Year 3 Case-based Learning 2024-2025

Case 1 Part 2

Facilitator Materials

Key Contributors:

Michael Trimble – Academic Lead for Year 3 CBL

Amy Taylor – ADEPT Fellow 2021-22

Contents

STUDENT MATERIALS

Surgical Outpatient Clinic Letter

Eastside Medical Practice

Bracton Terrace

Belfast

3rd October 2022

Dear Dr Denniston,

RE: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Your patient was reviewed at the surgical outpatient clinic today, on a red flag basis. She had a recent admission under our medical colleagues for altered bowel habit. She was found to have a right sided colonic adenocarcinoma with associated anaemia. Further imaging revealed no distant metastases. She was discussed at our regional colorectal MDT and it was agreed that surgical intervention is appropriate. She received treatment for iron deficiency anaemia during her stay.

Mrs Bibi has remained well since discharge but is suffering from ongoing diarrhoea which she describes as nearly black in colour. She has been eating and drinking small amounts but describes ongoing weight loss.

She is usually fit and well. She doesn't work and is fully independent. She has hypertension, for which she takes Ramipril, and has never had any abdominal surgery. On examination today, her abdomen is soft and non-tender and there are no masses palpable. There are no scars.

I have had a long discussion today with Mrs Bibi about the indication for surgery and the expected peri-operative course. We have discussed the risks of surgery in general and the risks specific to a laparoscopic right hemicolectomy. She is keen to proceed. She will meet our colorectal specialist nurse today who will explore options for psychosocial support.

I will make arrangements for her admission, which will likely be next week.

Yours sincerely,

Ms Nicola Stapleton

Consultant Colorectal Surgeon

Surgical Admission Document

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: Farah Bibi :D
B: Age 64 :E & F
412 035 7027 :G
C: 14 St Anne's Place :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

11.10.2022 Surgical admission
08.00 A. Connors, Surgical FY1

Consultant: Miss Stapleton

PC: Elective admission for Laparoscopic Right Hemicolectomy

PMH: Hypertension, osteoarthritis

Allergies: Penicillin - rash

Drugs: Ramipril 10mg MANE
Paracetamol 1g PRN

Family history: Sister - UC
Brother - Colon ca (RIP)

Social history: Lives with daughter
Widow
Non-smoker
Fully independent

Alcohol screen: Nil

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS1214

Text:

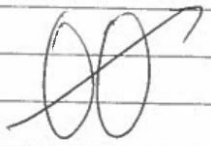
Patient:	Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place
Consultant:	Stapleton Admitting Doctor: A. Connors Designation: FY1
Date:	11/10/2022
Time:	08:00
Presenting Complaint:	Elective Admission for Laparoscopic Right Hemicolectomy
Past Medical History:	Hypertension, Osteoarthritis
Allergy Status:	Possibly had rash with penicillin as a child
Medication:	Ramipril 10mg mane
	Paracetamol PRN
Family History:	Sister: UC
	Brother: Colon Cancer
Social History:	Widow, non-smoker, lives with daughter
	Fully independent.
Alcohol Screening:	Nil

Cont.

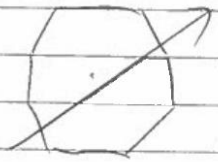
O/E RR 16 Pulse 65
SpO_2 99% RA BP 125/68
Temp 36.6 °C BM 6.9
(A)VPU Weight 54kg
GCS 15/15

Looks well, mucous membranes slightly dry

HS1 + 11 + 0, JVP not visible, nil oedema



Trachea central
Expansion equal
Nil added sounds



SNT
BS +

For theatre today

Plan:

A Connors FY1
#4484

Text:

O/E: RR 16, SpO2 (99% RA, Pulse 65, BP 125/68, AVPU A, Temp 36.6, BM 6.9, weight 54Kg, GCS 15/15.

General Examination:	Looks well, slightly dry mucus membranes
Cardiovascular Examination:	HS I + II + nil, JVP not visible, no oedema
Respiratory Examination:	Trachea central, expansion equal, resonant to percussion, breath sounds vesicular, nil added
Gastrointestinal Examination:	Abdomen soft, non tender
Diagnosis / Differential:	For theatre today
Management Plan:	Admit

Signed A Connors FY1

Consent form

FORM 1
CONSENT FOR EXAMINATION, TREATMENT OR CARE

WHEN COMPLETING THIS FORM
PLEASE ENSURE THAT IT IS OPEN FLAT ON A HARD SURFACE

PRESS FIRMLY WITH BALLPOINT PEN ONLY

Guidance to healthcare professionals

What a consent form is for
This form documents the person's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver - if individuals, for example, do not receive enough information on which to base their decision, then the consent may not be valid, even though the form has been signed. They are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire, by providing a check-list of the kind of information which should be offered, and by enabling the person to have a written record of the main points discussed. In no way, however, should the written information provided be regarded as a substitute for face-to-face discussions.

The law on Consent
See the Department of Health, Social Services and Public Safety publication Reference Guide to Consent for Examination, Treatment or Care for a comprehensive summary of the law on consent (also available at www.dhsspsni.gov.uk).

Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17, and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form (Form 2) is available for this purpose. Even when a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If an individual is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that s/he has given consent orally or non-verbally.

When NOT to use this form
If the person is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A person will not be legally competent to give consent if:
- s/he is unable to comprehend and retain information material to the decision and/or
- s/he is unable to weigh and use this information in coming to a decision.

You should always take all reasonable steps (for example involving more specialist colleagues) to support an individual in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.

Information
Information about what treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for people when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, people may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that they receive at least very basic information about what is proposed. Where information is refused, you should document this on the form and in the case notes.

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

May 2006

Text:

FORM 1
CONSENT FOR EXAMINATION, TREATMENT OR CARE
WHEN COMPLETING THIS FORM
PLEASE ENSURE THAT IT IS OPEN FLAT ON A HARD SURFACE
PRESS FIRMLY WITH BALLPOINT PEN ONLY
Guidance to healthcare professionals
What a consent form is for
This form documents the person's agreement to go ahead with the investigation or treatment you have proposed. It is not a legal waiver - if individuals. for example, do not receive enough information on which to base their decision. then the consent may not be valid, even though the form has been signed. 'They are also entitled to change their mind after signing the form, if they retain capacity to do so. The form should act as an aide-memoire, by providing a check-list of the kind of information which should be offered, and by enabling the person to have a written record of the main points discussed. In no way, however, should the written information provided be regarded as a substitute for face-to-face discussions.
The law on Consent
See the Department of Health, Social Services and Public Safety publication Reference Guide to Consent for Examination, Treatment or Care for a comprehensive summary of the law on consent (also available at www.dhsspsni.go.y.lrlk).
Who can give consent
Everyone aged 16 or more is presumed to be competent to give consent for themselves, unless the opposite is demonstrated. If a child under the age of 16 has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", then he or she will be competent to give consent for himself or herself. Young people aged 16 and 17. and legally 'competent' younger children, may therefore sign this form for themselves, but may like a parent to countersign as well. If the child is not able to give consent for himself or herself, someone with parental responsibility may do so on their behalf and a separate form (Form 2) is available for this purpose. Even when a child is able to give consent for himself or herself, you should always involve those with parental responsibility in the child's care, unless the child specifically asks you not to do so. If an individual is mentally competent to give consent but is physically unable to sign a form, you should complete this form as usual, and ask an independent witness to confirm that s/he has given consent orally or non-verbally.
When NOT to use this form
If the person is 18 or over and is not legally competent to give consent, you should use form 4 (form for adults who are unable to consent to investigation or treatment) instead of this form. A person will not be legally competent to give consent if:
• s/he is unable to comprehend and retain information material to the decision and/or
• s/he is unable to weigh and use this information in coming to a decision.
You should always take all reasonable steps (for example involving more specialist colleagues) to support an individual in making their own decision, before concluding that they are unable to do so. Relatives cannot be asked to sign this form on behalf of an adult who is not legally competent to consent for himself or herself.
Information
Information about what treatment will involve, its benefits and risks (including side-effects and complications) and the alternatives to the particular procedure proposed, is crucial for people when making up their minds. The courts have stated that patients should be told about 'significant risks which would affect the judgement of a reasonable patient'. 'Significant' has not been legally defined, but the GMC requires doctors to tell patients about 'serious or frequently occurring' risks. In addition if patients make clear they have particular concerns about certain kinds of risk, you should make sure they are informed about these risks, even if they are very small or rare. You should always answer questions honestly. Sometimes, people may make it clear that they do not want to have any information about the options, but want you to decide on their behalf. In such circumstances, you should do your best to ensure that they receive at least very basic information about what is proposed. Where information is refused, you should document this on the form and in the case notes.
Health, Social Services and Public Safety An Roinn Slåinte, Seirbhfsi Söisialta

HSS TRUST Belfast | GP PRACTICE or other
Hospital Unit RVH | Primary Care Provider

FORM 1 – CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name Bibi
First names Farah
Date of Birth Age 64
☐ Male ☑ Female H+C No. (or other identifier) 412 035 7027
Special requirements (language or other) Interpreter used with consent

Statement of healthcare professional

Responsible healthcare professional Miss N. Stapleton Job Title Consultant
Name of proposed procedure or course of treatment *(include side of body or site and brief explanation if medical term not clear)*
Laparoscopic Right Hemicolectomy +/- open

I have explained the procedure. In particular, I have explained:

The intended benefits Removal of colon cancer

Serious or frequently occurring risks bleeding, infection, collection, conversion to open, damage to surrounding structures, ureteric injury, anastomotic leak, stoma, further surgery, DVT, PE, pneumonia
Possible additional procedures which may become necessary during the procedure.
☑ Blood transfusion ☑ other procedure (please specify) Ileostomy
This procedure will involve: ☑ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

☐ The following leaflet/tape has been provided

Signed J Dillon Date 11/10/22
Name (Print) J DILLON Job Title General Surgery ST5

Contact details *(if patient wishes to discuss options later)*

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed Sharmin Akter Date 11.10.2022
Name (Print) Sharmin Akter

Copy accepted by person giving consent Yes/No (please circle)

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Female

Consultant: Ms N Stapleton

Name of Proposed Procedure: Laparoscopic Right Hemicolectomy +/- open

I have explained the procedure, in particular I have explained:

The intended Benefits: Removal of Colon Cancer

INTERPRETER USED WITH CONSENT

Serious or frequently occurring risks: Bleeding, Infection, Collection, Conversion to Open, Damage to surrounding structures, Ureteric Injury, Anastomotic leak, Stoma, Further surgery, DVT, PE, Pneumonia.

