up commode
	• Physio 1x p/w. S/V ~~[illegible]~~ ̄c 4WF is usual mobility but does mob (I) at home 'at her own risk'
	• Preps own light meals / cups of hot drinks
	• cog'ly some STM loss but "competent".
	S/W plan:
	. Await ACCR (old) to be faxed
	. Liaise ̄c Dr re TRAC referral pls
	. Liaise ̄c team re current level of function
	. Complete TCP referral + New ACCR + get new ACCR delegated.
	Social worker a/ 3

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
19/8/	**PHYSIOTHERAPY** PT student consent ✓ Blanket referral
1230	received for this 61 ♀ c̄ (R) UL&LL weakness ? brainstem
	stroke.
	S/ Pt agreeable to physio. ° c/o pain/headache. N/S report 2×(A)
	bed → comode.
	PHx: (L) MCA infarct '04/'09, NSTEMI 08/09, T2DM, HTN
	SHx: see IP49 at rear
	O/Obs ✓ pt SOOB
	- Sensation: R=L UL&LL intact LT.
	- Strength: (L) UL&LL 5/5
	(R) UL: 3/5 grip, 2+/5 WF/WE, 3/5 EF/~~EE~~ (error 19/8), 2/5 Sh F/E/Abd, 2/5 EEx.
	LL: 3/5 DF, 1+/5 PF, 2/5 KF, 2/5 KE, 2/5 HF.
	- Proprioception: · ↑ tone (Tardieu 2, catch at
	· UL (R)=(L) intact ≈90° at V2 & V3) in (R) elbow flexors
	· LL (L) intact, (R) intact from ankle.
	- ♀̲ balance (I), able to move trunk upright from forward lean
	- ♀̲ & reach: able to reach out of BOS c̄ (L) UL in all directions,
	h/e ↓ (R) trunk control
	- ♀̲ → ♀ 2× mod (A) 2° ↓ (R) UL/LL strength & trunk control. Unable
	to march on the spot, Falls to (R) ++.
	Rx/Ax a/a
	- UL facilitation to reach // pt able to initiate movement
	at shoulder, elbow & wrist & perform terminal elbow
	ext, requires (A) to extend wrist & support weight of (R) UL
	through movement.
	- Hand function tasks:
	· Hold cup c̄ (R) hand // able to bring to mouth h/e can't tip
	towards face.
	· Small objects // unable to consistently/easily pick up paper
	chips etc
	· Pen // able to grasp pen h/e lacks strength to keep wrist
	extended & forearm pronated.
	A/ Pt 2× mod (A) ♀̲ → ♀ & t/fs. Requires functional, achievable
	tasks. Seems determined. Would benefit from IPR.
	P/ PT r/v to progress ♀̲ → ♀ & hand function. Please HF c̄ 2× mod (A)
	Await medical Mx plan & r/v. Would benefit from IPR.
	PT STUDENT.

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
19/8/	SCU WR
	Pt alert, SOOB
	O/E BP 110/60
	Ø facial droop
	RUL 3/5 pyramidal weakness
	RLL 2+/5 pyramidal weakness
	(P) 1. MRI c̄ sedation (oral)
19/8/ 1400	Nursing A.M.: pt is alert and oriented. Obs stable and afebrile. GCS 15, pupil reactive and unequal, R) side moderate weakness, FP on the lt side. Doctor has been informed. Needs assistance with mobility. Has been shower, passing urine in commode chair. Medication has been given as per charted. Seen by physio today. Nil further issue.

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
19/8/ 1800	OCCUPATONAL THERAPY Blanket isoft referral received for this 61 yo ♀. currently at MRI therefore OT unable to complete Ax / R/V full. Plan: OT Ax 1/7 — OT
19/8/ 2046	PM NURSING: Pt A+O, GCS 15, PEARL, mild to mod. weakness on R) side obs stable, afebrile. Pt continent of urine, BNO this PM. Pt transfer by 2. Pt had MRI done, been RIB. Good food + fluid intake Nil % pain. Med given as per charted — student nurse RN/AV
20/8/	Nursing ND: Pt GCS 15, PEARL, PP of L) side, Moderate weakness of L) arm, mild weakness of L) leg. vis urine. Sleep well overnight. BSL checked as chart. Nil c/o voiced. Nil other issue (RN)
20/8/ 0840	SCU WR
	MRI R/V'd.
	new (L) MCA subcortical infarct.
	O/E BP 145/60 HR 82
	BSL 6 – 10
	(P) 1. ↑ nocte metoprolol 12.5 mane 25mg nocte
	2. Go Rehab

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
20/8/	**PHYSIOTHERAPY** PT student consent ✓ R/V
0920	S/ °c/o pain, h/e Ⓡ UL "heavy." Happy to participate in PT.
	O/ OB ✓, Pt RIB.
	-Strength: Ⓡ UL shoulder F/Ad/Ab 3/5, elbow F/E 3/5,
	wrist F/E 3/5, grip 3/5. Ⓡ LL DF 2/5, KE 3/5, KF 3/5, HF 3/5
	Hip Ab/Ad 2+/5 — -sit reach: able to reach
	- → Ⓡ side lie Ⓘ, → Ⓛ side lie Ⓘ — out of BOS when reaching c̄ Ⓡ UL, able to touch floor
	- Ⓛ side lie → SOEOB Ⓘ — & sit upright again.
	- sit → stand 1x mod Ⓐ, requires prompts to bring Ⓡ foot back.
	- Amb ≈ 10m on ward c̄ 2x mod Ⓐ // ↓ Ⓡ heel strike, Ⓡ knee flicks
	into hyperextn, Ⓛ hip drop (Trendelenburg) Ⓡ c̄ Ⓡ stance. ~~Nom~~ ERROR 20/8/
	Reciprocal gait c̄ ↓ step length Ⓡ & Ⓛ. Return to chair.
	Rx/Ax & mobilise a/a // ↓ Trendelenburg when prompted to
	contract Ⓡ gluteal in Ⓡ stance
	A/ Pt improved ++ from yesterday, requires encouragement +
	reassurance, & achievable tasks. Please amb & HF c̄ 2x mod Ⓐ.
	P/ PT r/v to progress gait & UL function. Please amb & HF c̄
	2 x mod Ⓐ on ward. Note referral TRAC for IPR.
ADDIT	Pt reports her walking was — PT STUDENT
	good today - possibly better
	than pre-admission ∴ may
	be able to go directly Ⓗ
	if can be safe Ⓘ c̄ 4WF — G2AT
	- PT ongoing R/V - Trial 4WF

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
20.8 1300	AM NURSING: Pt A+O. GCS of 15. PEARLS. Mild weakness on R) side. Full Power on L) side. Obs stable. Pt transfer x2 with assistance. Pt showered this (AM) BNO x 2. Pt SOOB for lunch, good F+F intake. BSL was 11.6mmol/L prior lunch. Nil c/o pain. Nil other issues student nurse
	OTherapy
20/8/ 1500.	OCCUPATIONAL THERAPY Initial Ax completed this pm for this 61yo ♀ pt w. (R) hand clumsiness. OT role explained & consent obtained.
	PHx, SHx, Previous Occupational performance & Home Environment as per P49 c̄ thanks PT. Pt had TCP community package & son (A) also. Pt states son has recent # vertebra & d/c from RMH on W/E therefore unable to provide previous level of (A).
	Current occupational performance.
	- PADLs: Pt (A) c̄ showering, dressing & toileting this am.
	- Mobility: As per PT entry c̄ thanks.
	- Cognition: Pt appropriate in conversation. Able to provide reason details of admission.
	- UL: (R) handed. Currently unable to write. ↓ strength in (R) UL. reports NAD c̄ sensation. OT encouraged use of (R) UL in tasks. & pt agreeable.
	Impression: Pt currently appears below premorbid level of function. OT to further r/v re: ?directly H vs. IP Rehab.
	Plan: Ongoing OT r/v

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
20/8/ 2040	NURSING (PM): Pt GCS 15, PEARL, FP × L) LIMBS, MOD WEAKNESS IN R) LIMBS, VITALLY STABLE, MEDS GIVEN AS PER IPR, BSL 7.3 mmol/L @ 1730, FWD + FF WELL TOLERATED, PT ENCOURAGED TO ALTERNATE SIDES IN BED FOR PAC, BO, PU'T, T/F ×2 TO COMMODE. STAT SLOW K ii GIVEN @ 2000hrs. NIL FURTHER ISSUES STABLE AT TIME OF REPORT RN(DIV 1)
21/08/ 0300	Nursing (ND): Pt A+O, GCS-14, PEARL. Moderate weakness in R) limbs. Obs - stable, BSL - 7.6 mmol/L at 2245. Pt tolerating FWD and FF, Continent - BO & PU with bed pan. Pt slept well.
21/8/	SCU Reg WR BP 135/70 P/1. Aim d/c home today c̄ aspirin + clopidogrel if not dizzy + able to mobilise safely

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
21/8/	**PHYSIOTHERAPY** R/V
0945	S/ Pt well. reports some dizziness this AM,
4S	happy to mobilise. reports R) UL
	weakness and LL R) weakness worse
	than on previous D/C home.
	O/ Pt R13. obs:- as charted.
	T/F's - ☐ → ◻ c̄ S/V for safety + prompts.
	- ◻ → ☐ c̄ Min A x1 c̄ 4WF.
	Amb c̄ Min A x1 c̄ 4WF ≈ 15m.
	A// Ax a/a.
	Amb c̄ Min A x1 c̄ 4WF ≈ 15m // not safe
	for D/C, difficult c̄ R) LL placement,
	dipped frame x3, swinging c̄ abdu,
	↓ hip flexion, A to place R) UL on
	frame and to remove.
	Pt SOOB
	Plan// Pt to amb c̄ 4WF c̄ A x1 c̄ AFO on R)
	c̄ thanks.st. Pt not safe for D/C home.
	Ongoing r/v.
	D/c plan// Pt will need period of IPR
	to improve gait + R) UL func. ——
21/08/	Nursing AM:
1500hs.	remains GCS: 15/15. FP XAt: Mod weakness
(NS)	Rt: vital signs 122/86mmHg HR: 68/mt. Sats
	98% RA. afebrile; Had breakfast after
	setup by Nurse. She vomited ~~after~~ on half
	an hour; after meds and food.
	Felt dizzi before vomit. Took her back
	to bed. BP: 140/80 - ~~[illegible]~~ error.
	says, she feels okey after vomitting.
	Her BP ↓ to 83/60mmHg 1400hrs, when
	she was OOB for lunch; took her
	back to bed & found BP came back
	to 125/70mm.
	PRN; Metoclopramide 10mg given prelunch

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
21/8/	Nsg Pm: Feel giddy this pm, SOOB when receiving TOP – ↓ syst. 86, put to bed, ↓ syst. ↑ 125, feels better in bed, Advised to RIB, wheeled to the toilet to PU – pro this pm, SOOB c dinner time, & then back to bed, still not able to mobilized this late evening, don't feel dizzy this evening, settled then on bed watching TV – all meds taken as per IPR – RN1
22/8/ 0500	Nursing ND: – Pt neurologically GCS 14 PEARL, mod weakness in R) limbs, obs stable, FP x L) limbs. continent c pan. attended to her needs., BNO. settled & slept well o/n, pt been observed o/n. nil issues ——— RN1
22/8/	WR – well..
22/8/ 1300	NURSING (AM): Pt GCS 15, PEARL, FP x L) LIMBS, MOD WEAKNESS R) LIMBS, VITALLY STABLE, MEDS GIVEN AS PER IPR, BSL 12.9 mmol/L @ 1100hrs, Showered ½ c (A), SOOB for ½4 c/o "dizziness" repeat neuro obs + vitals + BSL done nil reportable issues, pt tf back to bed ~~nil~~ overview states "dizziness has gone", visited by son, diet + fluids well tolerated, BO, RIB stable at time of report – RNDN1
22/08/ 2045	Nursing pm: Pt GCS 15, PEARL, Moderate weakness to R) lower limb, mild weakness to R) upper limb. FP L) limbs Medications given as per IP12, BSL @ 1700 hrs 5.9 mmol/L, RIB this shift. Moderate intake of diet + fluids. c/o headache. 1 gm paracetamol given @ 1730 hrs with good effect. RND2. ———

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
23/8/ 6AM	Nursing ND:- Pt Neurologically GCS 15, PEARL, FP x L) side, Mod wkness on R) side, vitally stable. PUIB. pt settled & slept well O/N. Nil complaints voiced. RN1
23/08/ 1300	NURSING (AM): Pt GCS 15, PEARL FP x L) LIMBS MOD WEAKNESS R) LIMBS, vitally stable BP 100/50 Dr notified mane lisinopril 20mg (W) all other meds given as per IPIZ, BSL 14.4mmol/L @ 1100, Showered c (A), [illegible] for 1/2 4, diet + fluids well tolerated, BO, PUIT, nil further reportable issues stable at time of report (RNDV1)
23/08	Nsg. Pm: Not feeling dizzy this pm, vitally stable R/B, eating/drinking well. used bedpan for PU. Pt remain fully orientated, nil changes c limb strength, settled pm RN1
24/8/ 0500	Nursing ND:- pt Neurologically GCS 15 PEARL FP x L) limbs, mod wkness R) limbs vitals normal and charted - attended to her needs. pt remained comfortable continent c pan. nil issues. RN1
24/8/ 45 0930	**PHYSIOTHERAPY** RW S// Pt well. Reports dizziness over w/e, mainly 2/3. Feels sensation ting in R) foot. Agreeable to mobilise. O// Pt SOOB. Obs:- as charted. T/F's - B → ? Min (A) x1 c 4WF Amb c 4WF c Min (A) x1 c R) AFO ~15m. A// Ax a/a. Amb c 4WF c Min (A) x1 c R) AFO ~15m // clipped R) rear wheel x2, prompts to kick leg straight, lack of control at hip. Plan// Pt to T/F + Amb c 4WF c (A) x1 c R) AFO insitu c thanks. DTO.

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
24/8/	PHYSIO con't
0930	Plan// Please enc mob to bathroom.
	D/C plan// pt will benefit from period
	of IPR.
22/8/	Stroke care
	#5 Reports dizziness (pre-sync.) over w/e.
	Ongoing UL weakness → ∅ improve.
	Discussed further Ⓛ-sided stroke.
	→ V. keen on rehab at
	Ⓞ BP 100/60
	Ⓐ Recovering
	Ⓟ ① Pursit Rehab.
	② ↓ metoprolol to 12.5 } mild hypotension
	↓ Irbesartan to 150
	Cease frusemide
	③ ?Booked for CABGs → relate current event
	to Cardiothoracics (Liaison nurse).
24/8/	Nsg. Am: Had a shower this am, BP still ↓
	110/60, feels dizzy after shower, so was
	to ? KP by the team. ↓ HTN meds,
	D/C frusemide PD. – put back to bed
	before lunch per pt's request. Have showered &
	mobilised outside the corridor c̄ Ⓛ frame
	splint support – very dense Ⓡ sided
	weakness – transfer by 1-2 helped, eating
	& drinking moderately KNI

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
24/8/ 1345	**TRAC** Aged Care / Rehab — Thanks for referral to TRAC for consideration for IPR. Initial Ax completed + will discuss with consultant this pm. CNC
24/8/ 2125hrs	NURSING PM: Patient alert + orientated, afebrile, normal power L↑ limbs, mild weakness Rt ↑ limb, normal power Lt leg, mod. wkness in Rt leg. Passing urine in bed pan. Tolerating fluids & food well. Frusemide ↓, plastic splint on Rt leg when out from bed. Nil further issues. Medication administered as per drug chart (, DIV-1,
25/8/ 0700	NURSING: Pt alert, vitally stable. Limb strengths remains unchanged. BSL stable. Continent c̄ pan. Nil C/O pain / discomfort. Slept well O/N. ——— (RN)
25/8/	Consultant WR: Cardiology C/O "dizziness" - recent NSTEMI 08/ BP 110/80 Plan: - ↓Irbesartan - 12-lead ECG. - Encourage oral intake - Check LFT's. - ? CABG

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
25-8 1420.	NURSING PM: Pt remains A+O. Vitally stable. Tolerated diet. Enc fluids. BO x1 PU IT. Assist x1-2 transferring, Commode to toilet / shower today. Visited by family, taken downstairs in wheelchair. PLAN: TRAC for IPR ______ KADUK
25.8. 1550	**PHYSIOTHERAPY** review Pt RIB. Alert and orientated. Refusing PT input. P) TRAC for IPR. Please enc amb to bathroom c̄ 4WF + 1x (A) and (R) AFO insitu. Continue to monitor — CPT
25/8 1900	Nursing PM: Pt's v/s WNL. Tolerating well c̄ diet + fluid. Medications given as IP12. ECG done as MO ordered, MO reviewed. RIB most of the shift. Transfer x1 to commode. Continent in toilet / pan. BNO. Nil c/o voiced. Nil other issue. ______ (RN1)
25/8 0600hrs.	NURSING: Pt alert, RIB throughout this shift. Vitally satisfactory. Continent c̄ pan x2 O/N. Nil c/o pain or discomfort. Pt appeared to be sleeping whilst checked x3 O/N. Nil issues @ TOR. RN1)
26/8 1135	**PHYSIOTHERAPY** R/J Slept well. Reports some ongoing dizziness when T/F out of bed. Agreeable to mobilise. O/I Pt SOO3. Obs:- as charted ✓ T/F's – ⊊ → ⊊ Min (A) x1 c̄ 4WF c̄ (R) AFO. Amb c̄ 4WF c̄ Min (A) x1 c̄ (R) AFO ~20m. All Ax a/a. Amb c̄ 4WF c̄ Min (A) x1 c̄ (R) AFO ~20m // ↓ control of (R) swing and strike, toe drag+, c̄ prompts can ↑ toe clearance. PTO

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
26/8/	PHYSIO con't
1135	Pt SOOB c full positioned on pillow.
	Enc amb to bathroom c NS.
	Plan/ pt able to amb c 4WF c L AFO c
	(A)x1 c thanks++. Ongoing r/v.
	D/C Plan// Await IPR at
26-8-	NURSING AM: Pt vitals stable + WPL.
1500	Tolerating diet + fluids. BO x2
	PUIT. Ambulating to bathroom with
	4WF + Assist x 1. Awaiting daily R/V
	by SCU team. Nil changes at TOR.
	1RNDIV1
26.8.	Stroke W/R
16:05	
	No change in symptoms
	ECG from yesterday sighted → no change.
	BP: 118/60, stable.
	→ (N) Liver function tests.
	Plan/
	① Stable
	② t/f tomorrow
26/8/	Nursing PM. Pt a + o, vitally stable. All meds
2030	as per IP12. Eating + drinking satisfactory.
	PUIT, BNO. ASSIST x1 4 frame to toilet.
	BSL WNL. Nil concerns ator. For t/F →
	tomorrow. Nil Concerns.
	RNDIV1.

CLINICAL PROGRESS NOTES

DATE & TIME	PRINT NAME AND DESIGNATION, SIGN & DATE ALL ENTRIES
27/8/	NURSING: Pt alert, vitally stable. BSL 2.5
0545hrs	at the start of the shift. orange juice given
	and ↑ to 5.8 @ 2245hrs. Pt had Banana
	and apple. BSL at 0200hrs 6.8. Nil c/o
	pain/discomfort. Continent c̄ pan x2. Appeared
	to be sleeping during all physical checks
	O/N. RN1)
27/8/	Pharmacy:
	NB Terbinafine interacts w/ metoprolol
	to ↑ metoprolol levels.
	please monitor carefully (liase w/ GP)
	when ceasing Terbinafine as pt
	may require ↑ dose of metoprolol.
	thankyou
	pharmacy intern

✓Concession number: exp:

Local Doctor Ph/Fax: ✗Safety Net number: issue:

Drug allergies and sensitivities: include reaction description & data source

No known allergies

Medications taken prior to presentation to hospital (prescribed medicine incl. puffers, patches, topical, injected; OTCs, complementary)

Medication (including brand, strength and dose)	Comments - indication, issues, problems	Supply on d/c
Metoprolol 50mg ¼ BD	Metohexal	
Frusemide 40mg i	mane Frusehexal	N
Irbesartan 300mg i	mane Avapro	N
Clopidogrel 75mg i	mane Plavix	N
Aspirin 100mg i	mane DBL	N
Atorvastatin 80mg i	mane Lipitor	N
Metformin 1g i	BD Diabex	
~~[illegible]~~		
Esomeprazole 20mg i	mane TDS Nexium	N
Terbinafine 250mg i	mane Lamisil	N
Glipizide 5mg	(6) mane Minidiab	N
Tramadol 50mg i	nocte prn Tramal	N
N. Trolingual pump spray 400mcg / spray	prn Nitrolingual	N

Medications on admission considerations: (eg. monitoring, interactions, recommendations)
pt not taking diamicron
pt taking glipizide 30mg daily → w/ son payed intern pls flu SN card (pt doesn't have one, but maybe entitled)

Other admission medication information: Date admitted: Unit:

Social history: (home) / hostel / nursing home / rehab / other hosp — Medications usually administered by: Son.

Uses medication list: Yes No — Nebuliser Yes No — Spacer: Yes No

Dosett ® / Webster ® / Other Filled by: — Patientís own meds - at home / (bedside locker) / DA safe / ward fridge

Discharge destination: — Phone: Fax:

Source of information: (patient) / carer / GP / history / care facility / hosp / local pharmacy / (other)

Medication history by: Sign (pharmacist) Print name:

RISK ASSESSMENT

Lives alone	Y / N	History of non-compliance	Y / N
Cognitive Impairment	Y / N	Medication /dose changes DURING admission	(Y) / N
≥ 4 regular medications on PRESENTATION	(Y) / N	Cannot read	Y / N
Taking cardiovascular or diabetic drugs	(Y) / N	Renal or hepatic impairment	Y / N
Taking a drug requiring dosage adjustment	Y / N	Preferred language: Interpreter req'd	Y / N

Other : (Any other reason you feel patient may be at risk) Details:

webster please — education: flu N. trolingual. w. dosette box to be filled by son please.

Referred to HARP by: Pager: Date: Expected date of d/c:

PATIENT MEDICATION HISTORY

Presenting complaint: 61♀. R) hand clumsiness 1/7

Past medical history (as documented by medical officer): DM, L) MCA infarct 04/09, NSTEMI
T2DM - OHA, ↑Chol, HTN

Comments (medication management plan, changes to medication regimen, etc)

Date	Notes
	- aspirin & clopidogrel
	paged Artem re clopidogrel/aspirin note in H/x
	checked interactions
	· terbinafine ↑ levels of metoprolol - watch when it is ceased
	· esomeprazole + clopidogrel ⇒ ↑ thrombosis
	~~to ? sto pantoprazole~~ no need.
20/8	↑ nocte metoprolol 12.5mg mane 25mg nocte
21/8	aim d/c today
24/8	presyncope o/w/E P/ ↓ metop to 12.5mg BD
	↓ Irbesartan to 150mg
	cease frusemide.
	? booked for CABG
25/8	Irbesartan ↑ po intake. LFTs
26/8	Ⓝ LFTs f/f pt stable

Laboratory data + Drug levels HbA1c% 6.6% (5/8/9) **Height:** **Weight:** **BSA:**

Test/ Date		17/8	19/8						17/8					
WCC	~~17/8~~	12.3						dig	0.58					
PCT		483						Chol	4.4					
Cr		45						LDL	2.6					
K+		3.5	3.3					TG	1.5					

Discharge data:

Medication counselling to: patient / carer / not applicable (eg. Nursing home pt) / other (specify)__________ date: by:

Medication list provided: Yes No date: by:

Consumer Medicine Information provided: (specify drugs) __________ date: by:

Faxed: GP / pharmacy / aged care facility / hospital / other (specify) __________ date: by:

Liaised: (specify) __________ date: by:

CIS | LINKS | BOOKMARKS | HISTORY | | HELP | LOGOUT

Female

Authorised

09/R/0092867 General Radiology	**Service Provided** 17/08/20 11:52:00 PM
Primary Provider	**Report Authorised** 18/08/20 12:37:33 AM

CT Brain (Non contrast)

No evidence of acute ischaemia or haemorrhage.

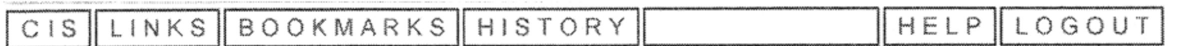
When directly compared to the previous examination from 27/04/20 , overall findings are similar, bar a well-established left centrum lacune.

The remainder of findings, with small lacunes in the lenticulostriate territories bilaterally, small bilateral thalamic lacunes, and multiple small cerebellar hemispheric infarcts are again noted.

In addition, there is extensive subcortical, periventricular and deep white matter low attenuation, compatible with severe chronic small vessel ischaemia.

Ventricular and sulcal size is age-appropriate.

Neuroradiology Fellow



Female

Amended

General Radiology	**Service Provided** 19/08/20 02:10:00 PM
	Report Amended 19/08/20 05:10:04 PM

Amendment made at 19-Aug 20 17:10

Addendum

No acute/diffusion restricting ischemic lesion in the posterior circulation territory, but old/subacute infarcts and small vessel ischaemic change in the brainstem and cerebellum are present.

R*adiologist*

Original Authorised Report at 19-Aug 2009 17:03

MRI BRAIN

Technique:

Multiplanar, multisequence images were acquired including DWI / ADC images and MRA images.

Findings:

A focus of diffusion restriction is noted in the left anterior corona radiata. A further focus is noted in the corona radiata and centrum semiovale more posteriorly. These are in keeping with foci of recent infarction. This is on a background of extensive periventricular high T2 signal in keeping with extensive chronic small vessel ischaemia and multiple focal infarcts in the cerebellar hemispheres.

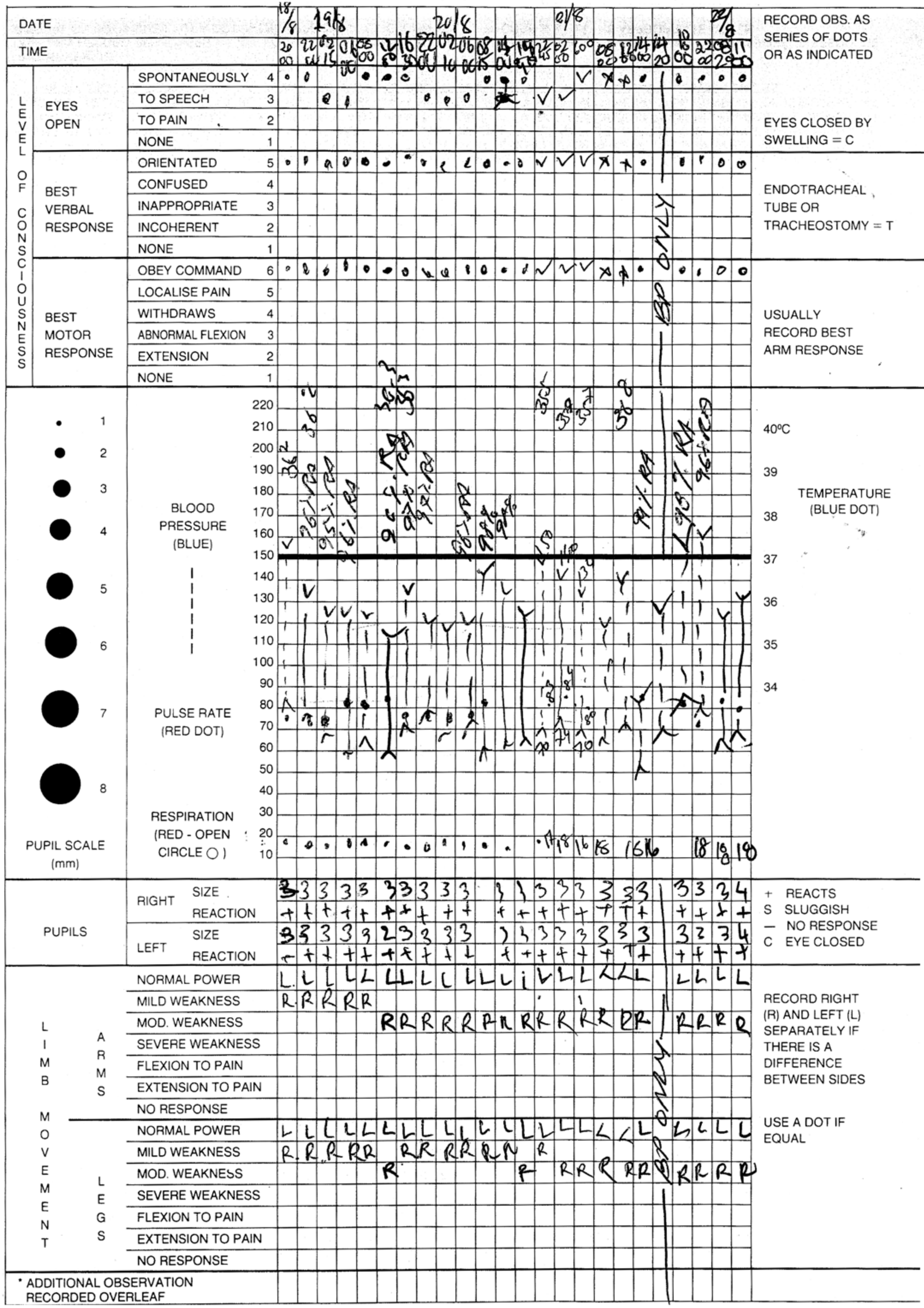
Marked vertebrobasilar atherosclerotic disease is noted - with irregular luminal contour. The right vertebral artery is dominant but even so both it and the basilar artery are of small calibre. The left vertebral artery not seen just before it merges with the right vertebral artery, suggestive of a flow gap. The PCAs are predominantly supplied by the PCOMs and there is narrowing of both P1s. Irregular narrowing is noted in the cavernous carotid arteries. Minor stenosis also noted at the right M1.

