Year 3 Case-based Learning 2024-25

Case 3 Part 2

Facilitator Materials

Key Contributors:

Michael Trimble – Academic Lead for Year 3 CBL

Amy Taylor – ADEPT Fellow 2021-22

Contents

STUDENT MATERIALS

Patient details

George Smyth survived his emergency surgery for ruptured AAA. She was recovering in HDU, but on day 6 developed chest pain and suffered an anterior STEMI. She proceeded to PCI and was transferred to CCU. The case starts with a CCU wad round 3 days later.

Coronary Care Unit Ward Round

CLINICAL NOTES

ENTER
A Full Name Mr./s/Miss &
B Address
C Consultant & Ward/Clinic
D Hospital No.
E S.M. or W.
F Date of Birth
G Occupation
H In-Patient Admn Date

A: George Smyth :D
B: 399 005 0001 :E & F
17 Oak Ave :G
C: :H

Insert G.P.'s Name and Address if not included on request letter or admission form

Age: Sheet no.

EACH ENTRY TO BE DATED AND SIGNED

Diagnosis

8-12-22 0940 WR M Kelly ST6 / D Lynch F1

B3 Pt anterior STEMI
-PCI x1 to LAD
-Echo: Severe LV impairment
-Commenced aspirin/ticagrelor

BG Initially admitted with ruptured infrarenal AAA
PG AAA repair c 6/7 HDU postop
PMH: inf STEMI c PCI age 77 Known to Heart failure team
T2DM Current smoker
HTN

Remains in bed
°further chest pain since PCI
°palpitations
°presyncope/syncope
°SOB

O/E Alert, comfortable
HSI +II+0
Bibasal creps
°signif lower limb oedema

Telemetry reviewed – 2 short runs NSVT overnight + this am (8 + 10 beats)

Cont. overleaf

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

Patient Details: 399 005 0001 SMYTH George (Male / 82 years)

17 Oak Avenue BT41 4LH

8/12/22 09.40

WR M. Kelly ST6/ D. Lynch F1

Day 3 Post Anterior STEMI

- PCI x 1 to LAD
- Echocardiogram: Severe LV impairment
- Commenced on aspirin & ticagrelor

Initially admitted with ruptured infra renal AAA

Day 9 AAA repair with 6 days in HDU post-operatively

Other PMH: Inferior STEMI and PCI age 77, T2DM, HTN, known to heart failure team, current smoker

Remains in bed. No further chest pain since PCI. No palpitations. No pre-syncope or syncope. No SOB.

O/E- Alert, comfortable, HS I+II+0, Chest - bibasal creps, no significant lower limb oedema.

Telemetry reviewed- 2 short runs of NSVT (non-sustained ventricular tachycardia) overnight and this am (8 & 10 beats)

8.12.22 Cont. WR Kelly/Lynch

Kardex - DAPT for 1y then aspirin lifelong, bisoprolol 5mg, ramipril 10mg

Bloods - UEEs stable

Reviews by heart failure team + cardiac rehab noted - smoking cessation advice reinforced

Imp: NSVT - treatment indicated

P: Commence amiodarone
Continue cardiac monitoring for further arrhythmia
Repeat bloods today - Hb, PLT, UEE, Mg, Bone

D Lynch FY1
7663321 #9912

Text:

Kardex - DAPT for 1 year then aspirin lifelong, bisoprolol 5mg, ramipril 10mg

Bloods – U&Es stable

Reviews by heart failure team and cardiac rehab noted – smoking cessation advice reinforced

Imp: NSVT – treatment indicated

Plan

Commence amiodarone

Continue cardiac monitoring for further arrythmia

Repeat bloods today - monitor Hb, Plt, U&E, Mg, Bone

Signed D Lynch F1

Echocardiogram report

Patient details: 399 005 0001 SMYTH George (Male / 82 years) Address: 17 Oak Avenue, Antrim BT41 4LH	Date: 6/12/22 Time: 09:00 Location: Acute surg 2 Referrer: Mr McAdoo

Indication:
Day 1 post Anterior STEMI. Inferior STEMI 5y ago.

Quality:
Reasonable views obtained. Difficult parasternal window. Sinus rhythm throughout.

Measurements:

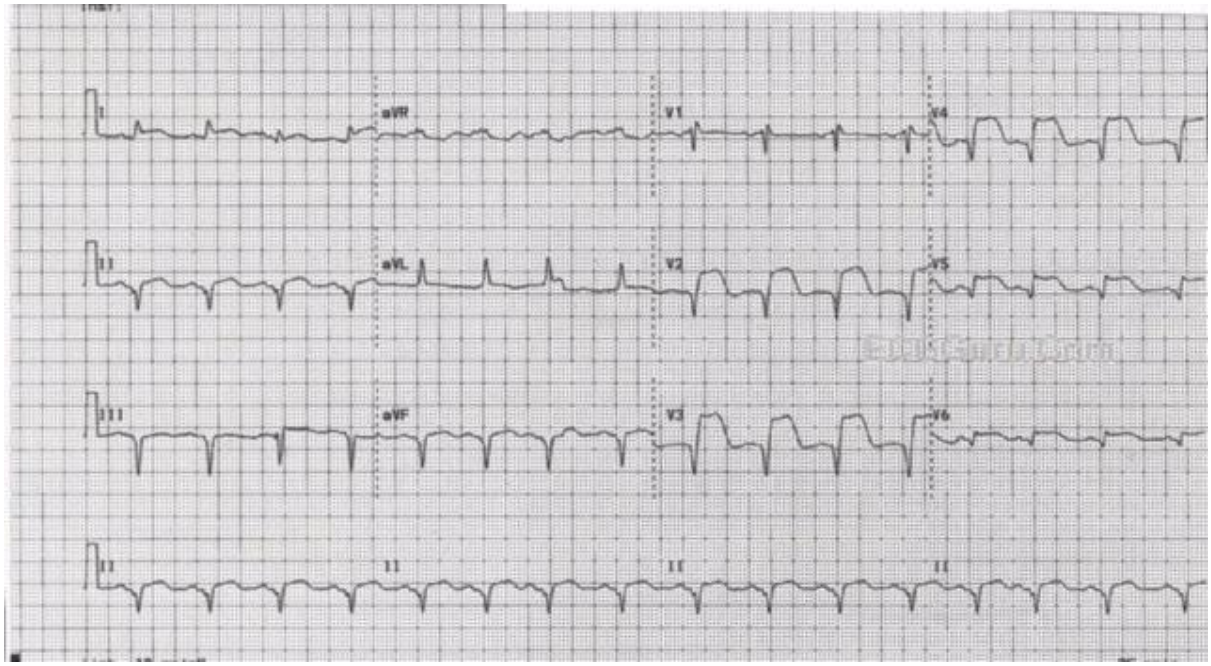
LVEDD: 64mm	LVESD: 52 mm
Septum: 8 mm	Inferior wall: 6 mm
Left atrium: 52 mm	
Aortic valve max velocity 0.8 m/s	LVOT max velocity 0.6 m/s

Chambers/valves:
Left ventricle: The left ventricle is significantly dilated. There is extensive akinesia of the inferior wall, the apex and much of the anterior and septal walls. The lateral wall contracts reasonably. Overall there is severe systolic dysfunction. LVEF is estimated by Simpson's rule in the range 15-20%.
Right ventricle: The right ventricle is borderline dilated. Systolic function is low normal.
Left atrium: The LA is mildly dilated.
Right atrium: The right atrium is normal.
Aortic valve: The aortic valve is tricuspid and opens reasonably. There is trivial aortic regurgitation.
Mitral valve: There is some tethering of the mitral valve leaflets related to chamber dilatation. There is moderate central mitral regurgitation.
Tricuspid valve: Trivial regurgitation.
Pulmonary valve: Normal.

Summary
Extensive inferior and anteroseptal wall motion abnormalities with severe LV systolic dysfunction. There is moderate mitral regurgitation which appears to be predominantly functional.

ECG

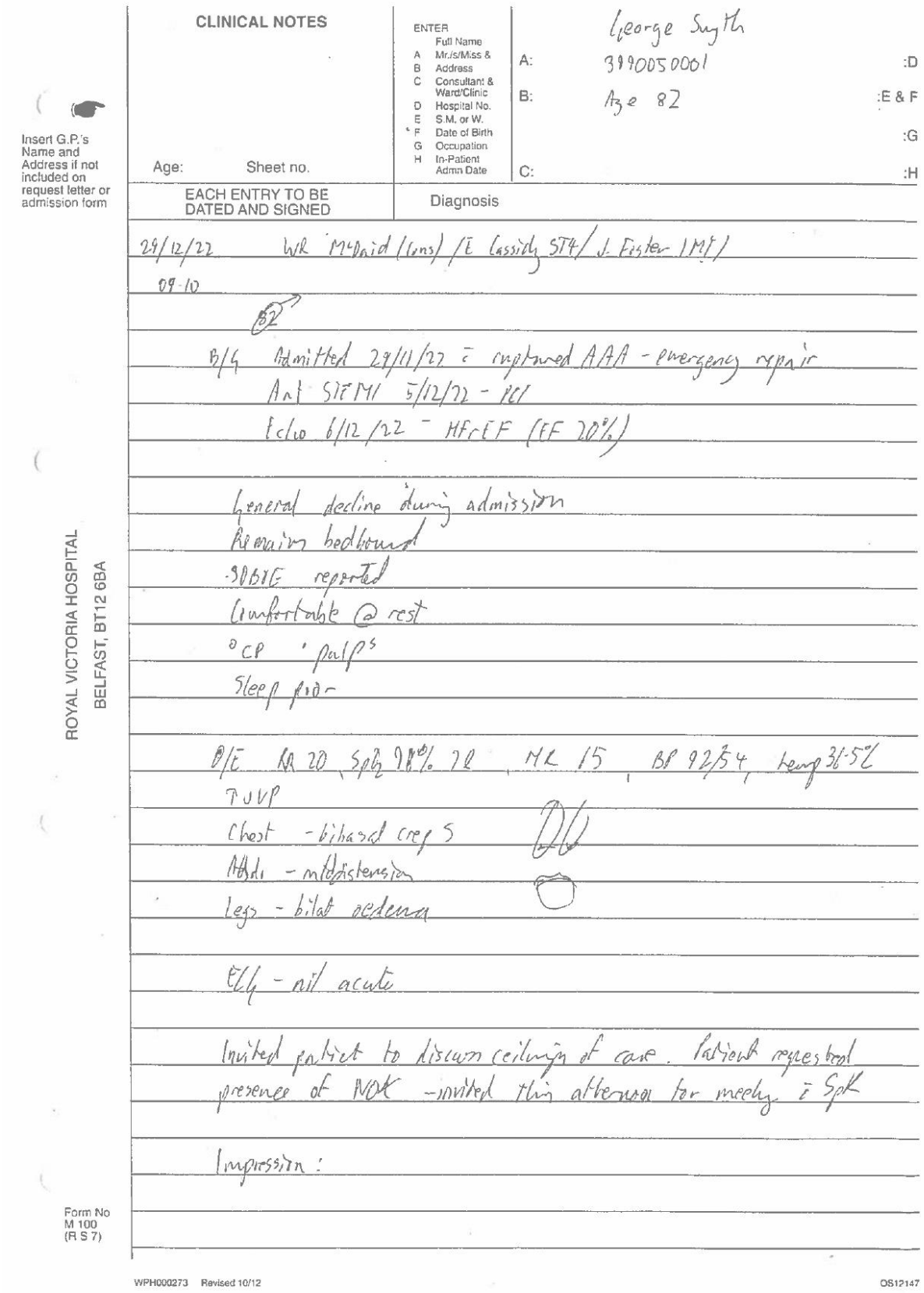
399 005 0001 SMYTH George (Male / 82 years)



The ECG shows ST segment elevation in leads V2-V6 in keeping with an anterior STEMI. The elevation extends slightly into lead I suggesting some lateral extension. There are Q waves already present suggesting necrosis/infarction is established. There are also Q waves without ST segment elevation in leads II, III and aVF suggesting an old established (non-acute) inferior infarction.

https://www.ems1.com/cardiac-care/articles/12-lead-ecg-case-a-tale-of-too-many-q-waves-kZIK377opGvp4PnB/

Cardiology Ward Round: 3 weeks later



CLINICAL NOTES

Insert G.P.'s Name and Address if not included on request letter or admission form

Age: Sheet no.