Possible additional procedures which may become necessary: Blood Transfusion, Ileostomy

The procedure will involve general and/or regional anaesthesia

Signed by Healthcare Practitioner: J. Dillon, 11/10/22

Job Title: General Surgery ST5

Statement of interpreter: I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed Sharmin Akter 11/10/22

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

.....

***I agree** that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. * *You may remove this sentence without affecting your care.*

Signature .....Farah Bibi.....Date .....11.10.22.....

Name **(Print)** .....Farah Bibi.....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature .....Date .....

Name **(Print)**.....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature .....Date .....

Name **(Print)** .....Job Title .....

Important notes: **(tick if applicable)**

☐ **See also advance directive/living will (eg Jehovah's Witness form)**

☐ **Person has withdrawn consent** .....Date.....

(ask person to sign/date here)

LPC 03/08/031 Web Version Oct 11 WPH000035

Text:

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment.

I have listed below any procedures which I do not wish to be carried out without further discussion.

*I agree that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. * You may remove this sentence without affecting your care.

Signature Farah Bibi, Name (Print) Farah Bibi, Date 11/10/22

A witness should sign below if the person is unable to sign but has indicated his or her consent.

Young people/children may also like a parent to sign here (see notes)

Signature…… Name (Print)..... Date .....

Confirmation Of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature…… Name (Print)..... Job title…..Date .....

Important notes: (tick if applicable)

See also advance directive/living will (eg Jehovah's Witness form)

Operation Note

The ROYAL HOSPITALS

Operation Notes

Name Farah Bibi
Address 14 St Anne's Place
Belfast

Fill in patient details opposite or affix ID label here

DOB 11 / 10 / 22
Male ☐ Female ☒
Hospital No. 412 035 7027
Consultant in charge Miss N. Stapleton
Consultant anaesthetist in charge L. McKane

Operation Notes

Theatre 1
Surgeon Miss J Dillon
1st assistant Miss N. Stapleton
2nd assistant

Date 11/10/22
Scrub nurse S Phillips
Anaesthetist L McKane

Procedure

Laparoscopic Right Hemicolectomy

Operative details and diagrams *(continue overleaf if required)*

General anaesthetic
Antibiotics given
Urinary catheter inserted
Infraumbilical incision
12 mm port inserted at umbilicus
Pneumoperitoneum by Hasson technique
12mm + 5mm ports placed under direct vision
Ileocolic pedicle identified + medial mobilisation carried out
Duodenum visualised + protected

WPH000276 Revised 10/12 OS12060

Text:

Operation Notes

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Date 11/10/2022

Consultant Responsible: Ms N Stapleton

Consultant anaesthetist: L. McKane

Operation notes

Theatre 1, date 11/10/22, Surgeon: Ms J Dillon ST5, Assistant: Stapleton

Scrub nurse: S Philips

Procedure: Laparoscopic Right Hemicolectomy

Operation details and diagrams:

General Anaesthetic

Antibiotics given

Urinary catheter inserted

Infraumbilical incision

12mm port inserted at umbilicus

Pneumoperitoneum by Hasson technique

12mm and 5mm ports placed under direct vision

Ileocolic pedicle identified and medial mobilization carried out

Duodenum visualised and protected

Operative details and diagrams *(continued)*

Hem-o-lok x3 to ileocolic artery + divided, 2 clips to remain
Lateral mobilisation to hepatic flexure
Hepatic flexure fully mobilised + right branch of middle colic artery preserved
Midline wound extended
Specimen resected + removed
Side-to-side anastomosis formed using TLC75 + TA 90 and oversewed

Closure

J-Vicryl to umbilicus, 3-0 monocryl to skin

Drains

Yes/No (if yes record size)

No

Post-operative instructions

Enhanced recovery. Eat + drink. Continue clexane.
Mobilise from tomorrow. Catheter out when mobile.
IV fluids down tomorrow if drinking.

Signature J Dillon ST5

Text:

Operative details and diagrams (continued)

Hemo-o-lok x 3 to ileocolic artery and divided, two clips to remain

Lateral mobilization to hepatic flexure

Hepatic flexure fully mobilised and right branch of middle colic artery preserved

Midline wound extended

Specimen resected and removed

Side to side anastomosis formed using TLC 75 and TA 90 and oversewed

Closure

J-Vicryl to umbilicus, 3.0 monocryl to skin

Drains

No

Post-operative instructions

Enhanced recovery

Eat and drink

Continue clexane

Mobilise from tomorrow

Catheter out when mobile

IV Fluids down tomorrow if drinking

Signature J Dillon

Histopathology

CLINICAL DETAILS

Bulky caecal tumour. Laparoscopic right hemicolectomy.

PATHOLOGIST'S REPORT

GROSS DESCRIPTION

TYPE OF SPECIMEN: Right hemicolectomy

SITE OF TUMOUR: Caecum

LENGTH OF SPECIMEN: 140mm terminal ileum,170 mm caecum / ascending colon, 70 mm appendix

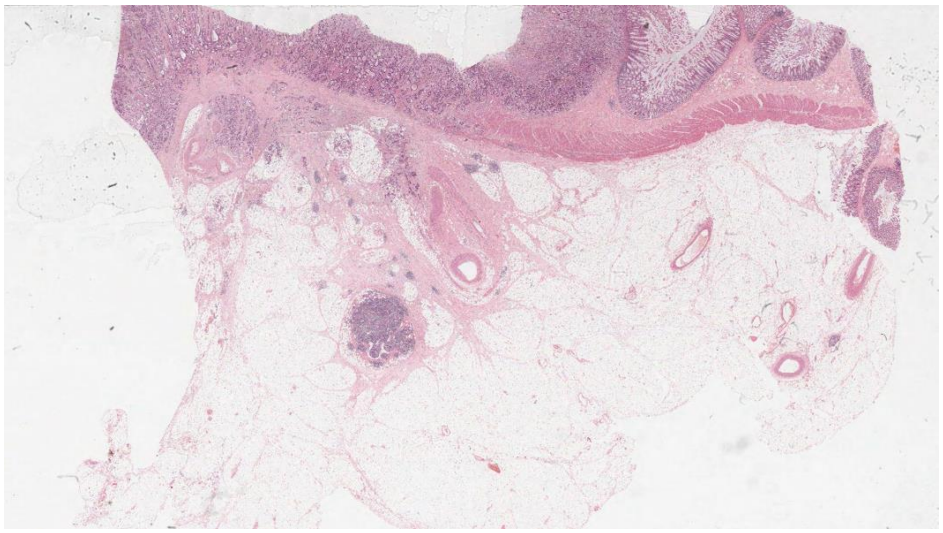
MAXIMUM TUMOUR DIAMETER: 65 mm

NATURE OF TUMOUR: Polypoid

TUMOUR PERFORATION: No

DISTANCE OF TUMOUR FROM NEAREST CUT END: Distal 110mm

HISTOLOGY



Click HERE to view digital slide

HISTOLOGICAL TYPE: Adenocarcinoma

DIFFERENTIATION: Moderately differentiated

LOCAL INVASION (TNM8): pT3

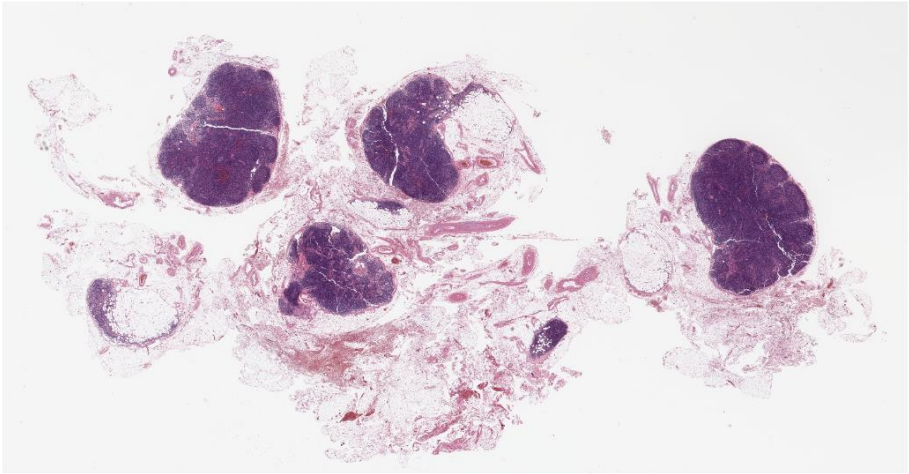
MAXIMUM DISTANCE OF SPREAD BEYOND MUSCULARIS PROPRIA: 5 mm