Low T1 signal focus is noted in the body of the corpus callosum and in the genu, in a patient with such extensive vascular disease these are likely old infarcts.

Impression:

New focal infarcts in the left corona radiata / centrum semiovale on the background of multiple previous infarcts.

MRI Fellow



NEUROLOGICAL OBSERVATION CONSCIOUS STATE

DATE

TIME

RECORD OBS. AS SERIES OF DOTS OR AS INDICATED

LEVEL OF CONSCIOUSNESS

EYES OPEN	SPONTANEOUSLY	4	
	TO SPEECH	3	
	TO PAIN	2	EYES CLOSED BY SWELLING = C
	NONE	1	
BEST VERBAL RESPONSE	ORIENTATED	5	
	CONFUSED	4	ENDOTRACHEAL TUBE OR TRACHEOSTOMY = T
	INAPPROPRIATE	3	
	INCOHERENT	2	
	NONE	1	
BEST MOTOR RESPONSE	OBEY COMMAND	6	
	LOCALISE PAIN	5	
	WITHDRAWS	4	USUALLY RECORD BEST ARM RESPONSE
	ABNORMAL FLEXION	3	
	EXTENSION	2	
	NONE	1	

PUPIL SCALE (mm): 1, 2, 3, 4, 5, 6, 7, 8

BLOOD PRESSURE (BLUE)

PULSE RATE (RED DOT)

RESPIRATION (RED - OPEN CIRCLE ○)

220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20, 10

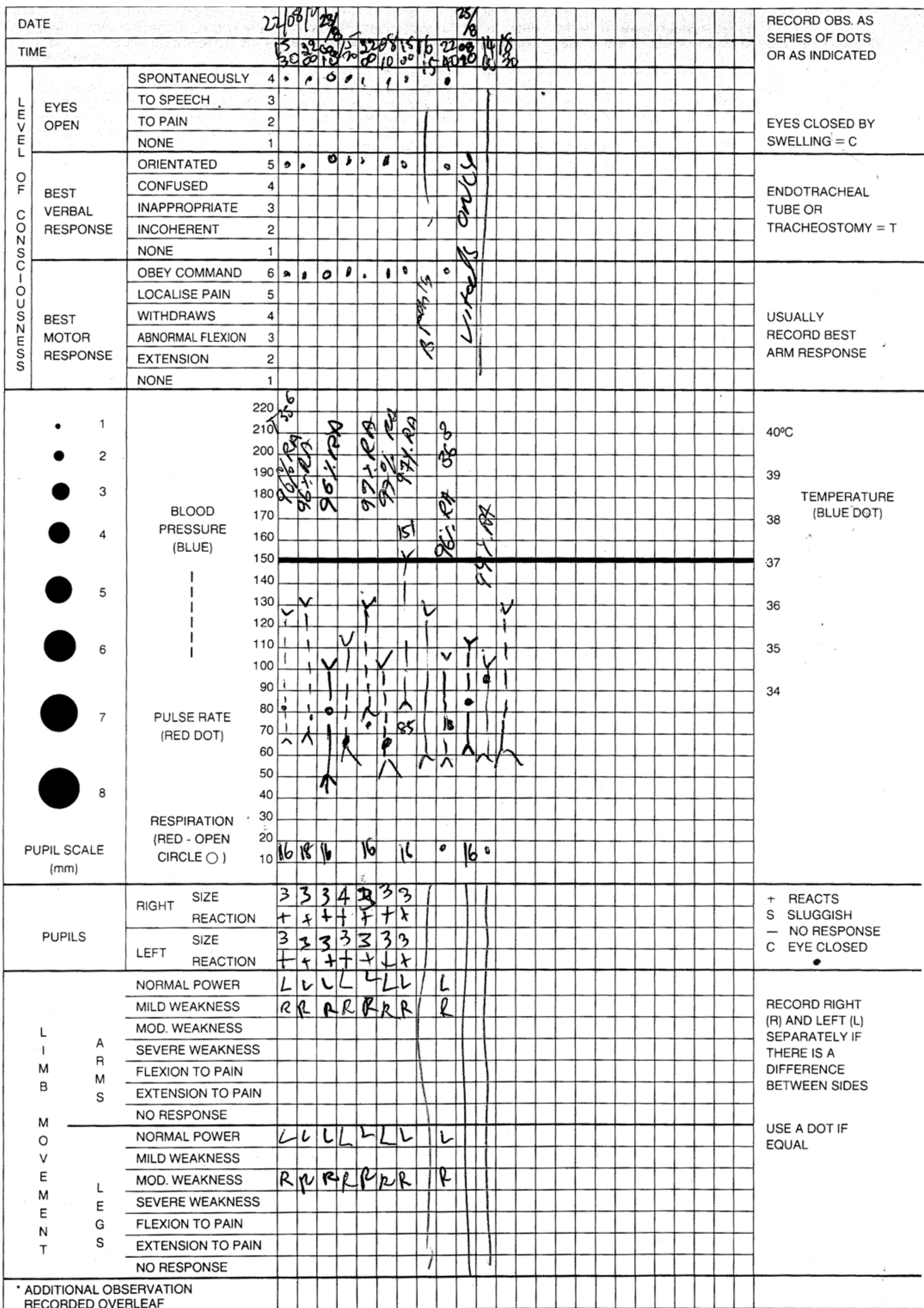
TEMPERATURE (BLUE DOT): 40ºC, 39, 38, 37, 36, 35, 34

PUPILS			
RIGHT	SIZE		+ REACTS
	REACTION		S SLUGGISH
LEFT	SIZE		— NO RESPONSE
	REACTION		C EYE CLOSED

LIMB MOVEMENT

ARMS	NORMAL POWER	
	MILD WEAKNESS	RECORD RIGHT (R) AND LEFT (L) SEPARATELY IF THERE IS A DIFFERENCE BETWEEN SIDES
	MOD. WEAKNESS	
	SEVERE WEAKNESS	
	FLEXION TO PAIN	
	EXTENSION TO PAIN	
	NO RESPONSE	
LEGS	NORMAL POWER	USE A DOT IF EQUAL
	MILD WEAKNESS	
	MOD. WEAKNESS	
	SEVERE WEAKNESS	
	FLEXION TO PAIN	
	EXTENSION TO PAIN	
	NO RESPONSE	

* ADDITIONAL OBSERVATION RECORDED OVERLEAF



NEUROLOGICAL OBSERVATION CONSCIOUS STATE

DATE				RECORD OBS. AS SERIES OF DOTS OR AS INDICATED
TIME				
LEVEL OF CONSCIOUSNESS	EYES OPEN	SPONTANEOUSLY	4	
		TO SPEECH	3	
		TO PAIN	2	EYES CLOSED BY SWELLING = C
		NONE	1	
	BEST VERBAL RESPONSE	ORIENTATED	5	
		CONFUSED	4	ENDOTRACHEAL TUBE OR TRACHEOSTOMY = T
		INAPPROPRIATE	3	
		INCOHERENT	2	
		NONE	1	
	BEST MOTOR RESPONSE	OBEY COMMAND	6	
		LOCALISE PAIN	5	
		WITHDRAWS	4	USUALLY RECORD BEST ARM RESPONSE
		ABNORMAL FLEXION	3	
		EXTENSION	2	
		NONE	1	

PUPIL SCALE (mm)		Scale	Temperature
1	BLOOD PRESSURE (BLUE)	220	
2		210	40ºC
3		200	
4		190	39
5		180	TEMPERATURE (BLUE DOT)
6		170	38
7	PULSE RATE (RED DOT)	160	
8		150	37
		140	
		130	36
		120	
		110	35
		100	
		90	34
		80	
		70	
		60	
		50	
		40	
	RESPIRATION (RED - OPEN CIRCLE ○)	30	
		20	
		10	

PUPILS	RIGHT	SIZE	+ REACTS
		REACTION	S SLUGGISH
	LEFT	SIZE	— NO RESPONSE
		REACTION	C EYE CLOSED

LIMB MOVEMENT	ARMS	NORMAL POWER	
		MILD WEAKNESS	RECORD RIGHT (R) AND LEFT (L) SEPARATELY IF THERE IS A DIFFERENCE BETWEEN SIDES
		MOD. WEAKNESS	
		SEVERE WEAKNESS	
		FLEXION TO PAIN	
		EXTENSION TO PAIN	
		NO RESPONSE	
	LEGS	NORMAL POWER	USE A DOT IF EQUAL
		MILD WEAKNESS	
		MOD. WEAKNESS	
		SEVERE WEAKNESS	
		FLEXION TO PAIN	
		EXTENSION TO PAIN	
		NO RESPONSE	

* ADDITIONAL OBSERVATION RECORDED OVERLEAF

ALLIED HEALTH ASSESSMENT

ASSESSMENT OF PREVIOUS HEALTH STATUS	**Past History:** (L) MCA infarct 04/09, NSTEMI 08/09, T2DM, HTN, exsmoker **Pain Management:** ______ **Hearing:** NAD ☐ ______ **Vision:** NAD ☐ ______ **Swallowing:** NAD ☐ ______ **Skin Integrity:** NAD ☐ ______ **Dietary Issues:** Nil ☐ ______ **Dentures:** Yes ☐ No ☐ **Recent Weight loss:** Yes ☐ No ☐ ______Kg in ______ days / months **Current Weight:** ______Kg **Bowels:** Normal ☐ ______ **Bladder:** Normal ☐ ______
SOCIAL HISTORY	*****If patient has DRA – write "refer to DRA" & no need to complete this section** **Lives:** Alone/Partner/(Family)/SRS/Hostel/NH/ Other: Son **Informal / Family Supports Available:** Son & grandaughter **Support Person Name:** ______ **Relationship:** Son **Tel No:** ______ **Existing Community Supports:** MOW ☐ HH ☑ RDNS ☐ Care Package ☐ PACFU ☐ **Other services / frequency:** shower 3/week, meal 1/week, clean 1/week **Personal Alarm:** Yes ☐ No ☐ **Company:** ______ TCP **Case Manager:** Yes ☑ No ☐ **Name:** ______ **Enduring Power of Attorney / Administrator / Guardianship:** ______ **Caring Responsibilities for others:** Yes ☐ No ☐ ______
PREVIOUS ACTIVITIES OF DAILY LIVING	(A) c̄ commode set up. **Personal ADL's:** Independent ☒ 3/7 PCA showering (A) dressing other days **Home Care:** Independent ☐ son **Meal Preparation:** Independent ☐ (I) light meals + hot drinks / son (A) **Shopping:** Independent ☐ son **Community Access:** son **Employment:** Not working ☐ Retired ☑ Currently Employed ☐ ______ **Driving:** Yes ☐ No ☑ **Type of Vehicle:** ______
PREVIOUS PHYSICAL FUNCTION	**Transfers:** (A) c̄ 4WF **Mobility:** (A) c̄ 4WF, wheelchair in community **Aids Used previously:** (see table below) **Distance Walked:** ______ **Limiting Factor(s):** ______ **Recent Falls:** ______

Aids Used previously:	SPS	PUF	Wh.Frame	Wheelchair/scooter	None
Indoors:	☐	☐	☑	☐	☐
Community:	☐	☐	☐	☑	☐

PREVIOUS COGNITIVE FUNCTION	**Cognitive Function:** NAD ☐ Impaired ☐ Some ↓ STM
PREVIOUS COMMUNICATION	**Issues with communication** NAD: ☐ Impaired ☐ **Expression:** **Comprehension:**
HOME ENVIRONMENT	**Accommodation Type:** Flat ☐ House ☑ Unit ☐ SRS ☐ Hostel ☐ N/Hone ☐ **Ownership:** Owner Occupier ☐ Renting ☐ Ministry of Housing ☐Other **Stairs:** Front: Rails: ☐ Yes ☑ No Back: Rails: ☐ Yes ☐ No Internal: Rails: ☐ Yes ☐ No Side: Rails: ☐ Yes ☐ No **Usual Entrance:** Garage, ° steps **Bathroom:** Shower over bath ☐ Shower Recess ☑ Rails / Equipment insitu: **Toilet:** Inside ☐ Outside ☐ Rails / Equipment **Telephone:** Yes ☐ No ☐ **Locations:** **Seating:** **Bed:** **Other issues:** **For Residents of hostel / SRS:** **Distance Required to ambulate:** **Other issues affecting return to facility:**
CONCERNS of PATIENT / FAMILY PRIOR TO ADMISSION TO HOSPITAL	? Son has recently broken 2 vertebra ∴ will be unable to complete tasks he used to. Pt already receives home help ++.
People Contributing to Assessment	Patient ☑ Family / Carer ☐ Residential Care Staff ☐ Community Services ☐ Other: ☐

Assessors:	Name:	Signature:	Pager No	Date
Dietitian Occ. Therapist Physio Social Worker Speech Path				

DIET	CURRENT INTAKE	RECOMMENDED INTAKE	HEIGHT (cm)
ENERGY (Kilojoules)			WEIGHT (kg)
CHO (gm; %E)			IDEAL WEIGHT (kg)

DATE	TIME	TREATMENT	BLOOD GLUCOSE mmol/l (5, 10, 15, 20, 25, >25)	URINE Gluc	URINE Alb	URINE Ket
17/8		10.3	•			
17/8	2105	6.4	•			
18/8	0720	8.9 mmol	8.9			
	1330	11.3 mmol/L post lunch				
	1655	8.0 mmol				
	2210		• 8.3 mmol/L			
19/8	0630		• 7.3 mmol/L			
	1155	pre-dinner	• 11.8 mmol/L			
	1650	10.2 mmol/L	• 10.2 mmol/L			
	2200		• 6.1 mmol/L			
20/8	0600		• 6.4 mmol/L			
	1115	prior lunch	• 11.6 mmol/L			
	1730		7.6 mmol/L			
	2245		• 7.6 mmol/L			
21/08	600		• 6.4 mmol/L			
	1700		• (9.6 mmol/L)			
	2200		• 5.6 mmol/L			
22/8	0600		• 8.5 mmol/L			
	1100		• 12.9 mmol/L			
	1700	5.9 mmol/L	•			
	2200		• 4.4 mmol/L			
23/8	0600					
	0810	Note Post Breakfast	• 9.3 mmol/L			
	1110		• 14.4 mmol/L			
	1710		6.9 mmol/L			
	2200		• 10.8 mmol/L			
24/8	06.40		6.7 mmol/L			
	1100		13.9 mmol/L			
	1640		• 8.7 mmol/L			

DIABETES RECORD

DIET	CURRENT INTAKE	RECOMMENDED INTAKE	HEIGHT (cm)
ENERGY (Kilojoules)			WEIGHT (kg)
CHO (gm; %E)			IDEAL WEIGHT (kg)

DATE	TIME	TREATMENT	BLOOD GLUCOSE mmol/l (5, 10, 15, 20, 25, >25)	URINE Gluc	URINE Alb	URINE Ket
25/8	0645		56 mmol/L			
	1130		13.1 mmol/L			
	1710		(9.4 mmol/L)			
	2200		8.2 mmol/l			
26/8	0700		6.9 mmol/L			
	1200		16.8 mmol/L			
	1205	new finger	12.0 mmol/L			
	1700		7.3			
	2215	Orange juice x1 Banana x1 Apple x1	* 2.5 mmol/l			
	2245	~~Orange juice x2~~ Banana x1, Apple x1	5.8 mmol/L			
27/8	0200		6.8 mmol/l			
	0700		5.5 mmol/L			

DIABETES RECORD

ALLERGIES & ADVERSE REACTIONS (ADR)

☑ Nil Known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

Sign ____________ Print ____________ Date ______

WARD ____________ UNIT ____________

REGULAR MEDICATIONS

YEAR 20____ DATE & MONTH →

Dates: 20/8, 21/08, 22/8, 23/8, 24/8, 25/8, 26/8, 27/8

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Time Of Dose
Route	Frequency (Dr to enter dose time and individual dose)	
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

Drug level / Time level taken / Dose / Prescriber / Time given / Nurse

WARFARIN (Marevan/Coumadin) select brand

Date	WARFARIN (Marevan/Coumadin)	Time Of Dose 1600 (4pm)
Route	Prescriber to enter individual doses	Target INR
Indication	Pharmacy	
Prescriber Signature	Print Your Name	Contact

INR Result / Dose (mg) / Prescriber / Nurse 1 / Nurse 2

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW enter times	Time	Pharmacy
20/8	METOPROLOL	PO	12.5 mg	mane	0800	1/4 x 50
20/8	METOPROLOL	PO	25 mg	nocte	2000	1/2 x 50
20/8	GLICLAZIDE MR	PO	30 mg	daily	0800	
21/8	GLIPIZIDE	PO	30 mg	mane	08	

Metoprolol 12.5 mg mane administration: 20/8 ✓; 21/8 68

Pharmaceutical Review:

RECOMMENDED ADMINISTRATION TIMES GUIDELINES ONLY

Morning	Mane	0800		
Night	Nocte			1800
Twice a day	BD	0800		200
Three times a day	TDS	0800	1400	200
Regular 6 hourly	6 hrly	0600	1200	180
Regular 8 hourly	8 hrly	0600	1400	220
Four times a day	QID	0600	1200	180

WARFARIN EDUCATION RE

Patient Educated by: ______
Sign: ______
Date: ______
Given Warfarin Leaflet: ______
Sign: ______
Date: ______

Tick if Slow release — SR=Sustained or m release formulation. If scored tablet, the can be given. Dose must be swall without crushing.

REASON FOR NURSE NOT ADMINIS Codes MUST be circled

Absent	A
Fasting	F
Refused - notify Dr	R
Vomiting	V
On leave	L
Not available - obtain supply or contact Dr	N
Withheld - Enter reason in Clinical Record	W
Self Administering	S

MEDICATION Chart No. ______ of ______

Campus: ______________________

ADDITIONAL CHARTS

☐ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ Other
☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Print Your Name	Given by	Time Given	Pharmacy
20/8	SLOW K	PO	ii	stat				2000 NC	

TELEPHONE ORDERS (To be signed within 24 hours of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1	Nr 2	Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Given by	Time Given

edicines taken prior to Presentation to Hospital
rescribed, over the counter, complementary) Own Medicines brought in? ☐ Y ☐ N Administration Aid (specify)__________

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

NOT FOR ADMINISTRATION

: **Community Pharmacy:**

umented by: (Sign) (Date) Medicines usually administered by:

☐ Nil Known ☐ Unknown (tick appropriate box or complete details below)		
Drug (or other)	**Reaction/Date**	**Initials**

Sign ______________ Date________

WARD Emergency

REGULAR MEDICATIONS

YEAR 20 **DATE & MONTH** → 18/8, 19/8, 20/8, 21/8, 22/8, 23/8, 24/8, 25/8, 26/8

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Time Of Dose	Drug level / Time level taken / Dose / Prescriber / Time given / Nurse
Route	Frequency (Dr to enter dose time and individual dose)		
Indication	Pharmacy		
Prescriber Signature	Print Your Name / Contact		

WARFARIN (Marevan/Coumadin) select brand

Date	Route	Prescriber to enter individual doses	Target INR	Time Of Dose 1600 (4pm)	INR Result / Dose (mg) / Prescriber / Nurse 1 / Nurse 2
Indication	Pharmacy				
Prescriber Signature	Print Your Name	Contact			

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW enter times	Indication	Pharmacy	Times
18.8	Metoprolol	O	12.5 mg	BD			0800, 1700
18.8	Frusemide	O	40 mg	mane			0800
18.8	esomeprazole	O	20 mg	mane		Swallow whole	0800
18.8	Metformin	O	1 g	BD		with food	0800, 1800

Tick if Slow release. Prescriber Signature / Print Your Name / Contact.

Pharmaceutical Review:

RECOMMENDED ADMINISTRATION TIMES GUIDELINES ONLY

Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800		2000	
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

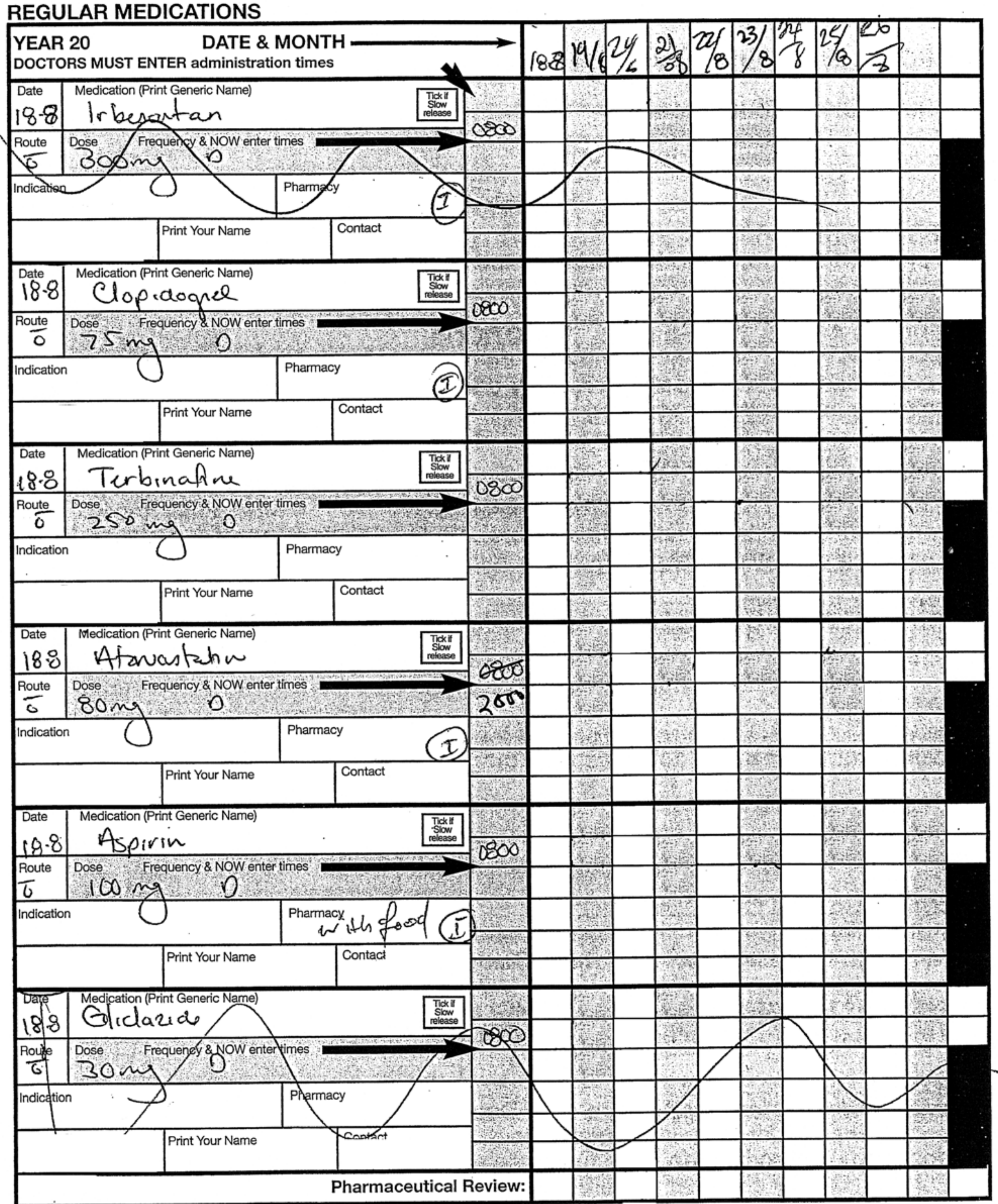
WARFARIN EDUCATION RECORD

Patient Educated by: ________
Sign: ________
Date: ________
Given Warfarin Leaflet: ________
Sign: ________
Date: ________

Tick if Slow release — SR=Sustained or modified release formulation. If scored tablet, then half can be given. Dose must be swallowed without crushing.

REASON FOR NURSE NOT ADMINISTERING Codes MUST be circled

Reason	Code
Absent	A
Fasting	F
Refused - notify Dr	R
Vomiting	V
On leave	L
Not available - obtain supply or contact Dr	N
Withheld - Enter reason in Clinical Record	W
Self Administering	S



REGULAR MEDICATIONS

YEAR 20 — DATE & MONTH → 18/8, 19/8, 20/8, 21/8, 22/8, 23/8, 24/8, 25/8, 26/8

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW enter times	Pharmacy	Administration times
18-8	Irbesartan	O	300mg	D	(I)	0800
18-8	Clopidogrel	O	75mg	D	(I)	0800
18-8	Terbinafine	O	250mg	D		0800
18-8	Atorvastatin	O	80mg	D	(I)	~~0800~~ 2000
18-8	Aspirin	O	100mg	D	with food (I)	0800
18-8	Gliclazide	O	30mg	D		0800

Each entry also has blank Tick if Slow release, Indication, Print Your Name and Contact fields.

Pharmaceutical Review:

REGULAR MEDICATIONS

YEAR 20____ **DATE & MONTH** → 24/8 | 25/8 | 26/8 | 27/8

DOCTORS MUST ENTER administration times

Field	Entry
Date	24/8
Medication (Print Generic Name)	Metoprolol
Tick if Slow release	
Route	ō
Dose	12.5mg
Frequency & NOW enter times	bd
Times	08⁰⁰, 20⁰⁰
Indication	
Pharmacy	

Field	Entry
Date	24/8
Medication (Print Generic Name)	Irbesartan
Tick if Slow release	
Route	ō
Dose	150mg
Frequency & NOW enter times	daily
Times	08⁰⁰ (24/8: X)
Indication	
Pharmacy	
Print Your Name	
Contact	

Field	Entry
Date	25/8
Medication (Print Generic Name)	Irbesartan
Tick if Slow release	
Route	ō
Dose	75mg
Frequency & NOW enter times	daily
Times	08⁰⁰
Indication	
Pharmacy	
Print Your Name	
Contact	

Field	Entry
Date	
Medication (Print Generic Name)	
Tick if Slow release	
Route	
Dose	
Frequency & NOW enter times	
Indication	
Pharmacy	
Prescriber Signature	
Print Your Name	
Contact	

Field	Entry
Date	
Medication (Print Generic Name)	
Tick if Slow release	
Route	
Dose	
Frequency & NOW enter times	
Indication	
Pharmacy	
Prescriber Signature	
Print Your Name	
Contact	

Field	Entry
Date	
Medication (Print Generic Name)	
Tick if Slow release	
Route	
Dose	
Frequency & NOW enter times	
Indication	
Pharmacy	
Prescriber Signature	
Print Your Name	
Contact	

Pharmaceutical Review:

RN MEDICATIONS

Date	Medication (Print Generic Name)				Date	21/08													
21/8	METOCLOPRAMIDE																		
Route PO	Dose 10mg	Hourly frequency TD[illegible]	PRN	Max dose/24 hours	Time	1400													
dication		Pharmacy			Dose / Route	10 / O													
			Contact		Sign														

Date	Medication (Print Generic Name)				Date														
Route	Dose	Hourly frequency	PRN	Max dose/24 hours	Time														
dication		Pharmacy			Dose / Route														
rescriber Signature	Print Your Name		Contact		Sign														

Date	Medication (Print Generic Name)				Date														
Route	Dose	Hourly frequency	PRN	Max dose/24 hours	Time														
dication		Pharmacy			Dose / Route														
rescriber Signature	Print Your Name		Contact		Sign														

Date	Medication (Print Generic Name)				Date														
Route	Dose	Hourly frequency	PRN	Max dose/24 hours	Time														
ndication		Pharmacy			Dose / Route														
rescriber Signature	Print Your Name		Contact		Sign														

Date	Medication (Print Generic Name)				Date														
Route	Dose	Hourly frequency	PRN	Max dose/24 hours	Time														
Indication		Pharmacy			Dose / Route														
Prescriber Signature	Print Your Name		Contact		Sign														

Date	Medication (Print Generic Name)				Date														
Route	Dose	Hourly frequency	PRN	Max dose/24 hours	Time														
Indication		Pharmacy			Dose / Route														
Prescriber Signature	Print Your Name		Contact		Sign														

Date	Medication (Print Generic Name)				Date														
Route	Dose	Hourly frequency	PRN	Max dose/24 hours	Time														
Indication		Pharmacy			Dose / Route														
Prescriber Signature	Print Your Name		Contact		Sign														

CLINICAL RECORD 2

Principal diagnosis: ____

____

Additional diagnosis: ____

Procedures: ____

HOSPITAL AREA	MEDICARE No.	HOSPITAL CODE No.	MEDICAL RECORD No.

