

HAVE YOU LABELLED THE

SPECIMEN CORRECTLY?

**PRESS FIRMLY ON EACH END
TO ENSURE A LEAKPROOF
SPECIMEN CARRIER**

JB:54593

Ver. BTS RF 02



BLOOD TRANSFUSION



EDINBURGH & SOUTH EAST SCOTLAND BLOOD TRANSFUSION CENTRE
 New Royal Infirmary 51 Little France Crescent Edinburgh EH16 4SA
 Telephone No. 0131 242 7501/02/05 Fax No. 0131 242 7503
 **** COMPLETE BOXES 1 - 6 ****



SPECIMENS MUST CONFORM TO BSCH GUIDELINES (SEE REVERSE). INCORRECTLY LABELLED (*) SAMPLES WILL NOT BE TESTED

1 Patient Details 700629263X M 17/01/1957 Atkinson, Alexander D Skinnergate Resettlement Unit, 16 Skinnergate, Perth, Perthshire, PH1 5JH CHI 1701570130 CHI 13975 Anti-D this pregnancy Y N Date & Dose Given E.D.D. Previous Surname Sample Type Venous / Cord		2 Patient Location & Requesting Medical Officer Details Hospital A&E Ward 10R Surgery Address Signature & Name (Please Print) of Person taking sample * Contact telephone/bleep no. #6837 Name of person requesting tests (if not as above) * K. STEWART Date & Time sample taken		3 Diagnosis/Reason For Request referral for cardiac surgery - mvc	
5 Urgency EXTREME (10-15 mins) <input type="checkbox"/> Very Urgent (<40 mins) <input type="checkbox"/> Within 3 hours <input type="checkbox"/> Same Day <input type="checkbox"/> Routine Antenatal request <input type="checkbox"/> Other (please give date/time) <input type="checkbox"/>		6 Maternal Details if Sample from Baby Surname Forename DOB Hospital / CHI No.		4 Requirements Group & Save Kleihauer Direct Antiglobulin Test Special Investigations (SEE REVERSE) RCC amount Platelets# amount FFP amount Cryo amount Anti-D amount Other Products# Special Requirements CMV Neg <input type="checkbox"/> Irradiated <input type="checkbox"/> #Medical clearance may be necessary	
LAB USE ONLY Specimen Details Received By: Blood Group E/Release Y N Registered By: Date of Last Transfusion Date & Time Received Order No. Antibodies Barcode					



BLOOD TRANSFUSION

LAB USE ONLY

Electronic Release Criteria

11

Auto/Allo absorption (By arrangement)

(Except Group 0)

Antibody Screening Agent

Fully automatic

ELECTRONIC WALLS

(Please circle)

二、

[illegible]

(BMS Staff) 4101

Patient Address

53

1



100

3

Easy Open



BIOHAZARD

request form for cord samples. Maternal samples **MUST** conform to the above criteria. Samples with details from another patient will be discarded.

700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compson

CARDIOTHORACIC SURGERY

Royal Infirmary of Edinburgh

Consultant NW
Operation MVR (m)
Cardiologist Deuchar

Date		17/14	1/5	2/5	3/5	4/5	5/5	6/5	7/5	8/5		
Time			10:30	10:30	1	2	3					
Days post op			10pm	10								
Hb	11.5 to 16.5	153	143		108	95	81	107	100	110		
WBC	4 to 11	8.3	7.3		10.9	14.2	11	8.4	6.7	7.8		
Plts	150 to 400	209	217		176	175	145	176	208	267		
PT	n=9		19	19	16				36			
INR	0.8-1.0		(1.4)	(1.6)	1.3	2.0	3.7	(6.1)	3.1	(1.6)		
APTT	27-(32)-38		36	35	31				44			
APTT Mix			1.1	1.2	1.0				31			
Fibrinogen	1.5 to 4		3.7	3.3	2.5				4.9			
Glucose	<11	5.5										
Urea	2.5 to 6.6	6.9	←	6.1	7.0	8.3	5.2	2.9	2.5	2.3		
Creatinine	60 to 120	76		94	82	72	53	52	55	61		
eGFR		260		760	260	760	760	760	760	760		
Sodium	135 to 145	139		137	131	135	129	133	138	136		
Potassium	3.6 to 5	4.1		4.8	5.6	4.5	3.1	3.8	4.9	4.5		
TCO2	22 to 30	28	←	30			27	28	27	24		
Bilirubin	3 to 16	14	←	15	13	16				18		
ALT	10 to 50	25		40	25	23				28		
Alk Phos	40 to 125	(133)		143	96	95				(175)		
Albumin	35 to 50	39		35	26	28				(29)		
Adj. Calcium	2.1 to 2.6	2.60		2.4	2.03	0.94				2.47		
Phosphate	0.8 to 1.4	1.31	←	1.36	1.06	0.79				1.18		
Magnesium	0.7 to 1.0	0.87	←	0.8	1.33					0.74		
Cholesterol		(6.1)										
Urate	0.12-0.42	0.50										
TSH	0.15-3.5	0.86										
Free T4	8-27	14										
CRP	0 to 10											
Lactate	0.6 to 2.4											
		MRSA										CXR
	DATE	17/14/13										17/14
	Nose	-ve										N
	Throat	-ve										
	Groin	-ve										
		50										50

bloodresults(1) 19/01/2012

17/14 HEP B -ve 17/4 mssu
Hep C -ve Alexella blue

Department of Cardiothoracic Surgery

Dr Compson
Mauve Practice drumhar health cent
North Methven Street
Perth
PH1 5PD

Date First Created 21/05/2013
Date Authorised
Date/Time Printed 21/05/2013 10:35
Our Ref 700629263X
CHI 1701570130

Patient: Alexander D Atkinson Skinnergate Resettlement Unit 16 Skinnergate Perth PH1 5JH	UHPI: 700629263X Date of Birth: 17/01/1957
Ward: Ward 102 RIE	Admission Date: 01/05/2013
Consultant: Mr W Walker	Discharge Date: 09/05/2013

Mr W Walker
Cardiac/Thoracic
Secretary Anne Weir
Tel 0131 242 3927

Mr S Prasad
Cardiac
Secretary Kathryn Chambers
Tel 0131 242 3902

Mr ET Brackenbury
Cardiac/Thoracic
Secretary Annette Stuart
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Mr V Zamvar
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Athena Pandelis
Tel 0131 242 3952 Fax 0131
242 3931

Thoracic Liaison Sister
Karen Macrae
Catherine Smart
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242 3930

Discharge Medication	Dose	Frequency	Duration	Additional Info
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Senna Tablets	15 MG	At NIGHT	Short Term	HOSPITAL TRANSFER
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Lansoprazole Capsules	15 MG	In the MORNING	Long Term	
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Tramadol Capsules	50 MG	As Required	Short Term	max QDS HOSPITAL TRANSFER
Dalteparin	12500 UNITS	ONCE DAILY	Short Term	until INR therapeutic (metal valve aim for INR 3) HOSPITAL TRANSFER

Prescribed By Date Print Name.....
 Dispensed By Date Print Name.....
 Pharmacist Check Date Print Name.....
 Final Check Date Print Name.....

Cont'd...

Ref: 700629263X

Patient Name: Alexander D Atkinson

Drugs Questions:

Warfarin Indication: Mechanical prosthetic heart valve

Target INR: 3-3.5

Warfarin Duration: lifelong

Warfarin Start Date: unknown

Patient has A/C booklet?: Yes

Recent INRs (Date, Dose, INR): 3/5 1.3 10mg; 4/5 1.4 10mg; 5/5 5.5
omit; 6/5 6.1 omit + smg vit K PO; 7/5 3.1 2mg; 8/5 1.8 2mg

Weight (Kg): 68

Renal Function (eGFR ml / min): over 60

LMWH Indication: metal valve and AF

LMWH Duration: Short term until INR therapeutic on warfarin alone

Dear Dr Compson

DIAGNOSIS: Mitral Regurgitation**OPERATION:** Mitral Valve Replacement -size 27 mm Sorin valve (02 05 13)**Other Procedures:** Ventilation X50.8

This 55 year old gentleman with a known history of severe mitral regurgitation, with mild aortic incompetence had experienced increased shortness of breath with associated chest tightness, worsening over the past six months. His father died after a myocardial infarction in 2010.

His past medical history was of Barretts Oesophagus, long-standing back pain of uncertain nature, worse at night, and previous drug abuse (Methadone) denying intravenous use, only smoking heroin. In 2010 he was found to be in atrial fibrillation treated with Digoxin/Warfarin therapy. In July 2012 he had pulmonary oedema treated in hospital and in 2009 he underwent laparoscopic cholecystectomy. Angiography on 12th December 2012 showed normal coronary arteries and he was referred for mitral valve replacement.

Post-operatively, Mr Atkinson's INR was 6.1.

Mr Atkinson was transferred to Perth Royal infirmary for further convalescence on 9th May 2013. He has been referred for cardiac rehabilitation and his further follow-up will be under the care of Dr Dewhurst.

Discharge investigation results were: Haemoglobin:110; WCC:7.8; PLT:267; INR:1.6.-On warfarin 4 mgs pre -op for atrial fibrillation .-Target 2.5-3.5 duration lifelong; Urea:2.3; Creatinine:61; Na:136; K:4.5; Cholesterol:6.1; ECG:sinus rhythm 70 beats per minute; Chest X-ray:06/5/13 -Lung Fields clear; Wound:clean dry and intact with stable sternum

Should any wound problems or other concerns arise please contact Nurse Practitioners Jim Delaney; bleep 2016, Daisy Sandeman, bleep 5628; Carole Herpich, bleep 2017 or Gloria Rigby bleep 1053 via the Hospital Switchboard (0131-5361000).

Yours sincerely



W S Walker

Cont'd... **Ref:** 700629263X
Consultant Cardiothoracic Surgeon

Patient Name: Alexander D Atkinson

cc Dr N Dewhurst
Consultant Cardiologist
Perth Royal Infirmary
PERTH
PH1 1NX

Cardiac Rehabilitation Office
Perth Royal Infirmary
PERTH
PH1 1NX

ROYAL INFIRMARY OF EDINBURGH, LITTLE FRANCE, EDINBURGH, EH16 4SU
DEPARTMENT OF CARDIOTHORACIC SURGERY
WARD 102/103/111/112

OPERATION NOTE

TO: Dr Dewhurst, Consultant Cardiologist, PRI

CONSULTANT -Mr Walker

NAME *Alexander Atkinson*
 Skinnergate Resettlement Unit
 16 Skinnergate
 PERTH
 PH1 5JH

DOB *17 01 57 1030*

Hosp No: *700629263X*

Date of Admission *01 05 13*

Date of Discharge *09 05 13*

DIAGNOSIS: *Mitral regurgitation*

PROCEDURE: *MVR 27 mm Sorin mechanical bileaflet prosthesis*

Date of operation *02 05 13*

Other procedures: *Ventilation X50.8*

SURGEON: Mr Walker

ASSISTANT: Dr Patronis

GA: Dr Dornan

INCISION: Median sternotomy

BYPASS DATA: Ascending aortic arterial inflow, bicaval venous drainage. Trans mitral and aortic root venting. Aortic root St Thomas solution cold multi-dose cardioplegia. Systemic temperature drift to 32°C. Bypass 95 minutes, cross-clamp 70 minutes.

FINDINGS: The left ventricle was dilated with good function. The LA was enlarged and clot free. The heart was in AF. The mitral valve annulus was dilated and the anterior leaflets prolapsing.

PROCEDURE: The chest was opened and the patient heparinised and cannulated for bypass. Perfusion was commenced and on full flow systemic temperature drift was initiated. The left ventricular apical vent was inserted. The aortic cross-clamp was applied. Cardioplegia was delivered to the aortic root with satisfactory arrest of cardiac action. The left atrium was then opened through a vertical atriotomy anterior to the right pulmonary veins. The mitral valve was visualised and the anterior leaflet excised. The posterior leaflet was preserved. The valve was replaced with a size 27mm Sorin mechanical bileaflet prosthesis sutured in place with 2/0 horizontal mattress pledgetted Ethibond sutures with the pledgets placed on the ventricular aspect of the annulus. During the tying down phase, systemic re-warming was initiated. The left atrium was loosely repaired with 3/0 Prolene in two segments and preliminary de-airing was carried out across the left atriotomy. The aortic cross clamp was then released, taking care to de-air the aortic root. Electrical activity returned as sinus rhythm. At normothermia final de-airing was carried out across the atriotomy, which was secured and bypass discontinued without inotropic support.

CLOSURE: Protamine was administered. The bypass cannulae were withdrawn and the Ethibond purse-string sutures used to secure the cannulation sites. The aortic cannulation site was under-run with a pledgetted 3/0 Prolene suture.

Pericardial and mediastinal drains were introduced through inferior stab incisions. One temporary bipolar RV pacing wire was left in situ. The pericardium was loosely approximated with interrupted 3/0 polypropylene and the sternum was closed with wires. Layered absorbable sutures were used for the soft tissues.

A handwritten signature in black ink, appearing to read 'W S Walker', written in a cursive style.

W S Walker
Consultant Cardiothoracic Surgeon

ww/aw

ROYAL INFIRMARY OF EDINBURGH
51 LITTLE FRANCE CRESCENT
OLD DALKEITH ROAD
EH16 4SU
WARD 102

DISCHARGE SUMMARY

Electronically generated from clinical database

To: Dr N Dewhurst
Consultant Cardiologist
Department of Cardiology
Perth Royal Infirmary
Taymount Terrace
Perth
PH1 1NX

Mr William Walker
Consultant Cardiothoracic Surgeon
Royal Infirmary Edinburgh

GP: Dr COMPSON, LINDSEY
North Methven Street
Perth
PH1 5PD

NAME: Mr ALEXANDER AITKINSON


Hospital Number: 700629263X
CHI Number: 1701570130

ADDRESS: SKINNERGATE RESETTLEMENT
UNIT

16 SKINNERGATE
PERTH
PH1 5JH

DoB: 17/01/1957

Date of Admission: 01/05/2013
Date of Procedure: 02/05/2013
Date of Discharge: 09/05/2013
Discharge Destination: Perth Royal Infirmary
DIAGNOSIS: Mitral Regurgitation
OPERATION: Mitral Valve Replacement
Other Procedures: Ventilation X50.8

	NHS Lothian
Nurse Practitioners	
Directorate of Cardiothoracic Surgery	
University Hospitals Division	
<input type="checkbox"/> Gloria Rigby	
<input checked="" type="checkbox"/> Jim Delaney	
<input type="checkbox"/> Daisy Sandaman	
<input type="checkbox"/> Carole Herpich	
Royal Infirmary of Edinburgh 51 Little France Crescent Old Dalkeith Road Edinburgh EH16 4SA Telephone 0131 242 3957	

DISCHARGE SUMMARY

Mr AITKINSON underwent Mitral Valve Replacement on 02/05/2013 .

Details of cardiac history:

55 year old gentleman with a known history of severe mitral regurgitation ,with mild aortic incompetence.Increased shortness of breath with associated chest tightness worse over past 6 months.
Family history father died of MI 2010.

Medical History -Barretts Oesophagus .

long back pain -nature uncertain worse at night.Previous drug abuse-methadone,denies IV ,only smokes heron.,2010-Atrial Fibrillation -on digoxin/warfarin therapy.July 2012-pulmonary oedema treated in hospital ,2009 laparoscopic Cholecystectomy

Cardiac Investigations

Coronary angiography on 12/12/2012 showed:

1. No Left Main Stem disease
2. No vessel with >50% diameter stenosis
3. Left ventricular function was Good (LVEF > 50%)

Pa Systolic was 30 mmHg.

The Mitral Valve was replaced with a size 27 mm Sorin valve.

POST-OPERATIVE COURSE/COMPLICATIONS

06/5 inr -overshot to 6.1

Discharge Investigation Results-08/5/13

Haemoglobin:110

WCC:7.8

PLT:267

INR:1.6.-On warfarin 4 mgs pre -op for atrial fibrillation .-Target 2.5-3.5 duration lifelong

Urea:2.3

Creatinine:61

Na:136

K:4.5

Cholesterol:6.1

ECG:Sinus rhythm 70 beats per minute

Chest X-Ray:06/5/13 -Lung Fields clear

Wound:clean dry and intact with stable sternum

ALEXANDER AITKINSON was discharged to Perth Royal Infirmary on 09/05/2013.

Known Drug Sensitivities:

Medications at discharge:

Please see attached Trak discharge letter.

Follow-Up Arrangements:

For Review By Cardiologist

This patient has been referred for cardiac rehabilitation.

Should any wound problems or other concerns arise please contact Nurse Practitioners Jim Delaney; bleep 2016, Daisy Sandeman, bleep 5628; Carole Herpich, bleep 2017 or Gloria Rigby bleep 1053 via the Hospital Switchboard (0131-5361000).

Discharge authorised by Mr Bilal Yusef-cardiothoracic registrar

Jim Delaney -nurse Practitioner

Royal Infirmary of Edinburgh

CC:

1. Cardiac Rehabilitation Clinic
2. General Practitioner - Dr. COMPSON, LINDSEY
3. File

Department of Cardiothoracic Surgery

Dr Compson
Mauve Practice drumhar health cent
North Methven Street
Perth
PH1 5PD

Date First Created 03/05/2013
Date Authorised
Date/Time Printed 09/05/2013 09:10
Our Ref 700629263X
CHI 1701570130

Patient: Alexander D Atkinson Skinnergate Resettlement Unit 16 Skinnergate Perth PH1 5JH	UHPI: 700629263X Date of Birth: 17/01/1957
Ward: Ward 102 RJE	Admission Date: 01/05/2013
Consultant: Mr W Walker	Discharge Date: 09/05/2013

Mr W Walker
Cardiac/Thoracic
Secretary Anne Weir
Tel 0131 242 3927

Mr S Prasad
Cardiac
Secretary Kathryn Chambers
Tel 0131 242 3902

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Thoracic Liaison Sister
Karen Macrae
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Tel 0131 242 3915 Fax 0131
242 3930

Discharge Medication	Dose	Frequency	Duration	Additional Info
Paracetamol Tablets	1000 MG	FOUR times daily	Short Term	HOSPITAL TRANSFER
Senna Tablets	15 MG	At NIGHT	Short Term	HOSPITAL TRANSFER
Methadone Mixture 1mg/ml	40 mL	ONCE DAILY	Long Term	daily supervised dispensing HOSPITAL TRANSFER
Gabapentin Capsules	300 MG	TWICE DAILY	Long Term	300mg morning and afternoon and 600mg at night HOSPITAL TRANSFER
Lansoprazole Capsules	15 MG	In the MORNING	Long Term	
Digoxin Tablets	125 MCG	In the MORNING	Long Term	HOSPITAL TRANSFER
Warfarin Tablets	2 MG	Daily as per INR	Long Term	HOSPITAL TRANSFER
Nefopam Tablets	60 MG	As Required	Short Term	max TDS HOSPITAL TRANSFER
Dihydrocodeine Tablets	30 MG	As Required	Short Term	max QDS HOSPITAL TRANSFER
Tramadol Capsules	50 MG	As Required	Short Term	max QDS HOSPITAL TRANSFER
Dalteparin	12500 UNITS	ONCE DAILY	Short Term	until INR therapeutic (metal valve aim for INR 3) HOSPITAL TRANSFER

Prescribed By Date Print Name.....
 Dispensed By Date Print Name.....
 Pharmacist Check Date Print Name.....
 Final Check Date Print Name.....

Cont'd...