DEEPEST LEVEL OF VENOUS INVASION: None

DEEPEST LEVEL OF LYMPHATIC INVASION: Extramural- block B4

DEEPEST LEVEL OF PERINEURAL INVASION: None

LYMPH NODES:



Click HERE to view digital slide

Number identified: 21

Infiltrated by tumour: 0

APICAL NODE: Not Involved

NUMBER OF TUMOUR DEPOSITS: None

PERITONEAL INVOLVEMENT: Not seen - see comments

PROXIMAL MARGIN: Not involved

DISTAL MARGIN: Not involved

NON-PERITONEALISED CIRCUMFERENTIAL MARGIN: Not involved

HISTOLOGICAL MEASUREMENT FROM TUMOUR TO NON-PERITONEALISED MARGIN: 1.3mm

PREOPERATIVE THERAPY GIVEN: No

PREOPERATIVE THERAPY RESPONSE: Not applicable

HISTOLOGICALLY CONFIRMED METASTATIC DISEASE: No

pTNM8 STAGING: pT3N0

COMPLETE RESECTION: Yes (R0)

DIAGNOSIS

CAECUM

ADENOCARCINOMA

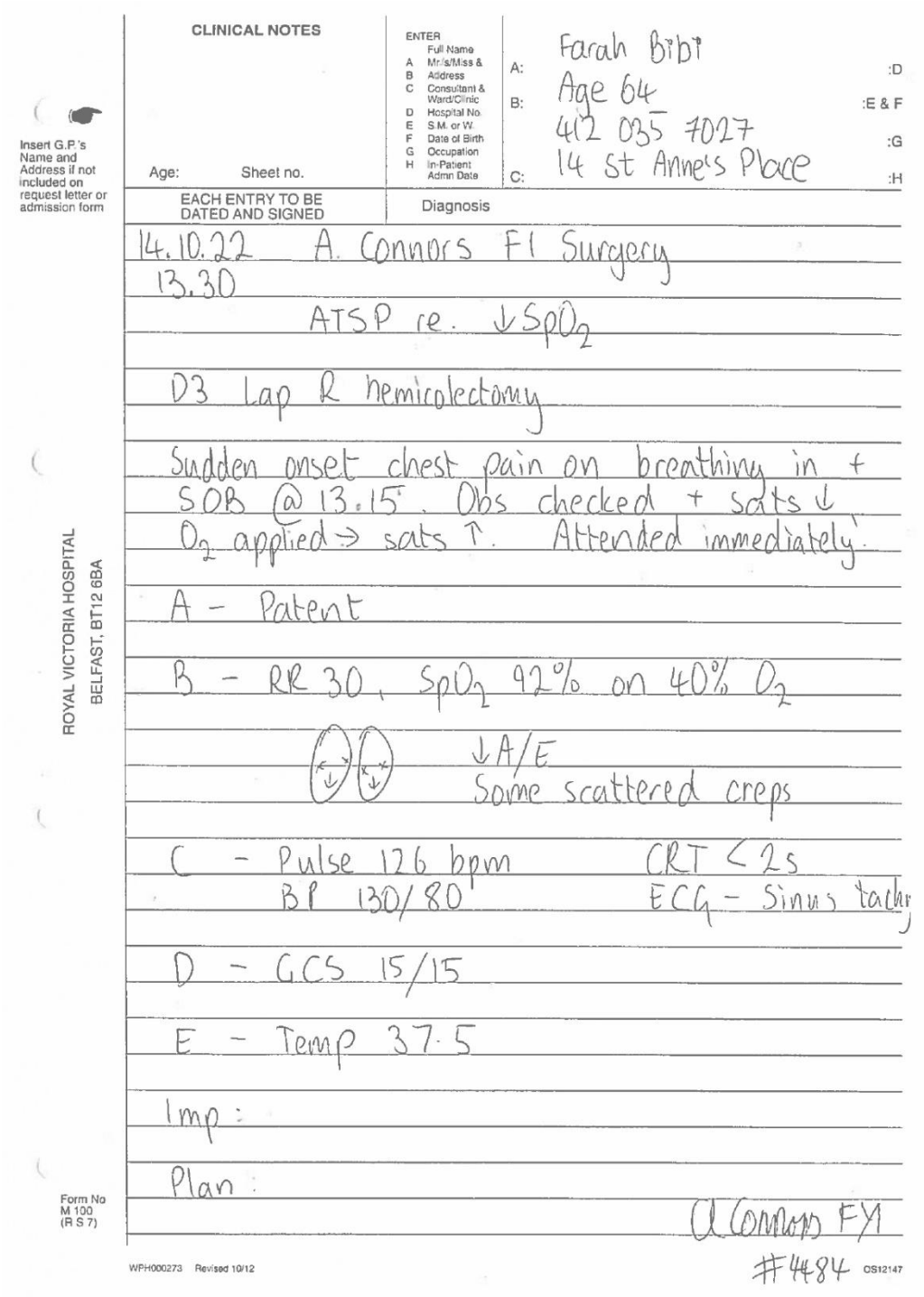
LYMPH NODES

NEGATIVE FOR TUMOUR

Day 3 post-op

Mrs Bibi is recovering on the surgical ward. IV fluids have been stopped, catheter has been removed and she is tolerating a light diet. Her pain was initially controlled with a PCA but she is now on oral analgesia. The F1 on the ward has been asked to see her urgently as she has developed chest pain and shortness of breath.

F1 Urgent Review



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: Farah Bibi :D
B: Age 64 :E & F
412 035 7027 :G
C: 14 St Anne's Place :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

14.10.22 A. Connors F1 Surgery
13.30
ATSP re. ↓SpO_2

D3 Lap R hemicolectomy

Sudden onset chest pain on breathing in + SOB @ 13.15. Obs checked + sats ↓ O_2 applied → sats ↑. Attended immediately.

A - Patent

B - RR 30, SpO_2 92% on 40% O_2
↓A/E
Some scattered creps

C - Pulse 126 bpm CRT < 2s
BP 130/80 ECG - Sinus tachy

D - GCS 15/15

E - Temp 37.5

Imp:

Plan:

A Connors FY1

ROYAL VICTORIA HOSPITAL BELFAST, BT12 6BA

Form No M 100 (R S 7)

WPH000273 Revised 10/12

#4484 OS12147

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

14/10/22 13.30 Connors F1 - urgent review

ATSP re. reduced sats

D3 Laparoscopic Right Hemicolectomy

Sudden onset chest pain on breathing in and SOB at 13.15. Obs checked and sats reduced, increased when O2 applied. Attended immediately.

A – Patent

B – RR 30, Sao2 92% on 40%v O2, chest examination – reduced air entry, some scattered creps

C – Pulse 126, BP 130/80, CRT <2s, ECG – sinus tachy

D – GCS 15/15

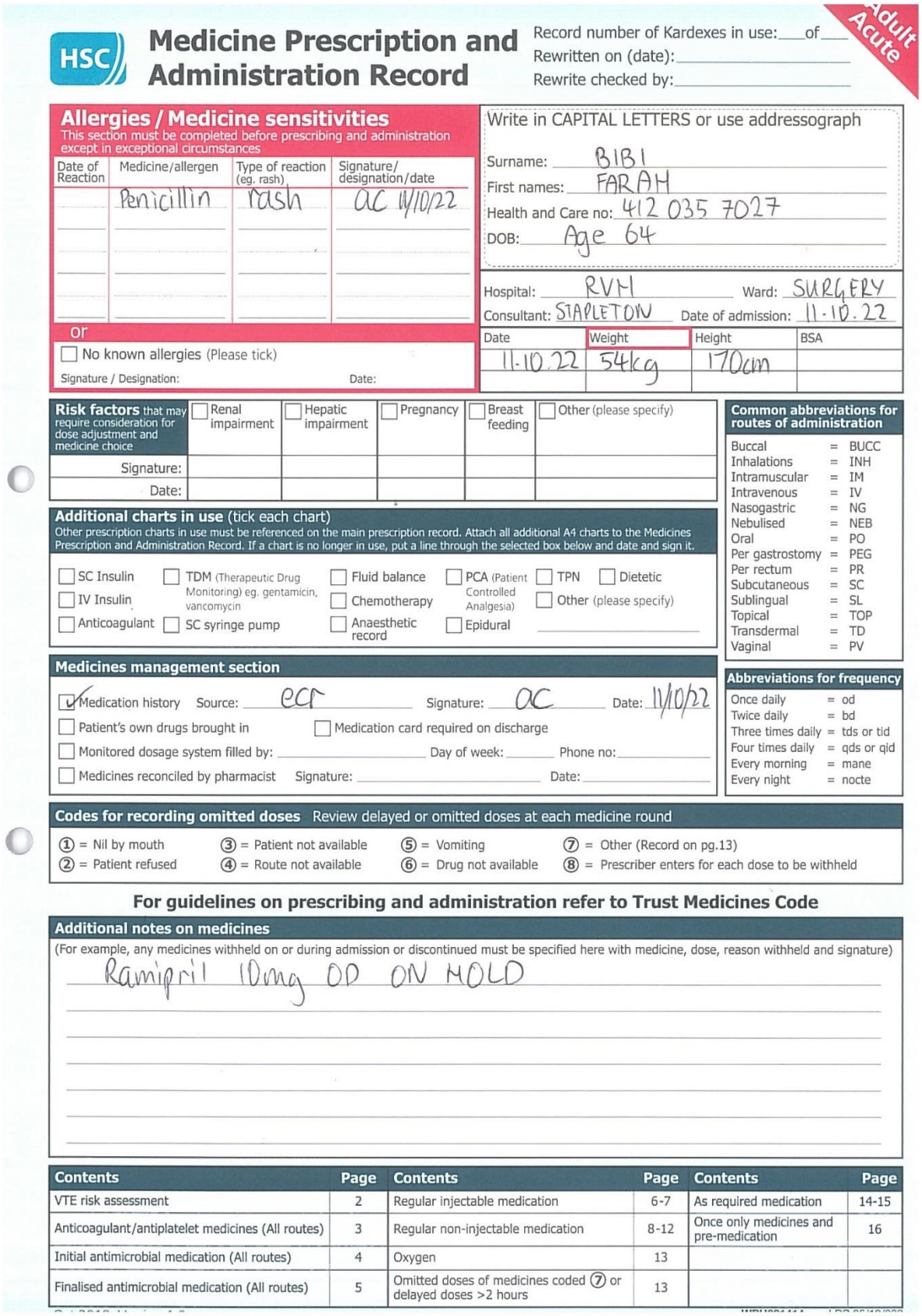
E – Temp 37.5

Impression:

P:

Signed Connors F1

Kardex



HSC

Medicine Prescription and Administration Record

Record number of Kardexes in use: ___ of ___
Rewritten on (date): _____
Rewrite checked by: _____

Adult Acute

Allergies / Medicine sensitivities
This section must be completed before prescribing and administration except in exceptional circumstances

Date of Reaction	Medicine/allergen	Type of reaction (eg. rash)	Signature/ designation/date
	Penicillin	rash	AC 11/10/22

or

☐ No known allergies (Please tick)

Signature / Designation: Date:

Write in CAPITAL LETTERS or use addressograph

Surname: BIBI
First names: FARAH
Health and Care no: 412 035 7027
DOB: Age 64

Hospital: RVH Ward: SURGERY
Consultant: STAPLETON Date of admission: 11.10.22

Date	Weight	Height	BSA
11.10.22	54kg	170cm	

Risk factors that may require consideration for dose adjustment and medicine choice	☐ Renal impairment	☐ Hepatic impairment	☐ Pregnancy	☐ Breast feeding	☐ Other (please specify)
Signature:					
Date:					

Common abbreviations for routes of administration

Buccal	=	BUCC
Inhalations	=	INH
Intramuscular	=	IM
Intravenous	=	IV
Nasogastric	=	NG
Nebulised	=	NEB
Oral	=	PO
Per gastrostomy	=	PEG
Per rectum	=	PR
Subcutaneous	=	SC
Sublingual	=	SL
Topical	=	TOP
Transdermal	=	TD
Vaginal	=	PV

Additional charts in use (tick each chart)
Other prescription charts in use must be referenced on the main prescription record. Attach all additional A4 charts to the Medicines Prescription and Administration Record. If a chart is no longer in use, put a line through the selected box below and date and sign it.

☐ SC Insulin ☐ IV Insulin ☐ Anticoagulant
☐ TDM (Therapeutic Drug Monitoring) eg. gentamicin, vancomycin ☐ SC syringe pump
☐ Fluid balance ☐ Chemotherapy ☐ Anaesthetic record
☐ PCA (Patient Controlled Analgesia) ☐ Epidural
☐ TPN ☐ Dietetic ☐ Other (please specify)

Medicines management section

☑ Medication history Source: ecr Signature: AC Date: 11/10/22
☐ Patient's own drugs brought in ☐ Medication card required on discharge
☐ Monitored dosage system filled by: _____ Day of week: _____ Phone no: _____
☐ Medicines reconciled by pharmacist Signature: _____ Date: _____

Abbreviations for frequency

Once daily	=	od
Twice daily	=	bd
Three times daily	=	tds or tid
Four times daily	=	qds or qid
Every morning	=	mane
Every night	=	nocte

Codes for recording omitted doses Review delayed or omitted doses at each medicine round

① = Nil by mouth ② = Patient refused ③ = Patient not available ④ = Route not available ⑤ = Vomiting ⑥ = Drug not available ⑦ = Other (Record on pg.13) ⑧ = Prescriber enters for each dose to be withheld

For guidelines on prescribing and administration refer to Trust Medicines Code

Additional notes on medicines
(For example, any medicines withheld on or during admission or discontinued must be specified here with medicine, dose, reason withheld and signature)

Ramipril 10mg OD ON HOLD

Contents	Page	Contents	Page	Contents	Page
VTE risk assessment	2	Regular injectable medication	6-7	As required medication	14-15
Anticoagulant/antiplatelet medicines (All routes)	3	Regular non-injectable medication	8-12	Once only medicines and pre-medication	16
Initial antimicrobial medication (All routes)	4	Oxygen	13		
Finalised antimicrobial medication (All routes)	5	Omitted doses of medicines coded ⑦ or delayed doses >2 hours	13		

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Allergy – penicillin (rash as a child)

Surgical ward, Consultant Stapleton, date of admission 11/10/22

Medication history source ECR

Ramipril 10mg OD ON HOLD

2 Venous Thromboembolism (VTE) Risk Assessment for Hospitalised Adults (excluding obstetric patients)

Patient Name: FARAH BIBI
H&C Number: 412 035 7027 DOB: Age 64

Step 1: Assess for level of mobility – All patients

	Tick		Tick		Tick
Surgical patient	✓	Medical patient expected to have ongoing reduced mobility relative to normal state		Medical patient NOT expected to have significantly reduced mobility relative to normal state	
Assess for thrombosis and bleeding risk below (Complete steps 2 – 5)				Risk assessment complete (Go to step 5)	

Step 2: Review thrombosis risk

Any tick for thrombosis risk factors should prompt consideration for thromboprophylaxis

Patient related	Tick	Admission related	Tick
Active cancer or cancer treatment	✓	Significantly reduced mobility for 3 days or more	
Age >60	✓	Hip or knee replacement	
Dehydration	✓	Hip fracture	
Known thrombophilias		Total anaesthetic + surgery time >90 minutes	✓
Personal history/first degree relative with history of VTE		Surgery involving pelvis or lower limb with anaesthetic + surgery time >60 minutes	
One or more significant medical comorbidities (eg. heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)		Acute surgical admission with inflammatory or intra-abdominal condition	
Obesity (BMI >30kg/m^2)		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing oral contraceptive therapy		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Varicose veins with phlebitis			
Pregnancy or <6 weeks post partum (see obstetric risk assessment for VTE)			

Step 3: Review bleeding risk

Any tick should prompt staff to consider if bleeding risk is sufficient to preclude pharmacological intervention

Patient related	Tick	Admission related	Tick
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorder (such as acute liver failure)		Lumbar puncture/epidural/spinal anaesthesia expected in the next 12 hours	
Concurrent use of anticoagulants known to increase risk of bleeding (such as warfarin with INR >2 or DOAC/NOAC such as apixaban, dabigatran, edoxaban or rivaroxaban)		Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Acute stroke		Other procedure with high bleeding risk	
Thrombocytopaenia (Platelets <75x10^9/l)		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Uncontrolled hypertension (>230/120mmHg)			
Untreated inherited bleeding disorder (such as haemophilia and von Willebrand's disease)			

Step 4: Tick the appropriate risk category

		Tick		Tick		Tick
Risk of VTE	High risk of VTE with low bleeding risk	✓	High risk of VTE with significant bleeding risk		Low risk of VTE	
Is thromboprophylaxis indicated?	Yes	✓	Type prescribed		Pharmacological eg. LMWH	✓
	No				Mechanical eg. Antiembolic compression hosiery	✓

Step 5: Signature

VTE risk assessed on admission

Signature: A Connors Print Name: A. Connors

Date: 11.10.22 Time: 08.30

VTE risk should be re-assessed within 24 hours and whenever clinical condition changes

For further information on pharmacological and mechanical prophylaxis, refer to Trust Thromboprophylaxis Policy

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Step 1 – Assess for level of mobility – All patients

Surgical patient

Step 2 – Review thrombosis list

Active cancer or cancer treatment, age >60, dehydration, total anaesthetic and surgery time >90mins

Step 3 – Review bleeding risk

Step 4 – Tick the appropriate risk category

High risk of VTE with low bleeding risk

Is thromboprophylaxis indicated? Yes

Type prescribed: pharmacological and mechanical

Step 5 – signature

VTE risk assessment on admission

Signature A Connor, print name A Connor, date 11/10/22, time 08:30

Anticoagulants & Antiplatelets

(All Routes)

Check allergies/medicine sensitivities and patient identity

3

Patient Name: Farah Bibi

H&C Number: 612035 7027 DOB: age 64

Year:

Day and month: → 11/10, 12/10, 13/10, 14/10

Circle times or enter variable dose/time

ENOXAPARIN

Medicine	ENOXAPARIN
Dose	
Route	S/C
Frequency	
Special instructions/Indication	
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New
Sign	
Prof. no.	
Print	
Bleep	
Start date	
Stop date	
Signature	
Supply	
Pharmacist	

Times: 06⁰⁰, 10⁰⁰, 18⁰⁰, 22⁰⁰ (entry crossed through)

Enoxaparin dosing must be based on the indication, patient's weight and renal function. For further advice consult Trust guidelines.

- Do not prescribe injectable anticoagulants with NOACs/DOACs such as **apixaban** (Eliquis®), **dabigatran** (Pradaxa®), **edoxaban** (Lixiana®) or **rivaroxaban** (Xarelto®) due to increased risk of bleeding
- Do not prescribe enoxaparin with warfarin **unless** bridging a sub therapeutic INR **or** managing acute DVT/PE
- Reference warfarin on this page and prescribe on separate warfarin prescription chart
- Check co-prescription of antiplatelets (eg. **aspirin, clopidogrel, ticagrelor, prasugrel, dipyridamole**) with an anticoagulant is clinically indicated before prescribing.