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A Full Name Mr./s/Miss &
B Address
C Consultant & Ward/Clinic
D Hospital No.
E S.M. or W.
F Date of Birth
G Occupation
H In-Patient Admn Date

A: George Smyth
B: 3990050001 Age 82
C:

:D :E & F :G :H

EACH ENTRY TO BE DATED AND SIGNED

Diagnosis

29/12/22 WR MPaid (Cons) /E Cassidy ST4/ J. Foster IMT/

09-10

82

B/G Admitted 29/11/22 ? ruptured AAA - emergency repair
Ant STEMI 5/12/22 - PCI
Echo 6/12/22 - HFrEF (EF 20%)

General decline during admission
Remains bedbound
SOBOE reported
Comfortable @ rest
°CP °palps
Sleep poor

O/E RR 20, SpO2 98% 2l, HR 15, BP 92/54, temp 36.5°C
TJVP
Chest - bibasal creps
Abdo - mildistension
Legs - bilat oedema

ECG - nil acute

Invited patient to discuss ceilings of care. Patient requested presence of NOK - invited him attend for meeting ? Spk

Impression:

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

399 005 0001 SMYTH George (Male / 82 years)

29/12/22 WR McDaid (Cons)/E. Cassidy ST4/J. Foster IMT1

B/G

Admitted 29/11/22 c Ruptured AAA - emergency repair

Anterior STEMI 5/12 – PCI

Echo 6/12 - HFrEF (EF 20%)

General decline during admission

Remains bedbound. SOBOE reported. Comfortable at rest. No chest pain or palpitations. Sleep poor.

O/E RR: 20 SaO2: 96% 2litre Pulse: 65 BP: 92/54 Temp. 36.5^{0}C

Raised JVP

Chest – bibasal creps

Abdomen – mild distension

Bilateral leg oedema

ECG – nil acute

Invited patient to discuss ceilings of care. Patient requested presence of next of kin – invited this afternoon for meeting with SpR.

Impression:

Cont: Plan: Daily bloods
Strict input/output
FR 100/hr
↑ Furosemide to 80mg IVBD
May require inotropes (likely ceiling)
Dr Cassidy to meet patient + family this
pm re. ceilings of care

D. Foster (HTI)
1778812

Text:

Plan:

Daily bloods

Strict input/output

FR 1000ml

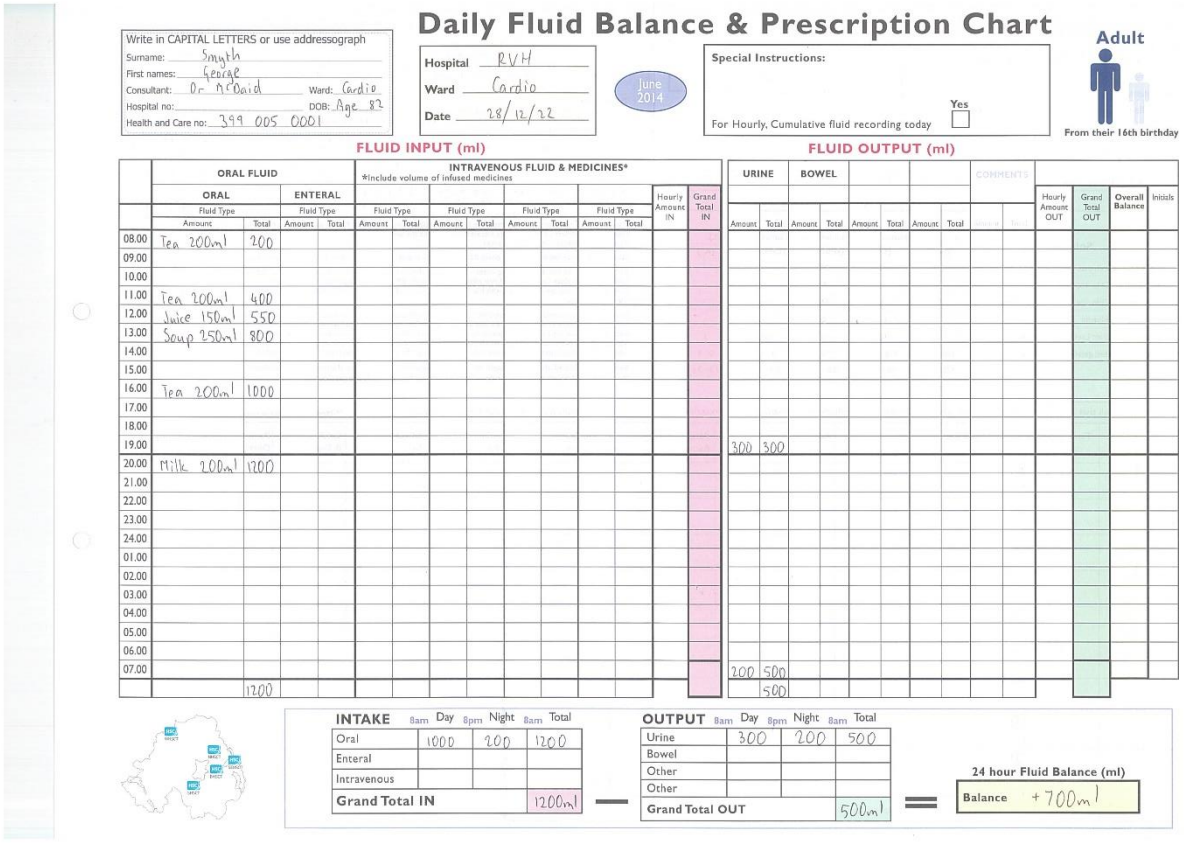
Increase furosemide to 80mg IV BD

May require inotropes (likely ceiling)

Dr Cassidy to meet patient and family this pm re ceilings of care

Signed J Foster IMT1 7778892

Fluid balance chart



Daily Fluid Balance & Prescription Chart

Write in CAPITAL LETTERS or use addressograph
Surname: Smyth
First names: George
Consultant: Dr McDaid
Ward: Cardio
Hospital no:
DOB: Age 82
Health and Care no: 399 005 0001

Hospital: RVH
Ward: Cardio
Date: 28/12/22

June 2014

Special Instructions:
For Hourly, Cumulative fluid recording today: Yes ☐

Adult
From their 16th birthday

FLUID INPUT (ml) | FLUID OUTPUT (ml)

	ORAL FLUID: ORAL Fluid Type / Amount	ORAL Total	ENTERAL Fluid Type / Amount	ENTERAL Total	INTRAVENOUS FLUID & MEDICINES* (*include volume of infused medicines)	Hourly Amount IN	Grand Total IN	URINE Amount	URINE Total	BOWEL Amount	BOWEL Total	Hourly Amount OUT	Grand Total OUT	Overall Balance	Initials
08.00	Tea 200ml	200													
09.00															
10.00															
11.00	Tea 200ml	400													
12.00	Juice 150ml	550													
13.00	Soup 250ml	800													
14.00															
15.00															
16.00	Tea 200ml	1000													
17.00															
18.00															
19.00								300	300						
20.00	Milk 200ml	1200													
21.00															
22.00															
23.00															
24.00															
01.00															
02.00															
03.00															
04.00															
05.00															
06.00															
07.00								200	500						
		1200							500						

INTAKE	8am Day 8pm	Night 8am	Total
Oral	1000	200	1200
Enteral			
Intravenous			
Grand Total IN			1200ml

OUTPUT	8am Day 8pm	Night 8am	Total
Urine	300	200	500
Bowel			
Other			
Other			
Grand Total OUT			500ml

24 hour Fluid Balance (ml)
Balance +700ml

Text:

Name: 399 005 0001 SMYTH George (Male / 82 years)

Consultant: Dr McDaid

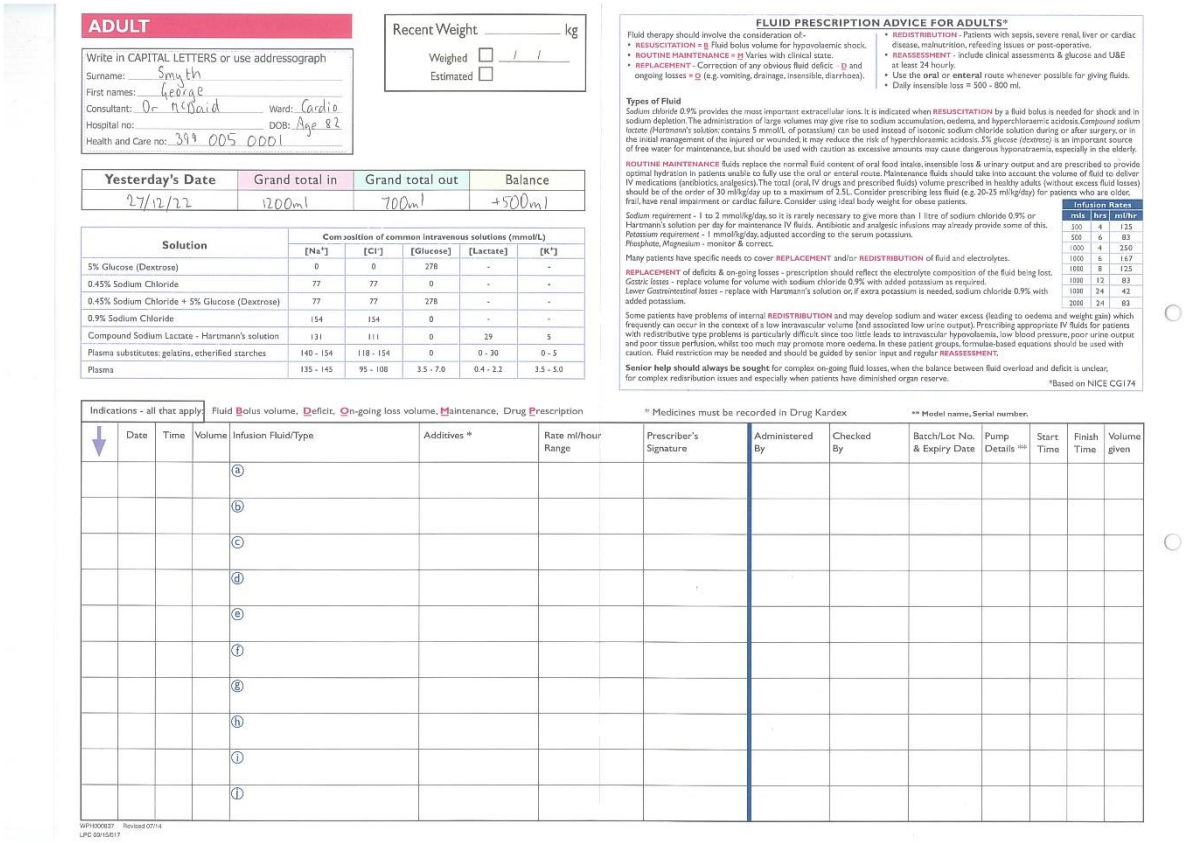
Ward: Cardio

Daily fluid balance and prescription chart 28/12/22

Input 1200ml (oral)