Ref: 700629263X

Patient Name: Alexander D Atkinson

Drugs Questions:

Warfarin Indication: Mechanical prosthetic heart valve

Target INR: 3-3.5

Warfarin Duration: lifelong

Warfarin Start Date: unknown

Patient has A/C booklet?: Yes

Recent INRs (Date, Dose, INR): 3/5 1.3 10mg; 4/5 1.4 10mg; 5/5 5.5
omit; 6/5 6.1 omit + smg vit K PO; 7/5 3.1 2mg; 8/5 1.8 2mg

Weight (Kg): 68

Renal Function (eGFR ml / min): over 60

LMWH Indication: metal valve and AF

LMWH Duration: Short term until INR therapeutic on warfarin alone

Dr Doctor,

Many thanks for accepting this patient under your care

PRINCIPAL DIAGNOSIS/PROCEDURE

1. Severe Mitral Regurgitation - Mitral Valve Replacement (Mechanical) on 02/05/2013

This 56 year old gentleman was referred for MV replacement. He suffers from shortness of breath and associated chest tightness which is brought on by exertion. His symptoms have become progressively worse in the last 6-8 months. He denies any syncope but admits to light-headedness. His background and relevant investigations include:

- a) Known Severe mitral regurgitation with mild aortic incompetence. Mild AR and mitral stenosis
- b) Atrial fibrillation on Digoxin and Bisoprolol pre-op
- c) Pulmonary oedema in July 2012
- d) Previous drug abuse, currently on Methadone. Denies IV drug abuse. Smoker (10 cigarettes/day)
- e) CCS0, NYHA II
- f) Coronary angiography 12/12/12: trivial irregularity of the RCA

TREATMENT

Mr Atkinson had a metallic mitral valve replacement on 02/05/2013 (Sorin). He was admitted to Cardiothoracic ICU post-op for observation and was transferred to ward level care day 1 post-op. His INR is currently subtherapeutic and he requires daily INR check's until this stabilises.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL

Follow-up with Cardiology

CHANGES TO DRUGS SINCE ADMISSION**PREVIOUS ADVERSE DRUG REACTIONS**

Apparently does not tolerate Dihydrocodeine

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

None

GP to please consider the following...closely monitor INR.

Should you need further information please contact...

Mr Walker's Team, Ward 102, RIE

Cont'd...

Ref: 700629263X

Patient Name: Alexander D Atkinson

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

This is an immediate discharge letter and a further letter may follow.

Inpatient Discharge Summary

CARDIAC SURGERY DIRECTORATE
WARDS 111, 112, 102
ROYAL INFIRMARY OF EDINBURGH,
51, LITTLE FRANCE CRESCENT,
OLD DALKEITH ROAD
EDINBURGH
EH16 5SA

FAXED

13/05/13

@ 10.10

Fax

No. of pages 6

To: CARDIAC REHAB

From: ROYAL INFIRMARY OF EDINBURGH

Cardiac Surgery Unit Ward 102

Fax: 01738 47 35 10

Date: 13/05/13

Phone: 01738 47 39 44

Fax: 0131 242 1025

Re: CARDIAC REHAB

Phone: 0131 242 1027

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• Comments:

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Department of Cardiothoracic Surgery

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Warfarin Duration: lifelong

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LMWH Indication: metal valve and AF

LMWH Duration: Short term until INR therapeutic on warfarin alone

Dr Doctor,

Many thanks for accepting this patient under your care

PRINCIPAL DIAGNOSIS/PROCEDURE

1. Severe Mitral Regurgitation - Mitral Valve Replacement (Mechanical) on 02/05/2013

This 56 year old gentleman was referred for MV replacement. He suffers from shortness of breath and associated chest tightness which is brought on by exertion. His symptoms have become progressively worse in the last 6-8 months. He denies any syncope but admits to light-headedness. His background and relevant investigations include:

- a) Known Severe mitral regurgitation with mild aortic incompetence. Mild AR and mitral stenosis
- b) Atrial fibrillation on Digoxin and Bisoprolol pre-op
- c) Pulmonary oedema in July 2012
- d) Previous drug abuse, currently on Methadone. Denies IV drug abuse. Smoker (10 cigarettes/day)
- e) CCS0, NYHA II
- f) Coronary angiography 12/12/12: trivial irregularity of the RCA

TREATMENT

Mr Atkinson had a metallic mitral valve replacement on 02/05/2013 (Sorin). He was admitted to Cardiothoracic ICU post-op for observation and was transferred to ward level care day 1 post-op. His INR is currently subtherapeutic and he requires daily INR check's until this stabilises.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL

Follow-up with Cardiology

CHANGES TO DRUGS SINCE ADMISSION**PREVIOUS ADVERSE DRUG REACTIONS**

Apparently does not tolerate Dihydrocodeine

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

None

GP to please consider the following...closely monitor INR.

Should you need further information please contact...

Mr Walker's Team, Ward 102, RIE

Cont'd...

Ref: 700629263X

Patient Name: Alexander D Atkinson

Information contained in this letter has been discussed with the patient/carer.

Yours sincerely.....

Staff Signature..... PrintName.....

Designation..... Date..... Time.....

Patient/Carer Signature.....

This is an immediate discharge letter and a further letter may follow.

Inpatient Discharge Summary

ROYAL INFIRMARY OF EDINBURGH
51 LITTLE FRANCE CRESCENT
OLD DALKEITH ROAD
EH16 4SU
WARD 102

DISCHARGE SUMMARY

Electronically generated from clinical database

To: Dr N Dewhurst
Consultant Cardiologist
Department of Cardiology
Perth Royal Infirmary
Taymount Terrace
Perth
PH1 1NX

Mr William Walker
Consultant Cardiothoracic Surgeon
Royal Infirmary Edinburgh

GP: Dr COMPSON, LINDSEY
North Methven Street
Perth
PH1 5PD

NAME: Mr ALEXANDER AITKINSON

Hospital Number: 700629263X
CHI Number: 1701570130

ADDRESS: SKINNERGATE RESETTLEMENT
UNIT

16 SKINNERGATE
PERTH
PH1 5JH

DoB: 17/01/1957

Date of Admission: 01/05/2013

Date of Procedure: 02/05/2013

Date of Discharge: 09/05/2013

Discharge Destination: Perth Royal Infirmary

DIAGNOSIS: Mitral Regurgitation

OPERATION: Mitral Valve Replacement

Other Procedures: Ventilation X50.8

DISCHARGE SUMMARY

Mr AITKINSON underwent Mitral Valve Replacement on 02/05/2013 .

Details of cardiac history:

55 year old gentleman with a known history of severe mitral regurgitation ,with mild aortic incompetence.Increased shortness of breath with associated chest tightness worse over past 6 months. Family history father died of MI 2010.

Medical History -Barretts Oesophagus .

long back pain -nature uncertain worse at night.Previous drug abuse-methadone,denies IV ,only smokes heron.,2010-Atrial Fibrillation -on digoxin/wartarin therapy.July 2012-pulmonary oedema treated in hospital ,2009 laparoscopic Cholecystectomy

Cardiac Investigations

Coronary angiography on 12/12/2012 showed:

1. No Left Main Stem disease
2. No vessel with >50% diameter stenosis
3. Left ventricular function was Good (LVEF > 50%)

Pa Systolic was 30 mmHg.

The Mitral Valve was replaced with a size 27 mm Sorin valve.

POST-OPERATIVE COURSE/COMPLICATIONS

06/5 inr -overshot to 6.1

Discharge Investigation Results-08/5/13

Haemoglobin:110

WCC:7.8

PLT:267

INR:1.6.-On warfarin 4 mgs pre -op for atrial fibrillation .-Target 2.5-3.5 duration lifelong

Urea:2.3

Creatinine:61

Na:136

K:4.5

Cholesterol:6.1

ECG:Sinus rhythm 70 beats per minute

Chest X-Ray:06/5/13 -Lung Fields clear

Wound:clean dry and intact with stable sternum

ALEXANDER AITKINSON was discharged to Perth Royal Infirmary on 09/05/2013.

Known Drug Sensitivities:

Medications at discharge:

Please see attached Trak discharge letter.

Follow-Up Arrangements:

For Review By Cardiologist

This patient has been referred for cardiac rehabilitation.

Should any wound problems or other concerns arise please contact Nurse Practitioners Jim Delaney; bleep 2016, Daisy Sandeman, bleep 5628; Carole Herpich, bleep 2017 or Gloria Rigby bleep 1053 via the Hospital Switchboard (0131-5361000).

Discharge authorised by Mr Bilal Yusef-cardiothoracic registrar

Jim Delaney -nurse Practitioner

Royal Infirmary of Edinburgh

cc:

1. Cardiac Rehabilitation Clinic
2. General Practitioner - Dr. COMPSON, LINDSEY
3. File

ROYAL INFIRMARY OF EDINBURGH
51 LITTLE FRANCE CRESCENT
OLD DALKEITH ROAD
EH16 4SU
WARD 102

DISCHARGE SUMMARY

Electronically generated from clinical database

To: Dr N Dewhurst
Consultant Cardiologist
Department of Cardiology
Perth Royal Infirmary
Taymount Terrace
Perth
PH1 1NX

Mr William Walker
Consultant Cardiothoracic Surgeon
Royal Infirmary Edinburgh

GP: Dr COMPSON, LINDSEY
North Methven Street
Perth
PH1 5PD

NAME: Mr ALEXANDER AITKINSON

Hospital Number: 700629263X
CHI Number: 1701570130

ADDRESS: SKINNERGATE RESETTLEMENT
UNIT

16 SKINNERGATE
PERTH
PH1 5JH

DoB: 17/01/1957

Date of Admission: 01/05/2013

Date of Procedure: 02/05/2013

Date of Discharge: 09/05/2013

Discharge Destination: Perth Royal Infirmary

DIAGNOSIS: Mitral Regurgitation

OPERATION: Mitral Valve Replacement

Other Procedures: Ventilation X50.8

DISCHARGE SUMMARY

Mr AITKINSON underwent Mitral Valve Replacement on 02/05/2013 .

Details of cardiac history:

55 year old gentleman with a known history of severe mitral regurgitation ,with mild aortic incompetence.Increased shortness of breath with associated chest tightness worse over past 6 months. Family history father died of MI 2010.

Medical History -Barretts Oesophagus .

long back pain -nature uncertain worse at night.Previous drug abuse-methadone,denies IV ,only smokes heron.,2010-Atrial Fibrillation -on digoxin/wartarin therapy.July 2012-pulmonary oedema treated in hospital ,2009 laparoscopic Cholecystectomy

Cardiac Investigations

Coronary angiography on 12/12/2012 showed:

1. No Left Main Stem disease
2. No vessel with >50% diameter stenosis
3. Left ventricular function was Good (LVEF > 50%)

Pa Systolic was 30 mmHg.

The Mitral Valve was replaced with a size 27 mm Sorin valve.

POST-OPERATIVE COURSE/COMPLICATIONS

06/5 inr -overshot to 6.1

Discharge Investigation Results-08/5/13

Haemoglobin:110

WCC:7.8

PLT:267

INR:1.6.-On warfarin 4 mgs pre -op for atrial fibrillation .-Target 2.5-3.5 duration lifelong

Urea:2.3

Creatinine:61

Na:136

K:4.5

Cholesterol:6.1

ECG:Sinus rhythm 70 beats per minute

Chest X-Ray:06/5/13 -Lung Fields clear

Wound:clean dry and intact with stable sternum

ALEXANDER AITKINSON was discharged to Perth Royal Infirmary on 09/05/2013.

Known Drug Sensitivities:

Medications at discharge:

Please see attached Trak discharge letter.

Follow-Up Arrangements:

For Review By Cardiologist

This patient has been referred for cardiac rehabilitation.

Should any wound problems or other concerns arise please contact Nurse Practitioners Jim Delaney, bleep 2016, Daisy Sandeman, bleep 5628; Carole Herpich, bleep 2017 or Gloria Rigby bleep 1053 via the Hospital Switchboard (0131-5361000).

Discharge authorised by Mr Bilal Yusef-cardiothoracic registrar

Jim Delaney -nurse Practitioner

Royal Infirmary of Edinburgh

cc:

1. Cardiac Rehabilitation Clinic
2. General Practitioner - Dr. COMPSON, LINDSEY
3. File

Department of Cardiothoracic Surgery

Dr Compson
Mauve Practice drumhar health cent
North Methven Street
Perth
PH1 5PD

Date First Created 03/05/2013
Date Authorised
Date/Time Printed 09/05/2013 09:10
Our Ref 700629263X
CHI 1701570130

Patient: Alexander D Atkinson Skinnergate Resettlement Unit 16 Skinnergate Perth PH1 5JH	UHPI: 700629263X Date of Birth: 17/01/1957
Ward: Ward 102 RIE	Admission Date: 01/05/2013
Consultant: Mr W Walker	Discharge Date: 09/05/2013

Mr W Walker
Cardiac/Thoracic
Secretary Anne Weir
Tel 0131 242 3927

Mr S Prasad
Cardiac
Secretary Kathryn Chambers
Tel 0131 242 3902

Mr ET Brackenbury
Cardiac/Thoracic
Secretary Annette Stuart
Tel 0131 242 3926

Mr V Zamvar
Cardiac/Thoracic
Secretary Linda Kane
Tel 0131 242 3581

Mr RP Pessotto
Cardiac/Thoracic
Secretary Kathryn Chambers
Tel 0131 242 3902

Mr Kelvin Lim
Cardiac/Thoracic
Secretary Annette Stuart
Tel 0131 242 3926

Miss F Carnochan
Associate Specialist Thoracic
Surgery
Tel 0131 242 3914

Cardiac Liaison Sister
Kirsty Stuart/Carol Mills
Tel 0131 242 3917

Cardiac Waiting List Co-ordinator
Athina Pandelis
Tel 0131 242 3952 Fax 0131
242 3931

Thoracic Liaison Sister
Karen Macrae
Catherine Smart
Tel 0131 242 3915 Fax 0131
242 3930

Discharge Medication	Dose	Frequency	Duration	Additional Info
Paracetamol Tablets	1000 MG	FOUR times daily	Short Term	HOSPITAL TRANSFER
Senna Tablets	15 MG	At NIGHT	Short Term	HOSPITAL TRANSFER
Methadone Mixture 1mg/ml	40 ML	ONCE DAILY	Long Term	daily supervised dispensing HOSPITAL TRANSFER
Gabapentin Capsules	300 MG	TWICE DAILY	Long Term	300mg morning and afternoon and 600mg at night HOSPITAL TRANSFER
Lansoprazole Capsules	15 MG	In the MORNING	Long Term	
Digoxin Tablets	125 MCG	In the MORNING	Long Term	HOSPITAL TRANSFER
Warfarin Tablets	2 MG	Daily as per INR	Long Term	HOSPITAL TRANSFER
Nefopam Tablets	60 MG	As Required	Short Term	max TDS HOSPITAL TRANSFER
Dihydrocodeine Tablets	30 MG	As Required	Short Term	max QDS HOSPITAL TRANSFER
Tramadol Capsules	50 MG	As Required	Short Term	max QDS HOSPITAL TRANSFER
Dalteparin	12500 UNITS	ONCE DAILY	Short Term	until INR therapeutic (metal valve aim for INR 3) HOSPITAL TRANSFER

Prescribed By	Date	Print Name.....
Dispensed By	Date	Print Name.....
Pharmacist Check	Date	Print Name.....
Final Check	Date	Print Name.....

Cont'd...

Ref: 700629263X

Patient Name: Alexander D Atkinson

Drugs Questions:

Warfarin Indication: Mechanical prosthetic heart valve

Target INR: 3-3.5

Warfarin Duration: lifelong

Warfarin Start Date: unknown

Patient has A/C booklet?: Yes

Recent INRs (Date, Dose, INR): 3/5 1.3 10mg; 4/5 1.4 10mg; 5/5 5.5
omit; 6/5 6.1 omit + smg vit K PO; 7/5 3.1 2mg; 8/5 1.8 2mg

Weight (Kg): 68

Renal Function (eGFR ml / min): over 60

LMWH Indication: metal valve and AF

LMWH Duration: Short term until INR therapeutic on warfarin alone

Dr Doctor,

Many thanks for accepting this patient under your care

PRINCIPAL DIAGNOSIS/PROCEDURE**1. Severe Mitral Regurgitation - Mitral Valve Replacement (Mechanical) on 02/05/2013**

This 56 year old gentleman was referred for MV replacement. He suffers from shortness of breath and associated chest tightness which is brought on by exertion. His symptoms have become progressively worse in the last 6-8 months. He denies any syncope but admits to light-headedness. His background and relevant investigations include:

- a) Known Severe mitral regurgitation with mild aortic incompetence. Mild AR and mitral stenosis
- b) Atrial fibrillation on Digoxin and Bisoprolol pre-op
- c) Pulmonary oedema in July 2012
- d) Previous drug abuse, currently on Methadone. Denies IV drug abuse. Smoker (10 cigarettes/day)
- e) CCS0, NYHA II
- f) Coronary angiography 12/12/12: trivial irregularity of the RCA

TREATMENT

Mr Atkinson had a metallic mitral valve replacement on 02/05/2013 (Sorin). He was admitted to Cardiothoracic ICU post-op for observation and was transferred to ward level care day 1 post-op. His INR is currently subtherapeutic and he requires daily INR check's until this stabilises.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL

Follow-up with Cardiology

CHANGES TO DRUGS SINCE ADMISSION**PREVIOUS ADVERSE DRUG REACTIONS**

Apparently does not tolerate Dihydrocodeine

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS

None

GP to please consider the following...closely monitor INR.

Should you need further information please contact...

Mr Walker's Team, Ward 102, RIE

700629263X M 17/01/1957

Atkinson, Alexander D

Skinnergate Resettlement Unit,

16 Skinnergate,

Perth,

Perthshire, PH1 5JH

CHI 1701570130

NAME:

13075 LL Compton

☐ Post Surgery Pack

☐ POC



Driving Advice Y/N

Discharged Home Y/N

Address if different

PR1 W04.

Tel no: 01738 565114.