FONDAPARINUX

Medicine	FONDAPARINUX
Dose	2.5mg
Route	S/c
Frequency	NOCTE
Special instructions/Indication	
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / (New)
Sign	AC
Prof. no.	1789321
Print	A Connors
Bleep	4414
Start date	11.10
Stop date	
Signature	
Supply	
Pharmacist	

Time		11/10	12/10	13/10	14/10
06⁰⁰					
10⁰⁰					
12⁰⁰					
14⁰⁰					
18⁰⁰					
(22⁰⁰)		NS	NS	NS	

TEDS

Medicine	TEDS
Dose	T
Route	TOP
Frequency	OVER 24 H
Special instructions/Indication	
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / (New)
Sign	AC
Prof. no.	178932[illegible]
Print	A Connors
Bleep	4480
Start date	11.10
Stop date	
Signature	
Supply	
Pharmacist	

Time		11/10	12/10	13/10	14/10
06⁰⁰			FP	NS	NS
10⁰⁰			FP	OR	LO
12⁰⁰			FP	OR	LO
14⁰⁰		NR	FP	OR	
18⁰⁰		NR	FP	OR	
22⁰⁰		NS	NS	NS	

Blank prescription boxes (×3)

Each box: Medicine / Dose / Route / Frequency / Special instructions/Indication / Medicines Reconciliation (circle): Pre-admission dose, Increased dose, Decreased dose, New / Sign / Prof. no. / Print / Bleep / Start date / Stop date / Signature / Supply / Pharmacist / 06⁰⁰ 10⁰⁰ 12⁰⁰ 14⁰⁰ 18⁰⁰ 22⁰⁰

①

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Enoxaparin 40mg SC NOCTE 22.00

TEDS stocking TOP over 24 hours

Signed A Connors Prof no 7989321 bleep 4484

Regular non-injectable medication

Check allergies/medicine sensitivities and patient identity

Prescribe anticoagulants/antiplatelets on page 3 only

Patient Name: Farah Bibi

H&C Number: 412 035 7027 DOB: age 64

Year: | Day and month: → | Circle times or enter variable dose/time

Medicine 1

Field	Entry
Medicine	Paracetamol
Dose	1g
Route	PO
Frequency	QID
Special instructions/Indication	
Start date	11.10
Stop date	
Signature	
Supply	
Pharmacist	
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / **New** (circled)
Sign	ac
Prof. no.	7989321
Print	A Connors
Bleep	4484

Time	11/10	12/10	13/10	14/10
06:00 (circled)		NS	NS	NS
10:00				
12:00 (circled)		FP	DR	LD
14:00				
18:00 (circled)	NR	FP	DR	
22:00 (circled)	NS	NS	NS	

Medicine 2

Field	Entry
Medicine	Ramipril
Dose	10mg
Route	PO
Frequency	MANE
Special instructions/Indication	
Start date	11.10
Stop date	
Signature	
Supply	
Pharmacist	
Medicines Reconciliation (circle)	**Pre-admission dose** (circled) / Increased dose / Decreased dose / New
Sign	ac
Prof. no.	7989321
Print	A Connors
Bleep	4485

Time	11/10	12/10	13/10	14/10
06:00				
10:00 (circled)		HOLD		
12:00				
14:00				
18:00				
22:00				

Medicines 3–6 (blank entries): Medicine | Dose | Route | Frequency | Special instructions/Indication | Medicines Reconciliation (circle): Pre-admission dose, Increased dose, Decreased dose, New | Sign | Prof. no. | Print | Bleep | Start date | Stop date | Signature | Supply | Pharmacist | Times: 06:00, 10:00, 12:00, 14:00, 18:00, 22:00

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Regular non-injectable medication: Paracetamol 1g QID PO, Ramipril 10mg MANE OD ON HOLD.

Signed A Connors Prof no 7989321 bleep 4484

Oxygen section

For use in adult patients (16 and over)

Patient Name: Farah Bibi

H&C Number: 412 035 7027 DOB: age 64

A prescriber must prescribe the initial flow rate and device. The method and rate of oxygen delivery should be altered by nurses or other healthcare professionals in order to achieve the prescribed saturation range.

NB. The initial prescription does NOT need to be rewritten if the device or flow rate is changed by the nurse or physiotherapist who must document the change in clinical notes. Remember, rapid changes in clinical condition require medical review.

Prescriber: For most chronic conditions, oxygen should be prescribed to achieve a target saturation of 94-98% (or 88-92% for those at risk of hypercapnic respiratory failure ie. CO_2 retainers).

Is the patient a known CO_2 retainer?

☐ Yes ☑ No

Prescription: OXYGEN

Administration: Check and record flow rate (FR)/device (D) at each medicine round or other times specified.

Year: 2022

Day and month: →
Other times: ↓

☐ Continuous oxygen therapy
☑ Or 'When required' oxygen therapy

Target oxygen saturation ☐ 88-92% ☑ 94-98%

Other saturation range: ______

Tick here ☐ if saturation not indicated and state reason eg. end of life care

Starting device and flow rate:	Start date	Stop date
2L NC	11/10	Signature

Signature	Prof. No.	Pharmacist
AC	7989321	

Print name: A Connors Bleep: 448

Time														
06:00														
FR/D														
10:00														
FR/D														
12:00														
FR/D														
14:00														
FR/D														
18:00														
FR/D														
22:00														
FR/D														

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 rebreather mask, consider medical review.
V24 Venturi 24% (change figure as appropriate for % in use)	**NIV** Patient on NIV system	**RM** Reservoir mask	If target saturations are 88-92%, nebulised drugs should not be driven by oxygen (unless specified by the doctor).
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)			

Omitted doses of medicines coded ⑦ or delayed doses >2hrs

Date	Time	Medication, Dose, Route	Reason for omission coded ⑦/delay >2hrs	Signature

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

Oxygen section

Prescription: Oxygen

Year: 2022

Is this patient a known CO2 retainer? No

When required oxygen therapy

Target sats 94-98%

Starting device and flow rate 2litres NC

Start date 11/10

Signed A Connors Prof no 7989321 bleep 4484

As required medication

Check allergies / medicine sensitivities and patient identity
Check regular medicines

Patient Name: Farah Bibi
H&C Number.: 412 035 7027 DOB: age 64

Field	Value	Field	Value
Medicine	Ondansetron	Start date	11.10
Dose	4-8mg	Stop date	
Route	PO/IV	Signature	
Frequency	BD	Supply	
Special instructions/Indication		Pharmacist	
Max dose in 24hrs	16mg		
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New (circled: New)		
Sign	ac	Prof. no.	798932?
Print	A Connors	Bleep	4484

Date	11/10	
Time 24 hr clock	22.15	
Dose / Route	8mg / IV	
Given by	WS / FR	

Field	Value	Field	Value
Medicine	Shortec	Start date	11.10
Dose	5mg	Stop date	
Route	PO	Signature	
Frequency	4-6°	Supply	
Special instructions/Indication	FIVE	Pharmacist	
Max dose in 24hrs	30mg		
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New (circled: New)		
Sign	ac	Prof. no.	7989321
Print	A Connors	Bleep	4484

Date	11/10	12/10
Time 24 hr clock	21.00	14.15
Dose / Route	5mg / PO	5mg / PO
Given by	WS / FR	FP / TA

Field	Value	Field	Value
Medicine	0.9% NaCl	Start date	11.10
Dose	2.5ml	Stop date	
Route	NEB	Signature	
Frequency	QID	Supply	
Special instructions/Indication		Pharmacist	
Max dose in 24hrs	QID		
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New (circled: New)		
Sign	ac	Prof. no.	7989321
Print	A Connors	Bleep	4484

Date	
Time 24 hr clock	
Dose / Route	
Given by	

Field	Value	Field	Value
Medicine		Start date	
Dose		Stop date	
Route		Signature	
Frequency		Supply	
Special instructions/Indication		Pharmacist	
Max dose in 24hrs			
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New		
Sign		Prof. no.	
Print		Bleep	

Date	
Time 24 hr clock	
Dose / Route	
Given by	

Field	Value	Field	Value
Medicine		Start date	
Dose		Stop date	
Route		Signature	
Frequency		Supply	
Special instructions/Indication		Pharmacist	
Max dose in 24hrs			
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New		
Sign		Prof. no.	
Print		Bleep	

Date	
Time 24 hr clock	
Dose / Route	
Given by	

Field	Value	Field	Value
Medicine		Start date	
Dose		Stop date	
Route		Signature	
Frequency		Supply	
Special instructions/Indication		Pharmacist	
Max dose in 24hrs			
Medicines Reconciliation (circle)	Pre-admission dose / Increased dose / Decreased dose / New		
Sign		Prof. no.	
Print		Bleep	

Date	
Time 24 hr clock	
Dose / Route	
Given by	

Text:

Patient: Farah Bibi, age 64, HCN 412 035 7027, 14 St Anne's Place

As required medication O.9% NaCl 2.5ml NEB QID, Ondansetron 4-8mg PO/IV BD max 16mg in 24h, shortec 5mg 4-6 hourly PRN

Signed A Connors Prof no 7989321 bleep 4484

Investigations

412 035 7027 BIBI, Farah (Female / 64 years)