Output 500ml (catheter)

Balance +700ml



ADULT

Write in CAPITAL LETTERS or use addressograph

Surname: Smyth
First names: George
Consultant: Dr McDaid
Ward: Cardio
Hospital no:
DOB: Age 82
Health and Care no: 399 005 0001

Recent Weight ____ kg
Weighed / /
Estimated

Yesterday's Date	Grand total in	Grand total out	Balance
27/12/22	1200ml	700ml	+500ml

Solution	Composition of common intravenous solutions (mmol/L)				
	[Na+]	[Cl-]	[Glucose]	[Lactate]	[K+]
5% Glucose (Dextrose)	0	0	278	-	-
0.45% Sodium Chloride	77	77	0	-	-
0.45% Sodium Chloride + 5% Glucose (Dextrose)	77	77	278	-	-
0.9% Sodium Chloride	154	154	0	-	-
Compound Sodium Lactate - Hartmann's solution	131	111	0	29	5
Plasma substitutes: gelatins, etherified starches	140 - 154	118 - 154	0	0 - 30	0 - 5
Plasma	135 - 145	95 - 108	3.5 - 7.0	0.4 - 2.2	3.5 - 5.0

FLUID PRESCRIPTION ADVICE FOR ADULTS*

Fluid therapy should involve the consideration of:-
- RESUSCITATION = R Fluid bolus volume for hypovolaemic shock.
- ROUTINE MAINTENANCE = M Varies with clinical state.
- REPLACEMENT - Correction of any obvious fluid deficit - D and ongoing losses = O (e.g. vomiting, drainage, insensible, diarrhoea).
- REDISTRIBUTION - Patients with sepsis, severe renal, liver or cardiac disease, malnutrition, refeeding issues or post-operative.
- REASSESSMENT - include clinical assessments & glucose and U&E at least 24 hourly.
- Use the **oral** or **enteral** route whenever possible for giving fluids.
- Daily insensible loss = 500 - 800 ml.

Types of Fluid

Sodium chloride 0.9% provides the most important extracellular ions. It is indicated when RESUSCITATION by a fluid bolus is needed for shock and in sodium depletion. The administration of large volumes may give rise to sodium accumulation, oedema, and hyperchloraemic acidosis. *Compound sodium lactate (Hartmann's solution:* contains 5 mmol/L of potassium) can be used instead of isotonic sodium chloride solution during or after surgery, or in the initial management of the injured or wounded; it may reduce the risk of hyperchloraemic acidosis. *5% glucose (dextrose)* is an important source of free water for maintenance, but should be used with caution as excessive amounts may cause dangerous hyponatraemia, especially in the elderly.

ROUTINE MAINTENANCE fluids replace the normal fluid content of oral food intake, insensible loss & urinary output and are prescribed to provide optimal hydration in patients unable to fully use the oral or enteral route. Maintenance fluids should take into account the volume of fluid to deliver IV medications (antibiotics, analgesics). The total (oral, IV drugs and prescribed fluids) volume prescribed in healthy adults (without excess fluid losses) should be of the order of 30 ml/kg/day up to a maximum of 2.5L. Consider prescribing less fluid (e.g. 20-25 ml/kg/day) for patients who are older, frail, have renal impairment or cardiac failure. Consider using ideal body weight for obese patients.

Infusion Rates		
mls	hrs	ml/hr
500	4	125
500	6	83
1000	4	250
1000	6	167
1000	8	125
1000	12	83
1000	24	42
2000	24	83

Sodium requirement - 1 to 2 mmol/kg/day, so it is rarely necessary to give more than 1 litre of sodium chloride 0.9% or Hartmann's solution per day for maintenance IV fluids. Antibiotic and analgesic infusions may already provide some of this.
Potassium requirement - 1 mmol/kg/day, adjusted according to the serum potassium.
Phosphate, Magnesium - monitor & correct.

Many patients have specific needs to cover REPLACEMENT and/or REDISTRIBUTION of fluid and electrolytes.

REPLACEMENT of deficits & on-going losses - prescription should reflect the electrolyte composition of the fluid being lost.
Gastric losses - replace volume for volume with sodium chloride 0.9% with added potassium as required.
Lower Gastrointestinal losses - replace with Hartmann's solution or, if extra potassium is needed, sodium chloride 0.9% with added potassium.

Some patients have problems of internal REDISTRIBUTION and may develop sodium and water excess (leading to oedema and weight gain) which frequently can occur in the context of a low intravascular volume (and associated low urine output). Prescribing appropriate IV fluids for patients with redistributive type problems is particularly difficult since too little leads to intravascular hypovolaemia, low blood pressure, poor urine output and poor tissue perfusion, whilst too much may promote more oedema. In these patient groups, formulae-based equations should be used with caution. Fluid restriction may be needed and should be guided by senior input and regular REASSESSMENT.

Senior help should always be sought for complex on-going fluid losses, when the balance between fluid overload and deficit is unclear, for complex redistribution issues and especially when patients have diminished organ reserve.

*Based on NICE CG174

Indications - all that apply: Fluid Bolus volume, Deficit, On-going loss volume, Maintenance, Drug Prescription

* Medicines must be recorded in Drug Kardex

** Model name, Serial number.

	Date	Time	Volume	Infusion Fluid/Type	Additives *	Rate ml/hour Range	Prescriber's Signature	Administered By	Checked By	Batch/Lot No. & Expiry Date	Pump Details **	Start Time	Finish Time	Volume given
				ⓐ										
				ⓑ										
				ⓒ										
				ⓓ										
				ⓔ										
				ⓕ										
				ⓖ										
				ⓗ										
				ⓘ										
				ⓙ										

WP1000837 Revised 07/14
LPC 03/10/17

Text:

Name: 399 005 0001 SMYTH George (Male / 82 years)

Consultant: Dr McDaid

Ward: Cardio

Yesterday's date 27/12/22, Grand total in 1200ml, Grand total out 700ml, Balance +500ml

No intravenous fluids prescribed

Foundation doctor review

CLINICAL NOTES

ENTER
Full Name
A Mr/s/Miss &
B Address
C Consultant & Ward/Clinic
D Hospital No.
E S.M. or W.
F Date of Birth
G Occupation
H In-Patient Admn Date

A: George Smyth :D
B: 399 005 0001 :E & F
age 82 :G
C: :H

Insert G.P.'s Name and Address if not included on request letter or admission form

Age: Sheet no.

EACH ENTRY TO BE DATED AND SIGNED

Diagnosis

29/12/22 G. Thirumal FI

13.20 ATSP re increased RR / ↓ sats
B/G anterior STEMI - PCI
HFrEF
AAA repair
general decline
+ve fluid balance

A - Patent
B - RR 32 SaO2 84% 4l -NRB applied
widespread bilateral fine crepitations
C - HR 66 BP 70/44, CRT 4s, ECG nil acute
D - GCS 15/15, BM 7.8
E - Temp 35.6

Bloods today - AKI TK 6.7

Problem list:

Ddx :

Plan :

G. Thirumal FI
7923288

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

399 005 0001 SMYTH George (Male / 82 years)

29/12/22 13.20 G Thirumal F1

ATSP re increased RR/reduced sats

B/G Anterior STEMI – PCI

HFrEF

AAA repair

General decline

Positive fluid balance

A – Patent

B – RR 32, Sao2 84% on 4litres – NRB applied, chest examination – widespread bilateral fine crepitations

C – Pulse 66, BP 70/44, CRT 4s, ECG – nil acute change

D – GCS 15/15, BM 7.8

E – Temp 35.6

Bloods today – AKI, hyperK 6.7

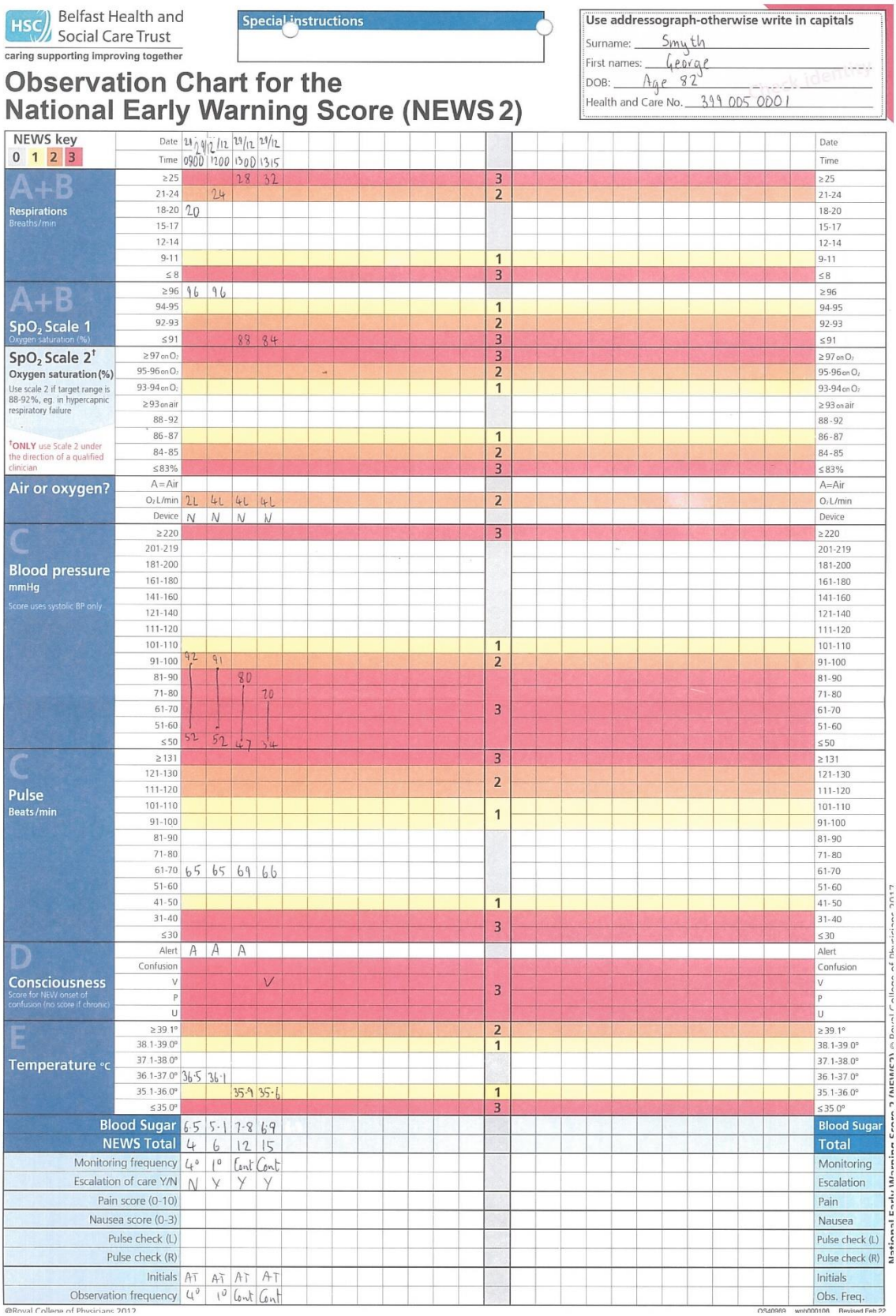
Problem list:

Differential diagnosis:

Plan:

Signed G Thirumal F1 7923288

NEWS Observation chart



Belfast Health and Social Care Trust
caring supporting improving together

Special instructions

Use addressograph-otherwise write in capitals
Surname: Smyth
First names: George
DOB: Age 82
Health and Care No. 399 005 0001

Observation Chart for the National Early Warning Score (NEWS 2)

NEWS key 0 1 2 3		Date	28/12	29/12	29/12	29/12		Date
		Time	0900	1200	1300	1315		Time
A+B Respirations Breaths/min	≥25				28	32	3	≥25
	21-24			24			2	21-24
	18-20		20					18-20
	15-17							15-17
	12-14							12-14
	9-11						1	9-11
	≤8						3	≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96		96	96				≥96
	94-95						1	94-95
	92-93						2	92-93
	≤91				88	84	3	≤91
SpO_2 Scale 2† Oxygen saturation (%) Use scale 2 if target range is 88-92%, eg. in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2						3	≥97 on O_2
	95-96 on O_2						2	95-96 on O_2
	93-94 on O_2						1	93-94 on O_2
	≥93 on air							≥93 on air
	88-92							88-92
	86-87						1	86-87
	84-85						2	84-85
	≤83%						3	≤83%
Air or oxygen?	A=Air							A=Air
	O_2 L/min		2L	4L	4L	4L	2	O_2 L/min
	Device		N	N	N	N		Device
C Blood pressure mmHg Score uses systolic BP only	≥220						3	≥220
	201-219							201-219
	181-200							181-200
	161-180							161-180
	141-160							141-160
	121-140							121-140
	111-120							111-120
	101-110						1	101-110
	91-100		92	91			2	91-100
	81-90				80			81-90
	71-80					70		71-80
	61-70						3	61-70
	51-60							51-60
	≤50		52	52	47	34		≤50
C Pulse Beats/min	≥131						3	≥131
	121-130						2	121-130
	111-120							111-120
	101-110						1	101-110
	91-100							91-100
	81-90							81-90
	71-80							71-80
	61-70		65	65	69	66		61-70
	51-60							51-60
	41-50						1	41-50
	31-40						3	31-40
	≤30							≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert		A	A	A			Alert
	Confusion						3	Confusion
	V					V		V
	P							P
	U							U
E Temperature °C	≥39.1°						2	≥39.1°
	38.1-39.0°						1	38.1-39.0°
	37.1-38.0°							37.1-38.0°
	36.1-37.0°		36.5	36.1				36.1-37.0°
	35.1-36.0°				35.9	35.6	1	35.1-36.0°
	≤35.0°						3	≤35.0°
Blood Sugar			6.5	5.1	7.8	6.9		Blood Sugar
NEWS Total			4	6	12	15		Total
Monitoring frequency			4°	1°	Cont	Cont		Monitoring
Escalation of care Y/N			N	Y	Y	Y		Escalation
Pain score (0-10)								Pain
Nausea score (0-3)								Nausea
Pulse check (L)								Pulse check (L)
Pulse check (R)								Pulse check (R)
Initials			AT	AT	AT	AT		Initials
Observation frequency			4°	1°	Cont	Cont		Obs. Freq.

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Text:

399 005 0001 SMYTH George (Male / 82 years)

Consultant Dr McDaid, Cardiology

29/12

0800 RR 20 /min. pulse 65/min BP 92/52. Sao2 96% on 2l. Temp 36.5. Alert. NEWS 4

1200 RR 24 /min. pulse 65/min BP 91/52. Sao2 96% on 4l. Temp 36.1. Alert. NEWS 6

1300 RR 28 /min. pulse 69/min BP 80/47. Sao2 88% on 4l. Temp 35.9. Alert. NEWS 12

1330 RR 32/min pulse 66/min BP 70/34. Sao2 84% on 4l. Temp 35.6. Voice. NEWS 15

Clinical Response to NEWS Triggers

NEWS score	Frequency of monitoring	Clinical response (Variance with response must be documented)
0	Minimum 12 hourly	• Continue routine NEWS with every set of observations.
Total: 1-2	Minimum 6 hourly	• Inform registered nurse who must assess the patient • Registered nurse to decide if increased frequency of monitoring and/or escalation of clinical care is required. **NEWS** of 4 or more? **THINK SEPSIS**
Total: 3-4	Minimum 4 hourly	
3 in 1 parameter		Inform CCOT (on RVH site only) 0[2]
Total: 5 or more	Increased frequency to a minimum of 1 hourly	• Registered nurse to urgently inform the medical team caring for the patient (and Critical Care Outreach Team (CCOT) on RVH site only) • Urgent assessment by medical team caring for the patient • Check for other adverse signs eg. Oliguria • Consider fluid balance chart. **NEWS** of 4 or more? **THINK SEPSIS**
Total: 7 or more	Continuous monitoring of vital signs Minimum of half hourly recording	• Registered nurse to immediately inform the medical team caring for the patient - at least Specialist Registrar or above (and CCOT on RVH site only) • Immediate response required (if peri-arrest call 6666). **NEWS of 4 or more? THINK SEPSIS**

Call medical team caring for the patient if you have any concerns about the patient regardless of the NEWS score

Pain score
0----------10
0 = No pain
10 = Worst imaginable

Nausea score
0 = No nausea
1 = Mild nausea
2 = Severe nausea
3 = Vomiting

Sepsis Screening Tool

Are any two of the following SIRS* criteria present?

- Temperature: <36 or >38.3°C
- Respiratory rate: >20/min
- Heart rate: >90 bpm
- WCC >12 or <4 x109/L

If **YES** patient has SIRS

Does your patient also have a history or signs suggestive of a new infection?

For example:

- Cough/sputum/chest pain
- Dysuria
- Abdo pain/distension/diarrhoea
- Headache with neck stiffness
- Line infection
- Endocarditis
- Cellulitis/wound infection/septic arthritis

If **YES** patient has SIRS

Treat for SEPSIS
Sepsis six bundle within one hour

- Highflow 02
- IV fluids
- Blood cultures
- Lactate
- IV antibiotics
- Urine output

Reassess for severe SEPSIS; any signs of organ dysfunction

For example:

- Hypotension
- Renal dysfunction
- Unexplained coagulopathy
- Unexplained altered mental state
- High Lactate

If **YES:** patient has severe sepsis

SIRS = Systemic Inflammatory Response Syndrome

Guidance on administering oxygen therapy Nurses: Sign this prescription chart on every drug round. Record flow rate and device (FR/D) at each drug round using the codes. Oxygen saturations should be recorded on the patient's observation chart.

A Air (not requiring O_2, weaning or on PRN O_2)	**CP** Patient on CPAP system	**SM** Simple mask	If a ward patient is requiring high flow oxygen via non rebreathe mask, consider medical review. If target saturations are 88-92%, nebulised drugs should not be driven by oxygen (unless specified by the doctor).
V24 Venturi 24% (change figure as appropriate for % in use)	**NIV** Patient on NIV system	**RM** Reservoir mask	
N Nasal cannulae (eg. 2 litres via nasal specs, prescribe as '2L/N')	**OTH** Other device (specify)	**TM** Tracheostomy mask	
H28 Humidified oxygen at 28% (change figure as appropriate for percentage in use)		**HFNO** (High Flow Nasal Oxygen)	

Text:

Clinical Response to NEWS Triggers

NEWS score

0

Frequency of monitoring Minimum 12 hourly

Clinical response (Variance with response must be documented)

Continue routine NEWS monitoring with every set of observations.

Total: 1 – 2	Total: 3-4
Frequency of monitoring Minimum 6 hourly	Minimum 4 hourly

Clinical response Inform registered nurse who must assess the patient

Registered nurse to decide if increased frequency of monitoring and/or escalation of clinical care is required.

NEWS of 4 or more? THINK SEPSIS

Total: 3 in one parameter	Total: 5 or more

Frequency of monitoring – Increased frequency to a minimum of 1 hourly

Clinical response Registered nurse to urgently inform the medical team caring for the patient (and Critical Care Outreach Team (CCOT) on RVH site only)

Urgent assessment by medical team caring for the patient

Check for other adverse signs eg. Oliguria

Consider fluid balance chart.

NEWS of 4 or more? THINK SEPSIS

Total: 7 or more

Frequency of monitoring Continuous monitoring of vital signs, Minimum of half hourly recording

Clinical response Registered nurse to immediately inform the medical team caring for the patient — at least Specialist Registrar or above (and CCOT on RVH site only)

Immediate response required (if peri-arrest call 6666).

NEWS of 4 or more? THINK SEPSIS

Call medical team caring for the patient if you have any concerns about the patient regardless of the NEWS score

Sepsis Screening Tool

Are any two of the following SIRS* criteria present? Respiratory rate: >20/min,Temperature: <36 or >38.30C, Heart rate: >90 bpm, WCC or <4x109/L

If YES patient has SIRS

Does your patient also have a history or signs suggestive of a new infection?

For example: Cough/sputum/chest pain, Abdo pain/distension/diarrhoea, Line infection, Cellulitis/wound infection/septic, arthritis, Dysuria, headache with neck stiffness, Endocarditis

If YES patient has SEPSIS

Treat for SEPSIS

Sepsis six bundle within one hour

Highflow 02, Blood cultures, IV antibiotics, IV fluids, Lactate, Urine output

Reassess for severe SEPSIS; any signs of organ dysfunction

For example: Hypotension, Unexplained coagulopathy, High Lactate, Renal dysfunction, Unexplained altered mental state

If YES: patient has severe sepsis

Pain score

O = No pain, 10 = Worst imaginable

Nausea score

O = No nausea, 1 = Mild nausea, 2 = Severe nausea, 3 = Vomiting

*SIRS = Systemic Inflammatory Response Syndrome

Guidance on administering oxygen therapy Nurses: Sign this prescription chart on every drug round. Record flow rate and device at each drug round using the codes. Oxygen saturations should be recorded on the patient's observation cart.