Home

Mob

A/O info

Date 9/5/15 Signature M. G. Ma SCR N

NURSING TRANSFER LETTER

700629263X M 17/01/1957
 N: Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 D: 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 A: CHI 1701570130
 13975 L. Compton

Next of kin SHIRLEY ATKINSON
 Relationship SON
 Discharge destination PRI
 Ward 6
 Operation MVR

Valuables returned yes / no

Date 8/5/13

Signed: M. Bruce

BP 102/60	Temperature 36.8	Blood sugar if diabetic
HR 71 Pacing wires Removed / out to skin	Arrhythmia AF Treatment WARFARIN	MRSA status <u>ve</u> Site of MRSA Treatment Date of discharge screen
Catheter RA 16	SaO2 RA % 95	Venflon site Date inserted

Medication:

Aspirin

Clopidogrel

Warfarin

Beta Blocker

Statin

Ace

Paracetamol

Dihydrocodeine

Other

AS Per IDL

Wounds

Observe / dressing / stitches

Swab

Treatment

Sternotomy / Thoracotomy			
R / L Arm			
R / L Leg			
Other			

Stitches

Yes / No

8/5/13

Site (s)

Date of removal

Wound care plans included Yes / No

Mobility	Independent	Managed stairs with physio
Diet & fluids	Normal Diet	Seen by dietician: Y/N
Nausea	NO	Weight on discharge:
Hygiene & dressing	Independent	Requires help with shower
Elimination	BO 8/5/13	Bowels moved 8/5/13
Problems with micturition	NO	Laxatives Senna
Psychological issues	Sleep Zopiclone	Hallucinations
Mood	Anxious	Nightmares NO
		Anxiety

Additional comments

Signed

M. Bruce

Designation

SIN

Date

8/5/13

NURSING TRANSFER LETTER

Name
DOB
Address

Next of kin
Relationship
Discharge destination
Ward
Operation

Valuables returned yes / no

Date

Signed:

BP	Temperature	Blood sugar if diabetic
HR Pacing wires Removed / out to skin	Arrhythmia Treatment	MRSA status Site of MRSA Treatment Date of discharge screen
Breathing	SaO2 % on air	Venflon site Date inserted

Medication:

Aspirin

Clopidogrel

Warfarin

Beta Blocker

Statin

Ace

Paracetamol

Dihydrocodeine

Other

WoundsObserve / dressing / stitchesSwabTreatment

Sternotomy / Thoracotomy			
R / L Arm			
R / L Leg			
Other			
Stitches Yes / No	Site (s) Date of removal Wound care plans included Yes / No		
Mobility	Managed stairs with physio		
Diet & fluids Nausea	Seen by dietician : Y/N Weight on discharge:		
Hygiene & dressing	Requires help with shower		
Elimination Problems with micturition	Bowels moved Laxatives		
Psychological issues Sleep Mood	Hallucinations Nightmares Anxiety		

Additional comments

Signed

Designation

Date

ROYAL INFIRMARY OF EDINBURGH

Cardiac Anaesthetic Chart

700629263X M 17/01/1957

Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH

CHI 1701570130
13975 LJ Compson

Proposed Operation:

Date of Assessment:

Assessed by:

Grade:

Elective

Expedited

Urgent

Immediate

General

- previous drug abuse
→ well done program
ga

barrett's oesophagitis

Heart

BP 105/65

HR 50/min irreg.

Lungs

SpO₂ 99%

RR

Teeth

proph. D
Own ↓

Mouth

MP II

Neck

previous IVU
recl. oc

Allen's

R/L

ASA

II

Height

5'9

Weight

67kg

Consent / Discussion

Anaesthetic technique

Critical care area

TOE

Dental damage

Post-operative pain relief

Other: Mella done issue

Allergies/Sensitivities

Warfarin
bunetanide
methadone
lansoprazole
acyclovir
domperidone
bisoprolol
digoxin.
methadone
gabapentin

Premedication

ECG

AF, 50/min,
IT, ST wave T issue

CXR

lung fields clear
& effusing
mild/mod

Angio's / ECHO

AOR
both in ant mitral
leaflet ± prolapse
dilated LA

LA appendage
phrombus

LA appendage
phrombus

LA appendage
phrombus

LA appendage
phrombus

LA appendage
phrombus

LA appendage
phrombus

Hb

143

WCC

7.3

Plat

217

APTT

36

INR

1.4

U

6.1

Na

137

K

4.8

CO₂

30

Ca

94

eGFR

>60

Glu

174

MRSA

neg.

STATUS

neg.

Theatre: 4/5/6/7/8

CICU / other

Machine check:

anaes rm

theatre

Ventilator: Yes / No

Dräger Cator Primus

Seimens Servo

Other

HMEF

Urinary cath

Supine / R LAT / L LAT

Eyes taped

Temp: N-P / Oes / Skin

Warmer: Fluids

Blanket

Anaesthetists: Consultant

Present / Supervising

Trainee / PAA

ETT: Type

#9

Laryngoscopy grade

2/3/4

Periph

146

Art

206

Central Line Insertion

Asceptic technique

Site: RIJ / LIJ / Other

US: Anatomy check

Visualised Insertion

Not used

Line type:

sheath

3 lumen arrow CIL

TOE

174

174

174

174

174

174

174

174

174

174

174

174

174

Surgeons:

Op performed:

Anaesthetists: Consultant

Present / Supervising

Trainee / PAA

WALKER

MUR

Darman

FURKE

Name Alexander Atkinson Age 55 Date 2/5/13

Time	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰
MV		5.4	5.4	5.2	
Paw		15/0	15/0	14/0	
FiO ₂ (N ₂ O/AIR)	0.21 - 1 - 0.8	0.47	0.47	0.47	0.4
H+	38.5	41.7	45.8	46.7	49.4
PCO ₂	6.7	6.88	2.10		6.71
PO ₂	8.30	15.26	20.58		22.9
SBC	29.7	29.6	28.0		24.9
SBE	3.7	3.6	1.2		1.8
HB	14.6	14.0	9.6		11.9
K+	3.78	3.66	3.32		5.0
Ca++	0.13	0.10	0.11		0.2
ACT		15.3	6.80	6.4	10.9
Gluc	5.8	5.4	6.11		9.2
SPO ₂		98	99	99	99
ETCO ₂		4.3	4.3	4.7	4.3
ET Vol	TIVA				
38					Valsalva
36					↑ Suction
34					
32					
Surface		37.0°C			
CO					
PAS					
PAD					
LA/W					
RA		5	5	4	4
Rhy	AF				52
Flow					
Pleg					
180					
160					
140					
120					
100					
80					
60					
40					
20					
Hep			20K		
K+					
Cefurox	1.5				
Propofol	4-3-2	2-4-3	3-2	3	5
Remif	2-5-3	3-7-6	4-3	3	4
Ric	20				
TXA		2g			
					morphine 5+5m
Urine	E1	CSL			
Fluid	500				pump blood

CONSENT FORM: Medical or Dental Investigation

700629263X - M. 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compson

Hospital
Patient's Surname
Other Names
Unit Number

Sex (tick box) Male ☒ Female ☐ Date of Birth
(To be completed by the medical, dental, nursing or paramedical practitioner. See notes)

Type of operation, investigation or treatment for which written evidence of consent is considered appropriate.

Mitral Valve repair/replacement

I confirm that I have explained to the patient in terms which in my judgement are suited to his/her understanding (and/or to one of his/her parents or guardians), the proposed operation, investigation or treatment, including options available, and if relevant, the need for anaesthesia or sedation.

Relevant Written Information given to the patient: ☐ Yes ☐ No

Signature Date *1.5.13*

Name and Status of Practitioner *J.C. Lanchard Locum SpR*

Re-confirmation of Consent on the day of admission:

Signature Date

Name and Status of Practitioner

To the Patient (or Parent or Guardian if Appropriate)

1. Please read this form and the notes overleaf very carefully.
 2. If there is anything that you don't understand about the explanation or if you want more information, you should ask the practitioner before signing.
- Please check that all the information on the form is correct. If it is and you understand the explanation, then sign the form.

I am the patient/parent/guardian (delete as necessary)

I agree ☒ to what is proposed, which has been explained to me by the practitioner named above
I understand ☒ that anaesthesia (general/regional/local) or sedation will be needed
☒ that the procedure may not be done by the practitioner who has been treating me so far
☒ that any procedure in addition to the investigation or treatment described on this form will only be carried out if it is necessary and in my best interests and can be justified for medical reasons

I have told ☒ the practitioner about the procedures I have noted below* which I would wish not to be carried out without my having the opportunity to consider them first

*
*
*

Signature *A. Atkinson*

Name *ALEX ATKINSON*

Address

Date *1.5.13*

NOTES TO ALL HEALTH PRACTITIONERS (DOCTORS, DENTISTS, NURSES, PROFESSIONS ALLIED TO MEDICINE)

A patient has an absolute legal right to grant or withhold consent prior to examination or treatment. Patients should be given sufficient information, in a way that they can understand, about the proposed treatment and the possible alternatives. Patients must be allowed to decide whether they will agree to the treatment and they may refuse or withdraw consent to the treatment at any time. The patient's consent to treatment should be recorded on this consent form (further guidance is given in the Trust Policy Statement).

NOTES TO PATIENTS

The health practitioner is here to help you. He or she will explain the proposed treatment and what the alternatives are. You can ask any questions and seek further information. You can refuse treatment.

You should be provided with sufficient information to allow you to come to a decision as to whether to consent to the treatment proposed. The type of information you should receive should include:-

- I. Nature of your condition & proposed procedures, including degree of urgency
- II. Benefits to be reasonably accepted of the procedure
- III. Nature & probability of material (= significant) risks involved, including consideration of ratio of risks and benefits
- IV. Inability of the practitioner to predict results
- V. Irreversibility of the procedure, if that is the case
- VI. The likely result of not having the proposed treatment or procedure
- VII. Alternatives available, including their risks and benefits

You may ask for a relative, a friend or a nurse to be present.

Training doctors, dentists, nurses and other health professionals is essential to the continuation of the health service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor, dentist, nurse or other health professional.

You may however decline to be involved in the formal training of medical, dental, nursing and other students without this adversely affecting your care and treatment. You must tell a senior doctor or nurse if you do not wish students to be involved in your care and you should write this on the consent form in the space for things that you do not wish to happen without your being given the chance to consider them first.

Department of Cardiothoracic Surgery

Dr Dewhurst
 Consultant Cardiologist
 Perth Royal Infirmary
 PERTH
 PH1 1NX

Date First Created 01/03/2013
 Date Authorised
 Date/Time Printed 05/03/2013 12:36
 Our Ref 700629263X
 CHI 1701570130

Patient: Mr Alexander Atkinson	UHPI: 700629263X
Skinnergate Resettlement Unit	Date of Birth: 17/01/1957
16 Skinnergate	
Perth	
PH1 5JH	
Clinic Code: SCD/WW	Attendance Date: 25/02/2013
Specialty: Thoracic Surgery	
Consultant: Mr W Walker	

Mr W Walker
 Cardiac/Thoracic
 Secretary Anne Weir
 Tel 0131 242 3927

Mr S Prasad
 Cardiac
 Secretary Kathryn Chambers
 Tel 0131 242 3902

Mr ET Brackenbury
 Cardiac/Thoracic
 Secretary Annette Stuart
 Tel 0131 242 3926

Mr V Zamvar
 Cardiac/Thoracic
 Secretary Annette Stuart
 Tel 0131 242 3926

Mr RP Pessotto
 Cardiac/Thoracic
 Secretary Kathryn Chambers
 Tel 0131 242 3902

Miss F Carnochan
 Associate Specialist Thoracic
 Surgery
 Tel 0131 242 3914

Cardiac Liaison Sister
 Kirsty Stuart/Carol Mills
 Tel 0131 242 3917
 Fax 0131 242 3931

Cardiac Waiting List
 Co-ordinator
 Athina Pandelis
 Tel 0131 242 3952

Thoracic Liaison Sister
 Karen Macrae
 Catherine Smart
 Tel 0131 242 3915
 Fax 0131 242 3930

Dear Dr Dewhurst,

I saw this 55 year old gentleman today in the Cardiac Surgery Pre-operative Clinic in order to discuss mitral valve replacement with him. You have shown Mr Atkinson to have quite marked mitral incompetence associated with thickened leaflets. He is in atrial fibrillation and has a history of pulmonary oedema. As an incidental he has very mild aortic incompetence and trivial irregularity of the right coronary.

I discussed mitral valve replacement using a mechanical prosthesis with Mr Atkinson. He understands that he would continue his lifelong Warfarin therapy. I have also said that it might take 12-18 months for him to appreciate the full benefit of valve replacement and that an element of the procedure is to prevent further deterioration in his left ventricle.

We will arrange for Mr Atkinson to attend the Pre-surgical Assessment Clinic in due course for his workup towards the procedure.

With kind regards
 Yours sincerely

W S Walker
 Consultant Cardiothoracic Surgeon

Dr Compson
 Drumhar Health Centre
 North Methven Street
 PERTH

Outpatient Clinic Letter

Cont'd...

Ref: 700629263X

Patient Name: Mr Alexander Atkinson

Consultant Cardiologist
Perth Royal Infirmary
PERTH
PH1 1NX

25/2

University Hospitals Division

DEPARTMENT OF CARDIOTHORACIC SURGERY

Royal Infirmary of Edinburgh, 51 Little France Crescent, Old Dalkeith Road,
Edinburgh, EH16 4SU



Clinical Director
Dr N G Uren

Dr N G Dewhurst
Consultant Cardiologist
Perth Royal Infirmary
PERTH
PH1 1NX

Our ref: WSW/AW/170157 0130
Date: 27th December 2012

Consultant Surgeons:-
W Walker
S Prasad
E Brackenbury
V Zamvar
R Pessotto
K Lim

Waiting List Enquiries:
Tel: 0131 242 3952

Out-Patient Enquiries:
Tel: 0131 242 3927
Fax: 0131 242 3930

Liaison Nurses:

Carol Mills
Kirsty Stewart
Tel: 0131 242 3917

Ward 102 - 0131 242 1028

HDU- WD 112 0131 242 3942
ICU- WD 111 0131 242 3940

Dear Dr Dewhurst

**Re: Alexander Atkinson, Skinnergate Resettlement Unit, 16 Skinnergate,
Perth PH1 5JH (d.o.b. 17 01 57)**

Thank you for your letter and helpful attachments concerning this 55 year old previous intravenous drug user currently on Methadone and negative for hepatitis and HIV.

I would be pleased meet with Mr Atkinson and discuss mitral valve replacement with him. Investigations have showed him to have a thickened partly stenotic and also severely regurgitant mitral valve. He has mildly aortic incompetence with an abnormal cusp. There is trivial narrowing of the right coronary.

Mr Atkinson would appear suitable for a mechanical mitral valve replacement, given his current Warfarin therapy for atrial fibrillation.

I will arrange to see him shortly.

With kind regards
Yours sincerely

W S Walker
Consultant Cardiothoracic Surgeon

700629263X

Medicine Department
Acute Services Division
NHS Tayside
Perth Royal Infirmary
PERTH
PH1 1NX
Telephone: 01738 623311
Fax: 01738 473510
www.nhs.net



Mr W S Walker
Consultant Cardiac Surgeon
Department of Cardiothoracic Surgery
Royal Infirmary of Edinburgh
51 Little France Crescent
Old Dalkeith Road
EDINBURGH
EH16 4SU

Date of clinic 4 December 2012
Date typed 5 December 2012
Your Ref
Our Ref NGD/MR 170157/0130
Direct Line 01738 473447
Email michelle.roger@nhs.net

Dear Bill

Alexander Atkinson, Skinnergate Resettlement Unit, 16 Skinnergate, Perth, PH1 5JH (DOB 170157)

I would be grateful if you would consider Mr Atkinson for mitral valve replacement. He was referred in late July of this year with significant mitral regurgitation, but whilst awaiting an urgent appointment was in fact admitted to Perth Royal Infirmary with pulmonary oedema. I enclose copies of the previous correspondence relating to the transoesophageal echocardiogram and his more recent cardiac catheterisation.

I spoke with Mr Atkinson when he attended for review this morning and despite Bumetanide 3mgs and good rate control of his atrial fibrillation he remains breathless and is very keen to be considered for mitral valve replacement. As you will see he is on a Methadone replacement programme but has been screened for Hepatitis B, C and HIV 1 and 2. All are negative. He is currently complying well with Warfarin and has accepted the need for this in the long-term.

His additional medication consists of Lansoprazole, Domperidone, Bumetanide 3mgs, Bisoprolol 10mgs and Digoxin 125 micrograms.

On examination he was in atrial fibrillation with a well controlled ventricular rate. Currently there are no features of heart failure but he has a widely propagated long systolic murmur maximal at the apex. Auscultation of the lungs reveals scattered crepitations and expiratory rhonchi.

His ECGs have shown atrial fibrillation with right bundle branch block and left axis deviation. I am enclosing the hard copies of the report of his recent cardiac catheterisation and echocardiography report. Many thanks for your assessment. With kind regards.

Yours sincerely

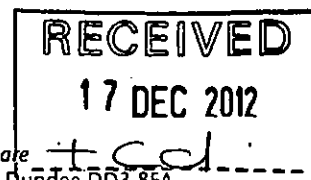
N G DEWHURST
Consultant Cardiologist

ENC(s)

LOGGED IN BOOK
PUT ON DATABASE
CLINIC APPOINTMENT
SECONDARY NOTES
OP WAITING LIST
TOMCAT



cc Dr L J Compson, Drumhar Health Centre, North Methven Street, PERTH
cc Mrs Lesley Brooks, Cardiac Specialist Nurse, Perth Royal Infirmary



Working with you for better health and better care
Headquarters: Kings Cross, Cleington Road, Dundee DD3 8EA
Chairman, Mr Sandy Watson OBE DL
Chief Executive, Mr Gerry Marr



Cardiology Department
Acute Services Division
NHS Tayside
Perth Royal Infirmary
PERTH
PH1 1NX
Telephone: 01738 623311
Fax: 01738 473510
www.nhstayside.scot.nhs.uk

Dr Shona Sinclair
Central Healthcare
Drumhar Health Centre
North Methven Street
PERTH, PH1 5PD

Date Dictated : 3rd September 2012
Typed : 24th September 2012
Your Ref
Our Ref PC/LB 170157/0130
Direct Line 01738 473578
Email lorna.burnett@nhs.net

Dear Dr Sinclair

Alexander Atkinson, Skinnergate Resettlement Unit, 16 Skinnergate, Perth, PH1 5JH (DOB 170157)

DATE OF ADMISSION : 01.08.12 DATE OF DISCHARGE : 07.08.12

DATE OF ADMISSION : 22.08.12 DATE OF DISCHARGE : 22.08.12

PROCEDURE : *Transoesophageal echocardiogram*

DIAGNOSES :

1. *Acute pulmonary oedema – likely secondary to 2.*
2. *Significant mitral regurgitation through 3.*
3. *Anterior mitral valve prolapse*
4. *Permanent atrial fibrillation – on Warfarin*
5. *Barrett's oesophagus*
6. *On Methadone replacement*

Mr Alexander Atkinson presented to the Accident & Emergency Department in Perth Royal Infirmary with a one week history of increasing breathlessness which had become increasingly intrusive. Physical examination at that time revealed that he was tachycardic with a blood pressure of 111/74 with crackles throughout both lung fields and a systolic murmur as before.

For some reason a Troponin T was checked and was negative. More importantly a chest x-ray confirmed pulmonary oedema with left atrial enlargement.

Mr Atkinson was treated aggressively with diuretic therapy and thankfully gradually improved. Hepatitis B and C screens were negative, as were tests for HIV1 and 2. These were carried out at my request.

On reviewing his Central Vision results, there appears to be a catheter specimen of urine revealing a *Klebsiella oxytoca* growth but I suspect an error has been made here as Mr Atkinson was never catheterised during his stay. Infection did not form part of his clinical picture. His Alk Phos was slightly elevated at 153 but thankfully his Albumin was at the lower limit of normal at 35. His U&Es stayed within normal limits.

Mr Atkinson was well enough for discharge on 7th August 2012 but was readmitted for transoesophageal echocardiography, which took place without incident on 22nd August 2012. This confirmed significant mitral regurgitation through bowing / mild prolapse of the anterior mitral valve leaflet. The left atrium was dilated but thankfully the left atrial appendage was clear. Unfortunately only poor transgastric images could be seen. A previous transthoracic echo had suggested that his left ventricular systolic function remained preserved, although the LV dp/dt measurement at the time of his transoesophageal study tended to suggest this was not as a result of flattening from off loading. Both studies tended to suggest that the right heart pressures were not significantly elevated.

The obvious concern here is that Mr Atkinson has run into problems with pulmonary oedema in the presence of significant mitral regurgitation. Although his social problems might confer some reluctance to take this further and particularly as his transoesophageal echocardiogram would suggest that replacement rather than repair of the valve is on the cards here, given that Mr Atkinson has never used injection drugs, I thought it was reasonable to work him up towards possible valvular surgery. As his care remains under my colleague, Dr Dewhurst, I will pass on the results of his transoesophageal echocardiogram and cardiac catheterisation to him directly and he will ultimately be able to make a decision regarding surgical referral in due course.