Complete Blood Count

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
HGB	* 100	130-180 (g/L)
HCT	* 0.30	0.40-0.54 (L/L)
WBC	*12.2	4.0-10.0 (x 10^9/L)
PLT	*100	150-450 (x 10^9/L)
RBC	* 3.2	3.8-5.8 (x 10^{12}/L)
MCV	* 71	76-100 (fL)
MCHC	* 300	320-360 (g/L)
MCH	* 25	27-32 (pg)
NEUT	*8.0	2.0-7.5 (x 10^9/L)
LYMPH	*3.8	1.0-3.5 (x 10^9/L)
MONO	0.3	0.2-0.8 (x 10^9/L)
EOSIN	0.06	0.04-0.4 (x 10^9/L)
BASO	0.01	0.01-0.1 (x 10^9/L)

* Denotes abnormal result

Electrolyte Profile

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
Sodium	135	136-145 (mmol/L)
Potassium	4.1	3.5-5.3 (mmol/L)
Chloride	95	95-108 (mmol/L)
CO2	23	22-29 (mmol/L)
Urea	5.0	2.5-7.8 (mmol/L)
Creatinine	47	45-84 (µmol/L)
eGFR	>60	<60 (mL/min/1.73m^2)

* Denotes abnormal result

Liver Profile

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
T. Bilirubin	13	<21 (µmol/L)
ALP	58	30-130 (U/L)
AST	*40	<32 (U/L)
GGT	27	6-42 (U/L)
ALT	*35	<33 (U/L)
Albumin	40	35-50 mg/L

CRP

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
C reactive protein (CRP)	*164	<5 (mg/L)

D dimer

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
D dimer	*1.87	<0.5 (mg/L)

NT pro-BNP

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
NT pro-BNP	300	5-349 (pg/mL)

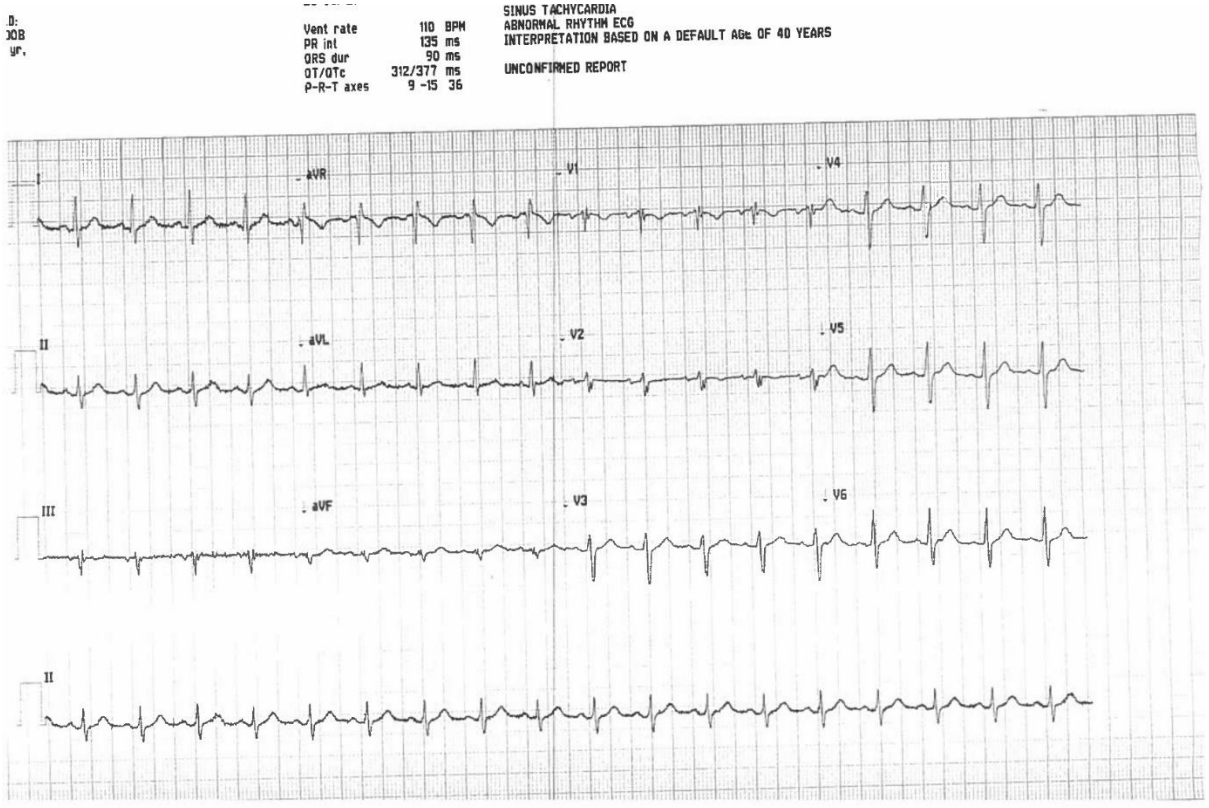
Troponin T

Number	1	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	14-Oct 2022 15:00	
Signed			
Source	BHSCT	BHSCT	
Troponin T	9	9	0-14 (ng/L)

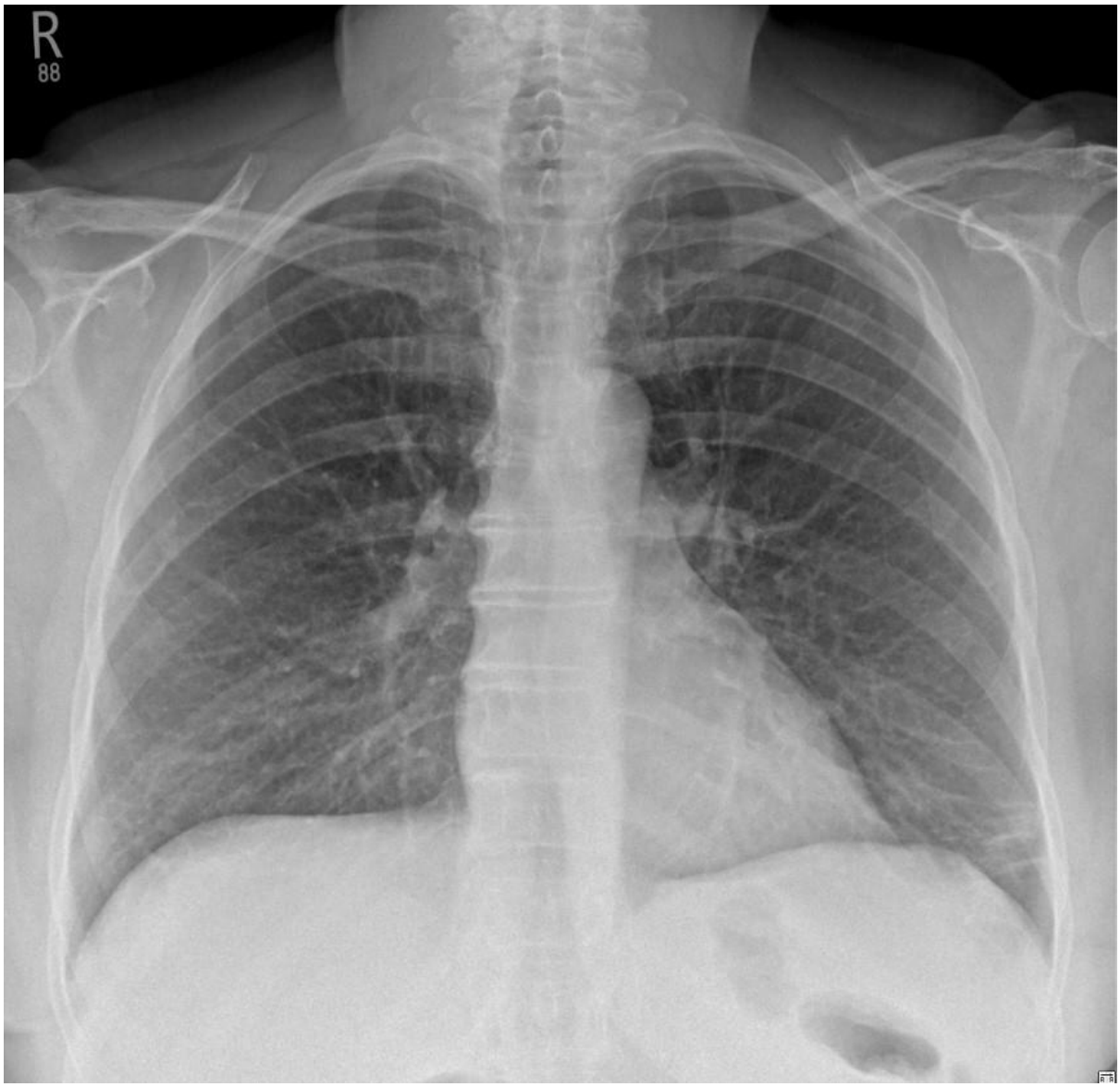
ABG

Number	1	Ref. Range (Units)
Collected	14-Oct 2022 14:00	
Signed		
Source	BHSCT	
Sample type	Blood	
Blood type	Arterial	
Temperature	37.0°C	
FiO_2	40%	
pH	*7.48	7.350-7.450
pCO2	*4.22	4.30-6.40 (kPa)
pO2	*7.9	11.00-14.40 (kPa)
Na^+	135	133.0-146.0 (mmol/L)
K^+	4.1	3.50-4.50 (mmol/L)
Cl^-	95	95.0-108.0 (mmol/L)
Ca^{2+}	1.3	1.150-1.350 (mmol/L)
Glu	6.7	4.0-7.7 (mmol/L)
Lac	*1.6	1.0-1.4 (mmol/L)
tHb	*100	115.0-180.0 (g/L)
Hct	*0.3	0.370-0.540 (%)
SO_2	*92	94.0-98.0 (%)
BE	0.45	-2 - +3 (mmol/L)
$cHCO_3$	23.1	22.0-29.0 (mmol/L)