A Air, CP CPAP system, SM Simple Mask, V24 Venturi 24% (change figure for % use), NIV NIVE system, RM Reservoir mask, N Nasal cannulae, OTH Other, TM Tracheostomy mask, H28 Humidified oxygen 28% (change figure as appropriate), HFNO (High Flow Nasal Oxygen)

If a ward patient is requiring high flow oxygen via non rebreathe mask, consider medical review.

If target saturations are 88-92%, nebulised drugs should not be driven by oxygen (unless specified by the doctor).

Investigations

Blood work

399 005 0001 SMYTH George (Male / 82 years)

Complete Blood Count

Number	1	Ref. Range (Units)
Collected	29-Dec 2022 09:30	
Signed		
Source	BHSCT	
HGB	115	115-165 (g/L)
HCT	0.40	0.37-0.47 (L/L)
WBC	*10.1	4.0-10.0 (x 10^9/L)
PLT	155	150-450 (x 10^9/L)
RBC	4.9	3.8-5.8 (x 10^{12}/L)
MCV	76	76-100 (fL)
MCHC	320	320-360 (g/L)
MCH	27	27-32 (pg)
NEUT	*7.6	2.0-7.5 (x 10^9/L)
LYMPH	3.5	1.0-3.5 (x 10^9/L)
MONO	0.6	0.2-0.8 (x 10^9/L)
EOSIN	0.3	0.04-0.4 (x 10^9/L)
BASO	0.09	0.01-0.1 (x 10^9/L)

* Denotes abnormal result

Electrolyte Profile

Number	2	1	Ref. Range (Units)
Collected	29-Nov 2022 14:37	29-Dec 2022 09:30	
Signed			
Source	NHSCT	BHSCT	
Sodium	139	141	136-145 (mmol/L)
Potassium	3.9	* 6.7	3.5-5.3 (mmol/L)
Chloride	96	99	95-108 (mmol/L)
CO2	23	12	22-29 (mmol/L)
Urea	3.1	* 21.7	2.5-7.8 (mmol/L)
Creatinine	55	* 469	45-84 (µmol/L)
eGFR	>60	* 7	<60 (mL/min/1.73m^2)

Liver Profile

Number	1	Ref. Range (Units)
Collected	29-Dec 2022 09:30	
Signed		
Source	BHSCT	
T. Bilirubin	11	<21 (µmol/L)
ALP	119	30-130 (U/L)
AST	*77	<32 (U/L)
GGT	42	6-42 (U/L)
ALT	*62	<33 (U/L)
Albumin	*24	35-50 mg/L

CRP

Number	1	Ref. Range (Units)
Collected	29-Dec 2022 09:30	
Signed		
Source	BHSCT	
C reactive protein (CRP)	*137	<5 (mg/L)

NT pro-BNP

Number	1	Ref. Range (Units)
Collected	29-Dec 2022 09:30	
Signed		
Source	BHSCT	
NT pro-BNP	*5178	5-349 (pg/mL)

ABG

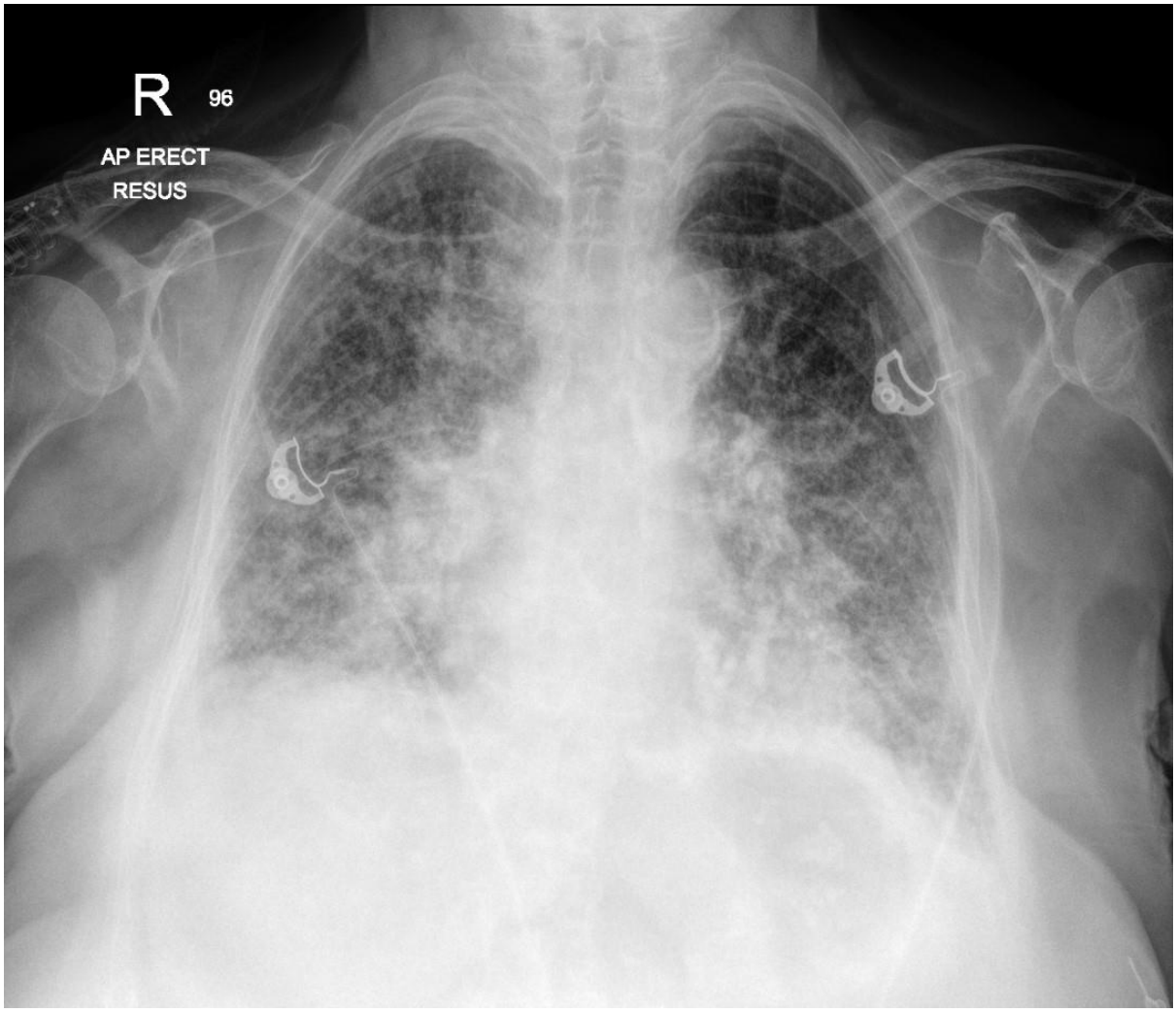
399 005 0001 SMYTH George (Male / 82 years)

ABG on 4l NC

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 15:00	
Signed		
Source	BHSCT	
Sample type	Blood	
Blood type	Arterial	
Temperature	37.0°C	
FiO_2	32%	
pH	*7.28	7.350-7.450
pCO2	*4.11	4.30-6.40 (kPa)
pO2	*7.5	11.00-14.40 (kPa)
Na^+	139	133.0-146.0 (mmol/L)
K^+	*6.8	3.50-4.50 (mmol/L)
Cl^-	*89	95.0-108.0 (mmol/L)
Ca^{2+}	1.35	1.150-1.350 (mmol/L)
Glu	4.9	4.0-7.7 (mmol/L)
Lac	*2.5	1.0-1.4 (mmol/L)
tHb	*111	115.0-180.0 (g/L)
Hct	*0.34	0.370-0.540 (%)
SO_2	*84	94.0-98.0 (%)
BE	*-3.2	-2 - +3 (mmol/L)
$cHCO_3$	*18.3	22.0-29.0 (mmol/L)

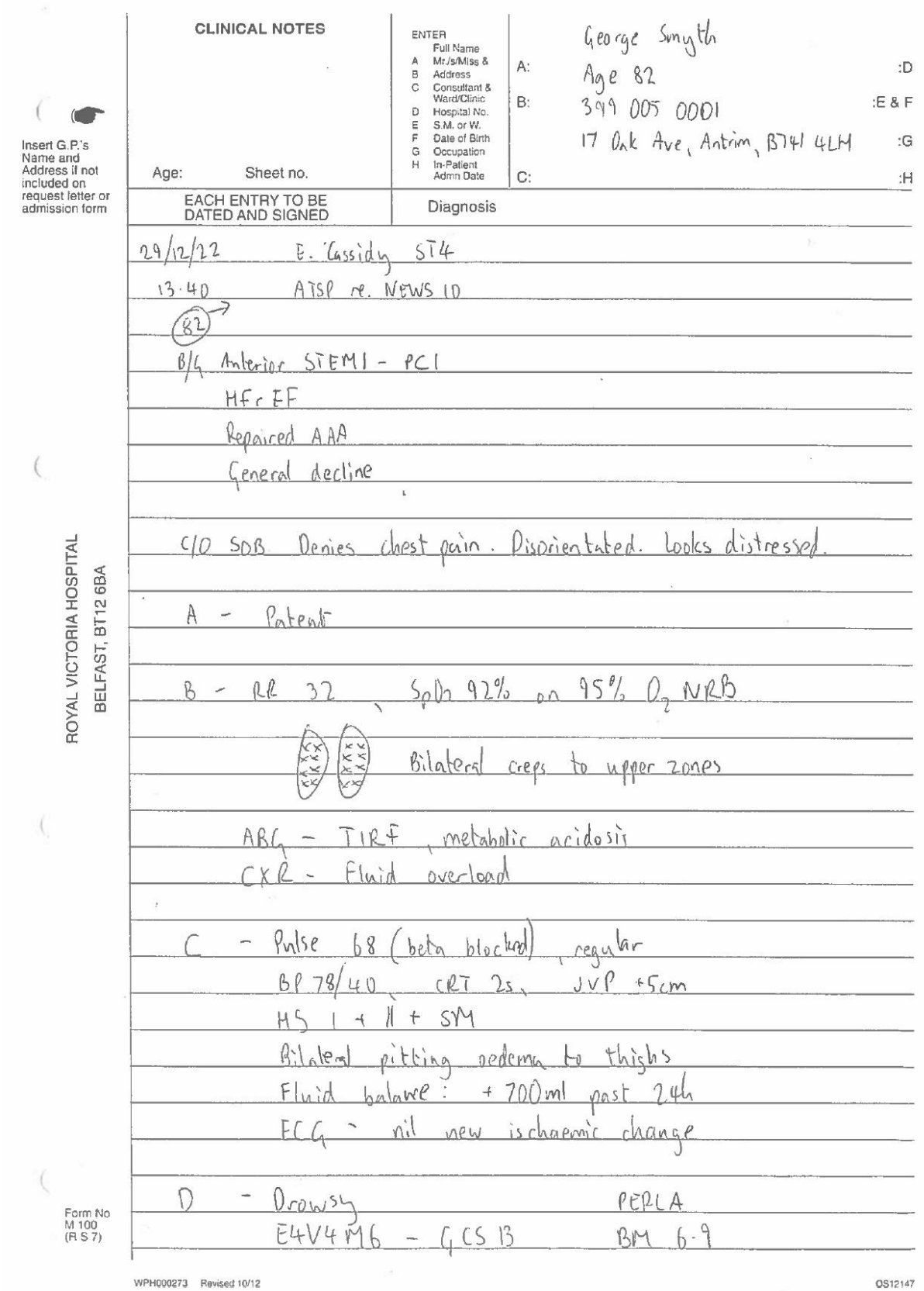
Chest X-ray

399 005 0001 SMYTH George (Male / 82 years)



ADDITIONAL FACILITATOR MATERIALS

Specialty Trainee review



CLINICAL NOTES

Insert G.P.'s Name and Address if not included on request letter or admission form

Age: Sheet no.