He comes in for day case cardiac catheterisation on 12th October 2012. I will write again in due course.

Yours sincerely

PETER CURRIE
Consultant Cardiologist

cc. Dr N G Dewhurst, Consultant Cardiologist, Perth Royal Infirmary
Dr A Connacher, Consultant Physician, Perth Royal Infirmary
Dr Hamish Dougall, Staff Grade in Cardiology, Perth Royal Infirmary

Department of Cardiology
Medicine Directorate
Acute Services Division
NHS Tayside
Perth Royal Infirmary
Perth
PH1 1NX

01738 623311
01738 473510
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Dr N Dewhurst
Consultant Cardiologist
Cardiology Department
Perth Royal Infirmary
Perth
PH1 1NX

Date	Dictated : 13 th November 2012 Typed : 21 st November 2012
Your Ref	
Our Ref	PC/LB/ 1701570130
Enquiries to	Lorna Burnett
Extension	13578
Direct Line	01738 473578
Email	lorna.burnett@nhs.net

Dear Dr Dewhurst

Alexander Atkinson, Skinnergate House, 16 Skinnergate, Perth, PH1 5JH (DOB: 17/01/1957)

DATE OF ADMISSION : 12.10.12 DATE OF DISCHARGE : 12.10.12
TO NINEWELLS

PROCEDURE : *Diagnostic coronary angiography (K63.4)*
 Left ventriculography (K63.3)
 Ascending aortography (L26.4)
 Pulmonary function tests

DIAGNOSES : 1. *Acute pulmonary oedema*
 2. *Significant mitral regurgitation through 3.*
 3. *Anterior mitral valve prolapse*
 4. *Permanent atrial fibrillation – on Warfarin*
 5. *Barrett's oesophagus*
 6. *Methadone replacement*

As you know Mr Alexander Atkinson had run into problems with acute pulmonary oedema and an echocardiogram has been performed recently.

Please accept my sincere apologies for the unacceptable delay in reporting his cardiac catheterisation, which took place on 12th October 2012. The cause of this delay was entirely outwith my own control. The procedure was carried out without incident by Dr Sim. A copy of the report has been filed in the Perth Royal Infirmary notes and a copy forwarded to Dr Compson, his General Practitioner.

You will see that unfortunately a right radial approach was impossible as this vascular route has been disrupted through the cardiac catheterisation he had via the right brachial in DRI in 1970. Dr Sim therefore completed the procedure from the left radial and I am pleased to say that this confirmed that he has no significant obstructive coronary disease. His left ventricular angiogram suggested that the left ventricular systolic function was preserved but in the presence of a severe degree of mitral regurgitation. I thought there was a mild / moderate degree of aortic incompetence.

Working with you for better health and better care
Headquarters: Ninewells Hospital & Medical School,
Dundee, DD1 9SY

Chairman, Mr Sandy Watson OBE OL
Chief Executive, Mr Gerry Mann

Clearly this is a difficult situation but given his presentation with pulmonary oedema, I told Mr Atkinson that it was quite likely you would be approaching one of our colleagues in Edinburgh for a surgical opinion at this stage. I would be very interested to hear what the ultimate decision might be as regards mitral valve repair or replacement, and also the feelings regarding the aortic valve.

I have made no arrangements to see Mr Atkinson again at this time.

Yours sincerely

Authorised on 23/11/2012 08:59:25 by Peter Currie.

Peter Currie
Consultant Cardiologist

PS. Recent pulmonary function tests were also performed and appeared to be quite reasonable.

(D) Dr LJ Compson, Mauve Practice, Drumhar Health Cent, North Methven Street, Perth, PH1 5PD

Ninewells Hospital
CARDIAC CATHETERISATION DIAGNOSTIC REPORT

1347945170
12/11/2012

Name: Alexander Atkinson	Date: 12 October 2012
Hosp.No.:	Consultant: Dr Justein Sim
CHI No.: 1701570130	Operators: Dr Justein Sim
Address:	Procedures: Coronary Angiography - Native vessels Left Ventriculography Ascending Aortography K63.4; K63.3; L26.4;

Day case. Catheterisation via the Left Radial artery, under local anaesthetic.
Artery closure method: Pressure - TR Band.

Catheters: Judkins L 3.5, Judkins R 4.0

Complications: None (in lab)

Pressures: LV EDP: 14 (mmHg)

LV angiogram: Ejection fraction estimated as 50 %.
Severe mitral regurgitation.
Normal wall motion.

Aortogram: Mild aortic regurgitation.
No aortic dissection identified. No aortic aneurysm identified.

Coronary Arteries: Left-dominant.

○ Proximal Circumflex:- Large

○ <25% stenosis in the proximal RCA. Minor disease in non dominant vessel.

Case Comment: Started right then moved to left radial

Report: Patient's consultant: Neil Dewhurst

Recent admission with pulmonary oedema secondary to Mitral valve disease.
Had cardiac catheterisation via R Brachial at DRI in 1970 aged 13 when MR was discovered.
R Brachial artery occluded with extensive collateral supply.
TOE confirms anterior MVL prolapse likely for replacement rather than repair.
TTE suggests mild/moderate mixed Aortic valve disease.
SH of drug use but has never injected and no history of IE. Currently on Methadone.
On warfarin for permanent AF.
No significant obstructive coronary disease.
Significant MR.
Moderate AI.
Peter Currie

Recommendation: Other

signed:

Echo Number:



Tayside

Perth Royal Infirmary
Cardiology Department
Echocardiography ReportTOE
Outpatient

Name: ATKINSON, ALEXANDER

CHI Number: 1701570130

Consultant: P F CURRIE

Ward/Clinic: Outpatient

Hospital: Perth Royal Infirmary

Date Performed:

03/09/2012

Operator:

Dr P Currie

Machine:

SEQUOIA

Reason For Request: Assess MV / MR

Study Quality: Reasonable

LVIDD

IVS

LA

LVIDS

LVPW

RA

FS

Ao

RV

EF

LVOT

IVC

Aortic Valve Tricuspid, minimal sclerosis, good leaflet excursion
No stenosis
Mild regurgitation
Mild central regurgitation.

Mitral Valve Thickened leaflets
No stenosis
Moderate/severe regurgitation
There is bowing / mild prolapse of the anterior MVL resulting in a significant jet of eccentric MR into a dilated LA.

Tricuspid Valve Normal
No stenosis
Trivial regurgitation

Pulmonary Valve Poorly visualised

Left Ventricle Poor transgastric images only.

Other LA appendage is clear. Thin intra atrial septum bowing left to right without obvious ASD or PFO.

CONCLUSION: *LV dp/dt 1279mmHg/s. Unable to obtain PISA radius.
Likely significant MR through prolapse of anterior MVL. May require MVR rather than repair.*

Reported By: Dr P Currie

Echo Number:

 Date Performed:
20/03/2012

 Operator:
C. McConnell
(Chief CCP)
Machine:
Vivid s6

 Tayside
Perth Royal Infirmary
Cardiology Department
Echocardiography Report
Transthoracic
Outpatient

Name: ATKINSON, ALEXANDER

CHI Number: 1701570130

Consultant: N G DEWHURST

Ward/Clinic: Cardiac Outpatient

Hospital: Perth Royal Infirmary

Reason For Request: Mixed valve disease.

Study Quality: Sub optimal images

LVIDD	6.2cm	IVS	0.8cm	LA	5.1cm
LVIDS		LVPW		RA	3.2cm
FS		Ao		RV	3.5cm
EF		LVOT	2.4cm	IVC	1.1cm

Aortic Valve	Calcified cusps	Peak Gradient	20mmHg
	Mild stenosis	Mean Gradient	9mmHg
	Mild/moderate regurgitation	AVA	1.9cm ²
	Regurg jet is approx 25-50% of LVOT/colour. Velocity 2.24m/s and the velocity ratio 0.38	AR PHT	586m/s

Mitral Valve	Hockey style appearance of the valve leaflets	DECEL Time	455m/s
	Moderate stenosis	PHT	154m/s
	Severe regurgitation	MVA	1.4cm ²
	Forward velocity of mitral inflow 2.23m/s. Regurge jet is central and fill approx 74% of the LA. PISA radius 1.1cm, ERO 0.4cm ² and VOL 68ml.	Mean Gradient	10mmHg

Tricuspid Valve	Opens well	Peak TR Gradient	45mmHg
	No stenosis	RAP	0-5mmHg
	Mild regurgitation	RVSP	45-50mmHg

Pulmonary Valve	No stenosis	Peak Gradient	4mmHg
	No regurgitation		

Left Ventricle	Preserved systolic function
	Mildly dilated

Wall Motion	No wall motion abnormality.
-------------	-----------------------------

Other	Dilated LA.
	Dilated RA. Normal RV size.
	Undilated IVC with >50% inspiratory collapse.

CONCLUSION: The LV appears mildly dilated with preserved LV function (using simpson rule the Ef is 58%) even in presence of moderate/severe mitral regurge (lv dp/dt 1277mmHg/s).

Moderate mitral stenosis and mild aortic stenosis with mild/moderate aortic regurge.

Some pulmonary hypertension now indicated (no significant hypertension noted in previous scan) with bi-atrial dilatation.

Echo Number:



Tayside

Perth Royal Infirmary
Cardiology Department
Echocardiography ReportTransthoracic
Inpatient

Name: ATKINSON, ALEXANDER

CHI Number: 1701570130

Consultant: P F CURRIE

Ward/Clinic: CCU Inpatient

Hospital: Perth Royal Infirmary

Date Performed:

02/08/2012

Operator:

C. McConnell

(Chief CCP)

Machine:

GE VIVID 9

Reason For Request: ?LV Function.

Study Quality: Reasonable

LVIDD	6.1cm	IVS	LA	5.3cm
LVIDS		LVPW	RA	3.6cm
FS		Ao	RV	1.9cm
EF		LVOT	IVC	

Aortic Valve Calcified cusps **Peak Gradient** 23mmHg
Mild/moderate stenosis **Mean Gradient** 12mmHg
Mild/moderate regurgitation **AVA** 1.5cm²
Velocity 2.4m/s and the gradient may be underestimated as **AR PHT** 576m/s
the LV is probably being fluttered as the valve area and valve
ratio are just within the range for moderate stenosis.

Mitral Valve Hockey style appearance of the leaflets. **DECEL Time** 365m/s
Moderate stenosis **PHT** 154m/s
Severe regurgitation **MVA** 1.4cm²
Regurge jet is broad and fills approx 75% of the LA. Forward **Mean Gradient** 11mmHg
velocity of mitral inflow 2.5m/s. Pisa radius 1.2cm, Vol 74ml
and ERO 0.4cm²

Tricuspid Valve Appears normal **Peak TR Gradient** 25mmHg
No stenosis **RAP** 5mmHg
Trivial regurgitation **RVSP** 30mmHg

Pulmonary Valve No stenosis **Peak Gradient** 4mmHg
No regurgitation

Left Ventricle Systolic function appears preserved
Mildly dilated

Wall Motion No obvious regional wall motion abnormality.

Other Normal Ao root diameter.
Dilated LA.
Mildly dilated RA. Normal RV size and function.

CONCLUSION: *The LV is mildly dilatyed and although it appears to be preserved but this could be fluttered by presence of severe mitral regurge, mild/moderate aortic regurge and the underestimation of the aortic vave velocity and gradient. No significant pulmonary hypertension indicated but bi-atrial dilatation. no significant change to previous echo mar 2012.*

Reported By: C. McConnell (Chief CCP)

O.P. CLINICAL NOTES

(Surgical)

MR WAHLER

NUMBER

NAME

13973 LJ Compson
700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130



DATE

SHEET No.

25/2/13

WT 72.4 kg

ATKINSON, ALEXANDER D
RIE Outpatients Department 3
Mid stream urine

17/01/1957

M 700629263X

WW

17/04/2013 - 17/04/2013

I

MU899831W Microbiology - RIE

17/04/2013 15:16 Mid stream urine

Urine culture :
Klebsiella oxytoca

1	D	2	E	3	L	4	Q	5	S	6	F	7	M	8	O	9	X	X
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Royal Infirmary of Edinburgh Cardiothoracic Unit

Name Atkinson, Alexander
Birthdate 17/01/1957
Patient Id 1701570130
Sex Male
Probe Number: ct91697

Exam Date 02/05/2013
Sonographer Dr Dornan, R
Surgeon Mr Walker, W
Physician Dr Dornan, R

Indications:

intraop MVReplacement intraop TOE 91697

Exam Type:

Preprocedure Data

<u>2 D</u>	
LVOT Diam	1.6 cm
MV Ann Diam	3.3 cm
AR VCD	0.3 cm
LA diameter	5.9 cm

M Mode

<u>Doppler</u>	
MV PHT	218 ms
MVA By PHT	1.0 cm ²
MR Vmax	5.12 m/s
MR Vmean	3.96 m/s
MR maxPG	104.81 mmHg
MR meanPG	72.01 mmHg
MR VTI	190.3 cm
AV Vmax	2.23 m/s
AV maxPG	19.85 mmHg
TR Vmax	2.80 m/s
TR maxPG	31.25 mmHg

Post Procedure

2 D

M Mode

Doppler

Preprocedure/ initial assessment

Dilated LA and RA. Calcification of both mitral valve leaflet tips. Thickening of both leaflets. Tethering of anterior mitral leaflet with 'hockey stick' deformity. Anterior mitral leaflet prolapse. Severe mitral regurgitation. Mild mitral stenosis. L atrial appendage, no thrombus seen. Calcification of leaflet tips of aortic trileaflet aortic valve. Mild aortic regurgitation. No LV dilation and normal LV function. Mild Tricuspid regurgitation peak gradient 30mmHG.

Postprocedure/overall assessment

27 sorin bicarbon fitline mechanical mvr sited. well eated no paravalvular leak seen. no new rwa. unable to determine Ao regurg as poor transgastric views. aortic stenotic gradient 20mmHg peak. overall good LV. trace TR.

Signature.....