SEX: M — 1 Married/Defac

PHONE 1	PHONE 2		POSTCODE

ABORIGINALITY	RELIGION	REPATRIATION No.	BIRTH DATE	AGE
				84y

LANGUAGE USED AT HOME	COUNTRY OF BIRTH	ETHNIC ORIGIN	ATTENDING MEDICAL OFFICER
1201 ENGLISH	1101AUSTRALIA	4 NEITHER ABORIGIN	

PERSON FOR NOTIFICATION	RELATIONSHIP	ADDRESS
	W	

MENTAL HEALTH LEGAL STATUS ON ADMISSION: 1. Informal 2. Schedule 3. Temporary 4. Continued 5. De-gazetted 6. Forensic 7. Not Applicable

If the patient was admitted to a psychiatric unit, was this the patient's first admission to such a unit. 1. YES 2. NO
If no, report the year the patient was last accommodated in a psychiatric unit.

LOCAL MEDICAL OFFICER	ADDRESS	ADMISSION DATE	TIME	WARD
			0908	EMERG

PATIENT CLASSIFICATION	PREVIOUS ADM.	RE-ADMISSION IN 28 DAYS	DISCHARGE LAST 7 DAYS
30 VETERAN AFFAIRS		1	

SOURCE OF REFERRAL: 01 — If the Source of Referral is Category 4 or 5 Record the Code No. of the Hospital from which the patient was transferred.

DATE OF SEPARATION: 12/8/ — TIME: 1430 — LEAVE DAYS

SERVICE CATEGORY ON ADMISSION: CAS
1. ACUTE CARE
2. REHABILITATION CARE
3. PALLIATIVE CARE
4. MAINTENANCE CARE
5. UNQUALIFIED CARE
6. OTHER
7. GERIATRIC EVALUATION AND MANAGEMENT
8. PSYCHOGERIATRIC

PAYMENT STATUS ON SEPARATION
1. NON-CHARGE
2. PRIVATE
3. WORKERS COMP.
4. MOTOR ACCIDENT
5. VETERANS AFFAIRS
6. INELIGIBLE
7. DEFENCE FORCE
8. PUBLIC CONTRACT
9. NURSING HOME TYPE
10. PSYCHIATRIC PATIENT - CHARGEABLE
11. PSYCHIATRIC PATIENT - NON CHARGEABLE
19. OTHER

REFERRED TO ON SEPARATION: 8
1. OUTPATIENTS
2. COMMUNITY HEALTH
3. DISTRICT NURSING
4. MEDICAL PRACTITIONER
5. GROUP HOME
6. PALLIATIVE CARE TEAM
7. OTHER
8. NOT REFERRED
9. NOT KNOWN
10. PRIVATE PSYCHIATRIC PRACTICE
11. MENTAL HEALTH ALCOHOL & OTHER DRUGS INPATIENT FACILITY
12. MENTAL HEALTH ALCOHOL & OTHER DRUGS NON-INPATIENT FACILITY
13. COMMUNITY TREATMENT ORDER

MODE OF SEPARATION: 7
0. Discharged whilst on leave
1. Discharged by the Hospital
2. Discharged at the Patient's own risk
3. T'fer to Nurs. Home in Area/Region
4. T'fer to Hosp. in the Area/Region
5. T'fer to Hosp. outside the Area/Region
6. Died with an Autopsy performed
7. Died with no Autopsy performed
8. T'fer to other Health Care Accom.
9. Statistical Separation
10. T'fer to Nurs. Home outside Area/Region
11. T'fer to Psych. Hosp. in Area/Region
12. Transferred to Psych. Hosp. outside Area/Region
13. T'fer to Palliative Care Facility/Hospice

CONTRACT STATUS: 0
CORONER'S CASE: ☐ YES ☐ NO
IF THE MODE OF SEPARATION IS 4 OR 5, RECORD THE CODE NUMBER OF THE HOSPITAL TO WHICH THE PATIENT WAS TRANSFERRED.

PRESENTING PROBLEMS
SEPSIS

PRINCIPAL DIAGNOSIS (THAT WHICH, AFTER STUDY, WAS CHIEFLY RESPONSIBLE FOR THE ADMISSION)

CODED

DIAGNOSIS WHICH WAS CHIEFLY RESPONSIBLE FOR LENGTH OF STAY (IF SAME AS ABOVE, WRITE "AS ABOVE")

SECONDARY DIAGNOSIS AFFECTING TREATMENT OR LENGTH OF STAY
- COPD 2° to smoking.
- Peripheral vascular disease.
- Diabetes mellitus.

PRINCIPAL OPERATION OR MAJOR PROCEDURE	SURGEON	DATE
OTHER OPERATIONS OR PROCEDURES	SURGEON	DATE

EXTERNAL CAUSE 1 OF INJURY OR POISONING (IF APPLICABLE)	EXTERNAL CAUSE 2 OF INJURY OR POISONING (IF APPLICABLE)

PRINT NAME OF MO — SIGNATURE — DATE

REGISTRATION FORM

Hospital/Facility/Community Health Centre	MRN	
Title Family name	Consultant	
Given names	Sex	DOB
Address	Ward/Unit	

Ward

V.M.O.

L.M.O.

R.M.O.

ADMISSION DATE: 9/8/

DISCHARGE DATE: 12/8/

DISCHARGED TO:

DIAGNOSIS: Sepsis

OPERATIONS :

Problems on Admission: 1.

2.

3.

ASSOCIATED DIAGNOSIS / PROBLEMS: *(Please Tick)*

☑ COAD ☐ ASTHMA ☐ IHD ☐ CCF ☐ HYPERTENSION ☐ DIABETES

☐ OTHER *(Please specify)*

Management and Investigations: Include diagnostic tests, drugs etc.

Pt. presented c̄ severe sepsis. Did not want any treatment. Had pal care. Passed away on 12/8/

COMPLICATIONS: ☐ NIL *(Please tick if applicable)*

☐ WOUND INFECTION ☐ WOUND DISRUPTION ☐ HAEMORRHAGE/HAEMATOMA

☑ UTI ☐ CHEST INFECTION ☐ DVT / PE ☐ OTHER *(Please specify)*

Problems on discharge:

Medication on Discharge	Dose	Frequency	Duration	Medication on Discharge	Dose	Frequency	Duration

Allergies:

FOLLOW UP:

V.M.O. .... days/weeks

L.M.O. .... days/weeks

Others .... days/weeks

Name ______ (print) Signature Pager No ______ Date 1/9/19

Discharge Summary

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White copy: Medical Record White copy: LMO White copy: VMO

NSW Registry of Births Deaths & Marriages

Attorney General's department of nsw

DUPLICATE

New South Wales

Births, Deaths and Marriages Registration Act, 1995 (Section 39)

Medical Certificate of Cause of Death

THIS CERTIFICATE MUST NOT BE ISSUED FOR A DEATH WHICH OCCURS IN CIRCUMSTANCES SPECIFIED IN THE CORONERS ACT

First names of deceased	Surname of deceased
Date of death (DD/MM/YYYY) 12/08/20__	☑ Male ☐ Female
Place of death	
Date of birth (DD/MM/YYYY) 09/03/19__	Age 84 years
Date last seen alive by me 12/08/20__	Was the body viewed after death? ☑ Yes ☐ No
Was the deceased of Aboriginal or Torres Strait Islander origin? (For persons of both Aboriginal and Torres Strait Islander origin, mark both "YES" boxes).	☑ No ☐ Yes, Aboriginal Origin ☐ Yes, Torres Strait Islander origin
Did the deceased undergo an operation or procedure within 4 weeks of death? If YES, specify: • Type of operation ____ • disease/condition ____	☐ Yes ☑ No ☐ Not known

Cause of Death (PLEASE PRINT CLEARLY, DO NOT ABBREVIATE)		Duration between onset and death
Part 1 **Line (a) Disease or condition directly leading to death** **Lines (b) to (e) Antecedent causes** (morbid conditions, if any, giving rise to the abovementioned cause, stating the underlying condition last)	(a) ADVANCED EMPHYSEMA due to	
	(b) SEPSIS due to	
	(c) DIABETES MELLITUS due to	
	(d)	
	(e)	
Part 2 **Other significant conditions** contributing to the death, but not related to the disease or conditions causing it.		

Was an injury involved in the death? Yes ☐ No ☑ If YES, check Coroner's requirements (see inside front cover)

Was the deceased pregnant within 6 weeks prior to death? Yes ☐ No ☑ between 6 weeks and 12 months of death? Yes ☐ No ☑

I hereby certify that I am a currently registered medical practitioner and that:
- I was responsible for the medical care of the abovenamed deceased immediately before death AND/OR
- I examined the body of the abovenamed deceased after death

and that the particulars and cause of death above written are true to the best of my knowledge and belief. This certificate is signed pursuant to Section 12 B of the Coroner's Act, 1980 (see Notes inside front cover)

Signature	Date 13/08/20__
Full name of medical practitioner	
Address HOSPITAL	Telephone

An advance care directive does not imply a change to other clinical decisions. It may be compatible with maximal therapeutic care including CPR. It may exclude certain specific intraventions such as CPR or insertion of a naso-gastric tube. Treatment plans and clinical decisions should continue to be formulated and documented with full reasoning.

Instructions: The form is only applicable for the current episode of care. The form is to be filed at the front of the patient's medical record for that current episode of care.

Underlying Diagnosis: Sepsis

The patient agrees to discuss issues surrounding their care in the future ☑ Yes ☐ No

Immediate response

	Yes	Withhold
MET call		✓
CPR		✓
Intubation		✓
Defibrillation		✓
ICU admission		✓

Other on-going management

	Yes	Withhold
Blood Products	✓	
Antibiotics	✓	
IV or SC fluids	✓	
NG/PEG feeding		✓
Other – please specify		

Discussion included the following people:
(Designation includes Patient, Kin, AMO, Registrar, RMO, Nurse, Social Work, Chaplain, Other-please specify)

Name	Designation	Name	Designation
Dr.	consultant		
Dr.	Registrar		
	patient		
	wife		

Rationale for order:
- respect patient wishes
- premorbidly – poor quality of life

Medical Officer completing form

Print name: ______ Designation: ______

Signature: ______ Date: 10/ 9/

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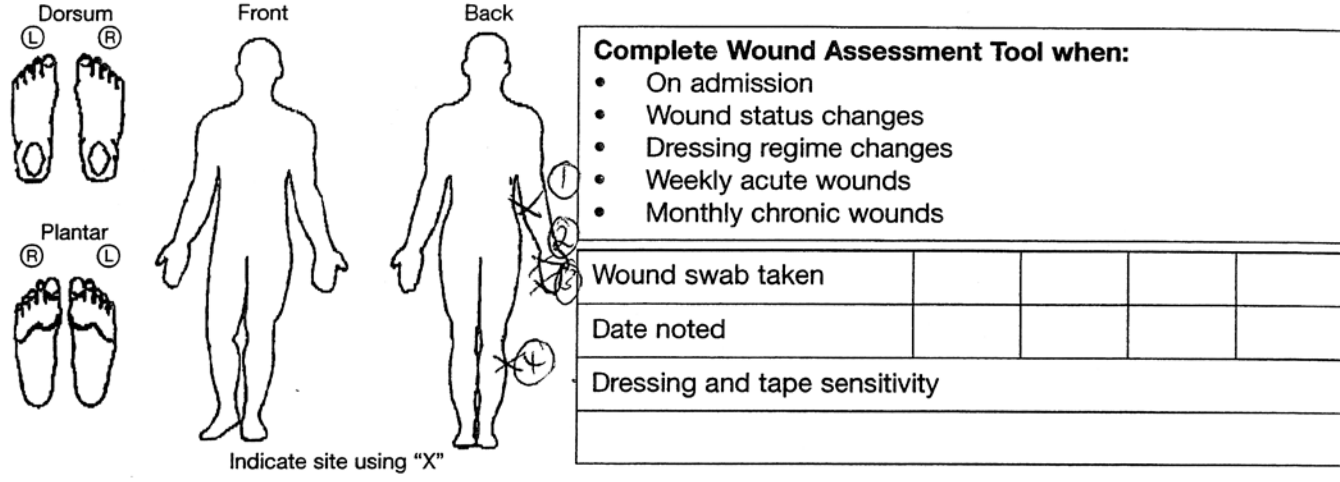
Advance Care Directives Near the End of Life



Complete Wound Assessment Tool when:

- On admission
- Wound status changes
- Dressing regime changes
- Weekly acute wounds
- Monthly chronic wounds

Wound swab taken				
Date noted				
Dressing and tape sensitivity				

Date of onset 10 / 8 /

Type ☑ Tick or indicate with number if more than one wound (eg 1, 2)

☐ Burn ☐ Drain ☐ Fistula ☐ Friction/shear
☐ Laceration ☐ Skin graft ☑ Skin tear 2, 3 ☐ Sinus
☐ Suture line/Dehisced (4) ☑ Ulcers: ☐ Malignant ☐ Neuropathic ☐ Pressure
☐ Vascular ☑ Other Bruising, odema (1)

	Date	10/9	10/9	10/9	10/9		
	Wound number	(1)	(2)	(3)	(4)		
Wound factors							
Tissue	Viable healthy wound base		✓	✓	✓		
	Non viable – eg sloughy, necrotic etc						
Infection							
Inflammation	erythema						
Moisture or Exudate	Normal		✓	✓	✓		
	Dry						
	Excessive						
Exudate type	Serous		✓	✓	✓		
	Blood						
	Purulent						
	Other						
	Malodorous						
Edge	Normal						
	Abnormal: eg rolled, raised etc						
Stage or tissue loss							
Suspected deep tissue injury (purple/discoloured intact skin or blood blister)		✓					
I. **Intact skin** (non blanching redness in light skin, persistent purple blue hue in dark skin)							
II. **Partial thickness** (shallow red ulcer or serum blister)							
III. **Full thickness** (subcutaneous tissue may be visible)							
IV. **Full thickness** (fascia, muscle, tendon or bone is visible)							
Unstageable – full thickness (can't determine depth due to slough or eschar)							

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Family name: ______________ Given names: ______________ MRN: ______________

	Date	10/8	10/8	10/8	10/8		
	Wound number	①	②	③	④		
Pain							
Scale No pain = 0 1 2 3 4 5 6 7 8 9 10 = Extreme pain		1	0	0	0		
Analgesia required before dressing							
Surrounding Skin	Normal		✓	✓	✓		
	Macerated						
	Dry and flaky						
	Oedema						
	Pigmented						
	Eczema						
	Blistered						
	Calloused						
	Other damaged, bruised, fragile	✓					
Wound progress	Improving						
	Deteriorating						
	No change <30% smaller in 4 weeks as per measurements – see graph						
Next review due							

Aims of treatment						
Debridment of unhealthy tissue						
Reduction of infection/inflammation		✓	✓	✓		
Exudate management		✓	✓	✓		
Odour management						
Promotion of granulation epithelialisation		✓	✓	✓		
Haemostasis						
Realign skin						
Skin protection		✓	✓	✓		
Pressure management						
Pain management						
Facilitation of venous return						
Removal of sutures, clips, drains Date						

Wound number	Date	Length in cm	Width in cm	Depth in cm	Undermining eg 5cm @ 3 o'clock
①	10/8	5cm	5cm	–	
②	10/8	2cm	.5cm		
③	10/8	2cm	.5cm		
④	10/8.	1cm	1cm.		

Family name: ____________ Given names: ____________ MRN: ____________

Date	Wound Number	Dressing Instructions	Signature and Designation	Client/Carer Signature
10/8	1	Nil dressing required	EEN.	
10/8	2	Atrauman, NAD		
		bandage applied	EEN	
10/8	3	Atrauman, NAD		
		bandage applied.	EEN.	
10/8	4	Atrauman Combine		
		and bandage		
		applied.	EEN.	

Wound Assessment Tool

Binding margin – no writing

Date/Time	Notes – each entry dated and signed	Page:
9/8/ 0945	NURSING. PT. ALERT. ORIENTATED. GCS – 15. SOB. PT. ON	
	HOME O_2 @ 3L/min. OEDEMA TO BOTH LEGS. SPO_2 – 95%.	
	ECG ATTENDED. BLDS ATTENDED. STATE UNABLE TO INSERT	
	IVC DUE TO VERY FRAGILE SKIN + BAD VEINS. C/O NECK	
	PAIN. HAD GIVEN MORPHINE 2.5mg S/C. CARDIAC	
	MONITOR APPLIED. AWAITING EDMO R/V ———	
9/8/ 1130	NURSING. PT. STILL IN SEVERE PAIN. HAD ENDONE 5mg PO.	
	DRESSING DONE TO LEAKING LEGS L). BSL 8.5mmol	
	PR – 113. BP 108/76 RR 24 SPO_2 – 87% ON O_2 3L/MR	
	EDMO INFORMED ———	
9/8/ 1200	WRITTEN IN RETROSPECT. NURSING. HAD CONSULTED NUMX2 ON	
	ARRIVAL OF PT @ 0925 HAS TO M/C BED 16 TO UPGRADE	
	CATEGORY FROM 4–3 BUT SAYS OBSERVE PT. & GIVE	
	PAIN RELIEF. WAS CONCERNED DUE TO SEVERE NECK PAIN	
	SOB + OEDEMATOUS LEGS ———	

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Date/Time	Notes – each entry dated and signed	Page:
09/08/	(ED resident)	
	81, O→	
	- presented to ED with (R) sided neck pain. started last night. worse on movement, sharp. able to swallow	
	- Denied chest pain / SOB	
	P/H OA - (R) wrist ? (L) wrist	
	DM	
	advanced emphysema - on O2 3-4 L home O2	
	dependent edema - 2yrs	
	- with leaking - in the last 6 months	
	- community nurse comes 2x to dress it.	
	- R hip replacement	
	- prostate operation 1997 - enlarged prostate	
	- urinary symptom	
	ex smoker - Quit 19-20 yrs ago	
	- 20 packs / day	
	- smoked for 45 yrs	
	social hx	
	- lives with wife - carer	
	- I & A with ADL	
	- walk with 4 WW for short distance + portable O2	

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Emergency Continuation

Family name: ______________ Given names: ______________ MRN: ______________

Date/Time	Notes – each entry dated and signed	Page:
	No allergy	
	Meds	
	prednisolone 20 mg daily	
	metformin 1000 mg BD	
	Diamicron MR 30mg mane	
	Tritace 10mg nocte	
	frusemide 10mg mane	
	10mg lunch	
	Seretide inh 250 mcg/50 mcg ii inhale daily	
	Atrovent i-ii tds [illegible]	
	O/E T: 35.8	
	RR 24	
	Sat 87% in 4 L NP	
	↓ AE	
	neck tenderness	
	bilat leg edema with tearing on left side	
	Upper limbs grossly normal	
	hard to assess (R) side due to pain.	
	unable to move neck due to pain.	
	Impression ? OA pain	
	Issue neck pain, bilateral leg edema	
	(P).	

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Date/Time	Notes – each entry dated and signed	Page:
09/08/	(ED registrar)	
	D/W ED Staff specialist	
	Impression septic? unknown source	
	(P) – CXR ✓	
	– C spine x-rays ✓	
	– Blood culture, CK, troponin	
	– PCT	
	– Lactate	
	– Urine culture	
	– Med reg R/V ✓	
	– Can start IV cephazolin	
	IV Gentamicin 300 mg.	
	after culture	

Emergency Continuation

Family name: ______ Given names: ______ MRN: ______

Date/Time	Notes – each entry dated and signed	Page:
9/8/	Med reg ED	
	84 year old ♂	
	Presented c neck pain	
	PMHx: 1) COPD	
	– Known to	
	– Managed by GP	
	– Home oxygen since 20	
	– Usual exercise tolerance is 10 metres c 4L/min	
	2) Type 2 DM 6) Prostatectomy	
	3) OA – No cancer	
	4) Cor pulmonale	
	5) HT.	
	HPI: Sudden onset of neck pain at 2PM yesterday	
	afternoon	
	Progressively became worse, worse c movement	
	Has some odynophagia	
	Started on left side then progressed to pain on ® side	
	No injury or fall.	
	Had a toothache few days ago. 1-2	
	– Has been unwell for last months with exacerbation	
	of COPD on various doses of steroids but no antibiotics	
	– Also has had weeping from both LL since 6 days ago	
	↑ SOB over last few days	
	∅ cough	
	∅ fevers / rigors	
	∅ chest pain	
	∅ abdo pain	
	∅ dysuria	
	∅ vomiting / diarrhoea	
	∅ headache	
	∅ ↑ erythema of LL.	

Emergency Continuation

Binding margin – no writing

Binding margin – no writing

Date/Time	Notes – each entry dated and signed	Page:
	Medicat^ns: Prednisone 50mg recently	
	Maintenance doses 10mg	
	Seretide	
	Atrovent (did not tolerate Spiriva) TDS.	
	via spacer and puffer.	
	Metformin / diamicron / Lipitor / frusemide	
	SHx: Lives c̄ wife who is his carer	
	bathroom is separate from room	
	(I) Toileting	
	showering x (A)	
	Home care – Community nurse calls in once/week.	
	cleaner fortnightly	
	Smoking: Ex since 15 years ago.	
	Pipe for 30 years.	
	Alcohol: 1 wine/day	

Emergency Continuation

Family name: ______ Given names: ______ MRN: ______

Date/Time	Notes – each entry dated and signed	Page:
	O/E: afebrile.	
	HR = 110	
	BP = 104/72	
	SaO2 = 99% on 15L via NRB !	
	Tender generally around neck even to light touch	
	No cervical lymphadenopathy palpable.	
	H dual	
	Examined anteriorly as pain +++	
	crackles at (L) base	
	No wheeze	
	abdo soft	
	BS	
	mild discomfort in LLQ	
	Peripheral oedema of both legs	
	wrinkled skin +++	
	Mildly erythematous, not hot	
	Both elbows have dependent oedema	
pH = 7.4	ECG = RBBB, sinus tachycardia	
pO2 = 51	CXR = No obvious patch of consolidation.	
pCO2 = 25.7	Bloods = CRP = 124 WCC = 11.6 (on pred) Plt = 160 Hb = 167.	
HCO3 = 15.5	Urea = 27.7 Cr = 183 K = 5.6 HCO3 = 17 (not acidotic). Trop ↑ = 29.	
	(I): 1) Neck pain ? cause } ? Pharyngeal abscess.	
	2) ↑ CRP ? source of sepsis → ? Biliary ? URTI	
	3) Acute renal impairment likely 2° dehydration c̄ ↑↑ Urea and ↑ creatinine	
	4) ↑ Trop ? significance	
	(P): – give O2 to aim for sats > 90–92%, likely chronically hypoxic	
	– CT Neck and C-spine	
	– Blood / urine / sputum culture.	
	* Rehydrate, w/H diuretic and ACEI metformin in view of renal impairment	
	– Serial troponin and ECG.	

Emergency Continuation

Binding margin – no writing

Binding margin – no writing

Date/Time	Notes – each entry dated and signed	Page:
	*. Please give hydrocortisone as on prednisone	
	long term.	
	– analgesia	
	* Monitor CRP.	
	– Echo	
	D/W neuro reg	
	– to change cephazolin to	
	IV metronidazole 400mg tds	
	IV ceftriaxone 1gm daily	
	– await for CT spine/neck	

Emergency Continuation

Date/Time	Notes – each entry dated and signed	Page:
9/8/ 1430	RN note: Patient had IDC inserted by RN . Aseptic technique applied. 10mls H_2O inserted for balloon inflation. Good diuresis 100mls. Urine sent for m/c/s. IV antibiotics given as charted. Med Reg r/v @ TOR.	
9/8/ 1530	Nursing: GCS-15, IVT commenced, IDC insitu, cardiac monitored tachy, meds given as charted	
9/8/	P/B (Med reg)	
	[illegible] ? neck pain!	
	Never previously had neck pain before	
	Neck pain appears to have spontaneously improved	
	[illegible]	
	— Admit	
	— Agree with above	
	→ [illegible] year old ♂ c̄ sepsis (↑CRP / Tachy / acute renal imp of ? focus possible LRTI / UTI !	
9/8/ 1900	NURSING: Pt r/c/B, tolerating only small amounts of fluids. c/o pain in groin area, MO made aware, paracetamol 1g given with some effect. IDC remains insitu, draining only small – moderate amounts. Awaits t/f to ward. Nil further complaints voiced to nursing staff @TOC.	
10/8/ 0200	Night JMO. Handover by Med Reg to cease metronidazole.	

Binding margin – no writing

Emergency Continuation

Date Problem no.	Time	Sign, print surname and record designation for all entries.
9/8/	1940	(Ey)
		ATSP re ↑ pain (R) wrist — kidneys
		B/G wrist # ~ 60 years ago. → IVF
		? caught when T/F to bed. → Urea 27
		Ø Neurovascular Δ's. Creat 137
		Cap refill < 2 seconds. ? dehydrated
		Unable to flex / Extend / rotate.
		Can Move fingers freely
		Ø erythema.
		Tender to palpation → 10/10 pain.
		(P) 1. XR target
		2. Oxycodone 5mg stat
		RADIOLOGY EXAMINATION R wrist DATE 9/8 RADIOGRAPHER
9/8/	2035	NURSING: Pt arrived to from ED at 1925. Pt obs attended BP - 133/70, P - 118, Resp - 24, Sat 92% NRebreather Mask. Pt on IVF 84mls/hr Hartmann's, Pt complained of Rt wrist pain, couldn't move hand. AHRMO notified came to RV pt, stat dose of endone TBG and stat wrist x-ray done at 2020. A/W AHRMO to RV. Pt resting in bed IVC overly well. EEW

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Date Problem no.	Time	Sign, print surname and record designation for all entries.
9/8/	2105	(E4)
		Pt wrist xr
		↳ ⌀ Acute #
		↳ Loss of radial joint space
		→ calcified joint space.
		(P) 1. Team N/U Mane
		2. Analgesia as charted
		3. ? ortho n/v mane if concerned
10/08/	0215	NURSING Pt is alert and orientated. IVF in progress @ 83mL/hour of hartmanns. Inhalers given note of pt. own supply. Pt is using nurse call as needed. Reporting severe (R) wrist pain. NP in situ O_2 3½L/min in progress, SpO_2 90-91%. (RN)
		ADDIT NURSING Endone 2-5mg PO prn dose given for report of severe (R) wrist pain. Wound to left lower leg dressed by community nurse twice/week, now oozing through dressing. Oedema (L) elbow noted. Heart rate elevated, BP 120/76. Awaiting effect of endone. (RN)
10/8		IMAU reg
10.01	pm	call from micro - has gram positive cocci in clusters in blood cultures.
		painful (R) wrist since last Thursday. also neck pain slightly improved, able to move neck around slightly. No headache or photophobia.

Progress Notes

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Date Problem no.	Time	Sign, print surname and record designation for all entries.
		MAU CASE CONFERENCE
		ATTENDING CONSULTANT:
		DATE: 10/8/ 0900
		ACTIVE MEDICAL ISSUES / MANAGEMENT:
		• For CT neck and spine
		• On IV antibiotics,
		•
		•
		•
		PHYSIO: } For initial review and assessment
		SW:
		OT:
		SPEECH/DIETITIAN: not required
		EDD / DESTINATION: ? D/C Tues/Wed
		Signature:
		Name: **Designation:** RMO

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/08	0955	NURSING: RESULT FROM MICROBIOLOGY -
		POSITIVE BLOOD CULTURES
		• BOTH BOTTLES GRAM +VE WITH
		CLUSTERS. RESULT GIVEN TO MAU
		REGISTRAR. ——— CNE
		MAU Reg.
10/8		addition to r/v.
10-08		
		Xray (R) wrist - no # or soft
		tissue swelling.
		Blood culture -
		gram +ve cocci in 2/2 blood cx
		(clusters) - ? staph
		aureus or contaminant
		D/W Dr
		stated speak to ID consultant
		D/W Dr - (ID consultant)
		→ for flucloxacillin.
		2g q6h iv and
		chase BC final
		report.
		→ for orthopaedic r/v
		(P) - Δ antibiotics to
		2g q6h flucloxacillin,
		Cease ceftriaxone.
		- orthopaedic consult re
		painful (R) wrist - ? septic
		arthritis.
		- repeat blood culture.