ECG


SINUS TACHYCARDIA
ABNORMAL RHYTHM ECG
INTERPRETATION BASED ON A DEFAULT AGE OF 40 YEARS
UNCONFIRMED REPORT
Vent rate 110 BPM
PR int 135 ms
QRS dur 90 ms
QT/QTc 312/377 ms
P-R-T axes 9 -15 36
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II

Chest X-ray



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: Farah Bibi :D
B: Age 64 :E & F
MCN 4120357027
14 St Anne's Place, Belfast :G
C: :H

EACH ENTRY TO BE DATED AND SIGNED | Diagnosis

ROYAL VICTORIA HOSPITAL
BELFAST, BT12 6BA

14/10/22 T Dillon ST5 – Urgent r/v
14.15

ATSP re. chest pain + SOB
D3 Lap R hemicolectomy
Sudden onset chest pain + SOB @ 13.15
Chest pain R sided, pleuritic, no radiation
Assoc c̄ SOB acutely
New cough prod. of clear sputum
Low grade temp 37.7°C

O/E
A – Patent
B – RR 28, SpO_2 92% on 40% O_2
Using accessory muscles — ABG – T1RF
↓ breathing sounds at base — PaO_2 8 on 40%
(↓)(↓) °creps — CXR – Basal atelectasis
°signs DVT
C – Pulse 126, regular — CRT <2s — ECG – Sinus tachy
BP 125/75 — HS I + II ∅ — Nil ischaemic change
°periph. oedema
Past 24h: Input 2950ml
Output 3000ml
D – Alert — PERLA
GCS 15/15 — BM 6.9
E – 37.7°C
No concern re wound
No signs of bleeding
Catheter draining clear urine
Kardex – prophylactic clexane px + given

Form No M 100 (R S 7)

WPH000273 Revised 10/12 OS12147

Text:

412 035 7027 BIBI, Farah (Female / 64 years)

14/10/22 14.15 Dillon ST5 urgent review

ATSP re. chest pain and SOB
D3 lap R hemicolectomy
Sudden onset chest pain and SOB at 13.15. Chest pain R sided, pleuritic, no radiation. Associated with acute shortness of breath. New cough productive of clear sputum. Low grade temp 37.7.

O/E

A – Patent

B – RR 28, Sao2 92% on 40%v O2, using accessory muscles, chest examination – Reduced breath sounds at base, no crepitations, no signs of DVT.
ABG – Type 1 respiratory failure, PaO2 8 on 40% O2
CXR – basal atelectasis

C – pulse 126, regular, BP 125/75, CRT <2s, HS 1+2+0, no peripheral oedema,
Past 24h Input 2950ml/Output 3000ml.
ECG – sinus tachycardia, nil ischaemic change.

D – Alert, GCS 15/15, PERLA, BM 6.9

E – temp 37.7

Abdomen exam – no concern re wound

No signs of bleeding.

Catheter draining clear urine.

Kardex – prophylactic enoxaparin prescribed

Cont. Impression: Pleuritic chest pain ?PE
?LRTI / HAP

Plan: Urgent bloods: (R), D dimer, BNP, TnT, procalcitonin
Urgent CTPA - d/w radiology
Blood cultures if temp spike
Sputum D+S
Increase O_2 to 60%
Therapeutic enoxaparin for ?PE
Cover c IV Abx (pen allergic) for ?LRTI
Continue input/outputs
Patient for escalation

J Dillon ST5

Text:

Impression:

Pleuritic chest pain ?PE

?LRTI/HAP

Plan:

Urgent bloods, D dimer, BNP, TnT, procalcitonin

Urgent CTPA – discussed with radiology

Blood cultures if temp spike

Sputum O&S

Increase O2 to 60%

Therapeutic enoxaparin for ?PE

Cover with IV Abx (pen allergic) for ?LRTI

Continue input/output

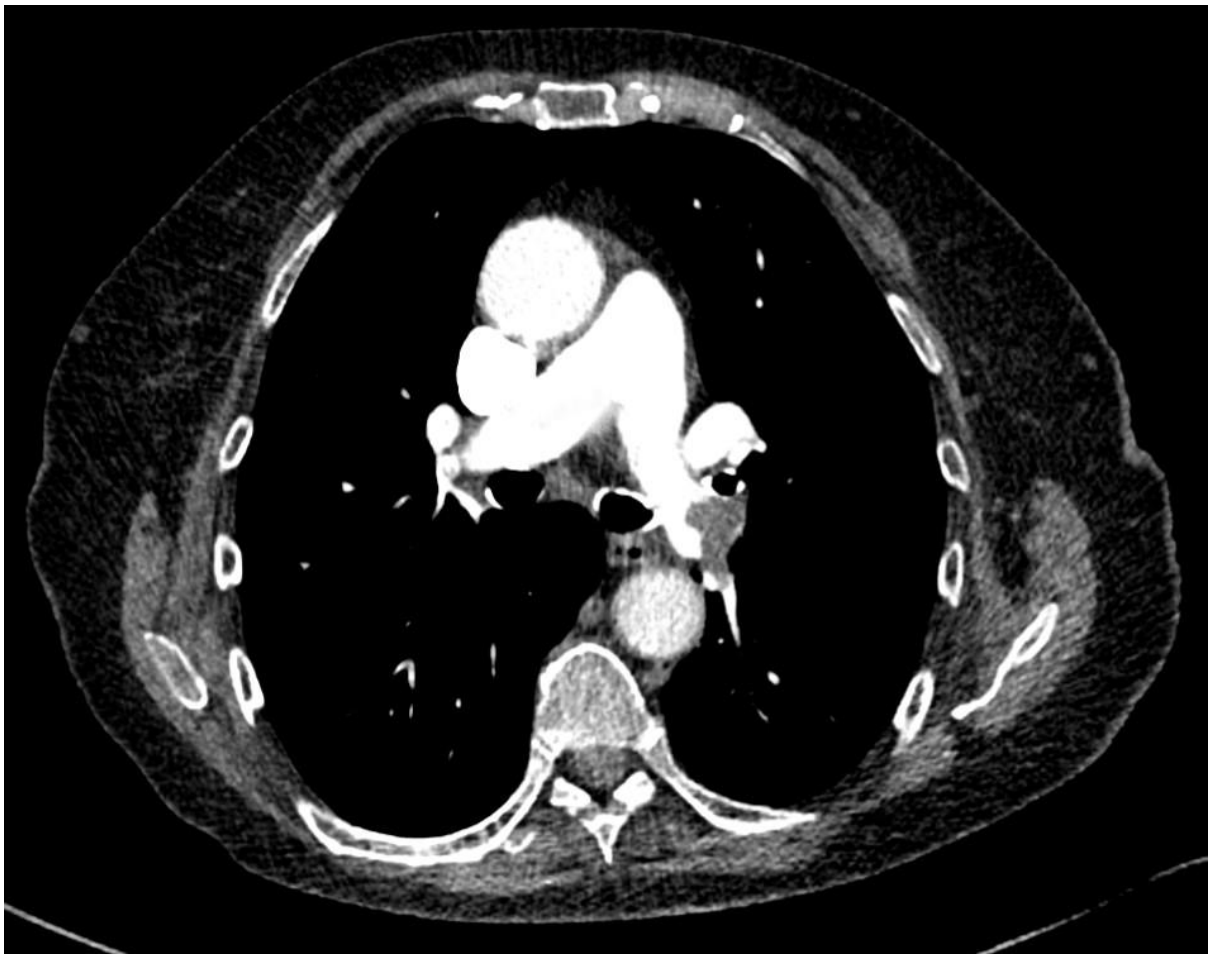
Patient for escalation in event of further deterioration