Print Date: 5/2/2013

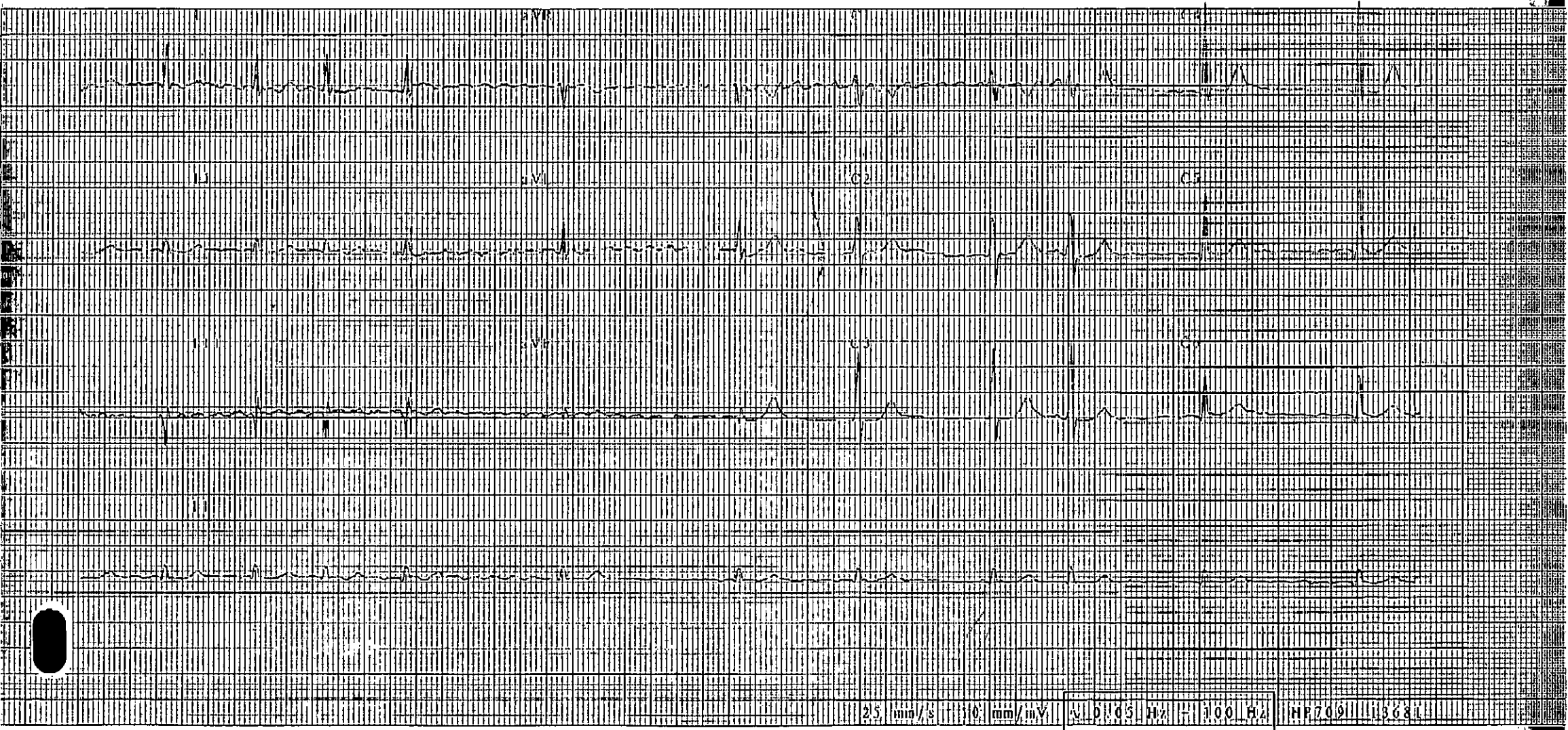
Date of report

5. Alexander Atkinson 11/01/1957.

AF / Filter

73 *Leu*
WAPOR

--Axis--	
P	Ind.
QRS	3
T	27



07-May-2013 09:48:13

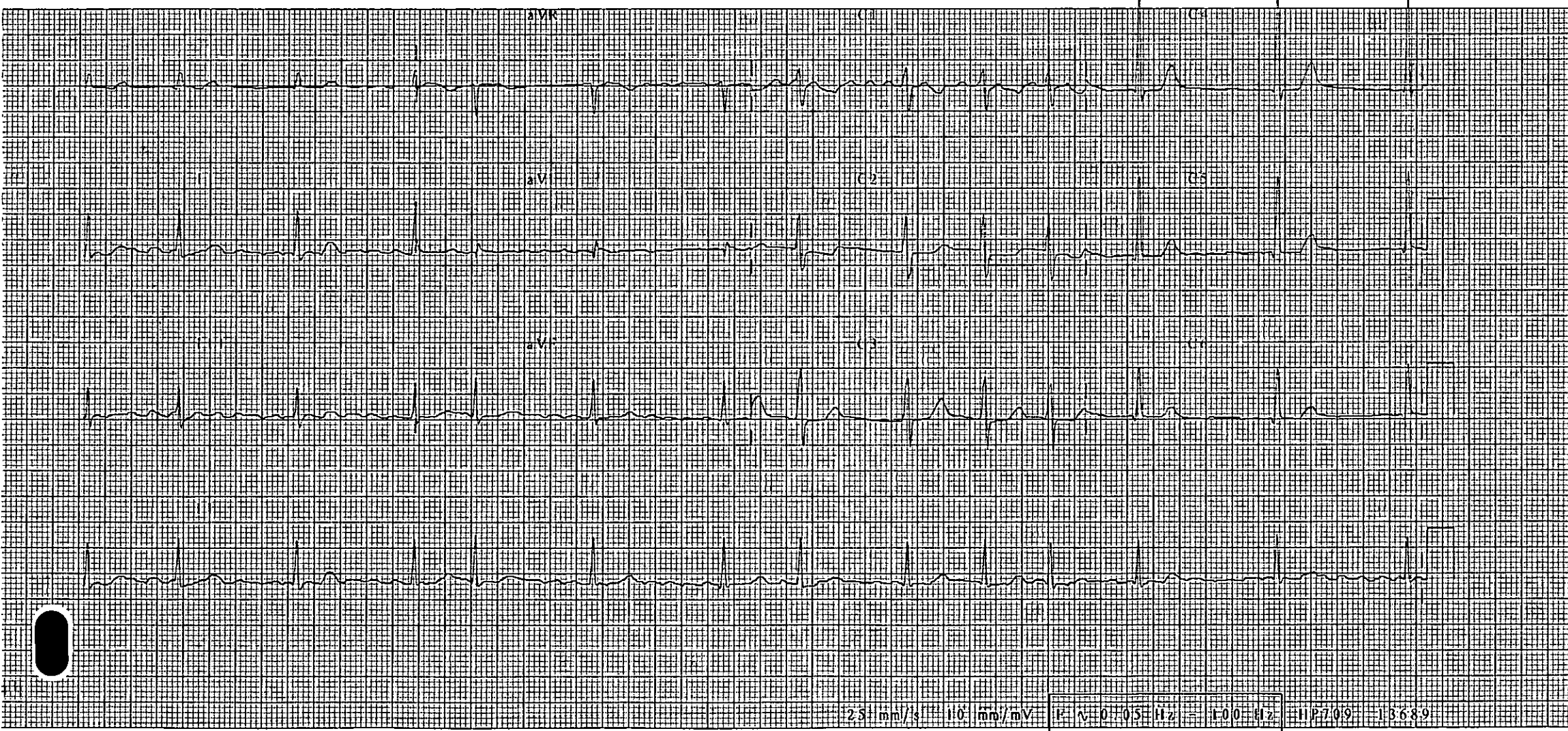
Alexander A. Atkinson DOB 17/1/57 55102

Rate 83
PR 0
QRSD 84
QT 370
QTc 435

--Axis--

P
QRS 44
T 15

Flutter.
~~atrial~~



06-May-2013 10:50:10

700629263X M 17/01/1957

Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH

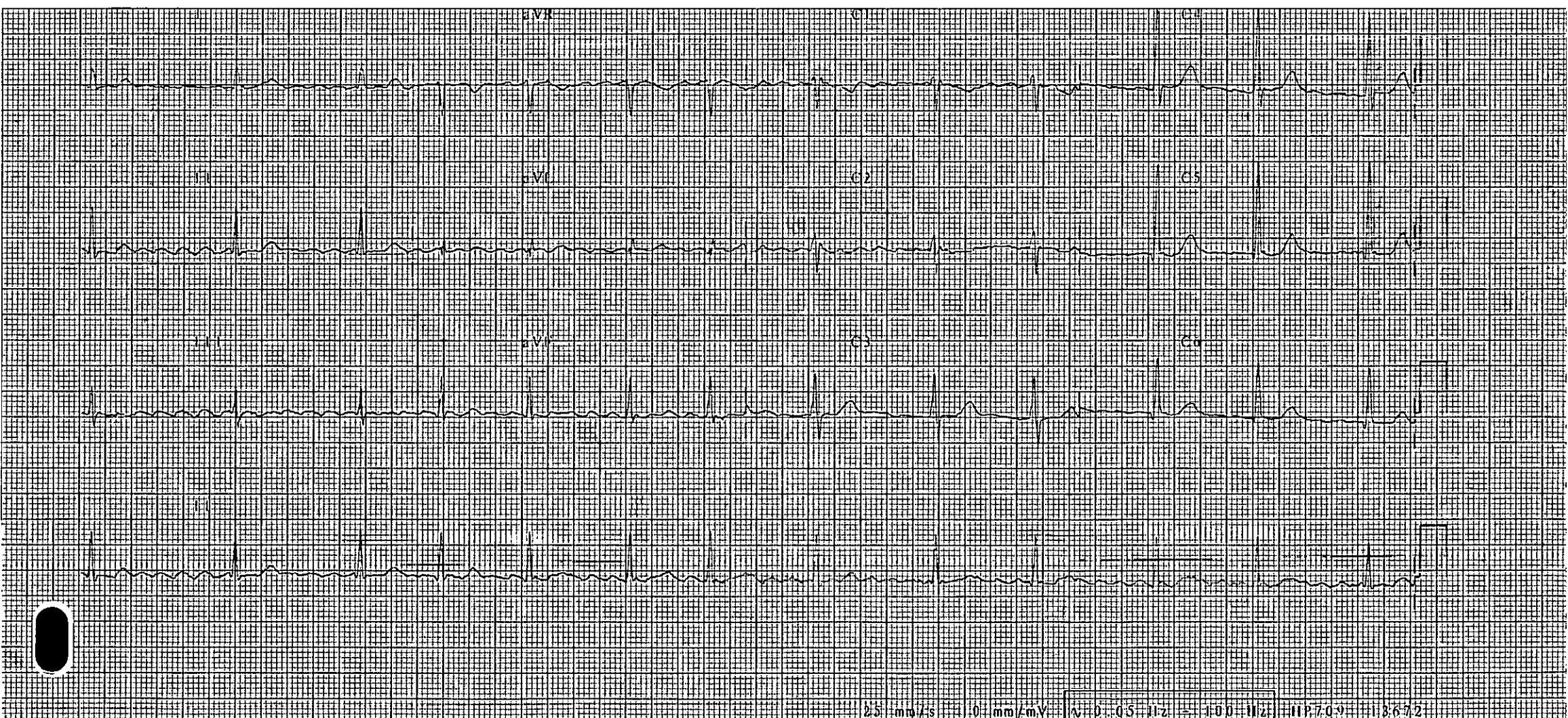
CHI 1701570130 
13975 LJ Compson

Rate 76
PR 0
QRSD 88
QT 379
QTc 426

--Axis--
P Ind.
QRS 48
T 36

Paroxysmal AF/Flutter
irregular.

[Signature] Hor
Cory



Dept: Ward 102


Rate 64 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
PR 183 . Sinus rhythm.....normal P axis, V-rate 60- 99
QRSD 87 . ST elev, probable normal early repol pattern.....ST elevation, age<55
QT 418
QTc 432

--AXIS--

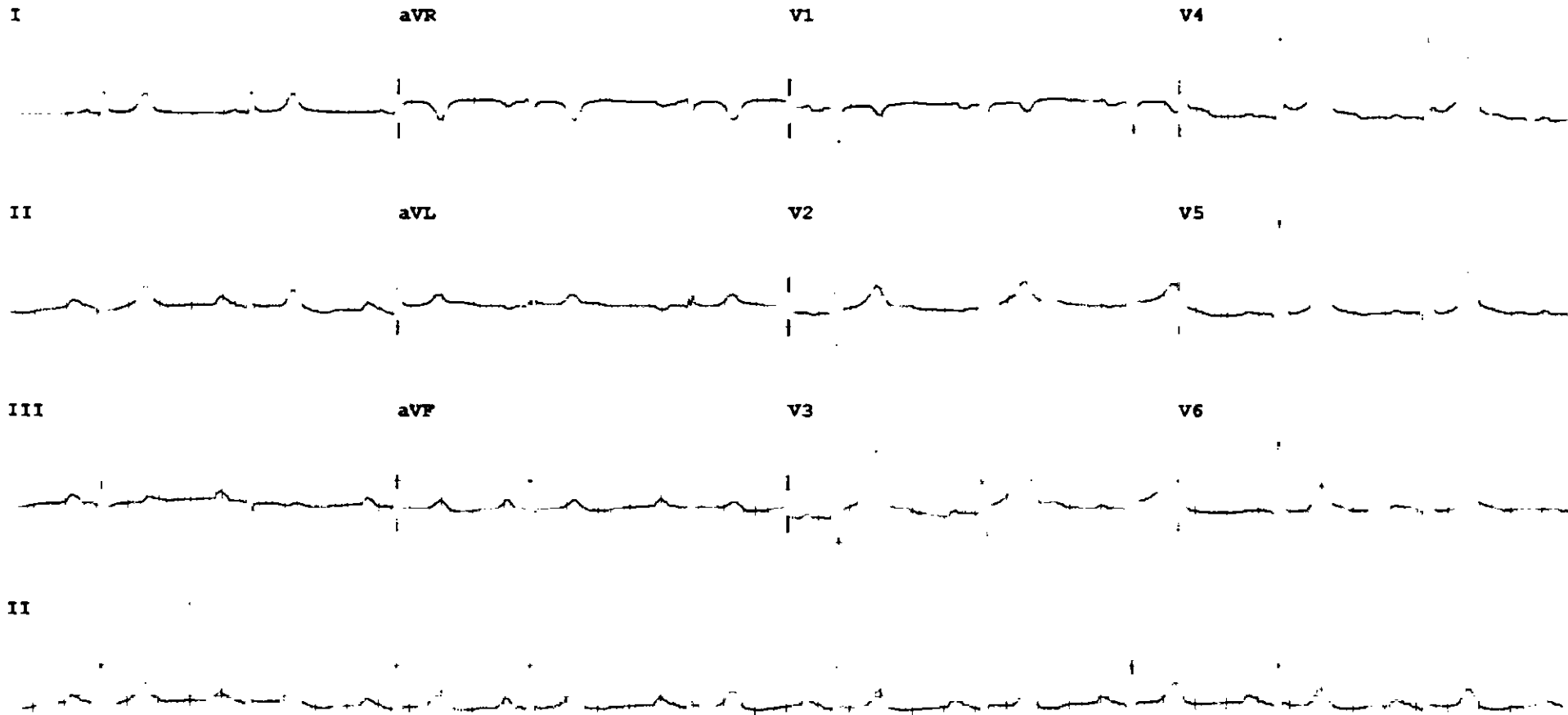
P 74
QRS 40
T 23

post op - Day 1

- NORMAL ECG -

700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130 
13975 LJ Compson

Unconfirmed Diagnosis



Dev: 351906

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

P 50+ 0.15-ID0 Hz PH100B CL P2

Dept: Ward 102

Rate 59 . Age not entered, assumed to be 50 years old for purpose of ECG interpretation
PR 205 . Failure to sense and/or capture (?magnet).....fixed pacing with async rhythm
QRS 83 . Sinus bradycardia.....rate< 60
QT 425 . Borderline prolonged PR interval.....PR >202, V-rate 50- 90
QTc 421 . ST elev, probable normal early repol pattern.....ST elevation, age<55

--AXIS--

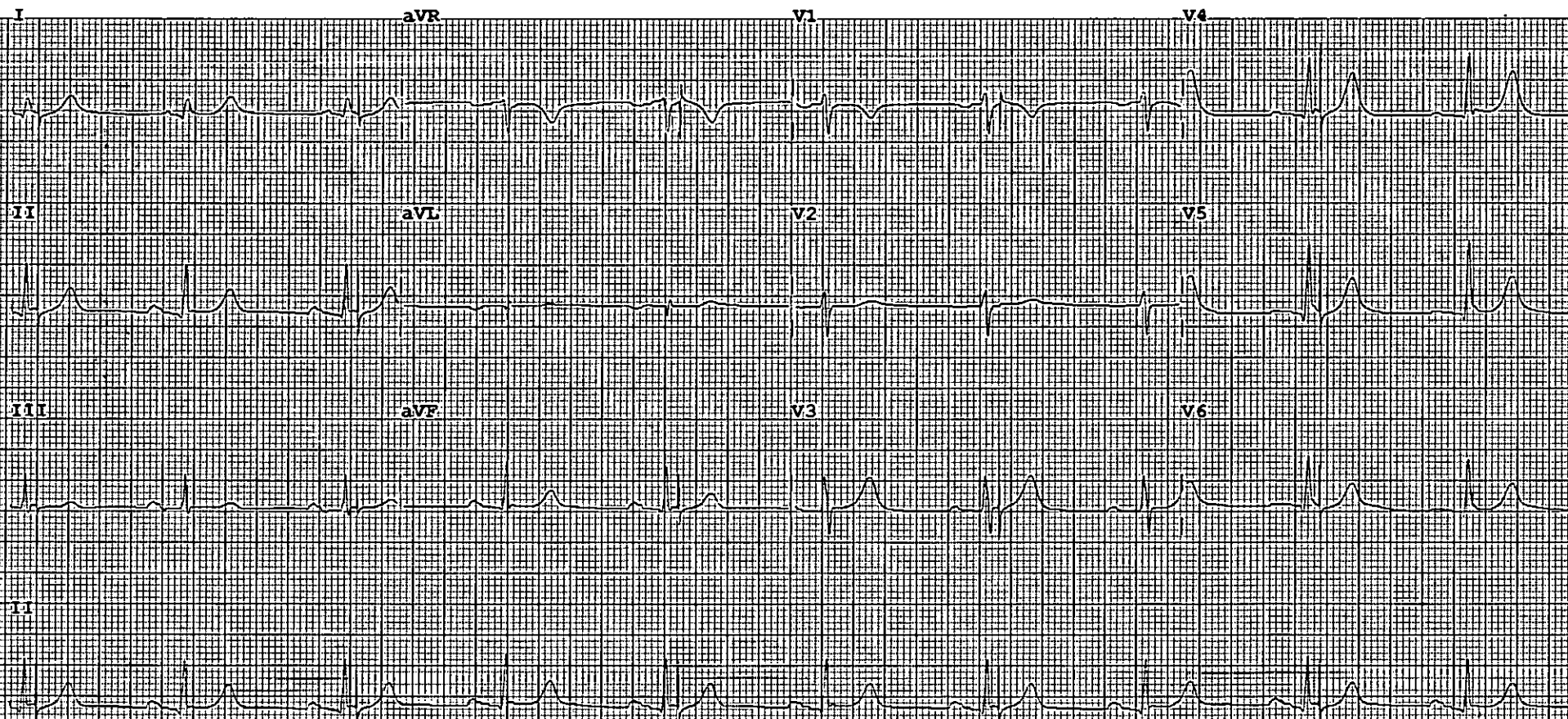
P 67
QRS 62
T 44

- ABNORMAL ECG -

Unconfirmed Diagnosis

700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compson

POST OP



Dev 351906 Speed 25 mm/sec Pump 10 mm/mV Chest 10.0 mm/mV P 50-0-15-100-Hz PH100B CI P2

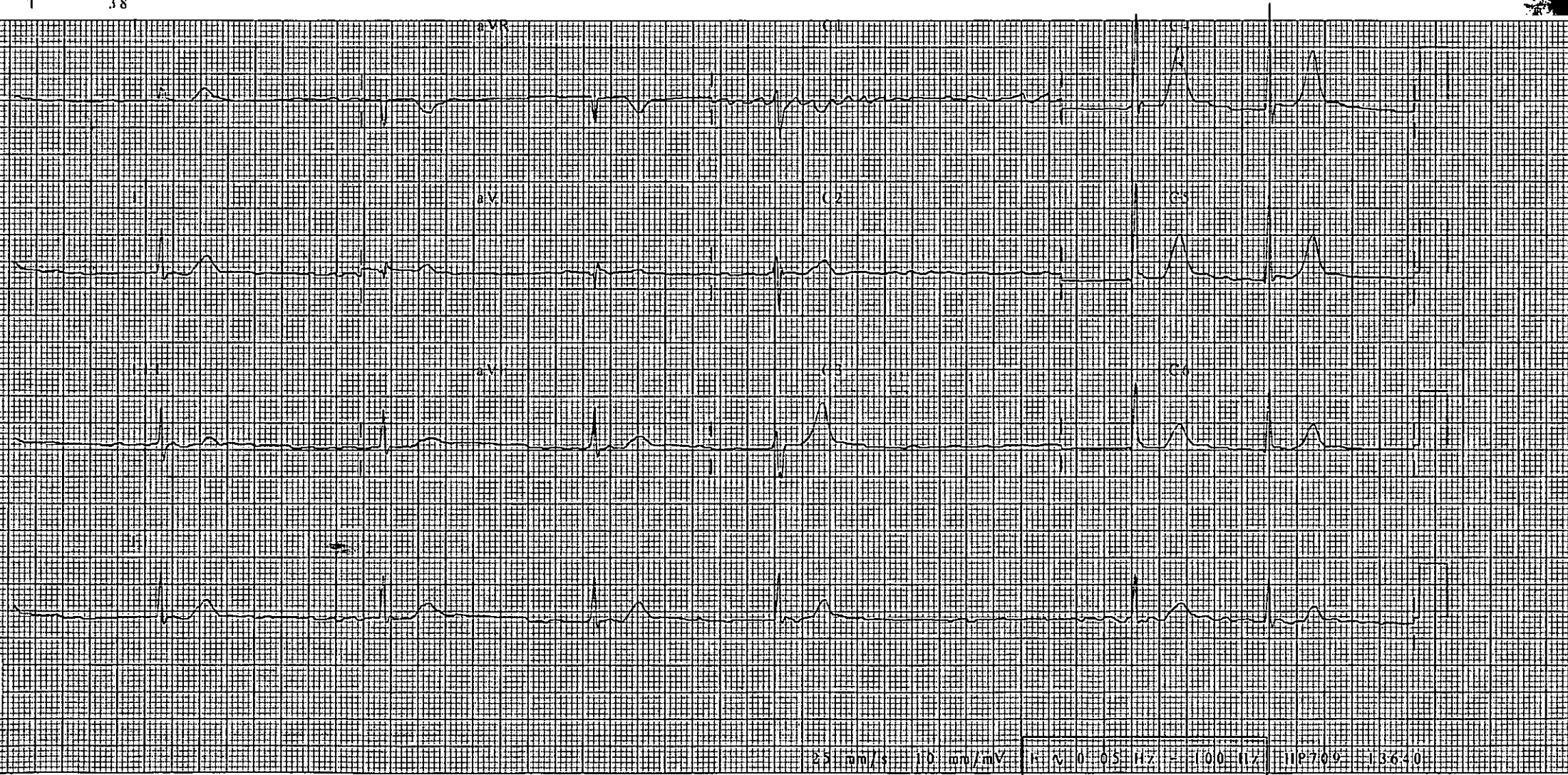
02-May-2013 07:08:00

Alexander Atkinson, DOB: 17/01/57

Rate 40
PR 228
QRSD 89
QT 451
QTc 368

--Axis--

P -71
QRS 52
T 38



1701570130
Born 17/01/1957

17/04/2013 15:02:26
Male

ATRINSON, ALEXANDER

R1E

Dept: ECG Dept

Oper: HILARY

Rate 47

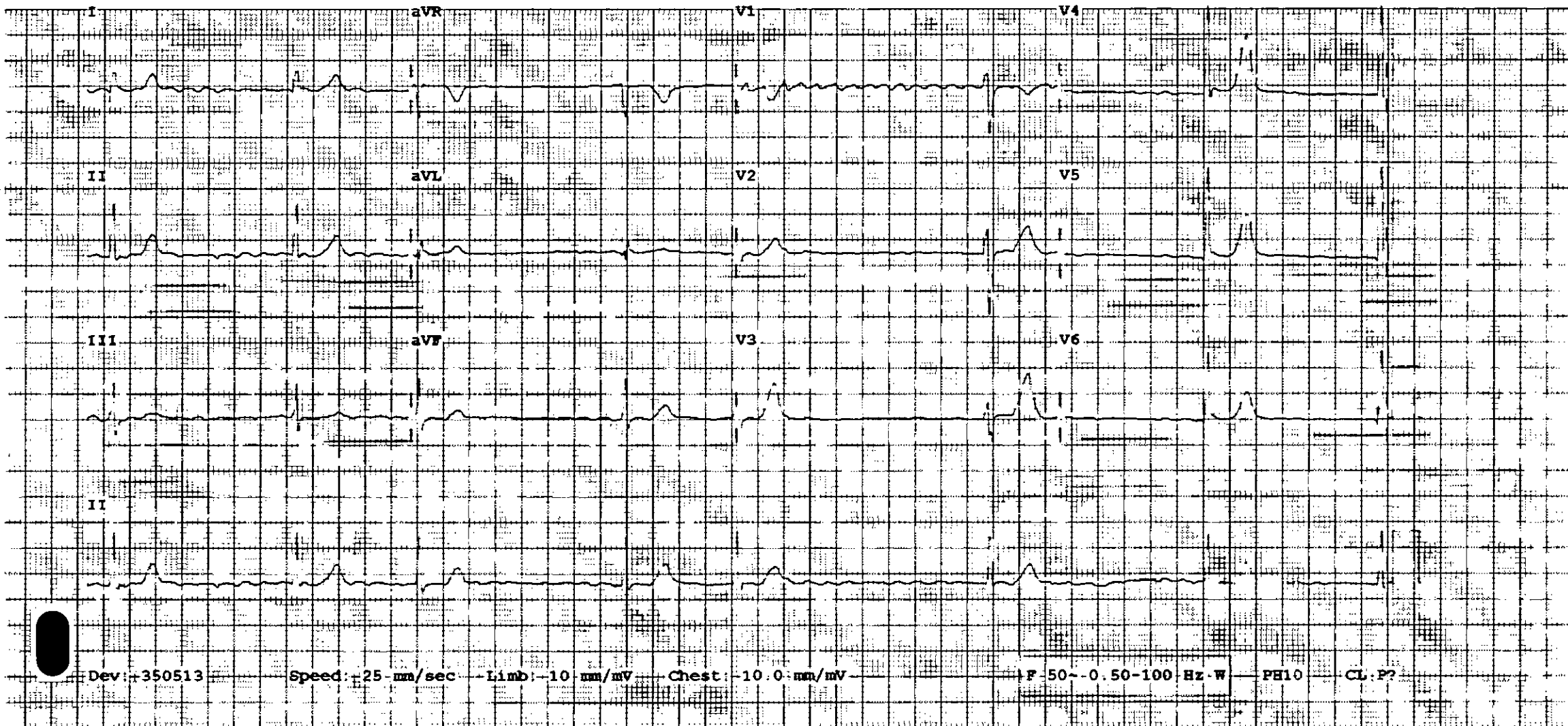
PR
QRSD 96
QT 459
QTc 406

--AXIS--

P
QRS 48
T 44

AF

CLL



Dev: 350513

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

PF 50~0.50-100 Hz W

PH10

CL P?