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Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8/	11:3-	Dadr /RMO
		D/W ortho reg on # regarding the consult
		and She will kindly review the patient.
		[signature]
10/8/		Ortho.
1330hrs		Thank you for your call.
		84y.o ♂ from home.
		initially admitted for neck pain
PmHx:		~~progressed to~~ Workup revealed
COPD { Home O_2 / prednisolone		sepsis ?source.
T2DM		Pt. in bed. Wife in attendance.
OA.		c/o severe pain (R) wrist. Unable to move
Corpulmonale.		wrist at all ∵ (P)#.
HT.		Started yesterday (late in evening.)
post cholecystectomy.		
		Pt. + wife report chronic wound/skin
		breakdown on post (L) lower leg.
		- daily community nurses dressing.
		- always oozing.
		- never really healed.
		Recent scrape over (L) dorsum of hand
		in stumble - skin tear
		(R) THR done x many yrs ago by Dr.
		→

Progress Notes

Family name: ____________ Given name: ____________ MRN: ____________

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8 Cont		O/E: Pt. in bed. Alert. Oriented.
		Frustrated.
		(R) wrist
		— tender +++
		— unable to move (R) wrist
		∴ pain +++
		—
		erythematous
		— (R) hand neurovascularly
		intact (median, radial, ulna
		motor + sensory.)
		— pulse strong.
		Bloods today:
		Na 137 K 5.5 Urea 28.7 eGFR 46.
		Cl 104 Creat 130.
		WCC 11.7 CRP 294 ← 124
		Imp: Clinically septic (R) wrist.
		Source (? chronic skin ulcer
		(L) lower leg post aspect)
		Currently on IV flucloxacillin.

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8/		M. and wife · spoke to
cont	7	me at length of end of life
		issues +/- withdrawal of treatment
		as "has had enough".
		Would like to know treatment
		options with regard to ortho.
		Explained at length. Ortho
		intervention if
		- aspiration of (R) wrist required
		to determine if septic joint
		- washout if required after
		consultation c̄ Ortho · consultant
		(Dr.) ī resting of joint.
		- IV antibiotics.
		+ wife reluctant to pursue
		~~to~~ surgical route ∵ co-morbid
		conditions.
		Would like to discuss withdrawal of
		Rx with Home Team
		P → · Geri team to discuss a/a issues
		c̄ pt + NOK
		→ happy to be contacted again
		if pt. willing to have wrist aspirat

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Progress Notes

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Progress Notes

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8/	1400	Nursing:- Patient alert and orientated.
		Patient sponged in bed this morning with full
		assistance. IDC remains insitu, draining
		moderate amounts of concentrated
		urine. Patient tolerating small amounts
		of diabetic diet, drinking well when
		encourage. Dressings attended to wounds
		x2 on left hand, wound care chart
		completed. Dressing attended to small
		ulcer on (L) leg, absorbant dressing, combine
		and bandage applied to (L) leg from
		ankle to knee. Observations within
		normal range. I.V therapy N/Saline
		remains patent running @ 40 mls/hr.
		I.V Antibiotics given as charted. Air
		mattress ordered for patient. Visited
		by his wife.
10/8/		Reg
2.45 pm.		
		I think this patient is
		septic - CRP is high. WCC
		is normal or slightly
		increased. S/B orthopaedic
		reg → opinion given that
		(R) wrist septic arthritis
		will need to be rule out
		I have spoken to the
		patient and his wife who
		would like palliative measures and

Family name: Given name: MRN:

Progress Notes

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
		withdrawal of Rx. His wife only brought the patient to hospital because she wanted pain relief. He has a background of severe COPD on home oxygen and is nearly polycythaemic. He states his quality of life is poor and his mobility is poor 2° CAL and peripheral vascular disease. He was unwell last week but wife decided not to bring him to hospital. He is seen by community nursing for (L) leg wound which is broken down Imp - sepsis - advance care directives needs to be addressed. D/W - she will r/v patient in half an hour to address these issues (P) - await discussion by Dr - continue IV Abs pro temp - start dose morphine to assist w/ transfer
10/8	1500	Nursg → pt to be moved onto air mattress c/o pain ↑↑ ∴ morphine 2.5mg s/c given awaits effect and pt on 31% O2 via venturi mask and saturating 88%.

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
		MAU CASE CONFERENCE
		~~ATTENDING CONSULTANT:~~
		DATE: 10/8/ 15:00
		ACTIVE MEDICAL ISSUES / MANAGEMENT:
		On home O2.
		• Staphylococcus Sepsis
		• Blood culture/urine.
		n
		• uti
		•
		•
		PHYSIO:
		SW:
		OT: needs support at home.
		DVA.
		SPEECH/DIETITIAN:
		EDD / DESTINATION:
		Signature:
		Name: **Designation:** RMO

Progress Notes

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/08	3-20 PM	Dr , Dr
		✓ medical notes since admission
		including orthopaedics team Review
		& ID review noted with Thanks
		✓ patient's present condition and
		management options discussed in
		detail with the wife and the
		patient
		✓ wife stressed that Mr
		does not want any treatment
		including antibiotics. Both were
		informed and repeatedly it was
		reemphasised that he should agree
		to antibiotics and also possibly
		washout
		✓ Urine output 300ml in last 12 hrs
		✓ obs. chart noted
		alert, on O_2 5 litres
		BP 109/70, Pulse 116/m. afebrile
		Rt wrist swollen, ↓ ROM
		Ch [illegible] scattered wheeze
		Pt continues to stress that he does not
		want to have any active management.
		It was suggested to him to give
		IV antibiotics for 48 hrs and then
		await culture sensitivity change to oral

Binding margin - no writing

Progress Notes

Family name: ______ Given name: ______ MRN: ______

Date Problem no.	Time	Sign, print surname and record designation for all entries.
		antibiotics & possible discharge
		- Multiple comorbidities with COPD on steroids
		PO ✓
		Plan: ✓ IV antibiotics for 48 h
		✓ ✓ Psych Team Review
		✓ Otherwise continue
		✓ Possible discharge after 48 hrs
		✓ PT, OT & SW Reviews before
		discharge
		[illegible signature]
10/8	1630	PHYSIOTHERAPY
		Blanket referral on MAU for 84 yr
		old ♂ admitted c̄ (R) wrist
		pain & sepsis.
		S: RIB, c/o 8-9/10 pain (R) wrist
		when (R) UL moved & 6-7/10 pain
		at rest. Declined to mobilize
		2° pain.
		Medical H/O:
		Endstage COPD DM Type 2
		Prostatectomy HTN
		OA
		Social H/O: Lives at home c̄ wife.
		Mobilizes c̄ 4WW indoors ~ 5-10 mts.
		Limited 2° SOB. Has home O_2.
		FA: 1+1 step, nil rail, supports on
		wall. BA: 18 steps, does not use
		internal steps: 2 nil rails but
		pt has not used it for >1/12.
		Fall x2 in last 3/12. Fall x1 2°
		not using walking aid indoors & 2nd
		fall when 4WW slipped away from
		him when attempting to sit on
		(Breakes not locked).
		O: Swelling & redness (R) wrist & hand.

Progress Notes

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8	1630	PHYSIOTHERAPY contd
		· unable to do active movts (R) wrist ·
		· Declined to mobilize
		P: To R/V 11/7
10/8/		Ortho
	1745hrs	
		Geris input noted
		Discussion c̄ + wife noted
		Noted for IV abx x48hrs., review
		P → crepe bandage to (R) wrist to ↓ wrist
		movement. (ideally would require
		resting splint to rest joint but
		pt. skin thin++ risk of pressure areas high
		+ exquisitely tender at present to
		any movement.).
		→ Will inform Dr.
		→ happy to be called agn if ortho
		input required / pt. changes mind

Progress Notes

Binding margin - no writing

Family name: Given name: MRN:

Progress Notes

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8	1930	NURSING :- pt alert & orientated, co-operative c̄ pt care, Obs attended as charted — IVC remains insitu on R/ arm, WF, N/Saline running @ 100ml/hourly, meds given as — charted. Tolerated, small amount of dinner, IDC remains insitu, draining very slowly UOP as charted, Nil complaints voiced ATOR
	2030	Addit: Pt afebrile, RN requested regarding pt U/O & BP. Pt pain significantly decreased pt moving Ⓡ hand on request, he is currently feeling more positive due to ↓ pain level. IDC on 1/24 measures. Pt orientated to year, place, person.
	2040	Addit: Pt requested to contact wife to let her know, he is out of pain & can move hand, spoke c̄ wife is settled.
10/8.	2100	E2 Intern - ATSP re: ↓ Urine Output ⓑ <30ml/8hr.
		84yo ♂ ? septic. Unclear Advanced Care Directives. Only on fluids TKVO.
		Though dependent leg oedema, pt clinically looks dry + is c/o thirst.
		Ⓟ ↑ next bag to Q10hr.

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
		MAU CASE CONFERENCE
		ATTENDING CONSULTANT:
		DATE: 11/8/
		ACTIVE MEDICAL ISSUES / MANAGEMENT:
		• awaiting ~~#~~ sensitivity then commence on
		• oral antibiotics.
		• pain management OK.
		• Ball care consult. for psych review
		• CMO follow up
		PHYSIO: ongoing review 1+1 step at front + 2 internal
		SW:
		OT: needs Ax
		SPEECH/DIETITIAN:
		EDD / DESTINATION: ? 12/8/
		Signature:
		Name: **Designation:** OT

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Progress Notes

Family name: Given name: MRN:

Date Problem no.	Time	Sign, print surname and record designation for all entries.
10/8		D/W Dr (at case conference).
10.45am		- would like psych consult
		and palliative care consult.
		(P) psych consult requested.
		palliative care consult requested.

Progress Notes

Binding margin - no writing

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
1/8/[illegible]	0400	Nsg. pt alert & orientated. Bandage insitu on Rt wrist & dressing on Lt lower leg
		IVT in progress. IDC draining like 25-30mls/hr.
		B.P at 2345hr was 102/80 mmHg. Slept on
		& off.

Progress Notes

Date Problem no.	Time	Sign, print surname and record designation for all entries.
11/08	11:40 am	Dr (Psychiatrist)] CL Psychiatry Dr (Psych Reg) (CNS).
		lying in bed O2 nasal tongs. Eyes closed. ~~Rand~~ Dr explained purpose of assessment. ⇒ To assess competence/capacity 84y old Married Lives in with wife Reports In Hospital since ~~Saturday~~ Sunday, unable to move Rt. wrist → "clinched up" and didn't settle with Panadol Osteo. (very painful) Says take 6 Panadol/day for pain. Said pain here and there, not very specific. Says he is not sure where the infection is and he does not want to know Dr again emphasised and explained the need for our input He initially refused to talk, but then he said he wants to go, nothing will be useful, he does not want to be troubling others, expressing -hopelessness Reports low mood. Has given up "thats what I want to tell you"
Wife:-		Suffering from emphyseme for long time

Progress Notes

Binding margin - no writing

Family name: Given name: MRN:

Date Problem no.	Time	Sign, print surname and record designation for all entries.
		Until recently he was mobilising
		able to go to Sunroom, do crosswords,
		read paper; but Emphysema has
		reduced his capacity to mobilise extremely
		and he has been in bed for about
		2-3 wks only able to take only few steps.
		He has been feeling depressed in the last
		weeks.
		Bed mobilisation causing - circulation
		problems including oedema.
		- Wife reported that the GP has been
		trying to get a balance in O_2 + Prednisolone
		so that while treating one other does
		not suffer.
		Dr explained that Dr team
		wants to i/v antibiotics and that if
		untreated it can lead to widespread sepsis
		wife said Dr explained to them
		that Mr needs 48hrs of i/v
		antibiotics "I want lungs to clean up and
		it will be pain."
		Dr acknowledged low mood, ↓ motivation
		Dr suggested antidepressant, he was
		ambivalent but wife agreed.
		Memory Repeat Repeat
		Book ✓ ✓
		Tulip ✓ wandering ✓ with prompt
		Apple ✓ away. ✓
		Camera ✓
		Day - Tuesday.
		Month - August
		Year -
		Season - Winter
		Date - 4th X

Progress Notes

Binding margin - no writing

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
11/08	11:40 am	Place - ✓
		Bed - 14 ✓
		Floor - 3 ✓
		Time - Before lunch
		WORLD
		Backwards - D L O W R.
		Command. lt hand - Pt ✓.
		Left hand rt ear ✓
		Left hand my rt eye ✗.
		Able to read - large fonts from
		newspaper → wears reading glasses.
		Reports:
		h/o depression
		cried lots of financial issues
		No treatment in the past.
		Wife reported lot of financial stress about
		30yrs ago
		Alcohol - 7-8 scotches / month and
		(100mls) red wine, 5 nights a week.
		Emphysema → smoking; Stopped smoking
		about 20yrs ago.
		Impression
		- Depression associated with deteriorating
		respiratory f^n and resulting
		immobility. His mood may improve
		if his respiratory f^n does but
		this is a remote possibility

Progress Notes

Family name: Given name: MRN:

Date (Problem no.)	Time	Sign, print surname and record designation for all entries.
11/08	11:40am	He will is prepared to take an antidepressant to assist with mood. Lexapro 5mgs would be drug of choice, however given his compromised respiratory f^n + comorbidities there is a risk of developing hyponatraemia. Thus the prescription of this medication requires his Sodium to be monitored.
	(2)	He is not actively suicidal but has given up given his recent poor health. He is willing to have conservative treatment at home including PO antibiotics and PO antidepressants. Referral to Palliative Care is a good idea.
11/8	1300	Nursing: IDC removed, awaiting post void. EW
		Addit: Removed as per mau reg B/MO
11/8	1400	(Palliative Care Reg)
		84yo ♂.
		B/G:
		1) COPD
		End-stage
		Home O2 since 2005
		Chronic steroids
		2) cor pulmonale
		3) chronic oedema (ul+ll)
		Recurrent skin breakdowns
		4) DM
		5) OA
		6) HT
		7) Prostatectomy.

Progress Notes

Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
11/8		Meds noted. Bloods noted.
		lives at home with wife (his carer)
		Requires (A) with most ADL's
		Limited mobility (a few metres only) 2° SOBOE
		Admitted 9/8 with neck pain - now mostly
		resolved. (R) wrist pain +
		septic arthritis (with staph sepsis)
		is the current issue.
		Pt + wife report symptomatic / functional
		decline in last few mths. in particular
		Pt describes having no quality of life.
		Wife is happy to support him in any
		way but acknowledges that his QOL
		is essentially non-existent. Both feel
		that even if the infectn could be
		treated ; returning to his pre-morbid
		existence is not a desirable outcome.
		They have clearly thought about his
		options over the yrs → months of
		progressive decline + both feel his
		current QOL is unacceptable.
		Pt's wish is to be pain-free +
		comfortable. Wife is fully supportive.
		We discussed various options including
		continuing ABx vs stopping everything
		but symptomatic / comfort care.
		Pt + wife are both keen for comfort
		measures only. Possibility of T/F to another
		Pall. Care unit, (or if needed), or NH discussed

→ pt + wife accepting of that if needed.

Binding margin - no writing

Progress Notes

Family name: ____________ Given name: ____________ MRN: ____________

Date (Problem no.)	Time	Sign, print surname and record designation for all entries.
		Imp: Considering pt's pre-morbid conditions + progressive functional decline ; further deterioration with septic arthritis ; + in accordance with the pt's wishes, palliative care is appropriate.
		(P) Suggest:
		· Oxycontin 10mg BD (rather than 5mg Oxycodone TDS)
		· ~~cont breakthrough Ordine 2.5mg Q4H PRN~~ (error)
		· Regular aperients.
		· cont. ~~[illegible]~~ atrovent/seretide
		· PRN anti-emetics
		· Stop IVAB / IVF
		· I will D/W Dr
		· Breakthrough Morphine
		[illegible]
		Above noted
		Pt does not want any active Rx
		this decision is been made after
		d/w ID/Palliative.
		Although this condition is [illegible]
		Pt sensitive to most drugs
		require MRI spine/Echo/R wrist aspirate
		pt refuses above
		cognitively intact
		D/W ID Reg as above
		agreeable c̄ above, if refuses active Rx
		commence on oral keflex.
		Please keep pt comfortable
		Adequate analgesia

Progress Notes

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Binding margin - no writing

Date Problem no.	Time	Sign, print surname and record designation for all entries.
11/8/	1500	Nursing: Pt declined shower/washing this shift. BNO moved once during shift to change linen & gown. IDC removed yet to void. Pt given Breakthrough endone c̄ out much effect. Pt R/V regarding IVT ceased this shift. IVAB continue. Tolerated b'fast however declined lunch tolerating fluids. Pt oedematous to arms, legs and penis. incontinent pad insitu. Wife in attendance. Pt has O² via nasal prongs @ 3L. Dressings intact to (L) lower leg & hand. Pt moved very little this shift due to significant and distressing pain to (R) hand. EW
11/8	1615	(Pall. care Reg)
		D/W Dr →
		· Happy to take over care
		· Regular morphine 2.5mg SC Q4H + PRN breakthrough as charted
		· Oral prednisone (while he can tolerate oral intake, then stop)
		·
11/8/	1620	PHYSIOTHERAPY Lengthy discussion with pt and his wife re further Mx. Pt & wife both refused further physio intervention for mobility. D/W Palliative care registrar re same. P: D/C from physio R/V if reqd

Progress Notes

Binding margin - no writing

Progress Notes

Date	Time	Sign, print surname and record designation for all entries.
		MAU CASE CONFERENCE
		ATTENDING CONSULTANT:
		DATE: 11/8/ 15:00
		ACTIVE MEDICAL ISSUES / MANAGEMENT:
		• Sepsis – painful (R) hand; painful neck
		• pt refusing IV abs
		• r/v by pall care ; await Dr [illegible]'s r/v. ?to of care
		• becoming more unwell ; may not be going home
		•
		PHYSIO:
		SW: home c wife (assertive)
		OT: r/v tomorrow
		SPEECH/DIETITIAN:
		EDD / DESTINATION: ? LONG STAY
		Signature:
		Name: **Designation:** RMO

Family name: Given name: MRN:

Date Problem no.	Time	Sign, print surname and record designation for all entries.
11.8	1910	Nursing: Pt is orientated and co-operative.
		S/C butterfly for morphine in left thigh, IVC in
		R) wrist, had half of his dinner, visitor has been
		in attendance. He C/O pain in R) arm, PRN morphine given,
		now regular morphine charted, PAC given.
12.8	0300hr	Nsg: pt noted to be sleeping from the
		commencement of the shift. Slept well
		overnight. S/c needle insitu on Lt leg.
		Reg: morphine given RN
12/08	0850	NURSING Paging Dr team, Dr team
		advised of pt. C/O pain post morphine 2.5mg
		S/C breakthrough dose, and regular morphine
		signed as given. Team will r/v.
12/8		Pal Care
		ATSP - pt in severe pain
		pt. on 2.5 mg 4 hrly regular and 2.5mg
		morph PRN. The last dose 1 hour ago.
		O/E pt. moaning c pain. said he had a
		terrible night.
		c/o pain, "like chinese burn", in his (R) wrist.
		morphine 2.5 mg stat given.
		P/. try to try to SWY
		• consider pump
		• haloperidol for nausea
		• stop obs.

Progress Notes

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Date Problem no.	Time	Sign, print surname and record designation for all entries.
		MAU CASE CONFERENCE
		ATTENDING CONSULTANT: Dr
		DATE: 12/08/ 900.
		ACTIVE MEDICAL ISSUES / MANAGEMENT:
		• For T/F to S4D
		• End of life care - Nil active
		• Rx except pain relief.
		•
		•
		PHYSIO: } nil
		SW:
		OT:
		SPEECH/DIETITIAN: —
		EDD / DESTINATION: Extended care
		Signature:
		Name: **Designation:** Physiotherapist

Date Problem no.	Time	Sign, print surname and record designation for all entries.
12/9		Pal Care (n' team)
		pt. sleeping deeply
		had 5mg morph this am.
		P/ 2.5mg 3 hrly. regular. morph
		start haloperidol
		PRN 2.5mg PRN morph
		stop regular tabs.
		t/f to SHD when bed available.
12/08/	1320	NURSING Pt c/o pain, unable to tolerate touch, suggests that he wants to be left alone as he c/o nurse touching the pillow with some anxiety evident. Pt is on NP 3½L/min O2. Light sponging given only as tolerated. Repositioned up the bed on two slide sheets. Medications with-held as pt is too unwell to take them. Pt requested Nursing Staff "give me one tablet and put an end to it" meaning he wished to finish his suffering. Three S/C butterflys sited, Ⓡ thigh for maxolon, 2 on Ⓛ thigh for haloperidol at the strength of 5mg/1mL and the other for morphine - all labelled. Pt has not passed any urine since removal of IDC at 00:30 (handed over by night staff verbally), however documented that IDC was removed on p.m. shift. Insufficient information to definitely say when pt. last voided, however probably has not passed urine for 24 hours.
12/08/	1340	(RN). ADDIT IIMS completed for urine output, no. 712639-20 as FBC incomplete and same not seen on checking of charts handover RN

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Progress Notes

Date Problem no.	Time	Sign, print surname and record designation for all entries.
12/8	1420	Nursing: Oral meds (W/H) as pt was drowsy and (C) at times, wife in attendance + wants to speak with MO, no answer —
12/8	1450	(CMO)
		pt deceased today @ 1450
		no spontaneous breaths
		heartbeat
		pupils dilated & unreactive to light
12/8	1520	Nursing: Patient passed away, wife in attendance. Eye bank, team and pt. flow manager aware. Pt. transferred to end room.
12/8	16.20	Nursing :- Patient is being cleaned and placed in bag with labels attached. waiting for wards person

DATE 11/8/ H.M.O. ______ UNIT NO. ______

NAME ______ WARD ______ SEX ______ AGE ______

M.S.W.D. ______ CONSULTANT Psychiatry.

Summary of Clinical Notes: Inter/Pub

Thank you for r/v
84 year old man w/ sepsis.
Background of diabetes, COPD on home O2.
patient request withdrawal of Rx.
please advise whether or not the patient
is suicidal. Note - we have also referred
to palliative care.

OBJECTS OF CONSULTATION (Tick those required)

1. Transfer to Consultant's care.
2. Opinion and provisional diagnosis
3. Further treatment suggested.

M.O.

Consultation Reports

11/8/

Thank you.
Please see progress notes
dated 11/8

Date ______ Consultant......

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Consultation Sheets

09/08/20 09:42:15
Unknown

Rate	120	. AGE IS NOT ENTERED, ASSUMED TO BE 50 YEARS OLD FOR PURPOSE OF ECG INTERPRETATION
PR	92	. SINUS TACHYCARDIA..V-rate> 99
QRSD	139	. PROBABLE LEFT ATRIAL ABNORMALITY..........................P >50mS, <-0.10mV V1
QT	368	. RBBB AND LPFB..QRSd >120mS, axis(90,210)
QTc	520	. PROBABLE ANTEROSEPTAL INFARCT, AGE INDETERM................Q >30mS, T neg, V1-V3

--AXIS--
P Ind.
QRS 207
T 4

- ABNORMAL ECG -

Unconfirmed Diagnosis

I aVR V1 V4

II aVL V2 V5

III aVF V3 V6

II

Dev: Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10 mm/mV F 50~ 0.5-150 Hz W PH080A P?

Blood Culture

* Final Report *

Result Date: 09 August 13:34
Result Status: Auth Verified
Result Title: BLOOD CULTURE
Encounter info: Inpatient, 09/08/20 12/08/20

* Final Report *

BLOOD CULTURE
Test Reference:

BLOOD CULTURE
SOURCE: BLOOD COLLECTED: 09AU 1334
RECEIVED: 09AUG 1334

_________ FINAL REPORT __________

Staphylococcus aureus isolated from both bottles
[mecA gene was not detected in this isolate of S.aureus
by PCR. This isolate is sensitive to methicillin and
related antibiotics.]

____ SUSCEPTIBILITIES (S=SENS, R=RES) ____

	S.aureus
CEPHAZOLIN	S
ERYTHROMYCIN	S
FLUCLOXACILLIN	S
DICLOXACILLIN	S
PENICILLIN	R

Page 1 of 1
(End of Report)

Urine Culture

* Final Report *

Result Date: 09 August 14:23
Result Status: Auth (Verified)
Result Title: URINE CULTURE
Encounter info: HOSPITAL, Inpatient, 09/08/ 12/08/

* Final Report *

URINE CULTURE
Test Reference:

URINE CULTURE
SOURCE: URINE COLLECTED: 09AUG
RECEIVED: 09AUG

_________ MICROSCOPY __________
URINE MICRO
Leucocytes............. >100 X 10^6/Litre
Erythrocytes........... 10-100 X 10^6/Litre
Epithelial cells........ Nil
Organisms............... +
Casts................... ++ Hyaline casts
Crystals................ Nil

__________ FINAL REPORT __________

Bacterial count: >100 X 10^5/Litre
A Pure growth of Staphylococcus aureus isolated
[mecA gene was not detected in this isolate of S.aureus
by PCR. This isolate is sensitive to methicillin and
related antibiotics.]
Consistent with UTI

____ SUSCEPTIBILITIES (S=SENS, R=RES) ____

	S.aureus
CEPHAZOLIN	S
ERYTHROMYCIN	S
FLUCLOXACILLIN	S
NITROFURANTOIN	S
DICLOXACILLIN	S
PENICILLIN	R
COTRIMOXAZOLE	S

Page 1 of 1
(End of Report)

CTN Neck Soft Tissue

* Final Report *

Result Date:	09 August
Result Status:	Auth (Verified)
Result Title:	CT Neck Soft Tissue
Verified By:	Contributor system, GE_RIS on 09 August
Encounter info:	Emergency, 09/08/

* Final Report *

CT Neck Soft Tissue
CT Neck performed on 09-AUG-20 4:05 PM Clinical history Left-sided neck pain, worse on movement. ? Abscess. ? Malignancy. Technique A spiral contrast enhanced study of the neck was performed. Report There is asymmetry of the left piriform sinus with increased soft tissue opacification. No definite mass is visualised. There is no associated destruction of the adjacent thyroid cartilage. The oral, nasal and hypopharynx are otherwise preserved. No cervical lymphadenopathy is detected. No abscess formation is seen. The parapharyngeal and the retropharyngeal spaces are maintained. The thyroid and salivary glands are if normal appearance. No airway compression is detected. Note is made of emphysema in the visualised views of the lung apices. Degenerative changes of the cervical spine are noted. No bony destruction is identified. Conclusion The asymmetry of the left piriform sinus is nonspecific, with the differential including an inflammatory/infectious focus, or if the symptoms have been present for some time, neoplastic disease cannot be excluded. Direct endoscopy is suggested if there is clinical concern. No other significant abnormality is identified. REPORTED BY:

Completed Action List:
* Order by Contributor_system, GE_RIS on 09 August 5:53
* VERIFY by Contributor_system, GE_RIS on 09 August 6:14

Page 1 of 1
(End of Report)

Wrist Right

* Final Report *

Result Date:	09 August
Result Status:	Auth (Verified)
Result Title:	CR Wrist Right
Verified By:	Contributor system, GE_RIS on 09 August
Encounter info:	Inpatient, 09/08/20 12/08/

* Final Report *

CR Wrist Right
Xray Right Wrist performed on 09-AUG- 8:16 PM There are moderate to severe degenerative changes at the radiocarpal joint. There are mild degenerative changes at the scapho-lunate joint, scapho-trapezium joint and the lunate capitate joints. There are subchondral sclerosis with marginal osteophyte and joint space narrowing. There are small subchondral cysts noted at the radiocarpal joints. There is moderate chondrocalcinosis at the triangular fibrocartilage. On the lateral film, there is a 3 mm calcified opacity overlying the dorsal aspect of the wrist joint. It may be soft tissue dystrophic calcification however a small avulsion fracture cannot be excluded. No definite periarticular erosion is noted. REPORTED BY:

Completed Action List:
* VERIFY by Contributor_system, GE_RIS on 09 August

Page 1 of 1
(End of Report)