ENTER
A Mr./s/Miss & Full Name
B Address
C Consultant & Ward/Clinic
D Hospital No.
E S.M. or W.
F Date of Birth
G Occupation
H In-Patient Admn Date

A: George Smyth :D
Age 82
B: 399 005 0001 :E & F
17 Oak Ave, Antrim, BT41 4LM :G
C: :H

EACH ENTRY TO BE DATED AND SIGNED

Diagnosis

29/12/22 E. Cassidy ST4

13.40 ATSP re. NEWS 10

82

B/H Anterior STEMI - PCI
HFrEF
Repaired AAA
General decline

C/O SOB. Denies chest pain. Disorientated. Looks distressed.

A - Patent

B - RR 32, SpO2 92% on 95% O_2 NRB

Bilateral creps to upper zones

ABG - TIRF, metabolic acidosis
CXR - Fluid overload

C - Pulse 68 (beta blocked), regular
BP 78/40, CRT 2s, JVP +5cm
HS I + II + SM
Bilateral pitting oedema to thighs
Fluid balance: +700ml past 24h
ECG - nil new ischaemic change

D - Drowsy PERLA
E4V4M6 - GCS 13 BM 6.9

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

399 005 0001 SMYTH George (Male / 82 years)

Address: 17 Oak Avenue, Antrim BT41 4LH

29/12/22 13.40 E. Cassidy ST4

ATSP re. NEWS 10

B/G Anterior STEMI – PCI; HFrEF;, Repaired AAA; General decline

C/O SOB. Denies chest pain. Disorientated. Looks distressed.

A – Patent

B – RR 32, Sao2 92% on 95% O2 NRB, chest examination - bilateral crepitations to upper zones

ABG – Type 1 RF, metabolic acidosis

CXR – fluid overload

C – pulse 68(beta blocked), regular, BP 78/40, CRT 2s, HS 1+2+SM, JVP +5cm, bilateral oedema to thighs,

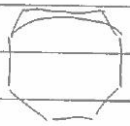
Past 24h +700ml balance

ECG –nil new ischaemic change.

D – Drowsy, E4V4M6 – GCS 13, PERLA, BM 6.9

Cont. E - temp 35.8°C

29/12/22



Fluid distension, non-tense

Catheter in situ - 20ml clear urine in bag today

Labs/

U+Es - AKI, hyperK

Imp: Fluid overload

AKI c acidosis

HyperK

B/G deteriorating patient c poor baseline

Time likely short

Plan: Repeat U+Es

D/W renal ? dialysis candidate

D/W ICU

? Trial CPAP for WOB

? Trial inotropes

D/W NOK - contact to attend ward asap

Elavia, ST4

7596759

Text:

29/12/22 Cont.

E – temp 35.8

Abdomen exam – fluid distension

Catheter in situ – 20ml in bag today

Bloods – AKI, hyperK

Impression: Fluid overload

AKI with acidosis

Hyperkalaemia

Background deteriorating patient with poor baseline

Time likely short

Plan: Repeat U&Es

D/W renal ?dialysis candidate

D/W ICU

?Trial CPAP for WOB

?Trial inotropes

D/W NOK –contact to attend ward asap

Signed E. Cassidy ST4 7596759

Ceilings of care discussions

CLINICAL NOTES

ENTER
Full Name
A Mr./s/Miss &
B Address
C Consultant & Ward/Clinic
D Hospital No.
E S.M. or W.
F Date of Birth
G Occupation
H In-Patient Admn Date

George Smyth
A: Age 82 :D
B: 399 005 0001 :E & F
17 Oak Ave, BT4 1LH :G
C: :H

Age: Sheet no.

Insert G.P.'s Name and Address if not included on request letter or admission form

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

EACH ENTRY TO BE DATED AND SIGNED	Diagnosis

29/12/22 E Cassidy ST4

14·10 P/w renal SpR on call
Hx relayed. Advised combination of cardiac failure + dialysis dependent AKI prognostically very bad.
Dialysis would likely prolong dying
Advised dialysis not in best interests.

P/w ICU SHO on call
Hx relayed + d/w consultant (Dr Cherry).
Recommended ward ceiling of care in best interests.
Patient not for escalation to ICU.

Patient too unwell for discussion about ceilings of care.
Previously happy for NOK to be kept informed.

Patient's niece Laura (NOK) attended ward. Advised really worried about George. Discussed premorbid baseline - confirmed home had been a struggle, mobilised for short distances only, requiring more assistance prior to adm. Laura has seen him become less well throughout adm. and has been told several times George has been so sick he could die.

Updated Laura that George has become less well again this afternoon, with trouble breathing + kidneys not working well. Advised we worry time could be short. Asked if George had ever talked about how he would like to be looked after if time was short - Laura

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

399 005 0001 SMYTH George (Male / 82 years)

29/12/22 14.10 E. Cassidy ST4

SpR continued

D/W renal SpR on call. History relayed. Advised combination of cardiac failure and dialysis dependent AKI prognostically very bad. Dialysis would likely prolong dying. Advised not in best interests.

D/W ICU SHO on call. History relayed and d/w ICU consultant (Dr Cherry). Recommended ward ceiling of care in best interests. Patient not for escalation to ICU.

Patient too unwell for discussion about ceilings of care. Previously happy for NOK to be kept informed.

Patient's niece Laura (NOK) attended ward. Advised really worried about George. Discussed premorbid baseline –confirmed home had been a struggle, mobilised for short distances only, requiring more assistance prior to admission. Laura has seen him become less well throughout admission and has been told several times George has been so sick he could die.

Updated Laura that George has become less well again this afternoon with trouble breathing and kidneys not working well. Advised we worry time could be short. Asked if George had ever talked about how he would like to be looked after if time was short – Laura

Cont. 29/12/22

advised George always said he wanted to be kept comfortable as a priority. I explained we felt we could best look after him if we kept him comfortable on the ward. Advised we d/w ICU + kidney doctors + they agreed that interventions like ventilation + dialysis would not likely be helpful + would not be in his best interests. Discussed CPR - advised worried if his heart stops beating, he is so frail, we would unlikely be able to restart it, so we should best look after him by keeping him comfortable instead. Family in agreement. All qs answered. Support provided.

Dr McDaid updated - in agreement with plan

HACP + DNACPR forms completed

Ebasindy ST4
759 6759

Text:

Cont. 29/12/22

advised George always said he wanted to be kept comfortable as a priority. I explained we felt we could best look after him if we kept him comfortable on the ward. Advised had discussed with ICU and kidney doctors and they agreed interventions like ventilation and dialysis would not likely be helpful and would not be in his best interests. Discussed CPR - advised worried if his heart stops beating, he is so frail we would unlikely be able to restart it, so we should best look after him by keeping him comfortable instead. Family in agreement. All questions answered. Support provided.

Dr McDaid updated – in agreement with plan.

HACP and DNACPR forms completed.

Signed E Cassidy ST4 7596759

Hospital Anticipatory Care Plan

Belfast Health and Social Care Trust
caring supporting improving together

Please keep at the front of the Patient Record

H&C no 399 005 0001
First name GEORGE DOB / /
Last name SMYTH Sex: ☒ M ☐ F
Address 17 OAK AVE
ANTRIM
BT41 4LH

Hospital Anticipatory Care Plan (HACP)

TREATMENT ESCALATION / LIMITATION, SUITABLE AT THE POINT OF ADMISSION TO HOSPITAL

The Hospital ACP is indicated when one or more of the following applies:

- The patient is unstable with the possibility of deterioration.
- He / she has severe frailty / is completely dependent for ADLs / has progressive / end stage organ failure / multiple co-morbidities / advanced cancer.
- He / she has specific wishes regarding medical of interventions.
- Treatment limitation in the event of a crisis / deterioration would be in the patient's best interests and would avoid harm.

Does the patient have Capacity to discuss acute care?
YES ☐ NO ☑
Discuss with next of kin or important others and document accordingly

Are any of the following active or already in place?
Community ACP Summary ☐
Previous HACP (if known) ☐
Advance decision to refuse treatment ☐
If so, refer to it before completing this Care Plan

Discussions should take place between patient, medical team and those important to the patient. Decisions can be taken by specialty trainees in conjunction with consultants.

If the patient is unable, for clinical reasons, to be involved in the discussion, decisions should be made in the patient's best interests by the consultant and informed by those important to the patient.

GOALS OF CARE It is often helpful to write down the treatment aims in your own words:
Poor baseline, deterioration during long admission ? repeat insult. Very poor prognosis. D/W renal - not for dialysis. D/W ICM - not a candidate. Comfort a priority.

FOR FULL ESCALATION, INCLUDING CPR ☐

DO NOT ATTEMPT CPR ☑ | ESCALATE / LIMIT TREATMENTS using options below ☑

Standard ward-based care * ☐	HDU level of care and possibility of NIV, CPAP, inotropes, etc. ☐
Consider ITU referral and possible mechanical ventilation ☐	For end of life care. Symptomatic and comfort measures only ☑

*Specific investigations, interventions or treatments which are considered appropriate or inappropriate e.g. IV fluids / antibiotics, surgical procedure, transfer for imaging:

APPROPRIATE Comfort only
INAPPROPRIATE

FRM.HAC/CA.18 15385.L

Text:

399 005 0001 SMYTH George (Male / 82 years)

Address: 17 Oak Avenue, Antrim BT41 4LH

Does the patient have capacity to discuss acute care? No – too unwell

Goals of care – Poor baseline, deterioration during long admission with repeat insult, very poor prognosis. Discussed with renal – not for dialysis. Discussed with ICU – not a candidate. Comfort a priority.