1701570130
Born 17/01/1957

17/04/2013 15:02:26
Male

ATRINSON, ALEXANDER

RIE

Dept: ECG Dept

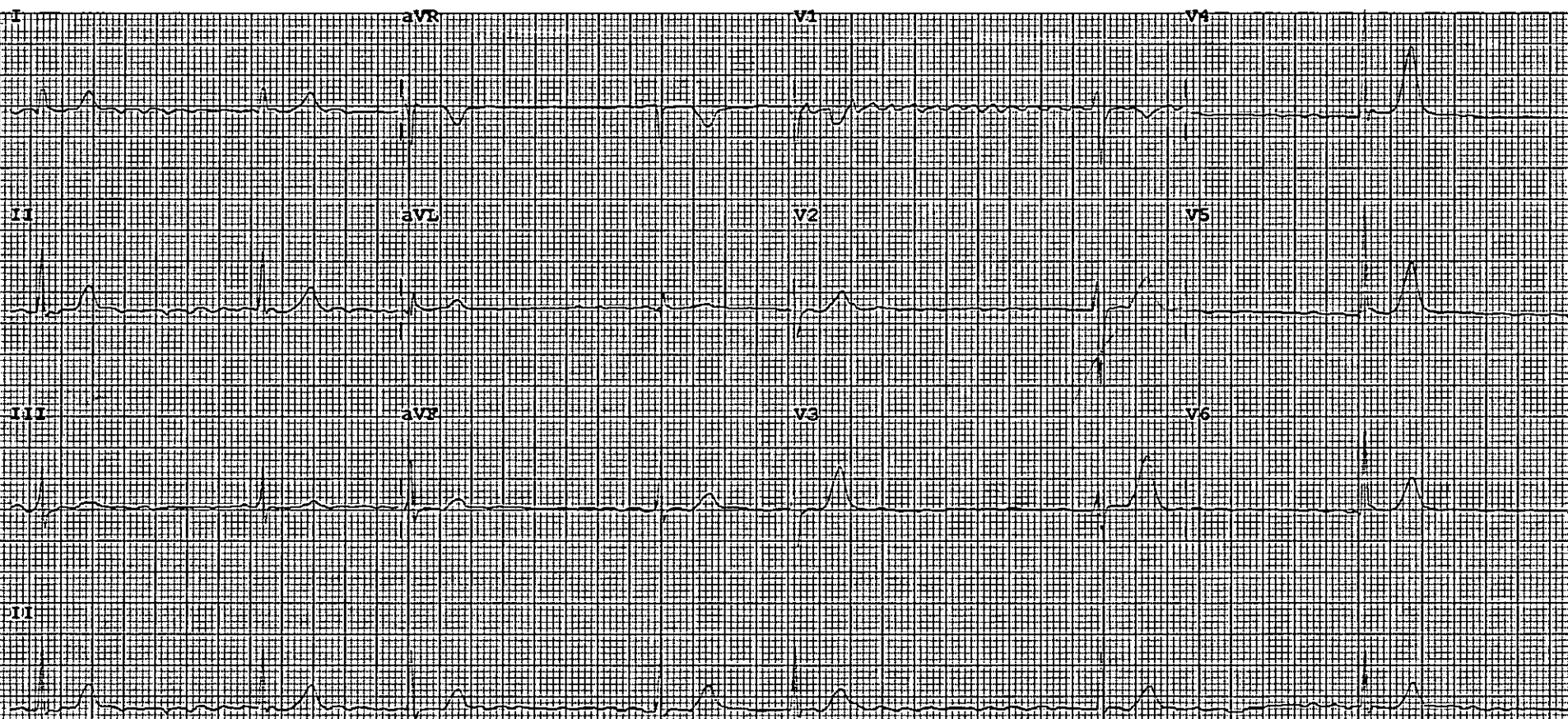
Oper: HILARY

Rate 47

PR
QRSD 96
QT 459
QTc 406

--AXIS--

P
QRS 48
T 44



Dev: 350513

Speed: 25 mm/sec

Limb: 10 mm/mV

Chest: 10.0 mm/mV

P-50-0.50-100 Hz W

PH10 CL P?

Name: ALEXANDER ATKINSON

DOB: 17-January-1957

Sex: M Age: 56.3 Ht: 1.715m Wt: 69.0kg BMI: 23.0 CHI: 1701570130

Report to: Cardiac Clinic

Ventilatory Capacity Report

DATE			17-Apr-2013		Predicted	Range *
			Value	%Pred		
Ventilatory Capacity						
FEV1 (L)			2.45	75	3.25	2.41 -- 4.09
VC (L)			3.75	92	4.08	3.07 -- 5.09
FEV1/VC (%)			65.0		77.1	65.2 -- 88.9

Clinical Details 17-Apr-2013

SMOKER; Beta Blockers

Ventilatory capacity is within the normal range.

SpO2 = 97%

PEFR = 403L/min (Predicted PEFR = 498L/min)

* This range encompasses 90% of the normal distribution



700629263X M 17/01/1957 RDIOTHORACIC SURGERY UNITARY PATIENT RECORD
DEMOGRAPHY

Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH

CHI 1701570130

13975 LJ Compson
Status: M. W. D. S. (circle)

Telephone Number 01738-565 114
Likes to be called

AGE: 55
Named Nurse
Religion

Chaplain Visit YES ☐ NO ☐

Nameband Applied ☐

PROPERTY

T / Glasses Yes / No
D: Yes / No

Jewelry: NO NO
locked away / sent home with relatives
Rings: locked away / sent home with relatives
Clothing: locked away / sent home with relatives
Itemised in register: Yes / No

Name: _____
Signature: _____
Date: _____

Next of Kin SANDY ATKINSON Relationship SON
Address 19 A STANLEY CRE Home Telephone Number: 01738-565 114
PERTH Work No: 07223-610560 Mob: 07840547717
Mobile: 07561-402-792
2nd Contact Name ANN ATKINSON
Relationship (SISTER) Telephone Number 01738-563 841

GP: DR. COMPTON
Address: DROMAIRE H/C.
NORTH MEHVEN ST.
PERTH
Telephone Number: 01738-622421

Admission
Admission Date: 1/5/13 From Home
Time: 21⁰⁰ hrs

Admitting Nurse: (sign)
(print)

Referrals

Discharge Date: 9/5/13
Discharged To: P.R.I. W.D.H.
Valuables returned to patient: Yes / No
Discharge / UPR complete:
Discharging Nurse: (sign)
(print)

Surgeon: WALKER	Diabetic? N / D NIDDM / IDDM / Diet
Cardiologist: DOWD	Allergies: NKDA
Diagnosis: MUR	Height: 5' 9"
Operation: MUR (mechanical)	Weight: 67 kg BMI
Pacing Wires: Westwood coil	
Number: 1	
Date removed: 7/5/13	

PRE-OPERATIVE ASSESSMENT (PATIENT SUMMARY)

700629263X M 17/01/1957
 Atkinson, Alexander D
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 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH

CHI 1701570130

Tel No: 07233610560114 Age 55
 Cardiologist: Dr Penhew GP Dr Compton, Drumhallow Hill
 Surgeon: Mr Walker Referring Hospital PRI
 Planned Operation: MUR (mechanical) Transport needed
 Seen by: Jy Miller Date: 25/2/13

Operative risk score at referral

U (Urgent)

E (Expedite)

R (Routine)

Cardiac History

trivial RCA disease.

Severe MR.

admission of pulmonary
oedema July 2012.

mildly aortic incompetence 1/2 abnormal aortic

AF.

trivial irregularity of RLA.
mild AR

LV Function preserved LV function.

Relevant PMH

previous IV Drug use. - on methadone.

Barrett's oesophagus.

Lower back pain, native Hawaiian.

Medication

Aspirin no

Statin

Clopidogrel no.

ACE Inhibitor

Warfarin YES.

Insulin

Immunosuppressants

Others

Methadone 40 mg qd
 Gabapentin
 - Bumetanide
 - Lamoprazole
 - Domperidone
 - Bisoprolol
 - Digoxin

? Ayclavir.

Checklist

- Dental referral *for supplied.*
- Specific requirements noted (eg TOE)
- Date of angiogram 12/10/2012.
- Short notice *yes.*
- Constraints on dates *none.*
- 1st group and save sample taken *no.*

Other concerns:

negative for hepatitis & HIV
 ? when tested.

Infection issues:

Home Circumstances

denies iv drug use
former smoker of heroin and
other substances

[illegible]

PRE-ADMISSION

PRE-OPERATIVE ASSESSMENT	COMMENTS
<input type="checkbox"/> Medical history & investigations complete <input type="checkbox"/> Demographic details confirmed <input type="checkbox"/> Ward notified of any individual requirements/referrals <input type="checkbox"/> Transport arranged for admission (see guidelines) <input type="checkbox"/> Pre -op medication stopped as per unit protocol <input type="checkbox"/> MRSA Screen done <input type="checkbox"/> Urine dipstick result: <i>PRO+</i>	<div style="text-align: right;"> <i>LA</i> <i>17/4/13</i> MSU sent Yes <i>Yes</i> <i>17/4/13</i> </div>

Bloods drawn / investigations ordered	tick box	Initials	Comment / Result	Initials
Group & Screen 1	<input type="checkbox"/>			
Group and Screen 2	<input type="checkbox"/>			
FBC	<input type="checkbox"/>			
Coag	<input type="checkbox"/>	<i>LA</i>		
(U&E, Glu, LFTs, Ca, Phos, Urate)	<input type="checkbox"/>	<i>17/</i>		
Cholesterol	<input type="checkbox"/>	<i>14/</i>		
TFT	<input type="checkbox"/>	<i>13</i>		
HbsAg	<input type="checkbox"/>			
CXR (PA & LLAT)	<input type="checkbox"/>			
Pulmonary function tests	<input type="checkbox"/>			
MRSA Screen	<input type="checkbox"/>			
Carotid doppler (surgeon's requirements)	<input type="checkbox"/>			
Dental assessment	<input type="checkbox"/>			
ECG x2	<input type="checkbox"/>			

Signed :		Print Name :	
Designation :		Date :	

Nursing Assessment

Cardiac History

Risk factors Genetics (family history) ☒ weight ☐ lack of exercise ☐ poor diet ☐ smoker ☒
 High cholesterol ☐ hypertension ☐ stress ☐ diabetes ☐ others _____

Past medical history Previous operations ☒ stroke ☐ TIAs ☐ fainting /dizzy spells ☒ epilepsy ☐ migraines ☐
 gastric ulcers ☐ or other problems _____

Pain Central chest pain ☒ tightness in the neck ☒ radiating down left arm ☐ Triggers: exertion ☐ nothing (it happens at rest) ☐ stress ☐

Frequency (chest pain) _____ / day week Coping mechanism Rest ☐ GTN spray ☐ nothing helps ☐

Pain (non cardiac) arthritis ☐ joint pains ☐ other _____ Scoring discussed Yes / No

Breathing

Smoking History: 10 / day

Cough/sputum: Chronic cough? Yes ☒ No ☐ Expectorating Yes ☒ No ☐ What colour? _____

Underlying respiratory disease: COPD ☐ Asthma ☐ Sleep apnoea ☐ Other _____

Mobility - Independent

Flat Exercise tolerance _____
 Worse when cold/windy? Yes / No

Musculo-skeletal problems?

Aids used? Walking stick ☐ Zimmer frame ☐

Hygiene & dressing - Independent
 Bath or Shower: - Independent

Independent / needs assistance?

Nutrition

Diet : Low Fat High Fibre Diabetic Low cholesterol Low Sodium High / Low protein

Other Alcohol No units / week

Requires Dietetic Referral Yes ☒ No ☐

Elimination

Bladder/Urinary problems : Enlarged prostate ☐ prev. TURP ☐ nocturia ☐ recent infections ☐ frequency ☐

Bowels (normal pattern) Regular laxatives used ☐ GI problems? - on Can 30 per day

Sleep - No problems

Recreation


Aids used? Yes / No

Work - unemployed

Communication

Sight
 Hearing
 Speech

Teeth own dentures top/bottom/both
 Glasses Reading glasses
 Hearing aid(s) - No
 Cultural/religious needs - c of S.

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CHI 1701570130 
13975 LJ Compson

☐ ☐ / ☐ ☐ / ☐ ☐

DRUGS PRESCRIBED ON ADMISSION CHECKED AND CORRECT

OOSETTE BOX YES / NO

SIGNATURE : .

PRINT NAMED

DATE _____

MEDICATION

[illegible]

19510 15 Compson
700629263X M 17/01/1957
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U.N. ADMISSION

CHI 1701570130



Admission observations

Blood sugar

Urinalysis

Temperature - 36.9

Pulse 59/min

BP 105/59

SPO2 - 99% on Air

Height 5' 9"

Weight 67 kg

regular/irregular

Admission Checklist

- ☐ Nursing assessment complete
- ☐ Demographic details checked and correct
- ☐ Property recorded on register and signed by patient
- ☐ X-Rays and notes on ward
- ☐ ECG
- ☐ PFTs
- ☐ Consent
- ☐ Anaesthetic consultation
- ☐ Has own drugs Yes / No Dosette Box Yes/No

IDENTIFIED CARE NEEDS

Name
Signature

700629263X M 17/01/1957
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 Perth,
 Perthshire, PH1 5JH
 NAME: CHI 1701570130 13075

ISK ASSESSMENT

DOB:

WARD 102

FALLS RISK ASSESSMENT	YES	NO
Admitted with fall or fall since admission.	1	0
Confused or agitated.	1	0
Function impaired by poor vision.	1	0
Frequent toileting.	1	0
Help or assistance to transfer/walk: (score 0 if bed bound)	1	0

COMPLETE THE YELLOW CHECKLIST OVER IF SCORE 2 OR MORE (AT RISK.)
INFORM PHYSIOTHERAPISTS

WEEKLY FALLS RISK SCORE				
DATE	SCORE	COMMENT	SIGN	PRINT
25/1	8	ON ADMISSION In ICU - Bed Bound independant	decker Glaire	L FENDY REYNOLDS
7/3	8			

FALLS RISK CHECK LIST

COMPLETE CHECKLIST ONLY IF SCORE 2 OR MORE (AT RISK).

ACTIONS	DATE	COMMENT	SIGN	PRINT
Advise to patient on safety precautions.		Has capacity. YES / NO		
Demonstrate call bell system.		Ensure within reach. YES / NO		
		Has capacity. YES / NO		
Check condition of feet and footwear.		Refer to Podiatrist if req. YES / NO		
Check suitable seating liaise OT/PT.		On going practice from admission.		
Always return bed to lowest level.		On going practice from admission.		
Erect and supine BP		Able to weight bear. YES / NO		
Move to easily observed area.		Ward geography allows. YES / NO Dependency/sex mix allows. YES / NO		
Consider bed rails – document rationale.		Able/attempting to climb over. YES / NO		
Alert Multidisciplinary Team		On going practice from admission.		
Consider special observations.		On going assessment from admission.		