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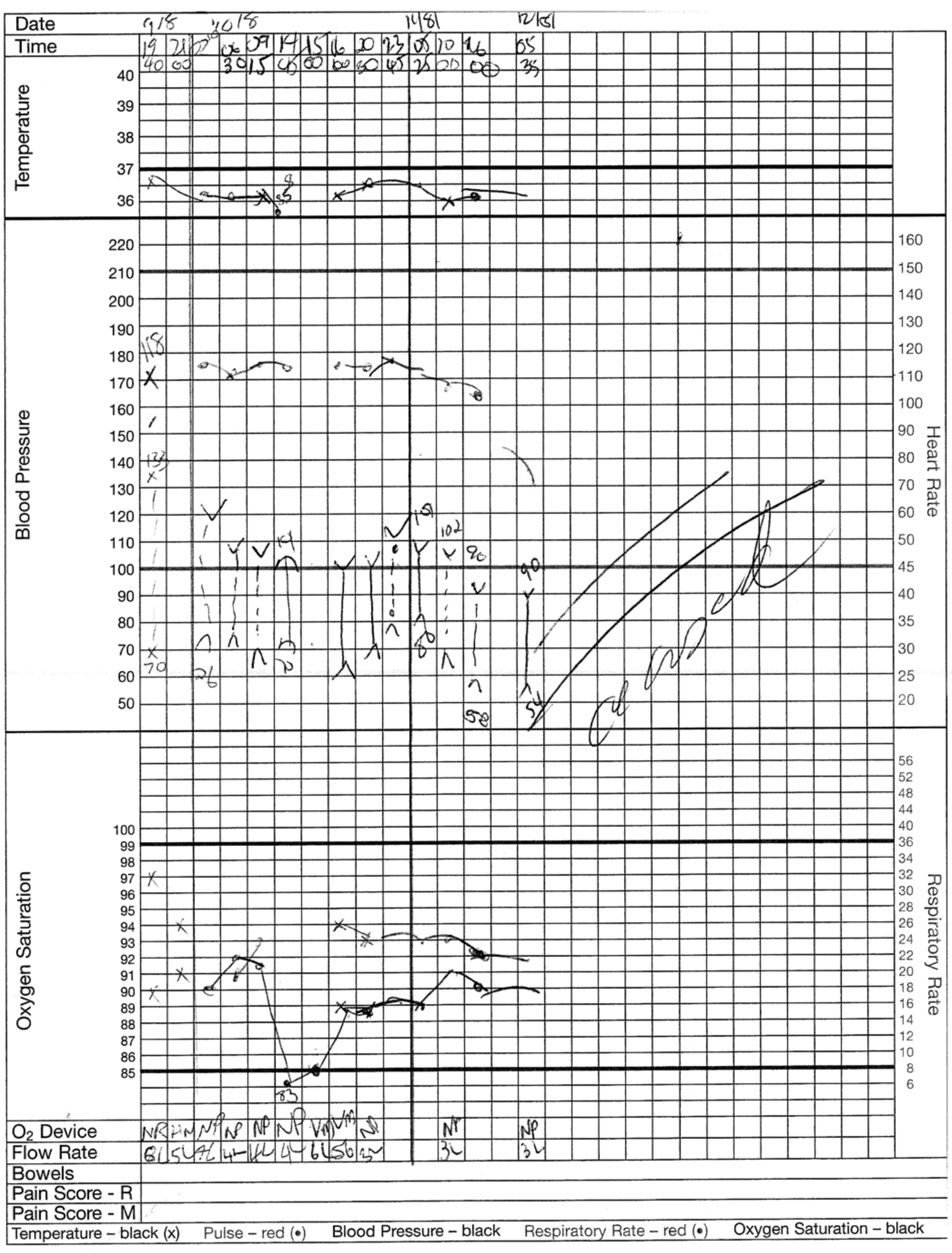
Observation Chart



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Diabetic Chart

Date	Time	Glucometer	BSL	Urinalysis		Treatment	
				Glucose	Ketones	Oral	Insulin units
9/8	1200		8.5 ml/L				
	2000		7.1 ml				
	~~[illegible]~~		~~BSL~~				
	2400					pls repeat BSL as pt	
10.8	0045		8.4 mmol/L.			has not eaten dinner.	
	0600		8.8 mmol/L				
	12MD.		10.1 mmol.				
	0730		11.0 mmol/L.				
11/8/	0530		9.5 mmol/L.				
	1230		9.7 mmol				
	1700		9.8 mmol/L				
12/8	0525		7.6 ml L				

stop checking BSL pls

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

☑ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

Sign Print Date 04/08

PRESS FIRMLY WHEN WRITING PATIENT DETAILS OR AFFIX PATIENT ID LABEL TO EACH COPY OVERLEAF

UR No: ______

Family Name: ______

Given Names: ______

DOB ______ Sex ☑ M ☐ F

1st Prescriber to Print Patient Name and Check Label Correct:

Patient Weight (kg) ______

Height (cm) ______

REGULAR MEDICATIONS

YEAR 20 ______ DATE & MONTH: 9/8, 10/8, 11/8, 12/8

VARIABLE DOSE MEDICATION

Date | Medication (Print Generic Name)

Route | Frequency — Dr to enter dose time and individual dose

Indication | Pharmacy

Prescriber Signature | Print Your Name | Contact

Time of Dose: — Drug level / Time level taken / Dose / Prescriber / Time given / Nurse

Date | **WARFARIN** (Marevan/Coumadin)

Route | Target INR range

Indication | Pharmacy

Prescriber Signature | Print Your Name | Contact

INR Result / Dose (mg mg mg mg mg mg mg) / Prescriber / 1600 Nurse 1 / Nurse 2

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Dose	Frequency & NOW enter times	Route	Times	Administration
09/08	Cephazolin	1gram	QID	IV	0600, 1200, 1800, 2200	9/8: 1420; See next med chart
09/08	Prednisolone	20mg	daily	PO		// Ø sepsis change to hydrocortisone
09/08	Metformin	1000mg	BD	PO		// Ø Acute renal insuff
09/08	Diamicron MR	30mg	mane	PO	0800	→ AW gw (W)

Pharmacy: gliclazide MR

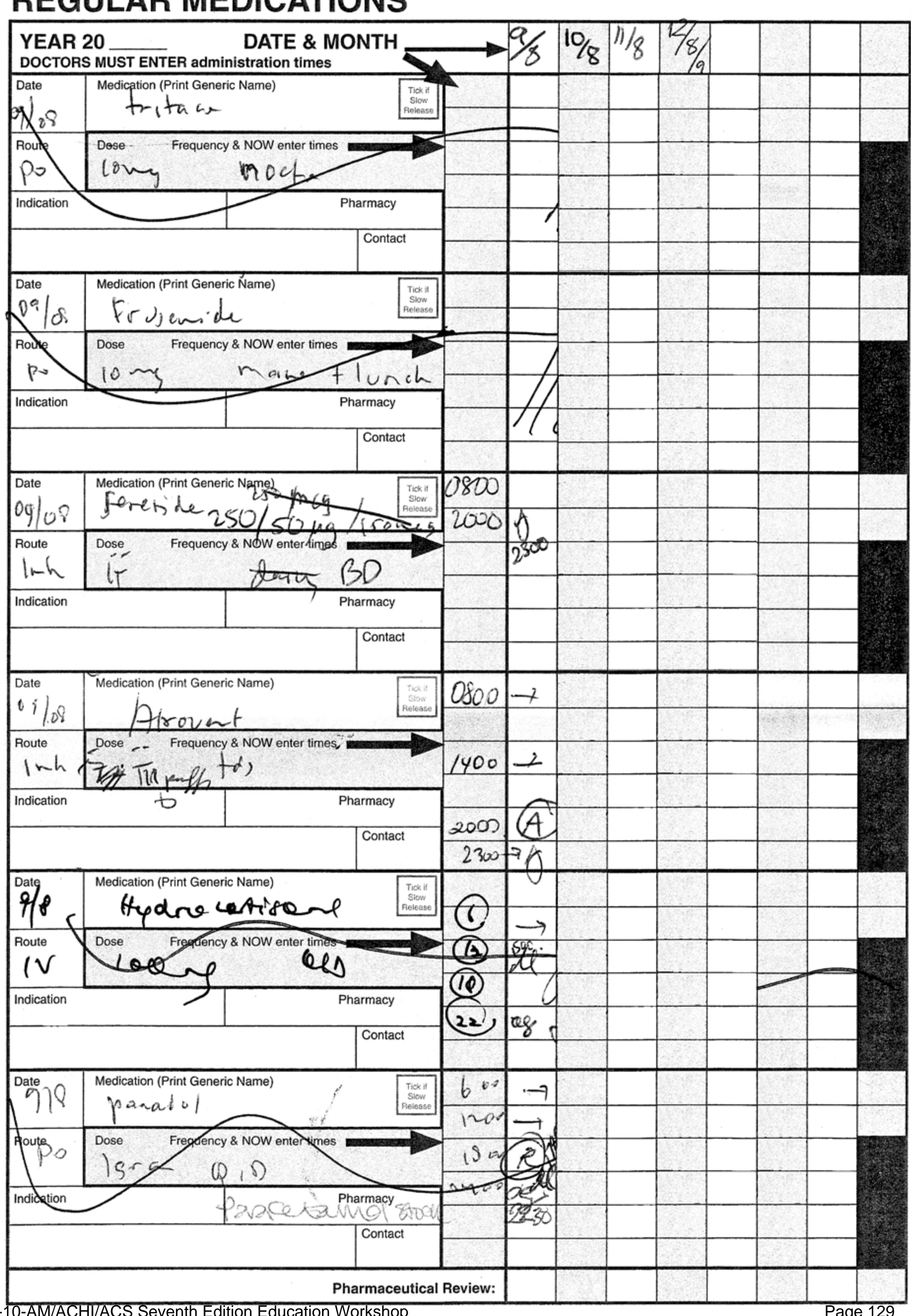
Indication | Pharmacy | Contact

Pharmaceutical Review:

AS REQUIRED "PRN" MEDICATIONS

Attach ADR Sticker

See front page for details



REGULAR MEDICATIONS

YEAR 20 ____ DATE & MONTH → 9/8 | 10/8 | 11/8 | 12/8/9

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Tick if Slow Release	Route	Dose	Frequency & NOW enter times	Times / administration
9/8/08	tritace		po	10mg	mane	
09/08	Frusemide		po	10mg	mane + lunch	
09/08	Seretide 250/50µg		Inh	ii	BD	0800; 2000 (9/8: 2300)
09/08	Atrovent		Inh	ii puffs	tds	0800; 1400; 2000 (A); 2300
9/8	Hydrocortisone		IV	100mg	QID	6; 12; 18; 22
9/8	panadol		Po	1g	QID	600; 1200; 1800; 2400 (9/8: 2230)

Each medication section also contains the fields: Indication, Pharmacy, Contact.

Pharmacy (panadol): Paracetamol stock

Pharmaceutical Review:

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Print Name	Given by	Time Given	Pharmacy
09/08	Gentamicin	IV	320mg					1420	
9/8	Oxycodone	PO	5mg	Stat				2045	
10/	Resonium	Po	30g	Stat				12 MD	
11/8	Coloxyl c Senna	PO	ii	N, m				1030	
12/8	Haloperidol	SC	1mg	Stat				1040	

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1	Nr 2	Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines Taken Prior to Presentation to Hospital
(Prescribed, over the counter, complementary) Own medications brought in? ☐ Y ☐ N Administration Aid (specify) ....

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

NOT FOR ADMINISTRATION

GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

MEDICATION CHART MR70

Date 9/08	Medication (Print Generic Name) panadol		Date				
Route PO	Dose 1gram	Hourly frequency Q 1D PRN	Max dose/24 hrs	Time			
Indication		Pharmacy	Dose				
			Route				
		Contact	Sign				

Date 9/8	Medication (Print Generic Name) Endone		Date	9/8	10/8	11/8	11/8
Route PO	Dose 2.5mg	Hourly frequency q 4hly PRN	Max dose/24 hrs	Time	02 30	09 55	10 10	14 40
Indication		Pharmacy	Dose	2.5	2.5mg	2.5	2.5mg
			Route	PO	PO	PO	PO
		Contact	Sign				

Date 11/8	Medication (Print Generic Name) Endone		Date
Route PO	Dose	Hourly frequency PRN	Max dose/24 hrs	Time
Indication		Pharmacy	Dose
			Route
Prescriber Signature	Print your name	Contact	Sign

Date 11/8	Medication (Print Generic Name) Morphine		Date	11/8	12/8/09
Route SC	Dose 2.5mg	Hourly frequency Q2H PRN	Max dose/24 hrs	Time	20 25	09 50
Indication pain		Pharmacy	Dose	2.5mg	2.5mg
			Route	SC	S/C
		Contact	Sign		

Date 11/8	Medication (Print Generic Name) Maxolon		Date	12/08
Route SC/IV/IM	Dose 10mg	Hourly frequency Q6H PRN	Max dose/24 hrs	Time	09 25
Indication N+V		Pharmacy	Dose	10mg
			Route	S/C
		Contact	Sign	

Date 12/8	Medication (Print Generic Name) Morphine		Date	12/08/09
Route SC	Dose 2.5-5mg	Hourly frequency Q1H PRN	Max dose/24 hrs 30mg	Time	09 05
Indication pain		Pharmacy	Dose	2.5mg
			Route	S/C
		Contact	Sign	

Date 12/8	Medication (Print Generic Name) Morphine		Date
Route SC	Dose 2.5mg	Hourly frequency Q1H PRN	Max dose/24 hrs 25mg	Time
Indication pain		Pharmacy	Dose
			Route
		Contact	Sign

BINDING MARGIN – DO NOT WRITE

REGULAR MEDICATIONS

YEAR 20 ______ DATE & MONTH		9/8	10/8	11/8	12/8			

VARIABLE DOSE MEDICATION

Date	Medication (Print Generic Name)	Time of Dose:	Drug level							
			Time level taken							
Route	Frequency Dr to enter dose time and individual dose		**Dose**							
Indication	Pharmacy		Prescriber							
Prescriber Signature / Print Your Name	Contact		Time given							
			Nurse							

Date	***WARFARIN*** **(Marevan/Coumadin)**	INR Result							
Route	Target INR range	**Dose**	mg	mg	mg	mg	mg	mg	mg
Indication	Pharmacy	Prescriber							
Prescriber Signature / Print Your Name	Contact	***1600*** Nurse 1							
		Nurse 2							

DOCTORS MUST ENTER administration times

Medication details	Time	9/8	10/8	11/8	12/8
Date: 09/08. Medication (Print Generic Name): Ceftriaxone. Tick if Slow Release. Route: IV. Dose: 1gm. Frequency & NOW enter times: daily. 10/8. Indication: ID approval req. Pharmacy: 3W. Contact	1700	1630. em			
Date: 09/08. Medication (Print Generic Name): metronidazole. Tick if Slow Release. Route: IV. Dose: 500mg. Frequency & NOW enter times: tds. Indication. Pharmacy. Contact	0600	→			
	1400	1610. em			
	2200	→			
		2400			
Date: 9/8. Medication (Print Generic Name): Flucloxacillin. Tick if Slow Release. Route: IV. Dose: 2g. Frequency & NOW enter times: q6h. Indication. Pharmacy. Contact	0600	→			
	1200	→			
	1800				
	2400				
Date: 11/8. Medication (Print Generic Name): Coloxyl w/ senna. Tick if Slow Release. Route: PO. Dose: II. Frequency & NOW enter times: bd. Indication: constipation. Pharmacy: stock. Contact	8	→	→		
	20	→			

Pharmaceutical Review:

AS REQUIRED "PRN" MEDICATIONS

Attach ADR Sticker

See front page for details

Year 20_____

WRITE PATIENT DETAILS OR AFFIX PATIENT ID LABEL

UR No: NOT A VALID

Family Name: PRESCRIPTION UNLESS

Given Names: IDENTIFIERS PRESENT

DOB __________ Sex ☐M ☐F

1st Prescriber to Print Patient Name and Check Label Correct: ....

REGULAR MEDICATIONS

YEAR 20 _____ DATE & MONTH → 11/8 12/8

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW enter times	Indication	Pharmacy	Times	11/8
11/8	Keflex 500mg	po	500mg	qid		cephalexin stock	0600, 1200, 1800, 2200	→, ⇒, MW, S
11/8	Prednisone	po	20mg	daily	chronic steroid use (COPD)		8	→(W)
11/8	Morphine	SC	2.5mg	Q4H	pain		2, 6, 10, 14, 18, 22	→, →, →, →
11/8	Frusemide	po	10mg	bd			0800, 1200	→, →
12/8	Haloperidol	SC	1.5mg	nocte	Nausea		20	→
12/8	Morphine	SC	2.5mg	Q3H	pain		2, 6, 10, 14, 18, 22	→

Pharmaceutical Review:

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature	Print Name	Given by	Time Given	Pharmacy
~~10/8~~	~~morphine~~	~~s/c~~	~~5mg~~	~~1430~~					
10/8	morphine	S/C	2.5mg	3.07				1505	
10/8	morphine	s/c	2.5mg				T	1520	

TELEPHONE ORDERS (To be signed within 24 hrs of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1/Nr 2		Dr Name	Dr Sign	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines Taken Prior to Presentation to Hospital
(Prescribed, over the counter, complementary) Own medications brought in? ☐ Y ☐ N Administration Aid (specify) ....

Medication	Dose & frequency	Duration	Medication	Dose & frequency	Duration

GP: **Community Pharmacy:**

Documented by: (Sign) (Date) Medicines usually administered by:

SALMAT Re-order code: NH606206 Check if patient has another Medication Chart

MEDICATION CHART MR70

NOT FOR ADMINISTRATION

CLINICAL RECORD 3

Principal diagnosis: ____

____

Additional diagnosis: ____

____

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____

Procedures: ____

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INPATIENT ADMISSION SUMMARY

MRN:

Title:	Surname:	Other Names:	Sex:	DOB:	Age:
Mrs			F	28/04/	36Y

Address:

HOME PHONE:	MOBILE:	BUSINESS PHONE:

NEXT OF KIN DETAILS

SURNAME:	FIRST NAME:	HOME:	MOBILE:	BUSINESS:	RELATIONSHIP TO PERSON:
					Husband

CALL INSTRUCTION:

EMERGENCY CONTACT DETAILS

SURNAME:	FIRST NAME:	HOME:	MOBILE:	BUSINESS:	RELATIONSHIP TO PERSON:
					Mother

FINANCIAL DETAILS

INSURANCE STATUS:	FUND NAME:	FUND NUMBER:	FINANCIAL CLASSIFICATION ON 10/08/
	Medical Benefit		**DC–Deferred Classificatio**

MEDICARE NUMBER:	EXP:	DVA NUMBER:	DVA COLOUR:	SERVICE CATEGORY ON 10/08/09
				Full Routine Medical/Surgical

MEDICAL OFFICER CONTACT DETAILS

ADMITTING DR:	SPECIALITY:	ATTENDING DR:	ATTENDING DR:
	Obstetrics		

GP:		PHONE:
		FAX:

REASON FOR ADMISSION

PROM

ADMISSION DATE:	ADM TIME:	ADMISSION WARD:	DISCHARGE DATE:	D/C TIME:	DISCHARGE WARD:
10/08/	21:10	Birthing Suite	10-9	1630	MAT

REFERRAL DETAILS:	REFERRING FACILITY:
Hospital in same Health Service	

CODING REQUIREMENTS

PRINCIPAL DIAGNOSIS:

DIAGNOSIS OR CONDITION WHICH BEST ACCOUNTS FOR LENGTH OF STAY(IF SAME AS ABOVE, WRITE "AS ABOVE")

SECONDARY DIAGNOSES AFFECTING TREATMENT OR LENGTH OF STAY(COMPLICATIONS AND/OR COMORBIDITIES)

PRINCIPAL PROCEDURE (THE MOST SIGNIFICANT PROCEDURE PERFORMED FOR TREATMENT OF THE PRINCIPAL DIAGNOSIS)

OTHER OPERATIONS OR PROCEDURES

DRG:	CODER:

MEDICAL OFFICER	**RECORD AUDITED**
PRINTED NAME	**NAME**
SIGNATURE DATE	SIGNATURE DATE

INPATIENT ADMISSION SUMMARY

PATIENT DISCHARGE REPORT

USE BALL POINT PEN - PRESS HARD - PRINT NEATLY

L.M.O — Age: 36Y Sex:F

L.M.O Address

Dear Doctor,

This patient was admitted on 1/8 and discharged on 8/9

to this address

to the care of Dr.

He/She was under the care of (Specialist) (Registrar)

and (Resident/Intern)

PRINCIPLE DIAGNOSIS: Premature preterm rupture of membranes

OTHER DIAGNOSIS: Cord prolapse requiring emergency LSCS @ 28/40

PRINCIPLE OPERATIONS & DATES: Emergency LSCS for cord prolapse and transverse lie on 4/9

OTHER OPERATIONS & DATES:

IMPORTANT INVESTIGATION RESULTS:

PROBLEMS FOR FOLLOW UP: pt will remain as boarder @ Maternity ward due to difficult social situation

The Patient has been discharged to: ☐ Home ☒ Other Health Care Facility - Specify: as a boarder

and will be followed up in: O.P.D,/by the Specialist/by the L.M.O. on:

This report checked prior to dispatch by Dr (Specialist/Registrar)

This is a final summary report on this admission ☒ A typed Discharge Summary will follow ☐ Specialist's letter will follow ☐

(Signed) M.O. for General Medical Supt. — 8/9 (Date)

DISCHARGE MEDICATIONS -

Use Addressograph label or print details.

PATIENT'S NAME:

UNIT NO.:

WARD:

SPECIALIST:

ONE WEEK'S SUPPLY IS STANDARD.
APPROVAL MUST BE OBTAINED FOR EXCEPTIONS.
FULL DETAILS MUST BE PROVIDED BEFORE DISPENSING.

	DRUG NAME & FORM (BLOCK LETTERS)	STRENGTH	DOSE	ROUTE & FREQUENCY	DURATION OF SUPPLY X = DO NOT DISPENSE PATIENT HAS OWN SUPPLY
1.	Panadeine forte		II	PO QID PRN	5 day supply please
2.	Vitamin C		I	PO daily	5 days
3.	Diclofenac		50g	PO TDS	5 days
4.	Fish oil		I	PO Daily	
5.	Natal vit		I	PO Daily	
6.	Ca^{2+}/Mg^{2+}		I	PO nocte	
7.					
8.					
9.					
10.					
11.					

CHECKED BY WARD PHARMACIST

WARFARIN CHART YES/NO

BINDING MARGIN DO NOT WRITE

YELLOW: MEDICAL RECORD COPY. WHITE: LOCAL DOCTOR COPY. WHITE: SPECIALIST'S COPY

Name of Medication Officer (Block Letters) — Date 8/9 — Medication Officer's Signature

Age: 36Y Sex:F

OTIS RECORD OF OPERATION DOWN TIME FORM

Date: 4 9
Consultant:

Description (operation performed)
LOWER SEGMENT CAESAREAN SECTION
DELIVERY OF LIVE FEMALE INFANT @0731

CMBS code
☐ Planned return
☐ Unplanned return

Type of Anaesthetic: ☑ General ☐ Spinal ☐ Epidural ☐ Local ☐ Neurolept ☐ Topical ☐ Other

THEATRE TIME	A-BAY TIME	SETUP/CLEAN UP	ANAESTHETIC TIME	RECOVERY TIME	TO WARD
Arrive 0725	Arrive 0725	Start 0700	Start 0726	Start 0840	R/Ret to ward
Depart	Into OR 0725	End 0835	End 0830	End 0945	

DELAY CODE
☐ Equipment breakdown ☐ Nursing staff delay ☐ Ward delay
☐ List over-booked ☐ Emergency-preceding operation ☐ Documentation incomplete
☐ Surgeon late ☐ Complication-preceding operation ☐ Other (user defined)
☐ Anaesthetic late ☐ Patient reasssessed

DELAY TIMES
.... mins

☐ Elective
☑ Emergency

OR room: OR 8

Discharge status: ☑ Ward ☑ HDU ☐ ICU

Anaesthetist ☐ Supervised ☑ Unsupervised	Assistant ☐ Supervised ☐ Unsupervised	Assistant ☐ Supervised ☐ Unsupervised	Perfusionist
Anaesthetic nurse	Anaesthetic nurse Time	Anaesthetic nurse Time	Anaesthetic nurse Time ....
Recovery nurse	Relief recovery nurse	Relief recovery nurse	Relief recovery nurse

Consultant	WOUND INTEGRITY ☑ Clean ☐ Contaminated ☐ Clean-Contaminated ☐ Dirty	Procedure time Start 0730	Procedure time End 0810
Surgeon ☑ Supervised ☐ Unsupervised	Assistant ☐ Supervised ☐ Unsupervised	Assistant ☐ Supervised ☐ Unsupervised	Assistant ☐ Supervised ☐ Unsupervised
Instrument nurse 1	Instrument nurse 2 Time	Instrument nurse 3 Time	Instrument nurse 4 Time ....
Scout nurse	Relief scout nurse Time 0730	Relief scout nurse Time 0745	~~Relief scout nurse~~ Time ....

Entered in OTIS ☐ Yes ☐ No
Date:........ By WHOM ....
An electronic medical record has been created for this procedure on the OTIS

MAY07 CATALOGUE NO. 08400

BINDING MARGIN DO NOT WRITE

OTIS RECORD OF OPERATION DOWN TIME FORM

INTRAOPERATIVE NURSES REPORT

Date 4/9

Operation Performed LOWER SEGMENT CAESAREAN SECTION

DELIVERY OF LIVE FEMALE INFANT @ 0731

Count Items	1st Count	Added during operation	Total	2nd count	Added	Total	Final Count
Raytec	10		10	10		10	10
Sponges	10.		10	10	5	15	15
Peanuts							
Neuro patties							
Vascular clamps							
Haemostats	10		10	10		10	10
Blades	2		2	2		2	2
Needles	5		5	5	1	6	6
Diathermy tip							
Liga reels							
TOWEL CLIPS	5		5	5		5	5

Initial/Sign to indicate first instrument check:

Initial/Sign indicate final instrument check:

Time out conducted: ☐ Yes ☑ No due to emergency situation.

Present: ☐ Anaesthetist ☐ Surgeon ☐ Anaesthetic nurse

☐ Instrument nurse ☐ Scout nurse

Discrepancy in count ☐ Yes ☑ No If yes, IMMS completed? ☐ YES ☐ NO

Xray taken ☐ YES ☐ NO Result:

An electronic medical record has been created for this procedure on the OTIS

INTRAOPERATIVE NURSES REPORT

BINDING MARGIN DO NOT WRITE

ANAESTHETIC REPORT

IVC .... Fg
Site ....NIL....
☐ Right ☐ Left
Prep used ....

ARTERIAL LINE ☑ Nil
Site ....
☐ Right ☐ Left
Prep used ....

CVAD ☑ Nil
Type .... No.Ports ....
Site .... ☐ Right ☐ Left
Prep used ....

IN ANAESTHETIC BAY: Monitoring (Please tick)
☑ None ☐ ECG ☐ Pulse Oximetry ☐ BP O_2 Delivery .... At .... L/min
Site where each batch used .... Other (please specify) ....

WARMING DEVICES (please tick) Room temperature ..20.. °C Patient temperature .... °C Temp probe used ☐ Y ☐ N
Active warming devices: types .... Setting ....
☑ Warm blanket ☐ Fluid warmer ☐ Nil ☐ Not available ☐ Other (please specify) ....

INTRAOPERATIVE MONITORING Bite block used ☐ Y ☑ N TOE probe used ☐ Y ☑ N

ANTI-EMBOLITIC MONITORING DEVICES: (please tick) ☑ Nil ☐ Not available
Sequential compression device ☐ Right ☐ Left TED stocking ☐ Right ☐ Left

NOTES ....
ETT # 7, eyes taped.
....

MEDICATIONS - administered by the nurse ....NIL.

INTRAOPERATIVE REPORT

PATIENT POSITIONING: ☑ Supine ☐ Prone ☐ Lithotomy ☐ Trendelenberg ☐ Lateral ☐ Right ☐ Left
☐ Other (please specify position and/or note if position is altered during surgery)
....
Patient positioned by (name) ....ANAESTHETIC / OBSTETRIC TEAM

POSITIONAL AIDS: ☑ Elbow pads ☐ Head ring ☐ Wedge
☑ Skids ☐ Carter Brane Arm Supports ☐ Jelly mattress ☐ Lateral Supports
☑ Heel Pads ☐ Lithotomy Poles ☐ 90 ☐ 45 ☐ Armboards ☐ Ulna nerve protectors
☐ Laminectomy Rest ☐ Frame protection ☐ Other ....

SKIN PREPARATION
☑ Providone/Iodine ☐ Alch Chlorhexadine ☑ Cetrimide FOR CATHETER ☐ Other ....

DIATHERMY: ☑ Monopolar ☐ Bipolar ☐ Site ....RIGHT THIGH
Applied by .... Removed by: ....R.L. 8vm
Comments: ....

TOURNIQUET/CLAMP: ☑ N/A
Site 1: .... Site 2: ....
Site 1 Pressure: .... Site 2 Pressure: ....
Time on: .... Time Off: .... Time on: .... Time Off: ....
Time on: .... Time Off: .... Time on: .... Time Off: ....
Time on: .... Time Off: .... Time on: .... Time Off: ....
Total .... (mins) Total .... (mins)

INTRAOPERATIVE MEDICATION/IRRIGATION USED ....
Suppositoris Voltaren 100mg and panadol 1g

DRESSING/PACKS INSITU ....
NIL

DRAINS/CATHETERS INSITU ....14 Fr urinary catheter x 1 on FREE DRAINAGE.

Secured: ☐ Yes ☐ No Suction: ☐ Yes ☐ No

SPECIMENS ☐ Frozen sections .... ☐ Histology (routine) .... ☐ Microbiology .... ☐ Other ....

WOUND INTERGRITY: ☑ Clean ☐ Clean-contaminated ☐ Contaminated ☐ Dirty

SKIN INTEGRITY POSTOPERATIVELY INTACT ☑ YES ☐ NO
Remarks ....