Do not attempt CPR

Escalate/limit treatments using options below – for end of life care, symptomatic and comfort measures only

Appropriate – comfort only

son completing this document

Signature: ECassidy **Print in Capitals:** E. CASSIDY

Position: ST4 Cardiology **Date:** 29/12/22

Discussed with:

Patient only ☐ **Patient plus relative/other** ☐ **Relative/other only** ☑

If not discussed with patient annotate reason: Too unwell for discussion

Names of relatives/other: Laura Forbes

Authorised by (consultant responsible) AM'DAID **Initials and date** AM'D 29-12-22

(To be authorised within 24hrs of completion)

Date of commencing this HACP 29/12/22

This HACP is (NEW) UPDATE on a previous HACP (please circle)

Guidance Notes

1. This HACP is a record of communication with the patient/significant others and aims to provide continuity of care.
2. A standard DNACPR form should be completed if the patient is not for attempted CPR.
3. An HACP should be completed prior to making an ICU referral.
4. Ensure ongoing discussion with patient (if appropriate) and with family/significant other regarding management and prognosis.
5. The HACP should be reviewed regularly during an admission. Do not make multiple entries on to a HACP - replace the existing one with an updated HACP.
6. **The plan only applies to the current admission.** At the time of any subsequent admission a new HACP should be completed. All old HACPs should have CANCELLED written across them in block capitals with date and initials.
7. If / when the patient is discharged HACP decisions should be referenced in the discharge summary and communicated to the GP. If possible, the information should be recorded in the Key Information Summary. Where appropriate, a copy of the HACP may be provided to the patient / GP for information.
8. It may be appropriate for team/GP to discuss ACP/ADRT with the patient following discharge.
9. When a patient is discharged please refer patient to the DN using the referral guidance on the palliative care hub, if appropriate.
10. During admission, a patient is identified as dying please use the hospital end of life guidance.
11. If patient has uncontrolled symptoms and/or distress please consider referral to the Hospital Specialist Palliative Care Team.

Text:

Signed by E Cassidy, print E. Cassidy ST4, 29/12/22

Discussed with relative/other only

If not discussed with patient annotate reason: Too unwell for discussion

Names of relatives/other: Laura Forbes, niece

Authorised by A McDaid Consultant

Date of commencing this HACP: 29/12/22

This HACP is NEW

Guidance Notes

This HACP is a record of communication with the patient/significant others and aims to provide continuity of care.

2. A standard DNACPR form should be completed if the patient is not for attempted CPR.

3. An l-IACP should be completed prior to making an ICU referral

4. Ensure ongoing discussion with patient (if appropriate) and with family/significant other regarding management and prognosis.

5. The HACP should be reviewed regularly during an admission. Do not make multiple entries on to a l-IACP - replace the existing one with an updated I-IACP.

6. The plan only applies to the current admission. At the time of any subsequent admission a new IIACP Should be completed. All old HACPs should have CANCELLED written across this in block capitals with date and initials.

7. If/ when the patient is discharged l-IACP decisions should be referenced in thc discharge summary and communicated to the GI. L If possible, the information should be recorded in the Key Information Summary. When appropriate, a copy of the HACP may be provided to the patient/GP for information.

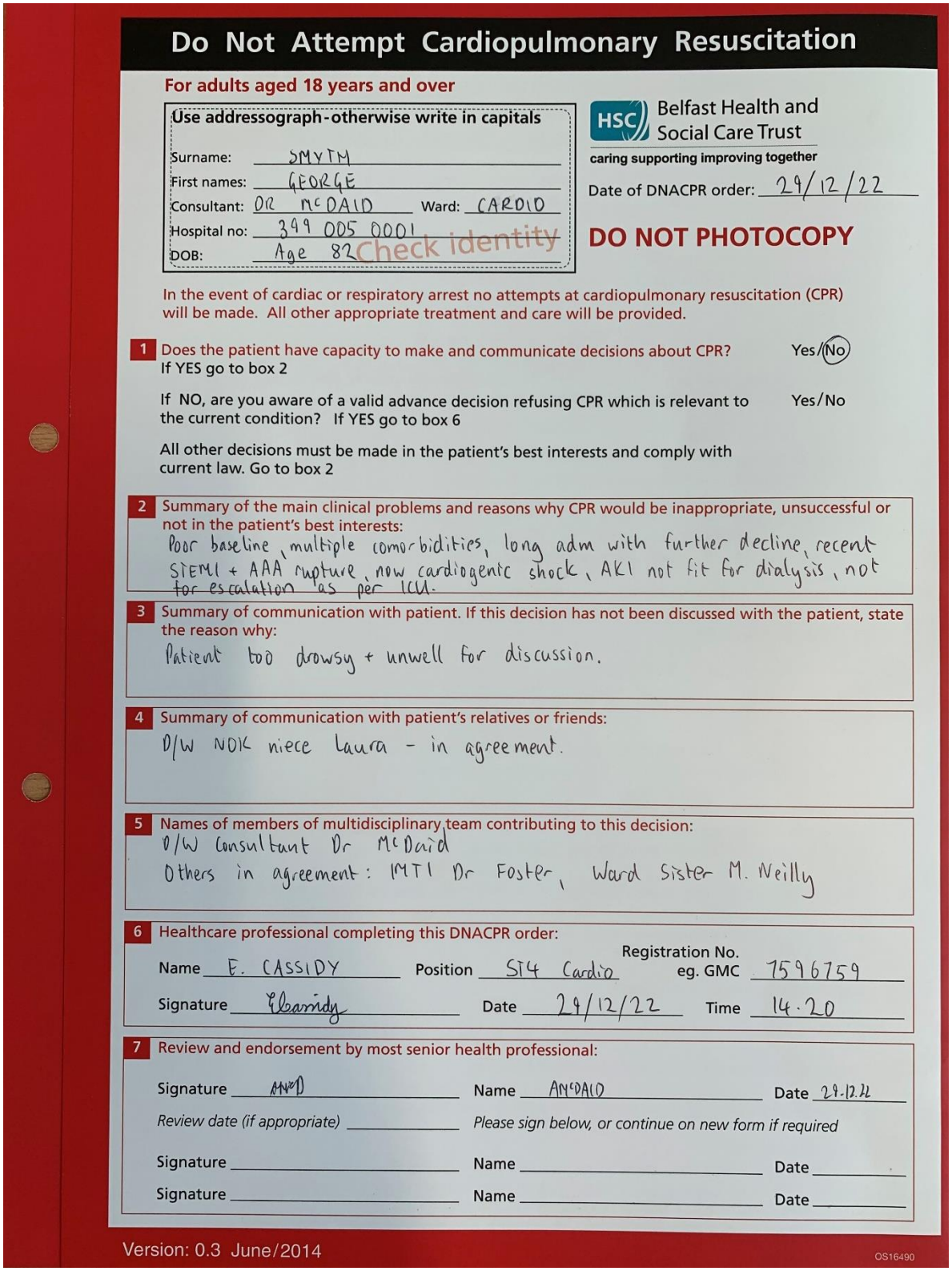
8. It may be appropriate for team to discuss ACP/ADRT with the patient following discharge.

9. When a patient is discharged please refer patient to the DN using the referral guidance on the palliative care hub, if appropriate.

10. During admission, a patient is identified as dying please use the hospital end of life guidance.

11. If patient has uncontrolled symptoms and/or distress please consider referral to the Hospital Specialist Palliative Care Team.

DNACPR form



Do Not Attempt Cardiopulmonary Resuscitation

For adults aged 18 years and over

Use addressograph-otherwise write in capitals

Surname: SMYTH
First names: GEORGE
Consultant: DR McDAID Ward: CARDIO
Hospital no: 349 005 0001
DOB: Age 82 Check identity

HSC Belfast Health and Social Care Trust
caring supporting improving together

Date of DNACPR order: 29/12/22

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1 Does the patient have capacity to make and communicate decisions about CPR? Yes/(No)
If YES go to box 2

If NO, are you aware of a valid advance decision refusing CPR which is relevant to the current condition? If YES go to box 6 Yes/No

All other decisions must be made in the patient's best interests and comply with current law. Go to box 2

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests:
Poor baseline, multiple comorbidities, long adm with further decline, recent STEMI + AAA rupture, now cardiogenic shock, AKI not fit for dialysis, not for escalation as per ICU.

3 Summary of communication with patient. If this decision has not been discussed with the patient, state the reason why:
Patient too drowsy + unwell for discussion.

4 Summary of communication with patient's relatives or friends:
D/W NOK niece Laura - in agreement.

5 Names of members of multidisciplinary team contributing to this decision:
D/W Consultant Dr McDaid
Others in agreement: IMTI Dr Foster, Ward Sister M. Neilly

6 Healthcare professional completing this DNACPR order:
Name E. CASSIDY Position ST4 Cardio Registration No. eg. GMC 7596759
Signature Ecassidy Date 29/12/22 Time 14.20

7 Review and endorsement by most senior health professional:
Signature AMcD Name AMcDAID Date 29.12.22
Review date (if appropriate) _____ *Please sign below, or continue on new form if required*
Signature _____ Name _____ Date _____
Signature _____ Name _____ Date _____

Version: 0.3 June/2014 OS16490

Text:

Do Not Attempt Cardiopulmonary Resuscitation

For adults aged 18 years and over

Surname: Smyth

First names: George

Consultant: Dr McDaid

DOB: 29/11/46

HCN: 399 005 0001

Ward: Cardiology

Age 82

Belfast Health and Social Care Trust

Date of DNACPR order: 29/12/22

DO NOT PHOTOCOPY

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) will be made. All other appropriate treatment and care will be provided.

1. Does the patient have capacity to make and communicate decisions about CPR? (No selected)
   If Yes, go to box 2
   If NO, are you aware of a valid advanced decision refusing CPR which is relevant to the current condition? If YES go to box 6 (No selected)
   All other decisions must be made in the patient's best interests and comply with current law. Go to box 2
2. Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests: Poor baseline, multiple comorbidities, long adm with further decline, recent STEMI and AAA rupture, cardiogenic shock, now AKI not fit for dialysis, not for escalation as per ICU
3. Summary of communication with patient. If this decision has not been discussed with the patient, state the reason why: Patient too drowsy and unwell for discussion
4. Summary of communication with patient's relatives or friends: D/W NOK niece Laura – in agreement

5. Names of members of multidisciplinary team contributing to this decision: D/W Consultant Dr McDaid. IMT1 Dr Foster and Ward Sister M. Neilly.
6. Healthcare professional completing this DNACPR order:

   Name E Cassidy

   Position ST4

   Registration No. eg. GMC 7596759

   Signature E Cassidy

   Date 29/12/22

   Time 14.20

   Review and endorsement by most senior health professional:

   Signature A McDaid

   Name A McDaid (Cons)

   Date 29/11/22

   Review date (if appropriate) ____Please sign below, or continue on new form if required

   Signature____ Name_____ Date_____

   Signature____ Name_____ Date_____

This form should be completed legibly in black ball point ink
All sections should be completed

This form should **only** be used when a decision has been made that attempted CPR would be inappropriate

- The patient's full name, date of birth and address should be written clearly.
- The date of writing the order should be entered.
- This order will be regarded as 'INDEFINITE' unless it is clearly cancelled or a definite review date is specified.
- The order should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare institution to another, admitted from home or discharged home.
- If the decision is cancelled the form should be crossed through with two diagonal lines in black ball-point ink and 'CANCELLED' written clearly between them, signed and dated by the healthcare professional cancelling the order. The cancelled form must be filed in the patient's chart. The cancelled form must **NOT** be filed in the front of the chart.

1 Capacity / advance decisions

Record the assessment of capacity in the clinical notes. Ensure that any advance decision is valid for the patient's current circumstances.