Patient detail 700629263X M 17/01/1957
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 13975 LJ Compton

PRESSURE SORE RISK / ASSESSMENT

Build/Average for 100 cm		Stomach/Rectal Visual/bisimulation		Sex/ Age		Surgical risks	
Average	(0)	Healthy	0	Male	(1)	Tissue malnutrition	
Above Average	1	Tissue Paper	1	Female	2	E.g. Terminal Cancer	8
Obese	2	Dry	(1)	14 - 49	1	Peripheral Vascular	5
Below Average	3	Oedematous	1	50 - 64	(2)	Disease	5
		Clammy (Temp)	1	65 - 74	(3)	Anaemia	2
		Discoloured	2	75 - 80	4	Smoking	(1)
		Broken? Spot	3	81 +	5		
Continence		Mouth		Appetite		Neurologic deficit	
Complete, catheterised	(0)	Fully	(0)	Average	(0)	E.g. Diabetes, MS	4-6
Occasional Incontinence	1	Restless/Fidgety	1	Poor	1	CVA motor/sensory,	
Cath/Incontinence of faeces	2	Apathetic	2	NG tube	2	paralegia	
Doubly incontinent	3	Restrictive	3	Fluids only	2		
		Inert/Traction	4	NBM/Anorexia	3		
		Chairbound	5				
Major Surgery / Trauma		Meditation		Waterlow Score		Admission Scores	
Orthopaedic - below waist spinal	5	Cytotoxics, high dose steroids,		10+ At Risk		1 st Admission Score :	5
On table > 2 hours	5	anti inflammatory	4	15+ High Risk		2 nd Admission Score :	
				20+ Very High Risk			

[illegible]

Alexander Atkinson

Date of Birth: 17/6/57 Ward: 102. Ulna length (cm):

Height (M): 5' 9"

Usual Weight- past 3-6 months (kg):

Step 5 - Actions

Step 5 - Actions		
0 Low Risk <u>Routine Clinical Care</u>	1 Medium Risk <u>Observe</u>	2 or more High Risk <u>Treat</u>
<ul style="list-style-type: none"> Repeat screening weekly 	<ul style="list-style-type: none"> Commence Medium Risk Guidelines Order fortified diet Repeat screening weekly Improve and increase overall nutritional intake 	<ul style="list-style-type: none"> 3 day food record chart Refer to Dietitian Order fortified diet Improve and increase overall nutritional intake

MEDIUM/HIGH RISK GUIDELINES

Guidelines for those identified at medium or high risk using MUST

1. Fortify dishes at mealtime.

- Breakfast: Cereal with Full Cream Milk.
- Lunch & Dinner: Add Butter to potatoes & vegetables
Encourage puddings

2. Provide Full Cream Milk – 2 to 3 x 200mls per day, perhaps with meals or a hot nourishing drink at bedtime.

3. Provide a nourishing Snack at mid afternoon & supper (prepared in ward kitchen) e.g. Bread with butter/jam/marmalade, Biscuits with butter or Breakfast cereal with full cream milk

4. If visitors wish to bring in snacks please ensure the following:

- Food items are labelled with the correct patient details
- Food items only offered to the specified patient
- Items are pre-packaged with expiry date
- Freshly prepared foods e.g. sandwiches, home-made meals should be discouraged & avoided

Visitors can be advised to bring the following foods:

- Sponge, fruit or tea cakes –not home-made and no cream
- Sweets, Chocolates, Biscuits, Crisps
- Fresh fruit, dried fruit, small tinned fruit
- Individual pots of UHT milk pudding – Kept refrigerated & not home-made e.g. custard, yoghurt, mousse, rice pudding.

5. Offer assistance choosing from the menu

6. Offer assistance, cueing, coaxing & encouragement with all diet & fluids

7. Repeat nutritional screening weekly using MUST

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700629263X - M 17/01/1957
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Clostridium difficile RISK ASSESSMENT

As part of a strategy to reduce preventable cases of *Clostridium difficile*, the following advice should be taken and this form completed **on admission** for **all patients**. This form should be kept in the patient's medical record and will be audited for presence and completion.

Is the patient in any of the following groups?

Patients of any age transferred from any ward/other hospital (excluding admission ward) Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>	Patients aged 65-82 and treated with any antibiotic <u>other than trimethoprim</u> in the last 14 days Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>	Patients aged 83 or older and treated with <u>any</u> antibiotic in the last 14 days Yes: <input type="checkbox"/> No: <input checked="" type="checkbox"/>	Patients has a Waterlow score > 20 Yes: <input checked="" type="checkbox"/> No: <input type="checkbox"/>
--	---	---	---

If "No" to all of the above, the patient is not at increased risk of *C. difficile*.
If "Yes" to one or more of the above, the patient is at increased risk and the actions below should be taken

- | | | | |
|--|--|--|---|
| 1. Stop PPI <i>if possible</i> | PPI stopped: <input type="checkbox"/> | PPI continued: <input type="checkbox"/> | Not on PPI: <input type="checkbox"/> |
| 2. Stop laxative <i>if possible</i> | Laxative stopped: <input type="checkbox"/> | Laxative continued: <input type="checkbox"/> | Not on laxative: <input type="checkbox"/> |
| 3. Record MUST score – refer to dietician if high risk | Referred: <input type="checkbox"/> | Not referred: <input type="checkbox"/> | BMI ≥20 & Albumin ≥30: <input type="checkbox"/> |
| 4. Set stop date for any current antibiotic | Stop date set: <input type="checkbox"/> | Stop date not set: <input type="checkbox"/> | Not on antibiotic: <input type="checkbox"/> |

Prescribing advice for new suspected infective illness

- Avoid blind prescription unless clinically necessary
- If blind treatment necessary consult UHD prescribing policy unless local policy in place.

FURTHER TREATMENT SHOULD BE BASED ON CULTURE & SENSITIVITY RESULTS AND SENIOR ADVICE.

Signature _____ Designation _____ Date _____ Ward _____ Site _____

For advice on the management of diarrhoea please turn over.

WARD 102 RECORD OF INVASIVE LINES

<u>Urine Catheter</u>		<u>Date Inserted</u>	<u>Date Removed</u>
<u>Supra pubic Catheter</u>		<u>Date Inserted</u>	<u>Date Removed</u>
<u>Venflon</u>	<u>Site</u>	<u>Date Inserted</u>	<u>Date Removed</u>
<u>Central Line</u>		<u>Date Inserted</u>	<u>Date Removed</u>
<u>Hickman Line</u>		<u>Date Inserted</u>	<u>Date Removed</u>
<u>Para vertebral Catheter</u>		<u>Date Inserted</u>	<u>Date Removed</u>
<u>Pacing Wires : Ventricle/ Atrial</u>		<u>Date Inserted</u>	<u>Date Removed/Cut to skin</u>
<u>Naso Gastric Tube</u>		<u>Date Inserted</u>	<u>Date Removed</u>
<u>Peg Tube</u>		<u>Date Inserted</u>	<u>Date Removed</u>

Post-operative Check List.

Alexander Atkinson DOB: 17/01/57

[illegible]

Lothian University Hospitals Division

WARD 102 CARDIOTHORACIC SURGERY

NURSING CARE PLAN

NAME:

UNIT NO/DOB:

700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
12075

ADMISSION DATE: ①

ADMITTING NURSE: (Signature)

RECORDS COMPLETED AND CHECKED ON TRANSFER/DISCHARGE/REWRITE
(Delete as appropriate)

SIGNATURE:

DATE:

Patient ID Label:

Actual/potential problems	Desired outcomes	Date	Nursing actions
1. <u>BREATHING</u> SaO ₂ below acceptable	Patient has unlaboured breathing at an acceptable rate Increase SaO ₂		Record respiratory rate and oxygen saturations (SaO ₂) as indicated and following anaesthetic. Administer oxygen. Position patient appropriately to maintain airway and chest expansion and prevent aspiration of gastric contents, until able to do so unaided.
Potential retention of chest secretions.	Prevent/resolve chest infection		Encourage deep breathing and coughing. Liaise with physiotherapist.
Pneumothorax/effusion	Drainage of thoracic cavity and re-expansion of lung via intercostal (I/C) under waterseal drain		Care of I/C drain as per Unit Standard. Observe drainage. Record amount of drainage daily (0800) and when bottle changed.
	Aid re-expansion of lung.		Apply low grade suction at prescribed level. Care of low grade suction as per Unit Standard.
2. <u>COMFORT & SAFETY</u>	Cardiovascular instability is recognised, reported and treatment instituted.		Record pulse and blood pressure as indicated and following anaesthetic.
Wound caused by:	Early detection of bleeding.		Monitor wound/s regularly for signs of bleeding/haematoma for 24 hours following procedure.
Reduced mental awareness peri-operatively	Maintain a safe environment.		Orientate patient to surroundings.
Pain caused by:	Provide optimum pain relief.		Assess pain by: 1. Observation of patient. 2. Enquiry Ensure adequate and appropriate analgesia is prescribed and administered as required/requested.
3. <u>MAINTAINING BODY TEMPERATURE</u>	Body temperature is within normal limits. No signs of infection post-operatively.		Monitor body temperature as indicated and record. Monitor any wounds/invasive sites for signs of inflammation/exudate indication possible infection.
Actual pyrexia/hypothermia	Bring body temperature to within normal limits.		Take appropriate action.

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Patient ID Label:

Date 4/5	Date 5/5	Date 6/5	Date 7/5	Date 8/5	Date 9/5	Date
6°	6°	6°	6°	6° Room Air	6° RA	
Upright	Upright	upright	upright	Upright	upright	
cont.	cont.					
/	/	/	/	/	/	
✓	✓	✓	✓	✓	✓	
6°	6°	Telemetry 6°	Telemetry 6°	Telemetry 6°	Telemetry 6°	
cont	cont	cont	cont	Westmead coil site		
wd 102	wd 102	102	wd 102	wd 102	102	
1+2 cont.	1+2 cont.	1+2 d/c	1+2 O/G	1+2 on (air)	1+2 O/G	
6°	6°	6°	6°	6	6°	
N LM	N LM	N LM	N LM	N LM	N LM	N
E	E	E	E	E	E	E
L	L	L	L	L	L	L

Patient ID Label:

Actual/potential problems	Desired outcomes	Date	Nursing actions
4. <u>NUTRITION</u> Potential for inadequate diet/hydration due to:	The patient's nutrition and hydration needs are met.		Provide fluids and offer appropriate choice of diet from menu. Monitor dietary intake. Liaise with dietician if appropriate.
Potential nausea and vomiting	Prevention and treatment of nausea and vomiting.		Monitor and treat nausea with antiemetic therapy as prescribed. Record fluid intake and observe for fluid/electrolyte imbalance. Weigh patient weekly and record on flow chart. Peripheral I/V access provided. Administer prescribed colloid/crystalloid intravenous fluid/ Change I/V given sets and connections as per unit policy.
5. <u>HYGIENE & DRESSING</u> Potential need for assistance with personal hygiene.	Patient is clean and comfortable.		Offer daily bath/shower/basin. Offer post-operative 'freshen up' wash as appropriate. Offer mouth care and hand washing facilities as appropriate.
6. <u>ELIMINATION</u> Potential for disrupted elimination pattern due to surgery/analgesia.	Normal or improved pattern of elimination.		Monitor bowel movements daily and record on flow chart. Record urine output. Ensure patient has passed urine post-anaesthetic and record on flow chart.
7. <u>MOBILITY</u> Potential complications of bedrest/reduced mobility.	Optimum mobility is maintained to prevent complications. Skin integrity is maintained/improved.		Assess and record Waterlow score as per Unit policy. If patient has a sore refer to Pressure/Wound Management page. Encourage mobility peri-operatively. Inspect pressure points and assist to change position as appropriate. State frequency.
Possible risk of injury to staff from assisting patient to move	Risk is minimised.		Take appropriate action according to patient's individual needs.
8. <u>COMMUNICATING</u> Potential lack of understanding information regarding illness.	Patient receives and understands information regarding illness.		Assess patient's and relatives' coping mechanisms, needs and anxieties and encourage their expression. Encourage participation in decision making. Explain all procedures and plans for treatment. Allow time for questions and ensure explanations are understood.
9. <u>SLEEP</u> Potential for sleep disturbance due to environment/surgery.	Optimum rest/sleep is achieved by patient.		Create environment conducive to sleep as per Standard. Identify factors which may affect ability to sleep/rest and attempt to minimise their effects.

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Patient ID Label:

Date 4/5	Date 5/5	Date 6/5	Date 7/5/13	Date 8/5/13	Date 9/5/13	Date
Norm DTF	Norm DTF	Normal DTF	Normal diet & fluid	Full Choice of Diet & fluids	Diet & fluids	
PRN	PRN	PRN	PRN	PRN	PRN	
Weight	Weight	Daily	Weight	DAILY WGT	Daily weight	
/	/	/	/	/	Bo Pu.	
Assist as req'd.	Indep.	Indep.	Indep.	Independent	Ind.	
BNO(N) PU(N)	BNO(N) PU(N)	No	Bo	BNO(N)		
cont	cont	Always	WLS 7 Grade 0	onwards	Older	
cont	cont	cont	Cont Inform	Continued	Older	
Nocte	Nocte	Nocte	Nocte	Nocte	Nocte	
N LM	N LM	N LM	N LM	N KR	N CR	N
E	E	E	E	E	E	E
L	L	L	L	L	L	L

The Royal Infirmary of Edinburgh NHS T

700629263X M 17/01/1957

Directorate of Cardiothoracic Surgery

Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
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Perthshire, PH1 5JH

Cardiac Surgery Nursing Care Plan

CHI 1701570130
13975 LJ Compson

Patient Name		
Cardiac Surgery Number		
Surgeon	Mr Walker	
Anaesthetist		
Admission Date	W103/4	W111 2/5/13
Care Coordinator		
Admitted By	W 103/4	W 111 Hendrick

Records completed and checked on transfer/discharge by

Name.....

Date.....

- Care plan entries are printed and made in black ink as per UKCC ruling
- Entries are dated and timed
- Printed name is entered below signature on numbered progress notes
- Student nurse / non CTS agency nurse entries are countersigned and the supervising nurse's name recorded as above

Activity	Desired Outcome	Date	A/P Problem	Nurses' Actions
<u>1</u> <u>sleeping & resting</u>	pt's sleep pattern returns to normal	2/5 ↓	<ul style="list-style-type: none"> noise in the lcu / wd continuous activity involving pt 	<ul style="list-style-type: none"> -Identify and correct where possible factors which may affect the patient's ability to sleep -ensure rest periods during the day
<u>b</u> <u>neurological recovery post CPB</u>	degree of neurological recovery from CPB is noted & reported promptly		<ul style="list-style-type: none"> neurological deficit anxiety / agitation 	<ul style="list-style-type: none"> -monitor neurological status freq, -note and report changes as necessary to the nicl doctor -give and monitor effects of prescribed sedatives
<u>2a</u> <u>breathing</u>	adequate respiratory function is maintained	2/5 ↓	<ul style="list-style-type: none"> hypoxia secretion build up / chest infection 	<ul style="list-style-type: none"> - give amount O2 as prescribed - monitor O2 saturations freq - monitor ETCO2 freq -report significant trends to nic -observe nature & consistency of secretions -report as required -humidify oxygen > 8l/min or if mechanically ventilated for > 24hrs -suction patient's trachea or naso / oropharynx freq ? -assist physiotherapist and carry out physiotherapy planned care as pt's condition allows -send specimen for c&s as reqd
<u>2b</u> <u>assisted ventilation</u>	the patient is mechanically ventilated safely and as prescribed	2/5 ↓	<ul style="list-style-type: none"> Inadequate ventilation due to machine failure gas leak/occlusion or self extubation unmatched orders and ventilator settings untreated deleterious changes in patient's condition 	<ul style="list-style-type: none"> -complete patient and system checks as per protocol on nurse changeover -a/a + monitor patency & security of tbg, traps and connections -do air entry checks as per policy -ensure orders sheet is updated appropriately by medical staff -monitor the ventilated patient continuously -report changes, including ABG results, to nic -report return of CXR to Dr

700629263X	M	17/01/1957
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Atkinson, Alexander D

Skinnergate Resettlement Unit,

16 Skinnergate,

Perth,

Perthshire, PH1 5JH

abbrev	dated changes	dated changes	dated changes	dated changes	dated changes
p-action					
sleep					
rest					
neuro					
sedatvs	Prompt //				
(C)					
cont					
Sat mon	cont				
co2	Capt				
trends					
secre					
hum 02	HMC //				
suction	RN				
physio					
bacter					
pt / sys checks	Kach				
security checks	Shift //				
a.e chks					
orders					
mon v					
cxt Dr					

Activity	Desired Outcome	Date	A/P Problem	Nurses' Actions
	nursing measures are taken to promote successful weaning	2/5	<ul style="list-style-type: none"> pain / anxiety preventing successful weaning the patient's position compromises chest expansion the selected weaning mode proves ineffective 	<ul style="list-style-type: none"> -give analgesia and sedation as prescribed to aid weaning -position pt to allow optimal chest expansion -monitor and report on effectiveness of weaning mode
3	<u>comfort & safety</u>	2/5	<ul style="list-style-type: none"> pt has insufficient / ineffective analgesia 	<ul style="list-style-type: none"> -assess and treat pain using unit protocol -monitor delivery and effects of patient controlled analgesia
4a	<u>cardiovascular instability</u>	2/5	<ul style="list-style-type: none"> undetected / reported cardiovascular instability hypokalaemia & related arrhythmia ischaemia related arrhythmia drug therapy related arrhythmia / instability 	<ul style="list-style-type: none"> -monitor hr & rhythm freq -record " " freq -monitor systemic blood pressure fre -record " " " fre -report trend abnormalities -know likely Rx & how to prepare -give prescribed Rx & report effects -monitor serum potassium level & give bolus KCL as per unit standing order <u>via central l/r</u> -report relevant ECG changes -give prescribed Rx observing unit protocol for the safe administration of drugs -ensure safe administration of drugs -report effects / side effects to nic -know likely treatment for side effects and how to prepare -record peripheral temperature during administration of vasoactive drugs

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[illegible]

Activity	Desired Outcome	Date	A/P Problem	Nurses' Actions
2 <u>hemostasis</u>		2/5	<ul style="list-style-type: none"> bleeding life threatening bleeding 	<ul style="list-style-type: none"> -know the types of blood loss possible post CPB -monitor & report significant trends/character of blood loss -give prescribed clotting factors -give colloid as prescribed -initiate treatment while reporting to nic & Dr
3 <u>effective chest drainage</u>	chest cavity is drained of blood and or pt's lung is reinflated within the optimum time	2/5	<ul style="list-style-type: none"> Inappropriate placement of / change in drainage tube position chest drainage system malfunction disconnection loss of patency pneumothorax / during removal undetected arrhythmia during removal 	<ul style="list-style-type: none"> -notify dr when cxx is returned -ensure security of the system before moving the patient -establish the system using unit protocols -ensure a continuous underwater seal -check set suction level freq -check drain connections freq -sleeve conn if pt is slv -milk drains (only if ordered) -observe unit policy on chest drain removal -continuously observe ECG during procedure
5 <u>controlling body temperature</u>	<p>deviations in body temperature are reported promptly</p> <p>nursing measures to regulate body temperature are taken</p>	2/5	<ul style="list-style-type: none"> Infection hypothermia 	<ul style="list-style-type: none"> -record pt's core / oral temperature freq -report pyrexia in non CPB pts immediately and pyrexia persisting beyond 48 hrs post CPB -send appropriate specimens for bacteriological examination -open / close windows at pt's bedside as req'd -tepid sponge pt freq if pyrexial -use bair hugger to rewarm pt if core temperature < 35 C -use blood warmer when transfusing > 2 units blood under pressure

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abbrev n action	dated changes	dated changes	dated changes	dated changes	dated changes	dated changes	dated changes	dated changes
knowlg		8/5						
tr / ch								
bld loss								
cltg fctr								
colloid								
em rx								
ex								
ch								
sq								
est sys								
UWS								
chk sectn	1/1/19							
dr conn								
sleek cn	✓							
removal								
arryth mia								
rc core / oral t fr	1-2°							
rpt abn								
bacterio								
window								
tepid sp								
bair hgr								
bld								

Activity	Desired Outcome	Date	A/P Problem	Nurses' Actions
personal cleansing and dressing	the patient feels clean and comfortable	2/5	pt is unable to maintain basic hygiene independently	attend to hygiene needs in the form of: bedbath clean teeth / dentures freq clean mouth freq wash @ bedside with help shower with help independent shower
	The patient's dignity & privacy are maintained	2/5		Keep patient covered at all times Ensure bed area is fully enclosed by screens before & during the carrying out of personal care.
wound healing	wound healing is promoted	2/5		monitor, maintain freq records of & report wound progress to nlc / dr send wound swab for c&s as req'd begin wound chart for complex needs
			<u>Wound specific</u>	<u>care plan</u>
		2/5	1 sternal/ thoracotomy	Tegaderm pad
			2 donor site(s)	
			3 drain site(s)	
			4 pacing wire site(s)	
			5 other.	