'FLASH' STERILISATION ☐ YES ☑ NO

BINDING MARGIN DO NOT WRITE

Maternity

Age: 36Y Sex:F

Date	4/9/
Anaesthetic	GA
Surgeon	
Assistants	
Anaesthetist	

Pre-Operative Diagnosis Cord prolapse ~28/40 transverse lie

Operative Diagnosis 1cm dilated.

OPERATION

LSCS

Incision

Pathology Found

Specimens to Pathology

Procedure GA

prep drape + IDC.
routine entry. / bladder reflected.
transverse low segment uterine incision.
delivered by breech extraction → LFI paed @ delivery.
placenta delivered by CCT.
2 layer uterine closure + haemostasis ✓
sheath closed fascia closed.
skin closed c̄ 3/0 monocryl.
fundus FTC post op.

(Please enter further details on back of sheet)

Wound Closure

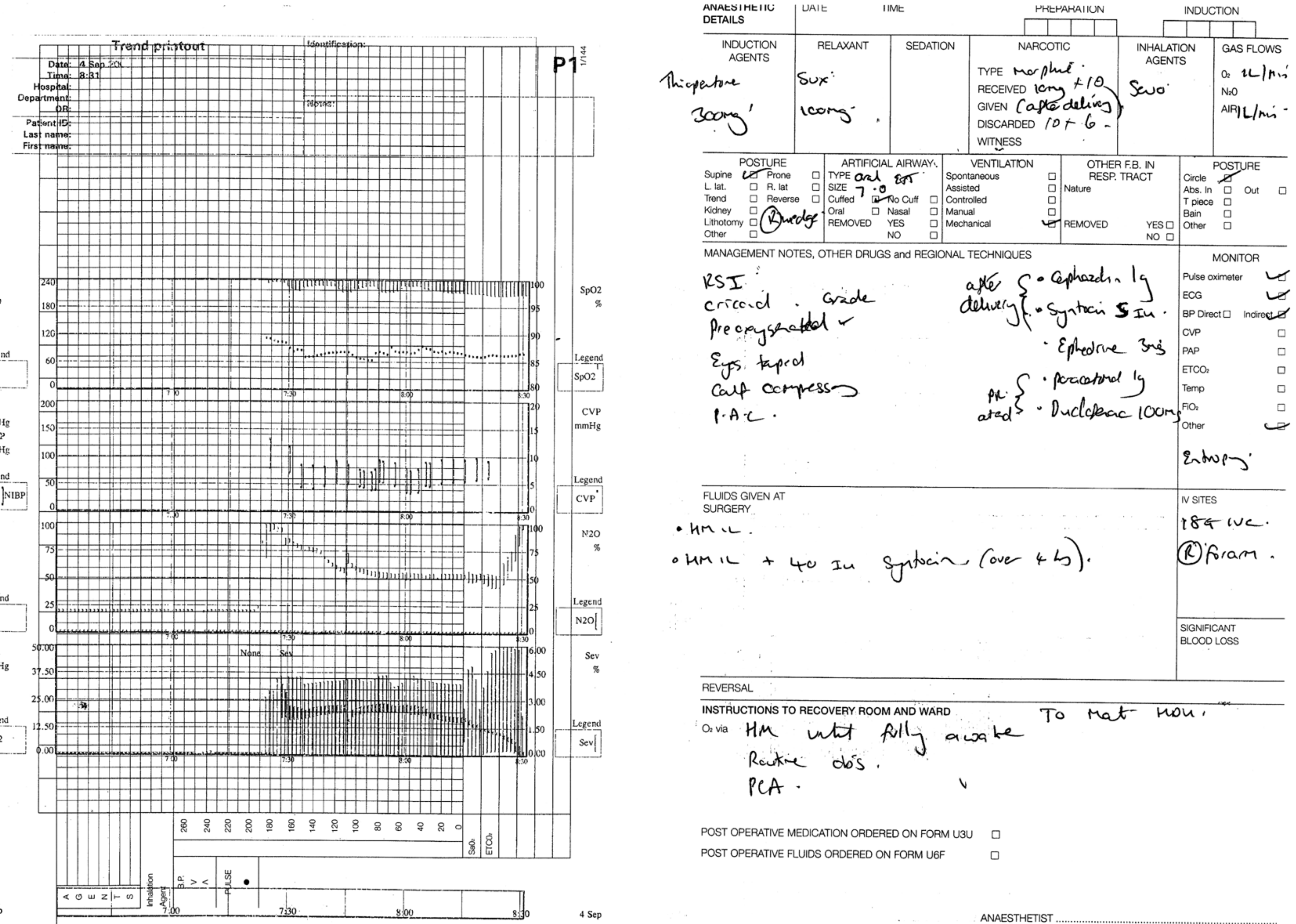
Drainage Tubes

Post Operative Instructions

routine post LSCS care

Medical Officer Signature

(Binding Margin)



Trend printout P1 1/144

Date: 4 Sep 20
Time: 8:31
Hospital:
Department:
OR:
Patient ID:
Last name:
First name:

Identification:

Chart	Left scale	Right scale
HR /min (Legend: HR) / SpO2 % (Legend: SpO2)	240, 180, 120, 60, 0	100, 95, 90, 85, 80
Art mmHg NIBP mmHg (Legend: Art NIBP) / CVP mmHg (Legend: CVP)	200, 150, 100, 50, 0	20, 15, 10, 5, 0
O2 % (Legend: O2) / N2O % (Legend: N2O)	100, 75, 50, 25, 0	100, 75, 50, 25, 0
CO2 mmHg (Legend: CO2) / Sev % (Legend: Sev)	50.00, 37.50, 25.00, 12.50, 0.00	6.00, 4.50, 3.00, 1.50, 0.00

Time axis: 7:00, 7:30, 8:00, 8:30

None Sev

260 240 220 200 180 160 140 120 100 80 60 40 20 0 SaO2 ETCO2

AGENTS Inhalation Agent B.P. V Λ PULSE •

Mark Event 4 Sep — 7:00 7:30 8:00 8:30 — 4 Sep

ANAESTHETIC DETAILS | DATE | TIME | PREPARATION | INDUCTION

INDUCTION AGENTS	RELAXANT	SEDATION	NARCOTIC	INHALATION AGENTS	GAS FLOWS
Thiopentone 300mg	Sux: 100mg		TYPE morphine RECEIVED 10mg ×10 GIVEN (after delivery) DISCARDED 10 + 6 WITNESS	Sevo	O2 1L/min N2O AIR 1L/min

POSTURE	ARTIFICIAL AIRWAY	VENTILATION	OTHER F.B. IN RESP. TRACT	POSTURE
Supine ☑ Prone ☐ L. lat. ☐ R. lat ☐ Trend ☐ Reverse ☐ Kidney ☐ Lithotomy ☐ (R) wedge Other ☐	TYPE oral ETT SIZE 7.0 Cuffed ☑ No Cuff ☐ Oral ☐ Nasal ☐ REMOVED YES ☐ NO ☐	Spontaneous ☐ Assisted ☐ Controlled ☐ Manual ☐ Mechanical ☑	Nature REMOVED YES ☐ NO ☐	Circle ☑ Abs. In ☐ Out ☐ T piece ☐ Bain ☐ Other ☐

MANAGEMENT NOTES, OTHER DRUGS and REGIONAL TECHNIQUES	MONITOR
RSI cricoid. Grade Preoxygenated ✓ Eyes taped Calf compress P.A.C. after delivery { • Cephazolin 1g • Syntocin 5 Iu. • Ephedrine 3mg PR: ated { • Paracetamol 1g • Diclofenac 100mg	Pulse oximeter ☑ ECG ☑ BP Direct ☐ Indirect ☑ CVP ☐ PAP ☐ ETCO2 ☐ Temp ☐ FiO2 ☐ Other ☑ Entropy

FLUIDS GIVEN AT SURGERY	IV SITES
• HM 1L. • HM 1L + 40 Iu Syntocin (over 4 hs).	18G IVC. (R) forearm.
	SIGNIFICANT BLOOD LOSS

REVERSAL

INSTRUCTIONS TO RECOVERY ROOM AND WARD

O2 via HM until fully awake
Routine obs.
PCA.
To Mat Hou.

POST OPERATIVE MEDICATION ORDERED ON FORM U3U ☐
POST OPERATIVE FLUIDS ORDERED ON FORM U6F ☐

ANAESTHETIST ....

1/150

ANAESTHETIC AND RECOVERY ROOM RECORD

Date 4/9/

Anaesthetist

Surgeon

Operation

Emergency LSCS (Cat 1)

36Y Sex:F

Waterlow Scale	10+ ☐	15+ ☐	20+ ☐	Existing Pressure Area ☐	Infection Risk	MRSA ☐	TB ☐	Blood Borne Pathogens ☐

PRE-OPERATIVE CHECK LIST

WEIGHT B/P P

FASTED FROM SOLIDS .... LIQUIDS ....

I/V MEDICATIONS DUE

TIME ....

VOMIT BOWL/URINAL SENT

CONSENT FORM		CONTACT LENS REMOVED		RINGS TAPED	
X-RAYS		MAKE-UP REMOVED		AREA SHAVED	
OLD NOTES		NAIL POLISH REMOVED		DENTURES SENT	
BLADDER EMPTIED		JEWELLERY REMOVED		CHARTS U6D, U6E, U3U, U3H	

PRE-ANAESTHETIC ASSESSMENT

Hb	Serum K	Creatinine	ASA STATUS
g/1	mmol/1	mmol/1	

Other investigations

PREVIOUS OPERATIONS AND ANAESTHETICS

AIRWAYS ASSESSMENT

ALLERGIES AND SENSITIVITIES

MEDICATIONS

RELEVANT CLINICAL DETAILS

(Brayda).
- Cat 1 LSCS - Cord Prolapse
35 ♀ G3 P2 - 28+3
Steroid Cover ✓ 40.

Bed / Medically well

PRE-OPERATIVE ORDERS

PRE-MEDICATION DRUG	DOSE	ROUTE	TIME	DRUG	GIVEN BY	TIME	DATE

OTHER INSTRUCTIONS

EFFECT OF PRE-MEDICATION

DOCTOR'S SIGNATURE...

RECOVERY ROOM CHART RECORD

Nursed by

Relieved by

Transferred by

36Y Sex:F

TIME	0840	0845	0900	0915	0930	0945	1000	1030	1100	1130	1200	1230
RESPS	20	20	16	16	16	16	16	16	16	14	14	
AIRWAY	C	C	C	C			C	C	C	C	C	
SaO2	98	98	98	99	98	99	98	99	99	99	99	
O2	M	M	RA	RA			RA	2L	2L	2L	2L	
L.O.C.	0	0	0	0			0	0	0	0	0	
TEMP												
SEN												
MOV												
PAIN			6	4								

(Graph scale 240 – 40; "S NICU" written on graph)

RECORD HEAVY LETTERING ONLY

AIRWAY: Clear; Assisted – jaw held; Bagged; Guedels; Naso Pharyngeal; Endo Tracheal; Laryngeal mask; Tracheostomy

OXYGEN MODE: Mask 6L; Nasal prongs 2L; Partial Re Breather 10L; Tracheostomy 4L; Percentage mask 24 28 35 40 50

LEVEL OF CONSCIOUSNESS: 0 Fully conscious; 1 Easily roused; 2 Heavily sedated but rousable; 3 Unconscious

SENSATION LEVEL: Waist; Hip; Thigh; Knee; Descended

MOVEMENT: ✔ Yes – No

Prescribed Drug and Doctor's Signature

Morphine 2mg 25 Min IV (x5)

Ondansetron 4mg IV

TIME	MEDICATION	ROUTE	SIGNATURE
0920	morphine 2mg	IVI	
0925	morphine 2mg	IVI	
0930	morphine 2mg	IVI	

Medications

IVI. Fluids

Hartmann's c synto.

TIME	FUNDUS CHECK	PV
0845	F+C ↓2	small
0900	F+C ↓2	small
0915	F+C ↓3	small
0945	F+C ↓3	mod.

Please circle

I.D.C. (YES) NO URINE

Voided YES NO

Drainage tubes

NIL

Recovery Notes:

0910 V. teary upon arrival in Recovery. Given reassurance as appropriate. Family members coming 0920 - husband now in attendance. Morphine PCA commenced; boluses providing adequate analgesia.

Fundal + pv obs within normal limits

[illegible].

DISCHARGE MET

YES NO

(See notes U3L)

SKIN INTEGRITY

Intact ☐

Other ☐

Received – Please tick	Rec	Wd
Adequate Handover		
X-Rays:		
Old notes:		
Dentures:		
Ward R.N. signature		

PROGRESS NOTES

DATE & TIME	
10/8/	G3 P2. 25+1/40. A POS. T/F from to
2150.	delivery suite @ 2110hrs. SROM today —
	@ 1600hrs ½ gush of pink fluid. Nil —
	tightening, nil pain. ?? cephalic. seen by O&G
	reg. IVC insitu in ® hand, CTG in
	progress. FHR 140bpm. scant pink/straw on
	panty liner. Celestone 1st dose given @
	@ 1920hrs and Ampicillin 2G
	1940hrs. Care handed over to night staff.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

DATE & TIME	
10.8.	(O+G REG)
2150	
	25+1/40 T/F from
	c PPROM not contracting
	G3P2
	x2 NVD at term.
	HPI: ? small gush of fluid
	this am. then 4pm
	today → large gush pink fluid
	not tightening
	no bleeding
	FMF ✓
	GBS (+) IV amp given x1
	Steroid x1.
	Antenatal Hx:
	A (+)
	Rubella immune
	Serology (−)
	GBS (+)
	NT low risk
	morph - (N) morph
	- concealed extramembranous
	haemorrhage
	- placenta post, not lowlying

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
	seen MFMU
	21/40 – API 6
	post placent clear as
	extramemb haem
	3.2 x 2.3 x 2.3
	23½ – API 4cm
	extramemb. haemorrhage
	– 3.4 x 1.4 x 4.3 cm
	SID 2.9
	PMHx:
	Medically well
	Now Hx of anxiety on
	20 log i early preg.
	OE:/ look well.
	[diagram] On scan. transverse back down
	Spec at Hornsby
	long tailed
	Plan: – Admit ↓AC
	– IVAB
	– 2nd obs seniors tomorrow

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

BINDING MARGIN
DO NOT WRITE

DATE & TIME	
	- LVS
	- MSU
	- Bloods
	- CTG
	- US in am.
	- NICU R/V in am.
	- S/W +/- ΨR/V.
10.8.	MIDWIFERY:
22[30]	Care taken over
	Observations stable, afebrile.
	Not contracting, draining
	yellow liquor.
	FHR 146 (R)
	LVS + MSU collected + sent to
	pathology.
	Bloods collected by Dr
	CTG trace attended.
	Settled to sleep - sedation declined.

Date: 10/8/ Time: 22[20] Hrs Maternal Pulse 80 Indication for Monitoring PROM

Risk Factors High Uterine Activity Nil.

Baseline FHR 130-140 Variability 75 Accelerations Present

Decelerations Nil

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Discontinue.

Findings/plan discussed with the woman ☑ Yes ☐ No RM 2nd Signature

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
11.8.	MIDWIFERY:
6^{40}	Slept intermittently overnight.
	No complaints
	IV antibiotics given as charted.
	2nd dose steroids due 19^{20}
	For ultrasound today.
11.8.	
800.	
	25^{+2}
	PPROM yesterday
	H/o of extra-membranous
	haemorrhage at 19/40
	→ serial USS showed
	↓AFI at 4 + 5.
	Still draining pink liquor
	Known GBS(+)
	not contracting
	SNT. Obs stable
	Plan: TEDS
	US
	IVAB
	Steroids
	Nicu RW
	CTG

BINDING MARGIN
DO NOT WRITE

PROGRESS NOTES

DATE & TIME	
11/08/ 0910	Midwifery: Care taken over at 0730 hrs, no contraction pink liquor, afebrile temp 36.7°c, IV Ampicillin 1G given at 08??hrs. Breakfast given. CTG commenced.
	Date: 11/08 Time: 0845 Hrs Maternal Pulse 72/min Indication for Monitoring PPROM
	Risk Factors High Uterine Activity Nil
	Baseline FHR 130-140 Variability >5bpm Accelerations Present
	Decelerations Nil
	Overall Assessment ☑NORMAL ☐SUSPICIOUS ☐PATHOLOGICAL 25+2/40
	Plan for ongoing care/Action To cease CTG
	Findings/plan discussed with the woman ☑Yes ☐No RM 2nd Signature
	Seen by Dr and . NICU Dr notified by Dr to see . For USG today.
0930	Midwifery: TEDS applied after shower. MCU registrar notified to review.
1040	Midwifery: has a tour in NICU. Still awaiting for USG and MCU registrar to review.
11/8/ 1200	MFMU U/S – Interim Report
	Single live fetus in breech presentation.
	Appropriate growth for 25/40 (EFW = 750g)
	Amniotic fluid volume is decrease, consistent with PPROM (AFI = 3cm)
	Normal umbilical artery flow (S/D = 2.3)
	Placenta is posterior + closed.
	The cervix is 3.3cm long + closed.
	AMS.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
11/08/	Midwifery: Returned from MFMU T/F to ward at 1230 hours.
	SITUATION: G3P2, 35+2/40, PPROM on 10/8/ GBS positive. IV Ampicillin and Steroid x ① given. Next steroid due at 1920 hrs tonight
	ASSESSMENT: Pink liquor and not contracting. Had CTG and USG done this morning. Cervix long and closed by ultrasound.
	VARIANCE: Nil
	EXPECTED OUTCOME:
	- 2nd Steroid injection tonight
	- Social worker review
	- NICU registrar to review
	SIGNATURE:
	Addit - Social worker paged.
11/8/ 13.00	Midwifery - c/o taken over. Haemodynamically stable. Apyrexial. Small yellow mucous on pad. On bed rest. IV AB covered. For 2nd Steroid dose 19.20. Nil tightenings
1920	ADDN - S/W Parking coupon given

PROGRESS NOTES

DATE & TIME	
11/8/ 2025	Midwifery: well, fetal movements felt. Remains afebrile. Pad check - yellow mucous only present. Second dose of celestone given IMI. Nil pains or tightenings felt - reported by . IV canula insitu fresh blood present around skin only small amount, area cleaned and restrapped and remains patent. IV antibiotics given. (SM/RN) —
12/08/ 0500	MIDWIFERY. sleeping for long periods. IV Antibiotic given, very hospitional. Afebrile, observations stable. Small amount pinkish / clear liquor. Fetal movements felt. Nil discomfort CM
12/8/ 850	MR PPROM / BR. – well / obs – FMF (US) ✓ – CTG in progress ✓ – systemically well – nil sig. uterine activity – scant clear/pink PV loss (P) – IVABx – NICU RV. – cont. Mx
12/8/	**SOCIAL WORK** Situation: 36 y.o. woman admitted at 25+1/40 after rupture of

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME

membranes.

BACKGROUND: Pt. has 2 sons aged 5 & 7 and has lived with her husband in their own home in ______. Pt. & husband have decided to separate and this understandably has caused ______ considerable distress compounding her anxiety about her pregnancy.

· Husband remains v. involved c̄ care of children & will pay child support.

Assessment: Pt. tearful & upset when talking about situation but at least feels husband will remain involved c̄ existing children & new baby. Her parents are now staying with the children & will not return to ______ until the baby is born. Pt. says the separation does not involve any financial changes for her as her husband will continue to pay mortgage.

Recommendation: Pt. keen to talk & appreciative of support → emotional support + practical help as required.

BINDING MARGIN
DO NOT WRITE

PROGRESS NOTES

DATE & TIME

DATE & TIME	
12/8/ 1040.	Date: 12/8/......, Time: 0843 Hrs Maternal Pulse 80 Indication for Monitoring PPROM Risk Factors ~~TPL PPROM~~ High Uterine Activity Baseline FHR 130-140 Variability ≥5 Accelerations ≥15 present Decelerations Nil Overall Assessment ☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL Plan for ongoing care/Action Daily CTG. Findings/plan discussed with the woman ☑ Yes ☐ No RM 2nd Signature
12/8/ 1150	Midwifery: Antenatal check attended as per U3LB2. Fetal movements felt, CTG as above. Nil tightenings draining scant pink PV discharge. TED's insitu. Remains afebrile @ 36⁴. Remains on bed rest. (SM/RN)
12/8/ 1320	Midwifery: just buzzed she had a gush of pink PV discharge which filled a pad... Fetal movements felt, nil pains or tightenings. Discussed with O+G resident will follow up with O+G reg by resident (SM/RN).
12/8/	(O+G SRMO) 36⁴ 25⁺¹ with PPROM. Midwifery staff reported gush of fluid @ 13:15. Pt stated filled pad + onto the bed different in amount to previous loss No pain/tightenings FMF ✓ O/E stable last measurement

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
12/8	cont →
	o/w [illegible] re: mx ?speculum
	-u/s cx 3.3cm LTC
	P/ Foetal HR doppler → if concerned please
	contact
12/8 16.10	Midwifery
	c/o taken over. Observation
	stable. Apyrexic. IVAB given
	Remains on bedrest. Denies
	any tightening s. Requested
	sleeping tablet for tonight.
	(SM)
12/08	Neonatologist
	Information (verbal + written) provided to
	regarding course and possible
	outcomes for [illegible] born at 25-28 weeks
	gestation.
12/8 20.35	Midwifery quite tearful
	this afternoon after speaking
	c̄ neonatologist. Remains
	apyrexic. Denies any more
	PV loss, FMF this pm. IVAB
	continue.
	(SM)

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

BINDING MARGIN
DO NOT WRITE

DATE & TIME	
13/8	midwifery 0445. Settled night. Not upset overnight. No pains. IV ABs continue.
13/8	
	Stable o/n (obs ✓ afeb.).
	ongoing clear PV loss
	O/w well
	(fever° / n/v / headache etc°)
	nil contractions°
	FMF ✓.
	S/B NICU ✓.
	Abdo soft
	nil tenderness / tone.
	(P) - FHS / CTG.
	- obs.
	- bedrest.
13.8.	S/B Dr.
	$G_3 P_2$ 25+4/40
	(a) PPROM at 25/40 transferred
	from HKH.
	MSU = NORMAL AFI = 3cm
	HVS = pending known GBS ⊕ tive

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME

ASTP re decelerations on trace.
CTG: Baseline 135-140
Variability > 5
Accelerations ✓
2x atypical variable
deceleration
(unprovoked)

complaining of lower back
pain
nil lower abdominal pain.

O/E
~~Obs stable afebrile~~
nil change in loss

fundus = dote
soft non tender.

PV
blood loss ↓
Speculum: long + closed
⊘ blood.

D/W Dr.
(P) - cont. to monitor.
- to inform if any further
concerns
- Analgesia
- Heat pack

PROGRESS NOTES

DATE & TIME	
13/8/ 1510	MIDWIFERY: Microbiology called - GBS positive on swab. Check done - Abdo soft however having some back ache towards lunch especially during CTG. Pink liquor continues to drain. CTG as below.
	Date: 13/8/ Time: 1200 Hrs Maternal Pulse 70 Indication for Monitoring PPROM
	Risk Factors High Uterine Activity Nil
	Baseline FHR 135-145bpm Variability 25bpm Accelerations present x3
	Decelerations 2x decel below 90 bpm
	Overall Assessment ☐ NORMAL ☑ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action
	Findings/plan discussed with the woman ☑ Yes ☐ No RM 2nd Signature
	O&G Reviewed as per last page, Nil further CTG requested & close monitoring. Obs stable. Afebrile. IV AB's given @ 0900 and 1500 today - RM
13/8/ 2130	Midwifery: antenatally well this shift. Nil pv loss reported, nil backache or tightenings. IVABX as charted ? Discontinue as > 48hrs given. Afebrile. Temazepam 10mg at 2130 as requested. No concerns. RM
Addit.	FMF ✓ FH ✓ No complaints.
14/8/	MIDWIFERY 0235. IV has now tissued - have contacted PALMS, re HVS result - being faxed through as no AUSLAB computer - HVS interim report only. (cont)

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

DATE & TIME	
14/8/	MIDWIFERY 0530, LVS – GBS identified
	but still interim report.
	For IV resite, Obs ✓
14/8	
9:30	→ Well 25+ PPROM
	→ No tightenings
	loss [illegible] clear
	→ No abdo tenderness
	→ Abdo soft
	→
	→ P Continue observat
	→ 1 dose Ampicillin then
	Δ to Erythromycin.
	→
	Care
	St John
	Wat.
14/8/	RB (O+G).
1230,	G^3P^2 / 25^{+5}/40 / PPROM 10/8/ / breech.
	currently on erythromycin / steroid covered.
	small PV loss today
	Ø abdo pain; feeling well; tired
	FMF ++
	obs: afebrile / obs stable
	discussed symptoms of chorio-amnionitis ū
	discussed that if labour begins: mode of delivery
	will depend on presentation of foetus ⇒ LSCS vs. NVD.

PROGRESS NOTES

DATE & TIME	
14/8/ cont'd	(P) · to remain inpatient for forseeable future
	· NICU r/w attended ☑
	· po erythromycin.
14/8/ 14:30	Midwifery:- c/o taken over. Apyrexic throughout shift. IVC resited and IVAB given. IVAB changed to POAB. Remains on bedrest. Antenatal checks tended to. Abdomen soft, denies tightenings. PV loss minimal spotting. Became quite tearful again today. CTG commenced. To continue + observe for signs of infection ——— (SM)
14/8/ 2145	Date: 14.8 Time: 1902 Hrs Maternal Pulse 89 Indication for Monitoring PPROM
	Risk Factors High Uterine Activity Nil.
	Baseline FHR 135-145 Variability >5 Accelerations present
	Decelerations Nil
	Overall Assessment ☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action Daily CTG. For O+G r/v
	Findings/plan discussed with the woman ☑ Yes ☐ No (SM) RM 2nd Signature

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
14/8/ 2145	Midwifery: remains in bed resting. CTG attended very active ~~baby~~ baby. Obs stable remains afebrile. Small PV loss, ~~[illegible]~~ nil pains or tightenings. Night sedation given as requested. (SM)
addit	: requested O+G to r/v CTG trace have not done so @ time of report. (SM)
0045 15/8/	Midwifery. afebrile [illegible] nil pads since 1930. CTG to be signed
0615 15/8/	Midwifery buzzed during night bed pad moderate pink liquor measured.
15.08. 08 20	(O+G)
	25+/40 G3P2
	mild PV loss: clear.
	feels well.
	obs not done today: afebrile previous
	soft
	FMF

PROGRESS NOTES

DATE & TIME	
	nil tightenings
	steroid covered
	pt teary and upset; easily reassured
	Plan ① con't mx
	IVC out.
	② short walks/mobilising
15/8 13⁰⁰	MIDWIFERY: Afebrile small pink liquor abdomen soft non tender, CTG attended and signed by Dr nil uterine activity

Date 15 / ...... / ...... Time: 940 Hrs Maternal Pulse .... Indication for Monitoring SROM

Risk Factors High Uterine Activity Nil

Baseline FHR 135-145 Variability >5 Accelerations Yes.

Decelerations Nil

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action discontinue CTG

Findings/plan discussed with the woman ☐ Yes ☐ No RM S/B Dr 2nd Signature

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
15/08/ 1640	Midwifery: haemodynamically stable. Afebrile. FMF. FHR noted. Small amount (10c) on previous pad. Nil uterine activity noted. ——— RM.
16/8/ 0700	MIDWIFERY: - Appears to have slept well. Nil pads left for sighting. Oral erythromycin given as charted. Denies contractions RM ———
16/8/ 10.00	3/B | ——— (O+G)
	25/40 with PPROM. steroid covered
	Well
	FMF ✓ Nil tightenings
	still has pinky PV loss, no change in colour
	some nausea ? due to antibiotic, took without food
	Feeling more settled this AM,
	nil chills/shakes. ↑T° felt
	O/E
	Afebrile + obs stable yesterday.
	Ⓟ 1, cont antibiotics
	2, CTG ☒ Reassuring
	3, Anti emetic if needed

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

DATE & TIME

16/8
1300

Midwifery: feeling well today. Antenatal check attended as charted. Small pink-clear pv loss. Afebrile. Nil uterine activity reported. Visited by family today. RM

CTG as below

Date 16/8/ Time: 1030 Hrs Maternal Pulse 74 Indication for Monitoring PPROM

Risk Factors HIGH Uterine Activity Nil, soft

Baseline FHR 135-145 Variability >5 Accelerations Present

Decelerations Nil, although loss of contact. Did not meet criteria.

Overall Assessment

☐ NORMAL ☒ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Daily CTG. O+G review - Discontinue.

Findings/plan discussed with the woman ☒ Yes ☐ No RM 2nd Signature

2030 MIDWIFERY: Remains afebrile. Scant clear-tinge pink x1 pad only. FMF ✓ Abdo soft. Oral abs as charted nil issues voiced.