16 and 17 year-olds: *Whilst 16 and 17 year-olds with capacity are treated as adults for the purposes of consent, parental responsibility will continue until they reach age 18. Legal advice should be sought in the event of disagreements on this issue between a young person of 16 or 17 and those holding parental responsibility.*

2 Summary of the main clinical problems and reasons why CPR would be inappropriate, unsuccessful or not in the patient's best interests

Be as specific as possible.

3 Summary of communication with patient

State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why this was inappropriate. It is not essential to discuss CPR with every patient.

If a patient is in the final stages of a terminal illness and discussion would cause distress without any likelihood of benefit this situation should be recorded.

4 Summary of communication with those close to patient

If the patient lacks capacity, those close to the patient must be involved in discussions to explore the patient's wishes, feelings, beliefs and values, as far as it is practical and appropriate to do so.

If the patient has capacity, ensure that discussion with others does not breach confidentiality.

State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. More detailed description of such discussion should be recorded in the clinical notes where appropriate.

5 Members of multidisciplinary team

State names and positions. Ensure that the DNACPR order has been communicated to all relevant members of the healthcare team.

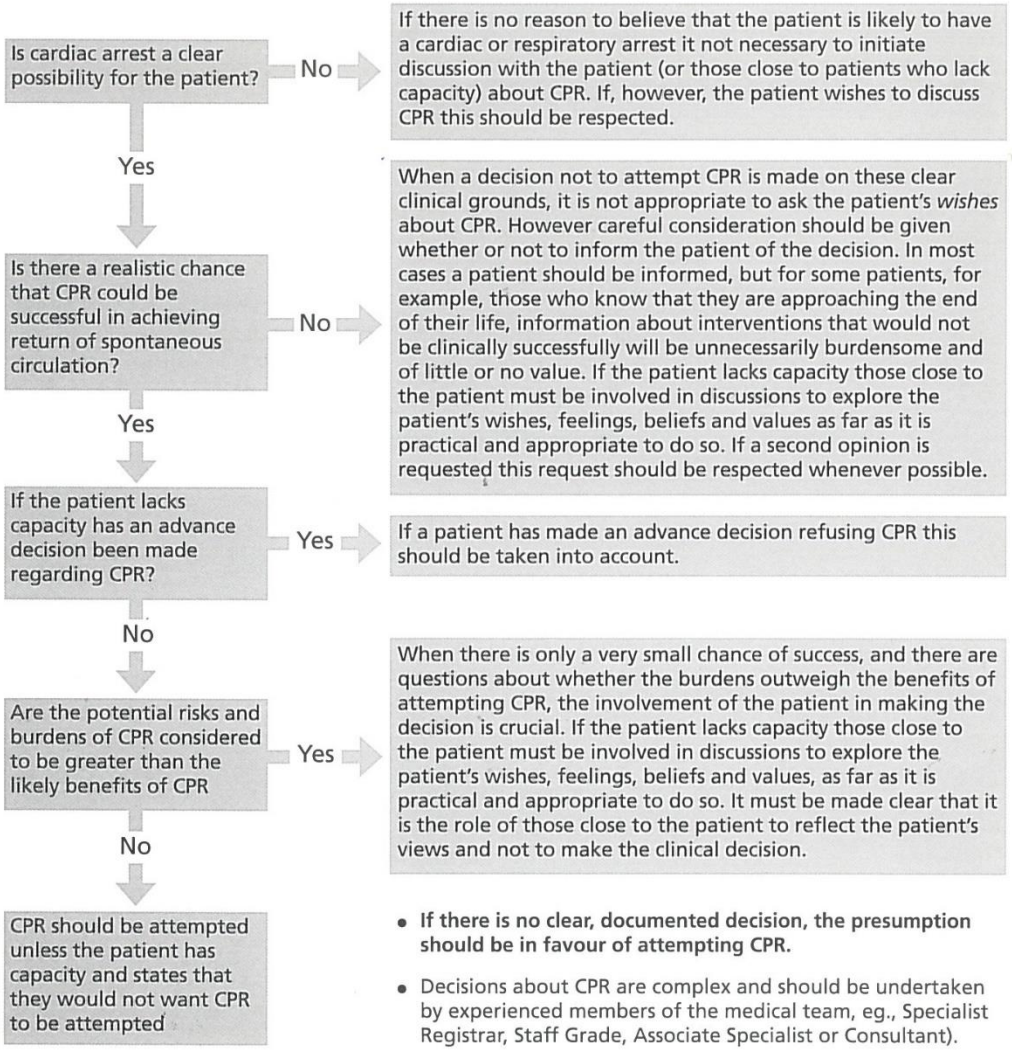
6 Healthcare professional completing this DNACPR order

This will vary according to circumstances and local arrangements. In general this should be the most senior healthcare professional immediately available.

7 Review / endorsement

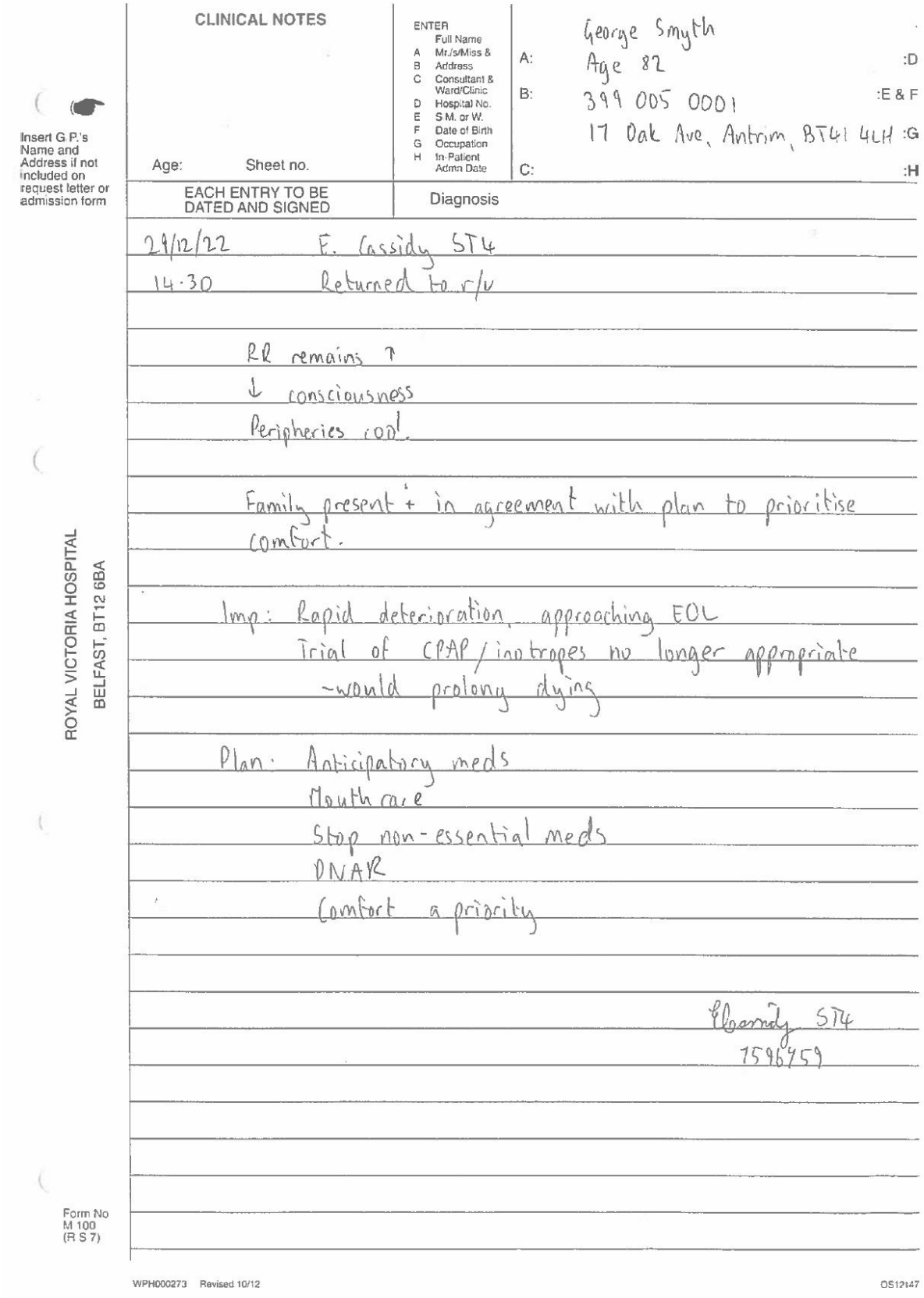
The decision must be endorsed by the most senior healthcare professional responsible for the patient's care at the earliest opportunity. Further endorsement should be signed whenever the decision is reviewed. A fixed review date is not recommended.
Review should occur whenever circumstances change. The decision should be reviewed on each senior ward round or at least weekly.

Framework for decisions relating to CPR in adults



- **If there is no clear, documented decision, the presumption should be in favour of attempting CPR.**
- Decisions about CPR are complex and should be undertaken by experienced members of the medical team, eg., Specialist Registrar, Staff Grade, Associate Specialist or Consultant).
- Decisions must be clearly documented in patients' notes and communicated to ward staff.
- Decisions should be reviewed regularly, eg., on each ward round and when circumstances change.
- Advice should be sought if there is any uncertainty.
- Even if a patient has DNACPR status it is common sense to attempt resuscitation if there is an easy remedial cause, eg. choking or blocked tracheostomy tube.
- For patients undergoing procedures with a risk of cardio-respiratory arrest, eg., general anaesthetics, please refer to guidance relating to **'DNACPR Decisions in the Perioperative Period'** produced by the Association of Anaesthetists of Great Britain and Ireland, which is available on the Intranet.

Specialty Trainee repeat review



CLINICAL NOTES

Age: Sheet no.

ENTER
Full Name
A Mr./s/Miss &
B Address
C Consultant & Ward/Clinic
D Hospital No.
E S.M. or W.
F Date of Birth
G Occupation
H In-Patient Admn Date

A: George Smyth
Age 82 :D
B: 399 005 0001 :E & F
17 Oak Ave, Antrim, BT41 4LH :G
C: :H

Insert G.P.'s Name and Address if not included on request letter or admission form

EACH ENTRY TO BE DATED AND SIGNED

Diagnosis

29/12/22 F. Cassidy ST4
14·30 Returned to r/v

RR remains ↑
↓ consciousness
Peripheries cool

Family present + in agreement with plan to prioritise comfort.

Imp: Rapid deterioration, approaching EOL
Trial of CPAP / inotropes no longer appropriate
-would prolong dying

Plan: Anticipatory meds
Mouth care
Stop non-essential meds
DNAR
Comfort a priority

F Cassidy ST4
7596759

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

399 005 0001 SMYTH George (Male / 82 years)

Address: 17 Oak Avenue, Antrim BT41 4LH

29/12/22 14.30 E Cassidy ST4

Returned to review

RR remains high.

Reduced consciousness.

Peripheries cool.

Family present and in agreement with plan to prioritise comfort.

Imp: Rapid deterioration, approaching EOL.

Trial of CPAP or inotropes no longer appropriate – would prolong dying

Plan: Anticipatory medicines

Mouthcare

Stop non-essential meds

DNAR

Comfort a priority

Signed E. Cassidy ST4 7596759