Signed J Dillon ST5

Investigations

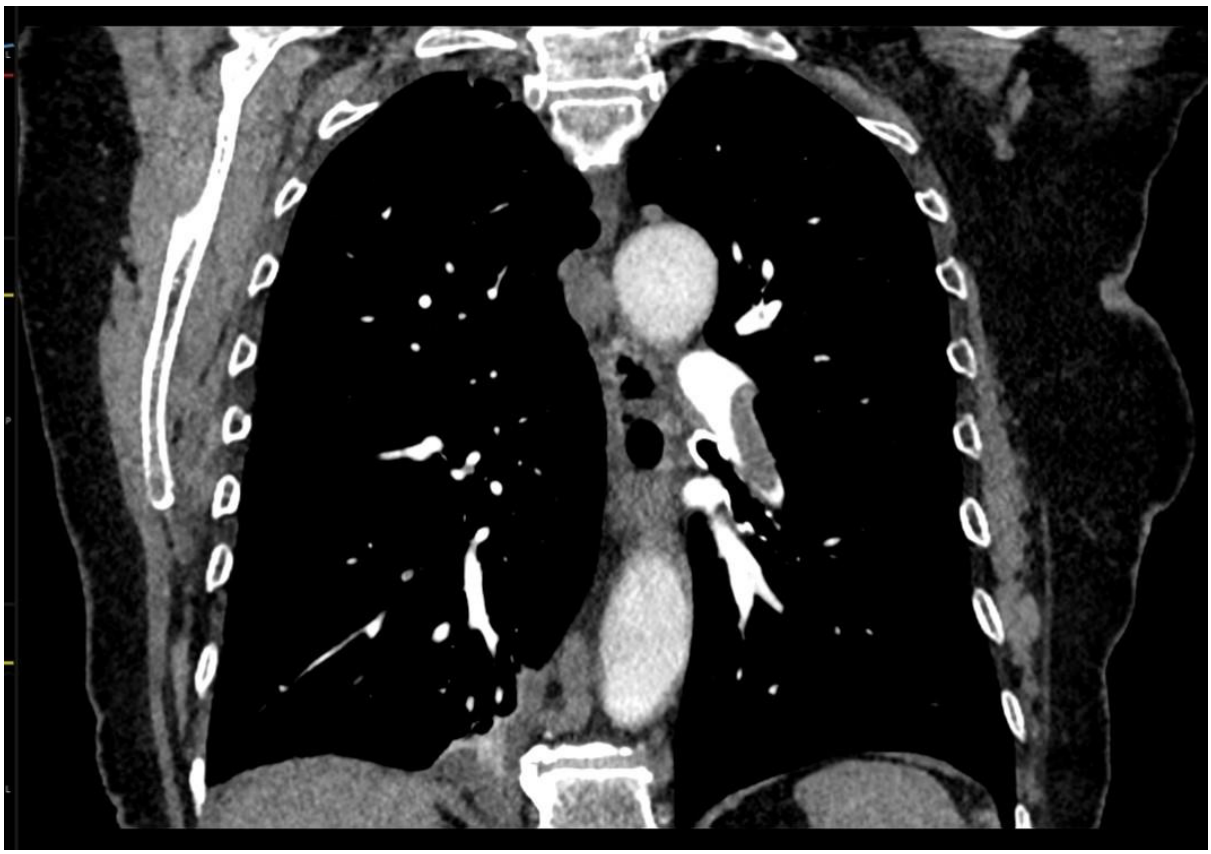
CTPA

Axial view



Left lower lob PE – axial view

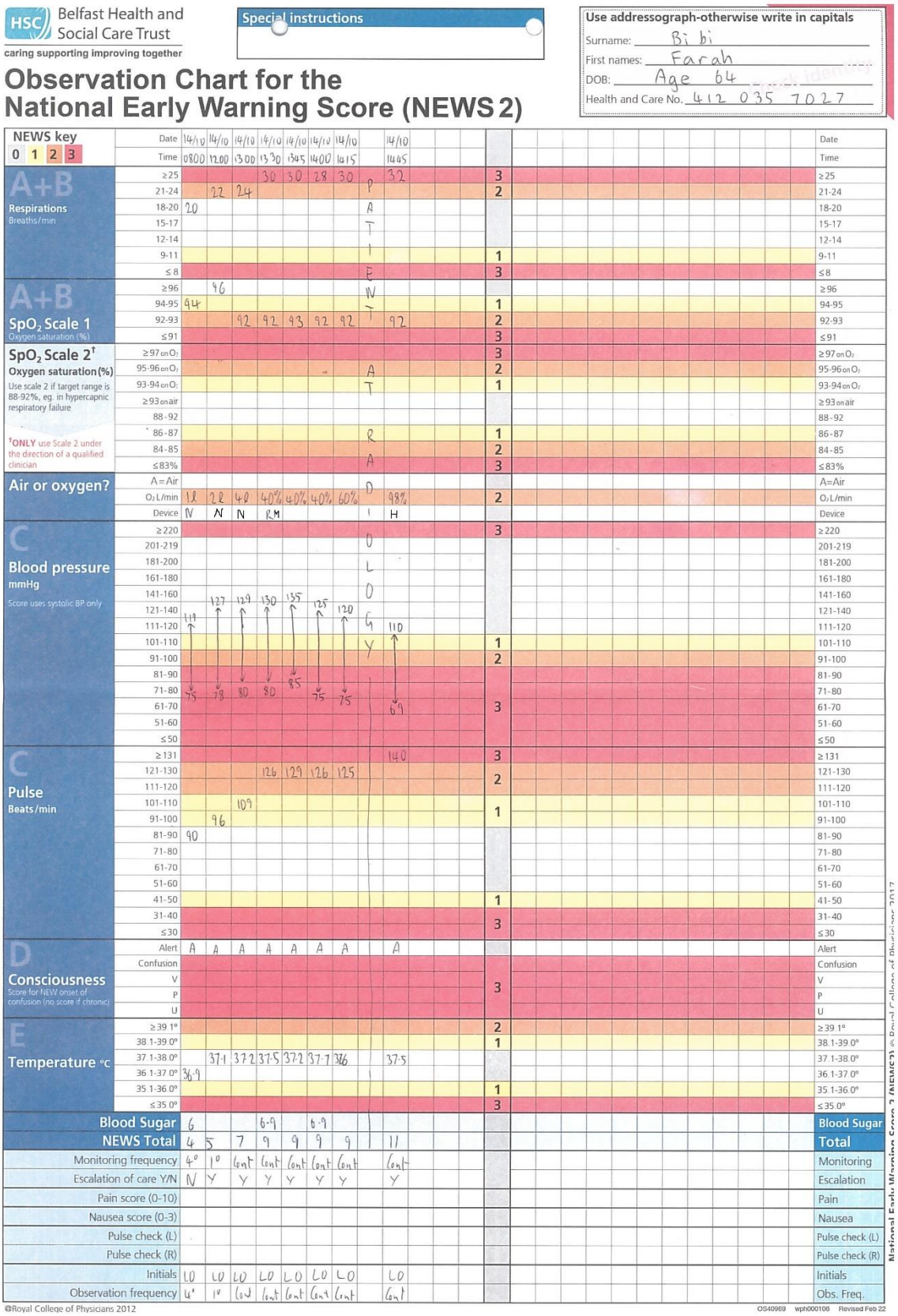
Coronal view



Left lower lob PE – coronal view

STUDENT MATERIALS

NEWS Observation Chart



Belfast Health and Social Care Trust
caring supporting improving together

Special instructions

Use addressograph-otherwise write in capitals
Surname: Bi bi
First names: Farah
DOB: Age 64
Health and Care No. 412 035 7027

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

NEWS key 0 1 2 3	Date	14/10	14/10	14/10	14/10	14/10	14/10	14/10		14/10		Date
	Time	0800	1200	1300	1330	1345	1400	1415		1445		Time
A+B Respirations Breaths/min	≥25				30	30	28	30	P	32	3	≥25
	21-24		22	24					A		2	21-24
	18-20	20							T			18-20
	15-17								I			15-17
	12-14								E			12-14
	9-11								N		1	9-11
	≤8								T		3	≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96		96									≥96
	94-95	94									1	94-95
	92-93			92	92	93	92	92		92	2	92-93
	≤91										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								A		2	95-96 on O_2
	93-94 on O_2								T		1	93-94 on O_2
	≥93 on air											≥93 on air
	88-92											88-92
	86-87								R		1	86-87
	84-85								A		2	84-85
	≤83%										3	≤83%
Air or oxygen?	A=Air								D			A=Air
	O_2 L/min	18	28	40	40%	40%	40%	60%		98%	2	O_2 L/min
	Device	N	N	N	RM				I	H		Device
C Blood pressure mmHg Score uses systolic BP only	≥220										3	≥220
	201-219								O			201-219
	181-200								L			181-200
	161-180								O			161-180
	141-160		127	129	130	135	125	120				141-160
	121-140	119							G	110		121-140
	111-120								Y			111-120
	101-110										1	101-110
	91-100										2	91-100
	81-90											81-90
	71-80	75	78	80	80	85	75	75				71-80
	61-70									69	3	61-70
	51-60											51-60
	≤50											≤50
C Pulse Beats/min	≥131									140	3	≥131
	121-130				126	129	126	125			2	121-130
	111-120											111-120
	101-110			109							1	101-110
	91-100		96									91-100
	81-90	90										81-90
	71-80											71-80
	61-70											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	A	A	A	A		A		Alert
	Confusion											Confusion
	V										3	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	37.2	37.5	37.2	37.7	37.6		37.5		37.1-38.0°
	36.1-37.0°	36.9										36.1-37.0°
	35.1-36.0°										1	35.1-36.0°
	≤35.0°										3	≤35.0°
Blood Sugar		6			6.9		6.9					Blood Sugar
NEWS Total		4	5	7	9	9	9	9		11		Total
Monitoring frequency		4°	1°	Cont	Cont	Cont	Cont	Cont		Cont		Monitoring
Escalation of care Y/N		N	Y	Y	Y	Y	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		LO	LO	LO	LO	LO	LO	LO		LO		Initials
Observation frequency		4°	1°	Cont	Cont	Cont	Cont	Cont		Cont		Obs. Freq.

©Royal College of Physicians 2012 OS40969 wph000106 Revised Feb 22

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

Text:

412 035 7027 BIBI, Farah (Female / 64 years) 14/10/22

NEWS Observation chart

0800 RR 20 /min. pulse 96/min BP 119/75. SaO2 94% on 1lNC. Temp 36.9. Alert. NEWS 4

1200 RR 22/min pulse 96/min BP 127/78. SaO2 94% on 2l. Temp 37.1 Alert. NEWS 5

1300 RR 24/min, pulse 109, BP 129/80, SaO2 92% on 4l NC, temp 37.2. Alert. NEWS 7

13.30 - RR 30 /min. pulse 126/min BP 130/80. SaO2 92% on 40%v O2. Temp 37.5, Alert. NEWS 9

13.45 – RR 30/min, pulse 129, BP 135/85, SaO2 93% on 40%, temp 37.2 Alert. NEWS 9

14.00 – RR 28/min, pulse 126, BP 125/75, SaO2 92% on 40%, temp 37.7. Alert. NEWS 9

14.15 – RR 30/min, pulse 125, BP 120/75, SaO2 92% on 60%, temp 37.6. Alert. NEWS 9

Patient at radiology

14.45 – RR 32/min, pulse 140, BP 110/69, SaO2 92% on 98% humidified, 37.5. Alert. NEWS 11

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).