17/8
0700

MIDWIFERY: - Slept well intermittently. Denies [illegible] contractions. Has not shown pads overnight ? Nil loss. Antibiotic continued. RM

17/8
0900

S/B / (O+G)

G3P2

25+6/40

PPROM

steroid - covered

afebrile; obs stable

draining clear liquor

pain free, no tightenings

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
cont'd 17/8/	O/E — soft. Non tender. Ø irritability. FMF.
	last US: breech ; AFI :3. EFW 750g. SD 2:3
	discussed implications of breech presentation at time of labour, and likelihood of LSCS for delivery if fetus remains breech. happy with plan.
	(P) - Cont. erythromycin.
17/8/ 1410	Midwifery: Antenatal check done NAD. meds given as charted. FMF ✓ FHR 130-140bpm. Remains afebrile. Nil tightenings or pain. Had visitors this morning. Nil complaints @ present. (signature)
17/8/ 21·15	Midwifery.- C/O taken over. FHR auscultated 135-147. Afebrile. Remains on bedrest. continues on PON. Denies any tightenings. Small pink PV d/c.
	(signature)

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

DATE & TIME	
18/8/	MIDWIFERY:- Appears to have slept well
0700	Antibiotics as charted. Afebrile Nil
	complaints — RM —
18/8/	Obstetric + Gynaecology ward round
08.30am	S/B Prof
	26/40 today.
	BP 115/70
	P 65
	afebrile
	still draining pinkish fluid, some days
	clear (brown earlier on)
	FMF
	Ⓛ leg ache from hip - lateral thigh + ant.
	tibia, calf soft + non tender, TEDS in situ
	Abdo S non tender
	Plan - remain in hospital
	- continue on AB for 10/7
	- NICU consult
	- ? social work consult

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
18/8/ 1140.	Midwifery- well, Antenatal check attended NAD. Remains afebrile. Draining small amounts of ~~clear liquor~~. pink liquor. Baby active Not contracting. Complained of pain in outer aspect of left thigh/hip. Medical staff advised r/v by Prof. most likely positional related. reassured by this. perinatal mental health nurse called to r/v. Will r/v later today. Awaiting CTG (SM/RN)— RM.
18/8/ 1240	Date: 18/8/ Time: 1150 Hrs Maternal Pulse 80 Indication for Monitoring PPROM Risk Factors High Uterine Activity Nil. Baseline FHR 125-135 Variability >5 Accelerations Present Decelerations Nil Overall Assessment ☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL Plan for ongoing care/Action Daily CTG As required Findings/plan discussed with the woman ☑ Yes ☐ No (Sig) RM 2nd Signature
18.8	Perinatal Mental Health - OK with having ceased St Johns Wort. Discussed management of anxiety 10 min relaxation TDS, relaxation CD's Rescue remedy in H_2O bottle Recommended book Living with it & talked of GP Mental Health package & given leaflets would like to go outside for short trips encouraged to talk to Midwife & perhaps if escorted. I am happy to see again if can be of assistance

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

DATE & TIME	
18/8	Midwifery:- C/O taken over
20:30	Appears in good spirits this
	PM. Remains apyrexic. Draining
	Small amounts of pink liquor.
	FM ✓✓ / PO AB as prescribed.
	Nil new to note.
	(Sm
19/8/	MIDWIFERY: - Small amt clear liquor on
0700	pad x1. Continues on oral antibiotics
	Denies contractions - RM
19.8.	S/B Dr. Med. Student.
09:30	26^{+1}
	G_3P_2 × 2 NVD at terms.
	SROM at 25^{+1} transferred from
last US	Hospital
11.8.	GBS ⊕ swab on Erythromycin.
× AFI = 3cm	↓ sleep overnight.
× no compromise	pv loss changed to ↑ redness
× satisfactory growth	informed again about ↑ risk of chorioamnionitis,
	? risk of growth restriction, bleeding (risk of
	abruption)
	FM ✓
	O/E
	Obs stable afebrile
	pv loss → mildly red
	soft non tender.
	unable to determine
	lie.

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
	Ⓟ - cont. pad chart. + temp.
	- pls inform if any concerns.
	- cont. Erythromycin
	- PRN Temazepam.
	- Socialwork R/V.
	- daily CTG pls.
	- can mobilise
	Addit: (gentle)
	pt teary as unable to stay
	asleep due to background
	noise and lights.
	suggested: ear plugs; eye mask;
	background music
19/8/	Date: 19/8/ Time: 0930 Hrs Maternal Pulse 74 Indication for Monitoring PPROM
1230	Risk Factors High Uterine Activity Nil
	Baseline FHR 125-135 Variability >5 Accelerations present
	Decelerations Nil
	Overall Assessment
	☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action Daily CTG as required.
	Findings/plan discussed with the woman ☑ Yes ☐ No ~~RM~~ 2nd Signature
19/8/	Midwifery: well this morning. A bit teary
1230	about stress of being away from other 2 children
	and relationship breakdown with husband. ANC
	attended. 1x pad with red ^fringed^ liquor ~~[illegible]~~.
	Next pad had small pink liquor. Remains afebrile
	and haemodynamically stable. CTG attended FHR
	125-135bpm FMF ++. oral erythromycin given as
	per med chart. Being visited by friend at present.
	(SM / RN)

PROGRESS NOTES

DATE & TIME	
19/8/	Midwifery: loss settling Nil further pad changes
1515	Obs stable. Oral erythromycin given as charted.
	FMF+ (SM/RN) ——
addit	S/W paged. not caring for . Paged
	on not answered. Pls follow up AS
	would like to talk to S/W feeling teary and
	sad as ELOS. (SM/RN)-
19/8/	MIDWIFERY
1945.	Erythromycin given as charted
	observations satisfactory
	afebrile. FMF. S/A drank dosage
	had. 1x spot of blood on toilet
	after washing ——
	[illegible]
20/8/	Midwifery 0515. Settled night. NIL
	complaints voiced. No pads sighted
	overnight
0700	bright pv loss this morning - small
	amount - x1 cramp like pain
	this morning but resolved by 5 mins
	- soft abdo now. FMF✓
	[illegible]
20.8.	S/B Dr. / O+G team.
10:10	26+2
	G3 P2
	PPROM 25+1 → transfer from HKH
	still pv loss
	nil contractions.
	otherwise feeling well.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
20.8.	
	O/E
	Obs stable afebrile
	soft non tender
	calfs soft non tender.
	(P) - cont. oral ABs
	- repeat US early next week.
	- cont. Erythromycin.
28/8/ 1135	Midwifery
	well today feeling
	less emotional ANC attended
	as per care plan [illegible]
	abdo soft non-tender, [illegible]
	nil PV loss obs [illegible]. meds
	as charted CTG attended.
	for S/W review pm. happy
	with obs nil concerns @ time of
	report RN
28/8/ 14.10.	**SOCIAL WORK** Referred by midwife for P/U.
	Situation: Pt. now 26+2/40, feeling more

PROGRESS NOTES

DATE & TIME	
20/8/ 14:00	(cont) positively about the pregnancy. Her home situation remains the same – i.e. her husband still intends to live separately but nearby. Able to identify some positives in the situation but feels sad for her boys aged 5 & 7. Says it helps to talk about it and she understandably has times when she feels down about everything. Plan: happy to see S.W. on a regular basis for support + any practical assistance required.
	Date 20/8/ Time: 15:20 Hrs Maternal Pulse 72 Indication for Monitoring [illegible] PPROM Risk Factors [illegible] Uterine Activity nil Baseline FHR 125-130 Variability >5bpm Accelerations yes Decelerations nil Overall Assessment ☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL Plan for ongoing care/Action Findings/plan discussed with the woman ☐ Yes ☐ No RM 2nd Signature
20/08/ 17:00	Midwifery: haemodynamically stable, afebrile. PDAB's as charted. FMF. Nil complaints voiced. RM.
21:30	Midwifery: appears to be coping well. Nil episodes of teariness this P.M. States she is practising meditation and feeling more positive about her ability to cope. RM.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
21/8/.	Morning 0620. Settled night.
	Happy before going to sleep. Not loss O/N
21.8	S/B Mau.
9:30	26+3/40
	P2
	PPROM 25+1 from HKH
	pads unchanged
	feeling well
	O/E
	Obs stable afebrile
	soft non tender.
	D/W p^x re cervical length study →
	p^x will think about study.
	(P) - cont. regular Obs
	- daily CTG
	- cont. Erythromycin
21/8/	Midwifery:- C/O taken
13.10	over. Haemodynamically
	stable. PO/AB continue. Abdomen
	soft. Small pink liquor on pad.
	Antenatal checks tended to.
	Appears in good spirits. For

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

DATE & TIME	
Cont..	CTG trace this PM. Nil new to note
21.8. 1350	S/B Prof Giles.
	Progress noted.
	Discussed mode of delivery eg still breech
	→ ideally LSCS.
	Plan: daily CTG.
	continue current Mx

Date: 21/8/...... Time: 14:28 Hrs Maternal Pulse 78 Indication for Monitoring PPROM

Risk Factors High Uterine Activity Nil

Baseline FHR 135-140 Variability >5bpm

Decelerations NIL Accelerations >15bpm

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Continue / get CTG tob r/v

Findings/plan discussed with the woman ☑ Yes ☐ No .... RM

DATE & TIME	
21/08/ 1850	Midwifery: haemodynamically stable, afebrile. FMF. FHR auscultated via doppler. Denies P.V. loss today, some in early AM as charted. POAB as charted ——— R.M.
22/8/ 0615	MIDWIFERY: Settled night, nil complaints voiced afebrile, FMF/ nil P.V loss RM

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
22/8/	SRB
0900	26+4 / PPROM
	P2
	GBS Pos
	on erythromycin
	feeling well
	fetal movements ✓
	nil temperature
	unchanged pv loss
	mobilising ✓
	O/E
	afebrile
	soft non tender
	breech.
	(P) - cont. m^x
	- mobilise gently.
	- on Erythromycin.
	- can walk outside hospital.

PROGRESS NOTES

DATE & TIME

22/8/ 1420 — Midwifery Satisfactory. S/B O+G team. Can walk around outside. CTG attended.

Date 22/8/ Time: 10:57 Hrs Maternal Pulse 72 Indication for Monitoring PPROM

Risk Factors Premature Delivery Uterine Activity NIL

Baseline FHR 131 Variability present Accelerations >10 bpm / >15 bpm } 15 secs

Decelerations NIL

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Daily CTG

Findings/plan discussed with the woman ☑ Yes ☐ No RM ....2nd Signature

PV loss: moderate dark pink liquor. Afebrile. Check attended → NAD.

(RM)

22/8/ 20.20 — Midwifery – C/O taken over. Haemodynamically stable. Apyrexic. Continues on PO AB. Small pink liquor on pad. FMF – Nil new to note

(SM)

23/08/ 0000 — MIDWIFERY – Gave to settle, oral antibiotic as ordered. Nil complaints voiced. CM

0100 — MIDWIFERY. Slept well. Small to moderate pinkish liquor. Fetal movements felt

CM

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
23/8/ 9:00	O & G
	$26^{+5}/40$
	Pt well
	Further pink loss overnight,
	not foul smelling
	No tightenings
	Tolerating diet
	BO
	Feels as if she's getting a
	cold - blocked nose - nil other
	symptoms, no fevers, no cough.
	Afebrile, obs stable.
	O/E, Alert, well.
	Abdo soft, non tender,
	no irritability,
	Plan: - repeat US early this
	week (pt's last US was
	Tuesday 2 wks ago).
	- continue current
	management

PROGRESS NOTES

DATE & TIME	
23/8/	Midwifery: in good spirits today.
1130	Check attended NAD. Continues on oral
	antibiotics. Afebrile. FMF✓. Small
	pink liqour on pad this morning.
	Visited by ex husband & children, away to
	coffee shop with them for half hour. Aware
	to come back to ward for CTG & further
	antibiotics or if any concerns. ———
	———
	RM
1300	Returned to ward. Antibiotics given. CTG
	attended as below. RM
	Date 23.08 Time: 1450 Hrs Maternal Pulse 74 Indication for Monitoring PPROM
	Risk Factors Preterm Uterine Activity
	Baseline FHR 130-135 Variability ≥ 5bpm Accelerations > 15bpm
	Decelerations Nil
	Overall Assessment
	☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action CTG daily. For OTG review.
	Findings/plan discussed with the woman ☑ Yes ☐ No RM .... 2nd Signature
21⁰⁰	Midwifery:– Resting quietly this evening.
	Afebrile. Nil pv loss since this ~~morning~~ pm.
	FMF+. Oral antibiotics continued.
	In good spirits. ——— (RM).
24/8/	MIDWIFERY. sleeping for long periods,
0600	nil complaints voiced. ———

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

DATE & TIME	
24/8	S/B Dr / Dr + Med Student
09:00	
	26+6/40 ē PPROM
	pt well. Slept well O/N
	Good fetal movement
	~~Stoo~~ pt's old Sxs have resolved
	obs afebrile
	pulse 70
	BP 110/70
	pt happy to participate in research project
	plan - cont on Erythromycin for 10 days
	in total
	- U/S this week
	- cont current Mx.
24/8/ 1420	Midwifery: Check attended. S/B O&G team. See above notes. Afebrile. PV loss: scant pink liquor. Nil contractions. For U/S Tuesday. Form sent to MFMU. Feels better after having more sleep.

PROGRESS NOTES

DATE & TIME

24/8/ 1420

Date: 24/8 Time: ~~131~~ 1217 Hrs Maternal Pulse 72 Indication for Monitoring PPROM

Risk Factors Prem Labour Uterine Activity soft

Baseline FHR 131 Variability present Accelerations 7(10bpm) 15secs, 7(15bpm)

Decelerations NIL

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Daily CTG

Findings/plan discussed with the woman ☑ Yes ☐ No RM ....2nd Signature

(RM)

24/8/ 20:00 Midwifery:- c/o taken over. Appears in good spirits. Has soaked pad tonight c̄ pink liquor. FMF ✓✓ Apyrexial. Haemodynamically stable. Has been resting this pm for VSS mane.

(SM)

Addit Nil tightenings, Abdomen soft

25/08/ 0500 MIDWIFERY. sleeping well. Up to toilet PV loss small amount pinkish-dark liquor. FHR 144 Regular, baby moving. Last dose - Day 10, oral antibiotic given. CM

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
25/8/	.S/B Prof
910.	
	27/40
	P2. x2 NVD
	PPROM at 25/40 GBS(+)
	Steroid covered.
	Still draining liquor. - pink
	Systemically well -
	Afebrile
	On erythromycin 10/7 course
	now ended.
	OE:/
	Soft.
	non-tender.
	TEDS ✓
	Plan: Continue daily CTGs
	US this week
	SOS GTT | FBC.

PROGRESS NOTES

DATE & TIME

25/8/ 12 30 hrs	MFMU Sonographer - Provisional US Report.
	- Breech.
	- Appropriate growth for 27wks
	- EFW of 1040g ± 150g
	- AFI 1·8cm consistent with history of PPROM.
	- Umb Artery S/D 2·2.
	- Placenta posterior and not low.
	- Cx long and closed on TA assessment.
	AMS
25/8/ 1440	Midwifery: well this morning. Appears in good spirits and happy. Been for ultrasound this morning. For daily CTG this afternoon. (SM/RN)
25/8/	Date: 25.8/ Time: 1450 Hrs Maternal Pulse 86 Indication for Monitoring PPROM
	Risk Factors High Uterine Activity
	Baseline FHR 135-145 Variability >5 Accelerations present
	Decelerations Nil
	Overall Assessment
	☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action Daily CTG
	Findings/plan discussed with the woman ☑ Yes ☐ No (SM) RM
25/8/ 1500	Midwifery: CTG complete good FMF ✓. Feeling well nil tightenings or pains (SM/RN)
25/8/ 20.40	Midwifery:- c/o taken over. Appears in good spirit. Afebrile. Continues to have small amount of clear liquor on pad. Denies any tightenings. For GCT mane

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
cont....	FMF ✓ Nil new to note
26/08	MIDWIFERY. has slept for long periods
0700	PV loss small amount light pinkish liquor. Nil
	complaints voiced. CM
26.8	(OTG)
9.10	
	27+1
	P2
	PPROM.
	Steroid covered.
	Blocked nose / sore throat
	otherwise well
	Skin draining clear fluid
	FMF. ✓
	no pain.
	Abdo
	Obs stable.
	soft breech.
	Plan: - Continue
	- FBC / SOG GCT
	- CTG

PROGRESS NOTES

DATE & TIME

26/8/ 1015 Midwifery: well this morning. Antenatal check attended NAD, continues to leak mod amount of pink liquor 2 x pads half soaked overnight. Feels slightly unwell like beginning of a cold. FMF ✓.

Date: 26.8. Time: 1010 Hrs Maternal Pulse 86 Indication for Monitoring PPROM

Risk Factors High Uterine Activity Nil

Baseline FHR Variability >5 Accelerations Present

Decelerations Nil

Overall Assessment
☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Daily CTG

Findings/plan discussed with the woman ☑ Yes ☐ No (SM) ~~RM~~ 2nd Signature

cont. Afebrile and haemodynamically stable. Nil complaints voiced. (SM/RN)

addit: 50g GCT today had glucose drink @ 950 for blood test @ 1050. aware not to eat. (SM/RN)

26/8/ 1230 Midwifery: has had GCT blood test. Back on ward now. CTG attended see above. FMF++. Nil complaints voiced. (SM/RN)

26/8/ 2135 MIDWIFERY: Nil PV loss this shift. Afebrile — RM

27/8/ Midwifery 0330. Teary at start of night with pink PV loss – on pad – reassured with FHR ✓ FMF ✓ Rx GTT 50 gm 5-0. Settled – (cm)

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

Surname: .... MRN: ....

Given Names: ....

Date of Birth: .... Sex: ....
(Affix patient label here)

PROGRESS NOTES

DATE & TIME	
27.8	
740	————
	PPROM now 27th.
	... ē bed.
	Obs stable.
	... ...
	... ...
27/8/	S/B. / (Reg / RMO O&G)
8[20]	
	· PPROM, 27+2
	· fresh bleeding overnight → × 3 pads.
	· nil pain
	· fetal movements (N).
	O/E: afebrile, obs stable.
	non-tender.
	soft.
	→ GTT 26/8 → (N) FBC 26/8 (N)
	(P) – USS
	– CTG
	– FMH screen.

PROGRESS NOTES

DATE & TIME	
27/8/ 9³⁰	MFMU Sonographer - Provisional US Report.
	- Umb Artery S/D 2·3.
	- Cx closed ed 2·7cm in length on TL assessment.
	- AFI - 1·1 cm.
	Ams.
27/8/ 12·00	**SOCIAL WORK**
	Seen briefly for support,
	discussion of pt's home situation. Assisted
	with some practical issues in relation to
	Child Support/Family Allowance.
27/8/ 1430	Midwifery - Antenatal check attended NAD.
	Nil pads sighted this shift. Attended U/S
	as above. Afebrile. CTG attended @
	1230hs. Baby active & difficult to trace.
	Dr. aware → continue CTG?. contiuing
	Date: 28/8/ Time: 12.30 Hrs Maternal Pulse 78 Indication for Monitoring PPROM
	Risk Factors .... Uterine Activity Nil.
	Baseline FHR 135-140. Variability 75 Accelerations Yes.
	Decelerations ? (baby active +++; mat. pulse traced).
	Overall Assessment
	☐ NORMAL ☑ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action Contine CTG.
	Findings/plan discussed with the woman ☑ Yes ☐ No RM .... 2nd Signature
27/8/	(O+G)
1650.	
	US → S/D 2·3
	AFI 1·1
	cervical length 2·7cm

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
	CTG (N)
	R/Ved c̄ Prof
	Continue current Mx
27/8/ 2210	MIDWIFERY: Pink loss on pad x 1, small amount. Nil tightenings. Afebrile —
28/8/	[illegible] 0600. Continues to drain pink liquor. No tightenings. Disturbed night with other patients in room.
28/8/ 805	27+3 PPROM
	Steroid covered.
	Well.
	FMF.
	Pink liquor.
	no pain
	Abs
	Obs stable
	Soft.
	Plan: Continue

PROGRESS NOTES

DATE & TIME

28/8 LSCUT
1245 S/B Prog
Mx noted.
Plan: Continue current Mx

28/08/ Date 28.8./ Time: 1400 Hrs Maternal Pulse 84 Indication for Monitoring PPROM.
Risk Factors [illegible]
Uterine Activity none noted
Baseline FHR 125-135 Variability > 5bpm Accelerations Present
Decelerations Nil
Overall Assessment
☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
Plan for ongoing care/Action Continue cares. Daily CTG. O&G sign off
Findings/plan discussed with the woman ☑ Yes ☐ No RM .... 2nd Signature

RM.

28/8/ Midwifery: C/O taken over. Appears in good spirits. Afebrile. Abdomen soft non tender, [illegible] pink PV loss CTG tended to. Nil tightening Nil new to note

SM)

28/08/ 2000hrs Midwifery: haemodynamically stable, afebrile, FMF. Continues to drain pink/clear liquor. teary this P.M. re: breakdown of relationship ē husband. RM.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
29/8/	MIDWIFERY 0445. Settled night. Nil complaints voiced.
	(04W)
	PPROM
	Stable
	Nil [illegible]
	contractions
	afebrile
	(P) Monitor
	[illegible]
29/8/ 1450	Midwifery: Check attended. CTG attended.
	Date: 29/8/ Time: 09:40 Hrs Maternal Pulse 86 Indication for Monitoring Ruptured Membranes
	Risk Factors Premature Del Uterine Activity soft.
	Baseline FHR 157 Variability present Accelerations >10bpm & 15 sec >15bpm + 15 secs.
	Decelerations NIL
	Overall Assessment ☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action Daily CTG
	Findings/plan discussed with the woman ☑ Yes ☐ No RM ..... 2nd Signature
	PV loss: small pink liquor. Nil contractions. Afebrile. (RM)
2300	Midwifery:- Visited by ex husband and 2 sons - out to oval. "Appears" in good spirits on return. Afebrile. Draining small pinkish liquor. FMF ++

PROGRESS NOTES

DATE & TIME	
30.08. 0100	MIDWIFERY. has been sleeping when observed. Nil complaints voiced. — CM
30-8. 1100	Midwifery & Check attended. CTG attended.
	Date: 30/8/ Time: 0954 Hrs Maternal Pulse 72 Indication for Monitoring PPROM
	Risk Factors Premature Delivery Uterine Activity soft.
	Baseline FHR 134 Variability 5 Accelerations >10bpm & 15sec >15bpm & 15 secs
	Decelerations NIL
	Overall Assessment
	☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL
	Plan for ongoing care/Action Daily CTG
	Findings/plan discussed with the woman ☑ Yes ☐ No RM .... 2nd Signature
	PV loss: moderate pink liquor. Afebrile.
	(RM)
30/8 12:51	S/B Drs + (O+G)
	36 ♀. 27+5/40 c̄ PPROM
	Steroid covered
	Pt well
	Pinky coloured D/C.
	Obs BP 110/55 ø Abdo tenderness.
	pulse 72
	afebrile
	ø Contractions
	Good fetal movements
	plan - cont current Mx

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME

30/8/ 1450 — Midwifery: Satisfactory. Check attended. CTG ✓attended.

Date: 30.8/ Time: 0954 Hrs Maternal Pulse 72 Indication for Monitoring PPROM

Risk Factors Foetal Welfare Uterine Activity soft.

Baseline FHR 134 Variability present Accelerations {> 10bpm + 15sec / {> 15bpm + 15 secs

Decelerations NIL

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Daily CTG ✓

Findings/plan discussed with the woman ☑ Yes ☐ No .... RM .... 2nd Signature

Afebrile. PV loss: moderate pink liquor. Nil contractions. S/B O&G Reg. Continue same treatment.

——— (RM) ———

20^00 — MIDWIFERY: x3 pads mod-small pink PV loss. FMF✓ Abdo soft. Afebrile. Nil issues voiced. TEDS✓ on

31/8/ 0700 — MIDWIFERY: - Sleeping when observed. Nil complaints voiced. — RN

31.8 840 — 1 (O+G) + T Med Student

27+6 PPROM
Steroid covered

Pt feels well
good fetal movements
pink fluid D/C (PV)

Obs: afebrile BP 105/55 pulse 75

PROGRESS NOTES

DATE & TIME

31/8/ | | (cont)

Abdo Soft nontender

Plan - cont Current Mx

31/08/ 1110hrs Midwifery: haemodynamically stable, afebrile. Draining moderate amounts of pink liquor overnight. FMF ✓. CTG attended as below

Date: 31/8/ Time: 1030 Hrs Maternal Pulse 80 Indication for Monitoring PPROM

Risk Factors high Uterine Activity Nil Ctt.

Baseline FHR 130-140 Variability >5bpm Accelerations Present.

Decelerations Nil

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Daily CTG. O&G sign off

Findings/plan discussed with the woman ☑ Yes ☐ No RM ...... 2nd Signature

RM.

22[30] MIDWIFERY: teary + distressed. Had just had a visit by her partner who she is recently separated from who told her some distressing news about his new r'ship. Reassurance given after actively listening to . happy for S/Work to visit + further discuss this situation tomorrow. Pink PV loss by several pads x2 streaks x1 fresh x1 old ? vessel like/ membraneous. Shown to RMO who will discuss same c O&G Reg. Afebrile FMF ✓ Abdo soft.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
	TEDs ✓ Wants temazepam at bedtime to help get to sleep – same handed over to N/Duty staff. TM
01/9/ 0430	midwifery: Has had x2 Temazepam. continued to drain small to moderate clear-pinkish liquor O/N. nil uterine activity reported. Asleep when observed. nil complaints voiced. —— R
1/9/ 0830	Professorial Ward Round.
	28/40
	G^3P^2 → 2x NVD
	PPROM – steroid covered 12/8/
	US 27/8/9: SD 2.3
	AFI 1.1
	Cx closed, 2.7cm
	GTT Ⓝ
	Prior US: post placenta; not low
	extramembranous haemorrhage
	+ 21 /23⁺/40
	* episode of PVB 27/8/9: 3 pads; bright – red. Now settled.
	draining pink liquor
	obs – afebrile
	BP 100/60.
	V. teary this am (events at home noted), Ø suicidal ideation, Ø hopelessness etc
	otherwise → Ø abdo pains / contractions
	→ pink liquor
	→ Ø NHV

PROGRESS NOTES

DATE & TIME

Cont'd — (P) - Social work r/w.
- ? gate leave pm some time this week to spend time c̄ sons

01/09/ 1805 — Midwifery: haemodynamically stable, afebrile. FMF. Draining large - moderate amounts of pink liquor. CTG attended as below.

Date: 01/09 Time: 1130 Hrs Maternal Pulse 74 Indication for Monitoring PPROM

Risk Factors High Uterine Activity

Baseline FHR 125-135 Variability >5bpm. Accelerations Present.

Decelerations nil

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Continue Cares. Daily CTG. Awaiting O&G review

Findings/plan discussed with the woman ☑ Yes ☐ No RM 2nd Signature

RM

1/9/ 1530 — **SOCIAL WORK**

Pt v. upset about home situation - husband's new girlfriend plans to arrive in Australia in 3 weeks time.

· Talked at length about this & her concerns for her boys aged 5 & 7.

· She is able to identify some positives - still 3 weeks away, impact ? their children upon this new relationship & a

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
	substantial financial commitment necessary
	to maintain mortgage for their marital home.
	. Pt. says it has been helpful to
	talk about situation
	Recommendation / Plan : I will continue to
	see on a regular basis +
	please contact me any time she feels
	she needs support + to talk.
1/9	Midwifery: well - seen by
	s/w today - Small pale pink liquor
	on pad FMF FHR 132bpm — RM
2/9	Midwifery: Temazepam 20mg given for night
0520	Sedation. Continues to drain small pinkish liquor.
	Asleep when checked o/n. nil complaints voiced.
	(RM)
2/9	WR 28+1
	PPROM,
	Stable
	systemically well pink PV loss ++.
	Obs ✓ (afeb).
	FMF ✓.
	Abdo - Soft ✓.
	Ⓟ Cont. Mx

PROGRESS NOTES

DATE & TIME	
2/9/ 1200	Midwifery: feeling well & in good spirits. Obs stable. CTG attended but had to leave & so loss of contact noted ~~not~~ on CTG. Moderate PV blood & liquor loss. FMF FHR 130bpm. Abdo soft & nil tightenings noted. RM
2/9/ 2040	MIDWIFERY: Nil change this shift. Nil complaints. Loss continues c mod pinky-clear PV loss. Afebrile. FMF. /cn
3/9/ 0530	Midwifery: Nil complaints voiced overnight [illegible]
3/9/	OVR. 28+2 PPROM
	Stable ✓ / obs ✓ Afeb., 105/55, HR80.
	Small - pink/clear PV loss
	FMF.
	c/o some nausea o/n?
	- nil dysuria° / alt. bowel°.
	- o/w systemically well.
	Abdo. SNT - ✓
	Ⓡ tone ✓. (u/s Mon?)
	calves SNT ✓.
	Ⓟ Blds today
	CTG.
	cont. Mx.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME

3/9/ 14[10] MIDWIFERY Antenatal check attended – NAD. Moderate pink liquor. Afebrile Nauseous overnight but not today. CTG attended. — RM

Date: 3/9/ Time: 13[00] Hrs Maternal Pulse 80 Indication for Monitoring prolonged prem ROM

Risk Factors .... Uterine Activity ....

Baseline FHR 125-130 Variability >5 Accelerations present

Decelerations nil

Overall Assessment

☐ NORMAL ☑ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action ....

Findings/plan discussed with the woman ☐ Yes ☐ No RM Signature

3.9. 1745hrs MIDWIFERY:– Resting this evening Moderate clear liquor on pads this evening. Afebrile. FMF. Transferred to Bed 12. RM

3.9. 2300 Midwifery: complaining of backache an tightening in front lower abdominal area, not constant discribed as coming and going. CTG attended. Deceleration registered. Night resident contacted. will R/V. Afebrile continues to have moderate pink liquor draining. RM

Date: 3/9/ Time: 2330 Hrs Maternal Pulse 78 Indication for Monitoring ? contracting

Risk Factors 28[+4] PPROM. Uterine Activity No.

Baseline FHR 130-140 Variability 7 5 bpm Accelerations present

Decelerations present

Overall Assessment

☐ NORMAL ☑ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action R/V by Resident

Findings/plan discussed with the woman ☑ Yes ☐ No RM 2nd Signature

PROGRESS NOTES

DATE & TIME	
4.9.	SRMO
00:30	ASTP: re decelerations on trace
	35♀
	$G_3 P_2$
	$28^{+3}/40$ 22.11.2009
	GBS ⊕ high vaginal swab
	Serology ⊖tive
	PPROM at 25^{+2} → transfered from
	, Hospital. draining pink liquor.
	steroid covered
	last US. 27.8.2009: AFI = 1.1
	Ⓝ fetal growth
	breech.
	had 1 episode of pv bleeding
	on 26-27.8.
	complaining of lower abdo cramping
	irregular durd & intensity.
	and back pain, not constantly in
	temp nad pain.
	feeling well.
	Q CTG: baseline 145
	good variability
	decelerations × 4
	? maternal puls.
	O/E
	transverse
	mild tightenings
	felt.

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

DATE & TIME	
	lasting ~ 20 sec.
	↳ mild tightenings.
	Speculum: c^x long + closed
	noted bright red
	pv loss in vagina.
	already red pv loss on pad
	Impression: – ? TPL
	– ??? abruption.
	(unlikely)
	(P) – D/W Dr.
	– Panadine forte
	– cont. CTG.
	S/B Dr. /
	noted Ux
	mild tightenings 2-3/10.
	improving since Panadine forte given.
	pain reduced in intensity.
	US performed transverse lie (back
	cranial).
	O/E
	fundus = dates
	transverse
	irregular tightenings.

PROGRESS NOTES

DATE & TIME	
4.9.	SIB Dr. / cons.
01:15	Impression: ? TPL.
	DIW Dr.
	happy with plan to give Nifedipine
	if tightenings unchanged despite
	Nifedipine.
	(P) - transfer to delivery Suite
	- ~~[illegible]~~ to Nifedipine if tightenings
	unchanged.
	- US mane.
	- cont. CTG.
	- close monitoring.
4. 9.	Midwifery - Received in delivery suite
0210	for repeat CTG & observation.
	CTG re commenced.

Date: 4 / 9 / Time: 0210 Hrs Maternal Pulse 85 Indication for Monitoring TPL · ? APH

Risk Factors 28/40 PPROM Uterine Activity yes

Baseline FHR 140-150 Variability > 5 Accelerations yes

Decelerations yes

Overall Assessment

☐ NORMAL ☑ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action continue

Findings/plan discussed with the woman ☑ Yes ☐ No RM .... 2nd Signature

Given nifedipine as per above notes.
CTG continues. Toco not recording
contractions. Same being marked
on trace.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME

4 . 9 .

Date: 4 / 9 / Time: 0300 Hrs Maternal Pulse 85 Indication for Monitoring TPL

Risk Factors 28/40 Uterine Activity yes not recording on trace

Baseline FHR 120-130 Variability 75 Accelerations yes

Decelerations No

Overall Assessment

☑ NORMAL ☐ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Cease

Findings/plan discussed with the woman ☑ Yes ☐ No RM .... 2nd Signature

The contractions continue but are decreasing in frequency & intensity.
The fetal heart is now remaining regular & no decelerations have been seen or heard for 30/60. CTG ceased with Dr Kulks permission, & settled to sleep.
given hot pack

0430 has slept for a short time.
Now feeling ~~[illegible]~~ cold & has tickly throat.
BP 104/60 T 36.5 P 96 FHR 132 & regular.
Given a new hot pack & blanket. Settled to sleep.

PROGRESS NOTES

DATE & TIME

4. 9. Midwifery

0720 ... has slept since last report. Awake at 0630 feeling very nauseated. Vomited x 1 & felt much better. Not feeling cold this morning. CTG re commenced. Temp 37' Pulse 86 BP 115/71

Date: 4.9. Time: 0704 Hrs Maternal Pulse 107 Indication for Monitoring TPL

Risk Factors 28/40 Uterine Activity yes irreg

Baseline FHR 135-145 Variability >5 Accelerations yes 150

Decelerations irreg sharp ? loss of contact.

Overall Assessment

☐ NORMAL ☑ SUSPICIOUS ☐ PATHOLOGICAL

Plan for ongoing care/Action Continue

Findings/plan discussed with the woman ☐ Yes ☐ No RM ....2nd Signature

Seen by R. at 07.03 speculum examination attended. Cord prolapse noted.

Positioned on all fours. Knee chest position.

CTG attempted. Fetal heart 140-150

IV canula inserted. 1 litre Hartmans commenced stat. Transferred to theatre for caesarean section.

cm.

04/09/1 MIDWIFERY - Care taken over at

0945 0705hrs. FHR hand-held 140-150 bpm. Explanation given to . transferred to theatre & progressed to:

CAESAREAN SECTION

under general anaesthetic for cord prolapse. remains

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

DATE & TIME	
	in main recovery. seen
	in main recovery for short
	debrief of events. Awaiting
	return to delivery suite.
	Placenta sent to histopathology.
	(RM).
Addit	is husband
	called prior to LSCS
	at request &
	now present in recovery
	with her. (RM)

PROGRESS NOTES

DATE & TIME

DATE & TIME	
7/9/	10+G.
	retrospective entry.
	slept overnight
	on waking tightenings felt + nauseated.
	CTG - brief early decels.
	Spec performed → cord prolapse.
	Code 1 LSCS performed.
	Dr + informed.
	IVC / FBC / G+H taken.
	OT / anaesthetist informed.
4/9/ 1110	MIDWIFERY - returned from recovery at 1000hrs. On arrival maternal obs stable. Given a wash in bed. Using PCA with good effect. In NICU visiting baby ATOR. (RM)
Addit	Wound reinforced as small ooze under dressing. (RM)
4/9/ 1200	MIDWIFERY. Post-natally well. Resting comfortably. S/W aware of C/S & will r/v.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
4/9/ 1310	MIDWIFERY - Fundus remains firm & central, 3cm below umbilicus. Small rubra lochia. Resting comfortably. (RM)
4/9/ 1400	MIDWIFERY - transferred to maternity ward ATOR. (RM)
4/9/ 15:27	**SOCIAL WORK** well-known to SW met w briefly explained SW is available if needed today + monday - Also explained about on-call roster. PLAN: to review on Tuesday
21^00	MIDWIFERY: Obs stable. IVF + IDC + PCA patent. Tolerating fluids. HPF ✓ tea + toast given. Sponged ✓ Fundus soft x2 occasions - rubbed up tender ++ Min PV loss. No clots seen. Expressed x2 (½)ml obtained at each session Periods of wave-~~length~~ -liked pain, no pain if remains still. Moving in bed well none the less TEDS✓ C.C.'s voltaren ✓ + Paradol ✓

PROGRESS NOTES

DATE & TIME	
4.9.	SIB Dr.
23:10	Do post LSCS
	debriefed patient about
	events this am.
	explained cord prolapse to patient.
	explained need to rush
	for LSCS.
	nil complications at LSCS.
	performed lower segment CS
	nil need for classical CS.
	pt understands events and
	feels currently ok and is coping
	well with above events.
	(P) - routine care pls.
	- SW input pls to cont.
	- call if any concerns
	- IDC out when mobile.
5/9/	Midwifery: debrief relating to events.
0625	PCA continues and effective. IVT
	running hartmanns, more fluid ordered.
	urine output good clear urine. BP 85/55
	encouraged to drink more fluid. Passed
	flatus. Wound dressing intact nil ooze.
	Small rubra loss. Hand expressed small

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
5/9/	midwifery: amounts of colostrum,
C/F	labeled and in room fridge. Km,
5/9/	(O&G RMO)
1020	
	Day 1 post emerg. LSCS for cord prolapse.
	- PCA remains → pt. reports feeling drowsy
	c̄ PCA.
	- ongoing pain on movement.
	- eating & drinking sm. amt.
	- flatus passed, BNO.
	- small PV bleeding.
	→ baby girl in NICU.
	O/E: afebrile obs stable
	tender wound dressed.
	firm fundus @ umbilicus.
	calves soft, non-tender
	TEDS in situ.
	(P) - anaes. r/v of PCA.
	- ~~pad chart please~~.

PROGRESS NOTES

DATE & TIME	
5/9 1510	Midwifery: ō IDC + Calf compressors removed prior to showering. Mobilising very gently. In pain when moving around but some relieved by regular attempts on her PCA. IVT now TKVO. Tolerating a light diet. TEDS in situ. Has visited babe in NICU - babe now on CPAP, under phototherapy and has commenced EBM feeds of 1ml q 2 hrs. Obs NAD, now sleeping. Teary this morning when talking about her family situation. Sons not coming in today ——— CM
	Addit Anaesthetic paged ( ) re PCA review - will attend this pm. CM
17^{15}	Midwifery: — R/V by Anaesthetist - on - call - PCA ceased @ 17^{20} hrs. Endone 5mgs given. Mobilising slowly. Up to NICU in wheelchair. Voiding well post IDC. Regular analgesia continued. IVC removed. Observations stable. Assistance given with hand expressing — cm
21^{00}.	Midwifery: - Experiencing moderate amount of pain after returning from NICU. Endone 10mgs given — cm
6/9 0600hrs	MIDWIFERY - Slept for long periods. Minimal assistance given c̄ expressing. Given regular Panadol as ordered + Endone @ 0100hrs c̄ good effect. R/M

BINDING MARGIN
DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
12 6/9/	Midwifery PN checks ✓ Breasts soft – EBM
	by hand. Visiting babe. Enc mobility.
	RM ————
21^00	Midwifery:– Teary this afternoon. TLC++
	given. Spent quality time with
	in NICU. Hand expressing increasing
	amounts of EBM. Advised slow
	ambulation to NICU as PCA only ceased
	24hrs ago. Regular analgesia given –
	———— (RM) ————
6/9/	S/B Dr (O+G RMO)
20:10	Day 2 post LSCS
	Pt feeling ok
	Abdo pain controlled c analgesia.
	Bowels opened this afternoon, passing urine.
	Obs BP 140/70
	pulse 62
	afebrile
	O/E Wound-loc ok
	small dark area ? collection
	nontender
	fundus below umbilicus, firm
	Calves soft nontender
	Plan Cont current Mx

PROGRESS NOTES

DATE & TIME	
7/9/1	[illegible] 0715. Assisted with expression using
	pump now. Teary at times. Cried this morning
	when asked about when she thought about
	going home. Spoke to [illegible] - can
	stay until Wed - then [illegible]. Given [illegible]
	x 3 overnight - in pain - this seems to be
	the problem. [illegible]
7/9/1 11:15	S/B (O+G RMO)
	Day 3 post LSCS
	Pt feeling ok
	- Quite emotional about situation
	- comforted.
	obs BP 105/65
	Pulse 80
	afebrile
	O/E fundus well contracted below umbilicus
	ooze from wound.
	Plan - cont current Mx
	- will RN wound [illegible]

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

PROGRESS NOTES

DATE & TIME	
6/9/ 14 30	Midwifery - Post natally satisfactory. Expressing with pump independently. Long talk about situation at home, husband is leaving the marital home when goes home. For extended length of stay. Can stay until Saturday and to be made a border tomorrow. SW dept aware of need for help especia with applying for services. R.
07/09/	**PHYSIOTHERAPY**
	Seen day 3 post LSCS *Provided with brochure *Educated re circulation exercises, bladder care, bed transfers and PFM exercises *Encouraged to attend next available Physio class for further education
7/9/ 1840	MIDWIFERY - seen for debrief re: delivery last friday. Explanations given re: timing & process around delivery. questions answered. Encouraged to ask if wishes to see midwives or doctors involved in delivery again. (RM)
21⁰⁰	Midwifery: - is feeling much more in control of things today. Would like to see Social Worker tomorrow regarding Centrelink forms. filling breasts yesterday

PROGRESS NOTES

DATE & TIME	
(cont)	increasing amounts for EBM. Better mobilisation to NICU without wheelchair —
8/9	[illegible] 0530 — Happy [illegible]. Evidence for pain. Independent with [illegible].
8/9 13.40	**SOCIAL WORK** (cont) Pt. seen in ward. Baby Lucy born on 4/9 & in NIC.
	Pt. assisted with some issues pertaining to Centrelink & given a letter explaining she could not attend Centrelink office in person due to having recently given birth.
	Home Situation: says the baby's father is to visit today. they have had some amicable discussion about arrangements for their 2 boys. Says he has been conscientious in looking after the boys & says he will continue to pay the mortgage & do some maintenance work around the house.
	Now that the baby has been born, is able to return home in due course & take an active role in the care of the boys. She is currently a boarder & plans to return home on Saturday. Various friends will drive her to to visit the baby.
	Planned future contact: as required.

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

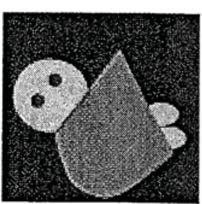
PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

DATE & TIME	
9/9/ 1530.	MIDWIFERY
	Up to visit baby most of day. analgesia given as charted
	D/C meds given to pt.
	For Boarder status this pm
	[illegible]
9/91 2120	MIDWIFERY - D/C from ward to boarder status independently expressing & going up to NICU to visit baby. —
	D/C at 16^00 hrs
	(RM)

PROGRESS NOTES

Birth Summary



EDB Date: **22/11/20**		Language: **English**
EDB Source: **LMP**	Gestation: **28.5**	Interpreter: **No**

Plurality and Parity

Plurality	**Number 1**
Any prior pregnancies	**Yes**
Number of term pregnancies	**Number 2**
Number of pre-term pregnancies	**Number 0**
Number of non-viable pregnancies	**Number 0**
Number of children now living	**Number 2**

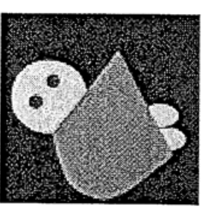
Patient

Blood group	**A**
Rhesus factor	**Positive**
Rubella status	**Immune**
Hepatitis B surface antigen	**Negative**
GBS screening	**Positive**
Syphilis serology	**Non-reactive**
Intended model of care	**Hospital-based midwifery**
Interpreter needed	No

Labour

Regular uterine activity on admission or before first intervention	No
Was prostaglandin used	No
Was cervix ripened mechanically	No
Spontaneous rupture of membranes	**Yes 10/08/20 16:00**
Ami	No **:29 Duration Rupture: 591 hrs 31 min**
Cervix dilatation at amniotomy	**Centimetres 1**
Indication for amniotomy	**Facilitate birth**
Oxytocics used	No
Time labour established	**Did not establish**
Indication/s for pre-labour intervention	**No prelabour intervention/s**
Complication/s in labour	Nil
Antibiotics in labour	Nil
Analgesia in stage one of labour	**Not applicable - no first stage**
Anaesthetic for birth/postpartum	**General anaesthetic**
Anaesthetic complication/s	No
Anaesthetist	**Name/s**

Birth Summary



EDB Date: **22/11/20**		Language: **English**
EDB Source: **LMP**	Gestation: **28.5**	Interpreter: **No**

Perineum

Third stage oxytocic	**Syntocinon**
Third stage complication/s	Nil
Genital tract trauma	Nil
Episiotomy	**Not performed**
Volume of blood loss	**Less than 500 mls**
Observed associations with blood loss of 500 mls or more	**Not applicable**
Intervention/s for blood loss of any volume	Nil
Suturing material	**Vicryl**
Sutured by	**Obstetric registrar KEITH T**

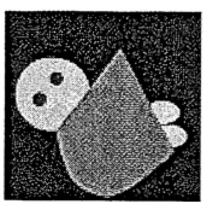
Fetal Assessment

Fetal auscultation	**Done**
Admission/baseline CTG	**Reassuring**
Continuous CTG	**Reassuring**
Method/s CTG	**External**
Fetal blood sampling	**Not done**

Birth Details

Baby # **1** *Baby MRN:* *Sex:* **F** *Baby DOB:* **04/09/20 07:31** *Gest Age:* **28.5**
Born at:

Mode of birth	**Caesarean section**
Caesarean section urgency classification	**Class 1**
Has there been SROM or labour?	**Yes**
CS decision time	**After admission to birthingsuite 04/09/20 07:03**
Obstetric indication/s	**Cord prolapse**
Fetal indication/s	**Oblique/transverse lie**
Past obstetric event	**No relevant past obstetric event**
Maternal indication/s	**No maternal indication**
Manoeuvres to birth shoulders	Nil
Related birth technique/s	Nil
Liquor color during labour/birth	**Clear**
Principal accoucheur for birth	**Obstetric registrar**
Other health professional/s giving care at birth	**Resident medical officer** **Obstetrician** **Paediatrician**
Midwife in charge of case	**Midwife**



EDB Date: **22/11/20**		Language: **English**
EDB Source:	Gestation: **28.5**	Interpreter: **No**

Neonatal Details

Place of birth	**Birth/operating suite**
Neonatal outcome	**Livebirth**
Birthweight	**Grams 1173**
Length	**Centimetres 43**
Head circumference	**Centimetres 26**
Apgar score one minute	**Observed 5**
Apgar score at five minutes	**Observed 7**
Apgar score at ten minutes	**Not observed**
Resuscitation intervention/s	**IPP endotracheal tube**
Minutes to spontaneous respiration	**Less than one minute**
Intubated by	**Neonatal registrar**
Resuscitation intervention/s	**Suction**
Arterial cord blood	**pH 7.374** **Lactate 1.9** **Base excess 0.7**
Venous cord blood	**pH 7.402** **Lactate 1.5** **Base excess 1.3**
Admission to separate neonatal nursery	**Yes**
Nursery admitted to at birth	**NICU (neonatal intensive care unit)**
Neonatal complication/s	**Respiratory distress** **Other PREMATURITY**
Pass urine/meconium	No
Neonatal temperature	**Degrees Celsius 37**
Vitamin K	**Intramuscular or intravenous**
Hepatitis B vaccine	**Not given**
Hepatitis B Immunoglobulin	**Not required**
Other medication/s given	Nil
Feeding at birth	**No feed given**

Placenta & Cord

Delivery of placenta	**Placenta delivered 04/09/20 07:35**
Method of placental delivery	**Delivered at CS**
Placenta appearance	**Complete**
Membrane appearance	**Ragged**
Weight of placenta	**Not weighed**
Number of vessels	**Three vessels**
Cord insertion	**Battledore**
Cord blood taken	**Taken - other purpose GASES**

CLINICAL RECORD 4

Principal diagnosis: ____

Additional diagnosis: ____

Procedures: ____

Press firmly using only a BIRO on a hard surface

Discharged from ward/unit: B5

Consultant at discharge: Dr.

Ward phone no (in full): ______ Admission date 17/8/ Discharge date 20/8/

General Practitioner: Dr. (Name) Family Medical Centre, (Address)

Initial diagnoses/problems on admission:
89yo♂ called in for assessment on blood cultures from recent admission culture positive
B/G: Recent admission for vomiting (black coloured) → Gastroscopy 16/8/7: chronic gastritis.
: IHD, CCF, GORD, Hypertension.

Management and investigations: include operations, diagnostic tests, drugs complications, relevant dates.
Blood culture taken 15/8/7 (? reason): Staph A isolated from aerobic bottle.
Pt well post d/c - nil further vomiting Afebrile.

On admission: Urea 8.6 / Creat 154 (as per baseline). UEC/CMP/LFT (N).
Hb 125 / WCC 7.5 / Plts 280. CRP 26. ESR 35. PCT - pending.
Repeat cultures (17/8/): nil growth after 48 hours. MSU: nil growth.
Pt treated c̄ IV Ceftriaxone & Gentamicin during processing of w/t Bl. cultures
On discharge: remained well, afebrile. CRP ↓ 10,
Consulted by ID → nil need to d/c c̄ any further abx.

Results pending: PCT level.

Principal and secondary diagnosis: HA SAB

Opinion and recommendations: Nil f/u required re above.
F/u as planned re: gastritis as per ~~last~~ prev. admission

Discharged to: ☑ Home ☐ Nursing home ☐ Other hospital Specify: ______

Follow-up appointment Dr. ______ O.P.D./Rooms Date / / Time ______

Name ______ Signature ______ Designation RMO. Date 20/8/7

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Discharge summary

Ward/Unit B5

Language spoken English

Male
17/08/20

Please tick ☑

Interpreter required ☐ Yes ☐ No

Preparation for discharge (Commence on admission)

Expected discharge date / /

			Comments
OT assessment required	☐ Yes	☐ No	
Physiotherapists required	☐ Yes	☐ No	
Social worker required	☐ Yes	☐ No	
Community care required	☐ Yes	☐ No	
Letter/s to VMO/LMO arranged	☐ Yes	☐ No	
Follow-up appointments arranged	☐ Yes	☐ No	
Discharged medication dispensed	☐ Yes	☐ No	
Medical certificate	☐ Yes	☐ No	
Own medication returned	☐ Yes	☐ No	
Transport arranged	☐ Yes	☐ No	

☐ Glasses ☐ Dentures ☐ X-rays ☐ Prothesis

Designation ____________ Date / /

(Score Yes = 1 No = 0) **Daily risk assessment scale**

Date							
Mental status							
Sensory deficit							
Decreased mobility							
Compromised nutrition							
Incontinence							
ADL assist							
Pressure area care							
Age > 70							
Total risk score							

Risk assessment score: minimal (0-2) moderate (3-5) high (6-9)

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Patient details

Diagnosis: ____

____

____

____

Procedures/investigations: ____

____

____

____

____

____

History: ____

____

____

____

Allergies: ____

____

Wound care

Wound description (ie wound, stoma, tracheostomy, pressure area)

Type(s)/Site(s): ____

____

____

____

____

____

Size: ____

____

____

Drains: ____

____

____

(According to Robinson)

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Date	Dressing requirements	Sign	Date	Dressing requirements	Sign

Ward ______

Emergency Department continuation sheet

DATE	TIME	
17/8	1600	Gastro / SR mo.
		Patient known to gastro team -2.
		- recent admission for vomitting of altered blood (black materials.) x 2 times on 15/08/07.
		- Gastroscopy done on 16/8 - gastritis. Histopathology - chronic gastritis.
		- D/c home with PPI
		- blood culture taken on admission grew Gram (-)ive rods.
		B/G.
		(1) IHD. Known to Dr in Hospital.
		MI in March . at Start pnt pm.
		(2) CCF
		(3) GORD.
		(4) Htn.
		HoPI.
		- feeling tired. + cough x 4 weeks + LMO commenced Augmentin DF a week ago. + vomitted black materials on 15/8/7. Blood culture grew Staph A. D/w Microbiology Reg. Advanced transfer of gastro team. Advised to readmit to reculture + IVAB

DATE, TIME, SIGN, PRINT SURNAME AND RECORD DESIGNATION FOR ALL ENTRIES.

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Emergency Department continuation sheet

DATE	TIME	
		MH - Coversyl 2.5 mg daily
		Somac 40 mg ~~daily~~ b.d.
		Astrix 100 mg daily
		Plavix 75 mg daily
		Dilatrend 6.25 mg b.d.
		Aldactone 25 mg daily
		Lasix 40 mg daily
		Lipitor 40 mg nocte
		NKDA
		Live with daughter.
		(I) ADL.
		OE
		well.
		HR 85/min
		T°
		BP.
		O_2 SAT
		~~ ~~ de
		soft.
		Leg no swelling
		Imp. staph A infection / bacteraemia

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DATE, TIME, SIGN, PRINT SURNAME AND RECORD DESIGNATION FOR ALL ENTRIES.

Ward ______________________

DATE	TIME	
		D/w Microbiology Reg &
		Advanced trainee of the gastro team
		plan. (1) to readmit. ↓ Dr
		(2) rpt blood cultures & urine culture
		FBC UEC LFT, CMP CRP ESR PCT
		(3). Commence IVAB.
		(4) Chase blood cultures & blood tests.

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Emergency Department continuation sheet

DATE, TIME, SIGN, PRINT SURNAME AND RECORD DESIGNATION FOR ALL ENTRIES.

CONTINUED OVER

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Progress Notes

Date / Problem no.	Time	Sign, print surname and record designation for all entries.
17/8	21:00	NURSING → patient admitted from A+E, & Dr [illegible]. An 89 yo. Gentleman, presenting c̄ Staph A in Urine + blood. Recently d/c home post endoscopy c̄ result of Gastritis, other PMHx: CCF, IHD, GORD + Htn. Condition on Arrival Satisfactory, AAO Vital Signs as follows: BP = 115/60, HR=85, R=20, T°=36.7, O2 Sats=99% as charted. Plan for treatment Noted. PIVC on (L) arm in situ + Patent. Ordered for Daily AB (IV). Reg. Meds given this evening as Ordered. observed settling in ward well, Ambulant to toilet c̄ Walking stick. No complaints voiced @ TOR. [illegible]
18/8	0530	- NURSING - Pt settled and appeared to have slept well - attending own needs
18/8	1300.	Nursing: Comfortable morning. (CCM) Patient alert & orientated. Mobilizing to bathroom as desires for toilet privileges.
		- IV cannula remains insitu in (R) arm..
		- Phone call from pathology - Staph A in aerobic blood culture bottles. Dr [illegible] made aware - he will review patient.
		- Patient has been tolerating diet & fluids well.
		- Obs 1130hrs afebrile. SpO2 99% (room air).
		- Pt voiding in toilet. Bowels open today

Family name: ______ Given name: ______ MRN: ______

Progress Notes

Date Problem no.	Time	Sign, print surname and record designation for all entries.
18/8	1310	/Gastro
		Bloods ok – WCC N
		– CRP falling
		Well
		Eating ok
		Afeb
		Obs stable
		Plan – continue IV a/b
		– N diet
		– mobilise as per usual
18/08/	1800	NURSING → patient's Overall Condition Satis-Factory, A&O, Afeb. other Vital Signs Stable as charted. (I) ĉ ADLs, mobilizing well ĉ W/stick, Reg. Meds & IVAB (Daily Ceftriaxone) given as Ordered. (HD)
19-08	0400	NURSING: Pt – observed to be sleeping well IVC in situ Obs. within normal range nil complaints voiced ATOR –
19/8/	1410	nursing: Satisfactory day. Patient alert & orientated Independent ĉ ADL's. Ambulating as desires with aid of walking stick. nil c/o pain
		– voiding in toilet, Bowels open today
		– IV cannula insitu in (R) arm – same is patent – nil redness @ IV cannula insertion site.
		– appetite: is eating & drinking well. Has been visited by relatives
19/8	1527	/Gastro
		Bloods ok
		Well
		Plan – team to D/W ID re D/C on Monday & need for a/b post D/C

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Ward ______________________

Date Problem no.	Time	Sign, print surname and record designation for all entries.
19/8/	1900	NURSING: Patient stable. Alert and Orientated. Ambulant and self caring. Tolerating diet and fluids well. Obs. as charted. Afebrile. Meds given as charted. (L) IVC Day 1 today. Pt. comfortable resting in bed. Nil c/o of any pain or any discomfort @ TOR EEN
20/8/	0440	Nursing: Patient observed to have slept well over night. Ambulant as desired. Nil voiced complaints noted at TOR. Pt remains asleep at present. EEN)
	0630	Nursing: Patient independently showered at TOR. Capped L PIVC insitu, remains patent. EEN)
20/8/.		[illegible] / SR [illegible].
		D/C : on Antistrokes
20/8/	1135	Nursing Afebrile. Ambulant. Tolerating meals/fluids. Alert + orientated. PIVC removed. For discharge. Daughter informed. For transfer to discharge lounge. Nil nurse escort required RN(
20/8	1255	Nursing: Pt arrived on ward. Pt has letters. Awaiting meds.
20/8	1310	Nursing: Pt was not waiting on meds, Pt D/C from POU with D/C letter

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Progress Notes