Activity	Desired Outcome	Date	A/P Problem	Nurses' Actions
<u>ating & drinking</u>	the patient has an adequate nutritional intake	2/5	<ul style="list-style-type: none"> malnutrition 	<ul style="list-style-type: none"> assess the patient's nutritional status on admission monitor same freq report difficulties in maintaining adequate nutrition seek & follow dietetic advice as nec assist pt to eat & drink as req'd give IV fluid / ng supplements as prescribed
	safe induction of anaesthesia		<ul style="list-style-type: none"> aspiration of stomach contents during induction of anaesthesia 	<ul style="list-style-type: none"> explain rationale and fast the pt pre operatively.
<u>elimination</u>	satisfactory fluid balance	2/5	<ul style="list-style-type: none"> inadequate urine output 	<ul style="list-style-type: none"> assist with toilet needs until independent maintain fluid balance records maintain a daily weight record give diuretic / fluid as prescribed
	the patient's bowel function returns to normal		<ul style="list-style-type: none"> irregular bowel habit 	<ul style="list-style-type: none"> maintain daily bowel function records report abnormalities treat constipation as per trust protocols
<u>10 communication</u>	the patient and his family receive and understand information about his illness and progress	2/5	<ul style="list-style-type: none"> the patient and / or his next of kin are not satisfied with the quality / consistency of information given 	<ul style="list-style-type: none"> ensure consistent information giving through use of appropriate documentation and shift to shift reports using unit checklist, give relevant routine information to patient / rel arrange for patient & / or rel to talk to m/c / Dr if they wish

Perthshire, PH1 5JH

[illegible]

Activity	Desired Outcome	Date	A/P Problem	Nurses' Actions
<u>mobilisation</u>	complications of restricted mobility are avoided	2/5	the development of pressure sores	<ul style="list-style-type: none"> -assess pressure sore risk freq -use pressure relieving aid as indicated -do passive /assisted limb movements freq -apply antiembolic stockings as per unit policy

MOBILITY CHART

	patient & staff are protected from lifting and handling injury		patient cannot move independently	use the following technique / lifting aid
		2/5	move up bed	} Assistance x2 + glide sheet
			rolling/ pressure care	
			sit - stand	
			stand sit	
			toileting	
			bathing	
			showering	
			lying sitting over edge of bed	
			transfer trolley bed	
<u>12</u> <u>work and recreation</u>	a return to self care in all activities is promoted	2/5	patient is dependent post operatively / on admission	promote independence

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[illegible]

Invasive Catheter Record.

[illegible]

Record of formal discussions with patient's relatives -

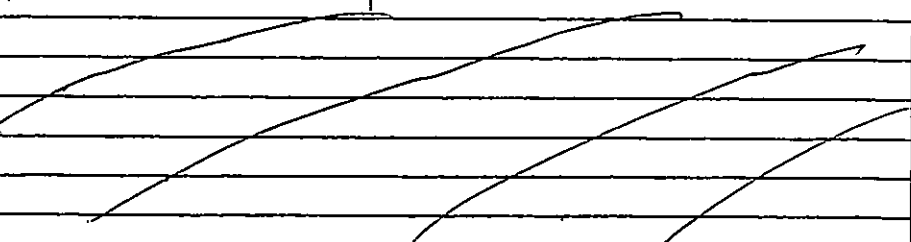
[illegible]

700629263X M 17/01/1957
 Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 CHI 1701570130
 13075 11 Common

Ward 102
 Date of admission 01/05/13 @ 21:00 hrs
 Consultant

Date & Time	IN-PATIENT PROGRESS/COMMUNICATION SHEET (State action taken after exception reporting)	Signature (print name & designation)
2/5/13 0045	Nursing Pt. arrived approx 9:30pm on ward. Admitted and draped by SN Joseph. Still to be seen by anaesthetist so no meds will be given @ 0600. Prescribed 3.75mg zopiclone by HAN on pt - very nervous/anxious. Sats = 10. No chest pain. Still awake at time of writing.	D. Johnston J. Johnston (N)
2/5/13 0700	Nursing Vital signs recorded HR - 48/101 Res obtained - Raste 40, but pt asymptomatic but very anxious. B-P 95/58, SpO2 97% on room air otherwise stable. Routinely Bloods + 2x BTS Sample sent last night.	(S) (N)
2/5/13 1940	Nursing: Patient returned from theatre at 18:50. Had MVR replaced with metal valve. CVS stable since return. Topical of KCL 10mmds. Drained 100mls from drain. Warm and well perfused. Sister dressed and advised of his return from theatre. Fully ventilated and off sedation. Plan for warm wake and warm. Had couple of episodes of bradycardia so far has been self reversing but attached to pacing box by night still. Good urine output. Ab stable in gas. ACT 156.	K. Dixon K. Dixon SN
2/5/13 0115	NURSING NOTES - NIGHT DUTY A-line Site: ② radial A-line still required? (Y) N Removed? Y / N Any signs of infection? (Y) N Hand washing performed? (Y) N Transparent dressing intact? (Y) N Correct sampling technique? (Y) N Red cap applied aseptically? (Y) N Dressing need changed? Should be changed at least every 7 days Y / N CVC Site: R IT Insertion date 2/5 CVC still required? (Y) N Removed? Y / N CVC > 7Days (Y) N Removed? Y / N Smartsites on appropriate port (Y) N Free from signs of Infection (Y) N Hand Hygiene? (Y) N Alcohol Hub Decontamination? (Y) N CVC site cleaned daily with blue clinell 2% alcoholic chlorhexidine Y / N Dressed? Y / N PVC in situ > 72hrs REMOVE! Confirm with NIC Jackson Phlebitis score 0	

Name Alexander Atkinson Date of Birth 17/01/57 Unit No

Date & Time	IN-PATIENT PROGRESS/COMMUNICATION SHEET (State action taken after exception reporting)	Signature (print name & designation)
2/5/13 07:15 Cnd	<p>NURSING NOTES CTND</p> <p>NEURO - Appears intact, PEARL moving all limbs equally & on demand. Morphine PCA In situ - 2mg bolus doses - cyclizine + morphine PCA made as prescribed 46mg given in total + 3x IV paracetamol. Complaining of pain when moving. At start of shift patient looked agitated - shaky + fidgety - anaesthetist came to review & said to recommence propofol. Propofol stopped @ 01:10hrs. Methadone not given this morning as quite sleepy. RESPS Extubated @ 06:15hrs, SU on 4L O₂ RR 8 SpO₂ 99% pO₂ 31.66, CO₂ 6.17 on 6L O₂ chest X ray taken at start of shift. Mo on suction down ETT but MP, -MP, when extubated - P sitting on top of cuff CVS SB - SR HR 55 bpm VP on demand @ 45 bpm HR preop 48 bpm ventricular ectopics occasionally. ECG taken - to be reviewed K⁺ 4.84, Hb 10.2. Drains 380ml in total 120ml / 6°, BP 132/53 mm 75, CVP 12 - 3x gels plasma given Temp 36.8 °C AL RM 2.6 on actrapid @ 2ml/hr no complaints of nausea GU IDC in situ, urine output ✓ 10 furosemide given to good effect. Skp intact, PAC given + bed bath with chlorhexadine wash TEDS on, Mouth care given - refused shave Bloods sent. Daughter & sister phoned & updated</p>	
		<p>Alexander Atkinson S/N</p>

Name Alex.
Atkinson.

Date of Birth

Unit No

Date & Time	IN-PATIENT PROGRESS/COMMUNICATION SHEET (State action taken after exception reporting)	Signature (print name & designation)
5/5/13 0410	Settled night. Slept long periods. Medical staff reversed tramorph dose due to pt's drug usage, same increased to long form. Oramorph was req'd x2 overnight with good effect each time. Obs as charted. Meds as per kardex. Pt remains on telemetry overnight, HR 70-80bpm, AF, Gt pre-op AF, warfarin used for same. Wound dressings remain dry/intact. Westmed coil remains in situ. Pt appears independent with ADL's, BNO overnight. No new issues to report.	ON MUNN <i>[Signature]</i>
5/5/13 1600	Nursing Sens - 0. Some clo pain - prn tramorph given with good effect. On tele → AF around 1600. Showered self and managing all other ADL's. BNO. Wound dressings intact and not due change. Eating and drinking all offered. MB tel so 2 x RBC prescribed for today. No other complaints or issues.	J. Schomb J. Schomb
6/5/13 03.10	Nursing Cardiovascular Stable Sens - 0 Pain remains an issue - oramorph given Dressings intact 2 units of Rbc given with no issues or concerns overnight. Pt appears to have settled and slept well.	<i>[Signature]</i> Shv
1500	NURSING - Pt showered independently. Telemetry remains in situ. Hr 70-80 bpm. All other obs stable. Pain appears problematic though does not hinder mobility or ADL's. Breakthrough analgesia given throughout day.	<i>[Signature]</i> Polch (slw) M. Pichon
7/5/13 NIGHT	Ans Saw score 0 medication is prescribed + breakthrough analgesic 1000 is given as INR 6.1. For early bloods Westmed coil remains in situ. Appears to have Settled and slept on/ct.	<i>[Signature]</i>

WARD

IN-PATIENT PROGRESS / COMMUNICATION SHEET

State Action/s taken After Exception Reporting
 Each entry should be dated & timed

Date & Time	Progress notes / Problems Action Taken & Investigations Required	Signature (Print name & designation)
7/5/13 14 ³⁰	Observations stable & satisfactory, INR 3.1. Wearable coil therefore removed telemetry ongoing as per protocol - remove more	
8/5/13 NIGHT 0011	NURSING - Patients observations stable, SEWS score 0, remains on telemetry HR 75 bpm controlled AF. Settled and slept well overnight. No complaints voiced.	JLW L. Roberts
8/5/13 14 ⁰⁰	Nursing - Patients vital obs stable SEWS 0 - Reviewed by Medical Staff telemetry to be removed, commenced on 12500 J of Deltapain - - Fully independent with Shered Mobility - Wound dry & intact, Dry dressing applied - No complaints of Pain or nausea voiced - Good Diet & fluid intake - no other issues or concerns.	M. Brown
9/5/13	Nursing nightshift. Observations stable as charted. Gt FY2 to speak to patient as he has a sore mouth/crums which was previously on treatment for. He is to see Dentist today. Had Zopiclone REYNOLDS as requested. Settled and slept FOR EARLY BLOODS.	ON Glare

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[illegible]

Sheet completed by: CHERIE NIP

Date: 17/04/13

"Alex"

700629263X M 17/01/1957 ✓
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate, CHANGING
Perth, ADDRESS
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compson 18/4/13

Cardiac History

History

WN For M (MVR).

Dr Dewhurst PR1

This 55 yr old gentleman has a known history of severe mitral regurgitation, with mild aortic incompetence & abnormalities. mild AR & mild irregularity of RCA. known Atrial Fibrillation - on warfarin. mild mitral stenosis.

Symptoms of shortness of breath & associated chest tightness increasing over last 6-8 mths - on exertion gets right-headed, no syncope.

FM. Father died 2 wks ago MI!

Previous Medical History

Barretts Oesophagus

Lower Back Pain - nature uncertain. - worse at night.

Previous ~~drug~~ Drug abuse - methadone - Denies IV only smokes heroin. ex smoke & substance abuse.

AF - 2010

Pul oedema July 2012 -> Hospital Admission.

herpes simplex - lips - on aciclovir

Cholecystectomy keyhole 2009/10.

Plays in prison
to get methadone
to say use
syringes.

Angina status pre-op

- ☒ CCS 0 None
- ☐ CCS 1 only on strenuous exertion
- ☐ CCS 2 on moderate exertion (e.g. climbing stairs rapidly)
- ☐ CCS 3 on mild exertion (e.g. walking 1 - 2 blocks at normal pace)
- ☐ CCS 4 on any activity or at rest

Dyspnea status pre-op

- ☐ NYHA I none or only on strenuous exertion
- ☒ NYHA II on moderate exertion (e.g. on climbing stairs rapidly)
- ☐ NYHA III on mild exertion (e.g. walking 1-2 blocks at normal pace)
- ☐ NYHA IV on any activity or at rest

Number of previous MIs

- ☐ None
- ☐ 1
- ☐ 2 or more
- ☐ unknown

Interval between operation and previous MIs

- ☐ No MI
- ☐ < 6 hours
- ☐ 6 - 24 hours
- ☐ 1 - 30 days
- ☐ 31 - 90 days
- ☐ > 90 days

Active Endocarditis? (Patient still under antibiotic treatment at time of surgery)

- ☐ Yes
☐ No

Claudication

- ☐ Yes
☐ No

Carotid stenosis > 50%

- ☐ Yes
☐ No

Previous or planned surgery of abdominal aorta, limb arteries or carotids

- ☐ Yes
☐ No

Previous cardiac, vascular, or thoracic surgical interventions:

- ☒ None
☐ CABG
☐ Congenital Cardiac
☐ Asc aorta/Aortic arch
☐ Other Thoracic
☐ Carotid endarterectomy
☐ Valve
☐ Other Cardiac
☐ Desc aorta/Abd aorta
☐ Other peripheral vascular

Date of last cardiac operation ____ / ____ / ____

Previous Interventions

Previous PCI

- ☐ No PCI
☐ PCI < 24 hrs before surgery
☐ PCI > 24 hrs before surgery; same admission
☐ PCI > 24 hrs before surgery; previous admission

Date of last PCI ____ / ____ / ____

Cardiac Investigations

Previous catheterisation

- ☐ Never
☐ This admission
☐ Previous admission

Date of catheterisation 12 / 12 / 12

Extent of coronary artery disease

- ☒ No vessels with >50% diameter stenosis
☐ One vessel with >50% diameter stenosis
☐ Two vessels with >50% diameter stenosis
☐ Three vessels with >50% diameter stenosis
☐ Not investigated

Left Main Stem Disease

- ☐ One vessel with >50% diameter stenosis No LMS disease/LMS disease <= 50% diameter stenosis
☐ One vessel with >50% diameter stenosis LMS disease >50% diameter stenosis
☐ Not investigated

- PA systolic if known ____ mm Hg
- LVEDP (mm Hg; 0 = unknown) ____ mm Hg
- AV gradient (if known) ____ mm Hg
- Mean PAWP/LA (if known) ____ mm Hg
- Severity of aortic valve stenosis ____ EO cm²

Ejection Fraction (value if known) ____

Ejection fraction category

- ☐ Good (>49%)
- ☐ Fair (30 – 49%)
- ☐ Poor (<30%)
- ☐ Not measured

Risk Factors for the acquisition of cardiac disease

Diabetes management

- ☒ Not diabetic
- ☐ Diet
- ☐ Oral therapy
- ☐ Insulin
- ☐ Unknown

Cigarette smoking history

- ☐ Never smoked
- ☒ Ex-smoker
- ☒ Current smoker

10 cigs / day

Stopped for 4 wks then started again

Hypertension

- ☒ No hypertension
- ☐ Treated or BP > 140/90 mm Hg on >1 occasion prior to admission

Pre operative Creatinine ____ µmol/l

Preop Haemoglobin ____ g/l

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Additional Medical History and Risk Factors

Renal Disease at the time of surgery

- ☒ None
- ☐ No dialysis but pre-op acute renal failure (anuria or oliguria <10ml/hr)
- ☐ Dialysis: Acute Renal Failure, onset within 6 weeks of surgery
- ☐ Dialysis: Chronic renal failure; more than 6 weeks prior to cardiac surgery

History of neurological disease

- ☒ No history of neurological disease
- ☐ TIA or RIND
- ☐ CVA with full recovery
- ☐ CVA with residual deficit
- ☐ Other

Neurological dysfunction (Disease severely affecting ambulation or day to day functioning)

- ☐ Yes
- ☒ No

Pulmonary disease

- ☒ Asthma
- ☒ COAD/Emphysema
- ☒ Long term use of bronchodilators or steroids
- ☐ FEV1 < 75% predicted
- ☐ Other

Carotid bruits

- ☒ No
- ☐ Yes

Other risk factors

- ☐ Pre-operative pacemaker
- ☐ Pre-operative VT/VF/aborted sudden death
- ☐ Asymptomatic AAA
- ☐ Dissecting thoracic aneurysm

- ☒ Refusal of blood products
- ☐ Severe substance abuse
- ☐ Thoracic aorta surgery

Medic: 700629263X M 17/01/1957
Patient: Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
DOB: CHI 1701570130

Patient	<input type="checkbox"/>	TRAK	<input type="checkbox"/>	Patient's Own Drugs	<input type="checkbox"/>
Relative/carer	<input type="checkbox"/>	(TRAK IDL or clinic letter)			
Community pharmacy	<input type="checkbox"/>	Nursing home Kardex	<input type="checkbox"/>	GP referral letter	<input type="checkbox"/>
Tel:					
Emergency Care	<input checked="" type="checkbox"/>	GP Practice	<input type="checkbox"/>	Other	<input type="checkbox"/>
Summary		Tel: -		Specify.....	

MANDATORY TO FILL IN ALL FIELDS

Specify.....
 + pr forget tabs +

Medicine/ Agent or Nil Known	Description of reaction	check dose on admission

(remember inhalers/ eyedrops/ creams/ injections, OTC, herbals)

WARFARIN ☒ Yes / ☐ No Indication: AF Duration: 1 week Target INR: 2.5 Usual Dose: 2mg (alt) days, 3mg INR on admission:

IN	Yes	No	Insulin type & Device:	Usual Doses:

[illegible]

(Yes) No Specify action required: (eg contact GP).....

Name: C. W. K. P. C. Y. Signature: [Signature] Date: 17/4/13

Name: HVEITZ Signature: [Signature] Date: 3/5/13

Medicine changes during admission

Date	Medicine	Change	Reason

Pharmaceutical Care Issues

Date	Issue/Desired Output	Plan / Action	Actual Output
	<p>Drugs prescribed on admission checked and correct Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

Discharge Planning Information

<p>Compliance Aid: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Type:</p> <p>Filled by (✓): Family <input type="checkbox"/> Patient <input type="checkbox"/> Carer <input type="checkbox"/> Community Pharmacy <input type="checkbox"/></p> <p>Methadone/ other Instalment prescription Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details</p>	<p>Community Pharmacy Details</p> <p>Community Pharmacy Contacted</p> <p>On admission by: Date:</p> <p>On discharge: Date:</p>
<p>Patients own medicines stored: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Medicine supply problem : Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details</p>	<p>Medication reminder chart on discharge Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Provided by: Date:</p>
<p>New Warfarin Prescription</p> <p>Indication: Target INR: Duration:</p> <p>Booklet provided Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Counselled by: Date:</p>	<p>Counselling required Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Details</p> <p>Counselled by: Date:</p>

Completed by C HERPICH NP
Date 17/4/13

Designation

700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
12075

Social History

Home situation Lives in supported Accommodation (Sawana Army) - Awaiting rehab to grand floor flat. Lives alone ☒

Employment Unemployed Artist

2 sisters } Son + daughter in 30s
1 brother } live locally.

Alcohol

Number of Units ☐☐ NIL
(Stopped 20yrs ago)

2 step sisters
1 step brother
Systems Enquiry

Cardiorespiratory: Cough nil

Sputum bloody - chest yellow

Haemoptysis nil

Wheeze occasional

GU: Dysuria "stingy"
not good flow
Frequency due to diuretic

Nocturia

Haematuria

GI:

Weight Loss Recently
not eating well

Abdominal Pain

Constipation/Diarrhoea

PR Bleeding nil

Teeth

↑ behaviour
Enforce drinks
CNS: Weakness
Fits
LOC
Dizzy
TIA Symptoms
Irregular
on bowel
screening programme

Dentures	Mouth condition
Lower only	Clean and healthy
Upper only	Requires dental advice
Both	
Partial plate upper	attending dentist currently undergoing treatment
Partial plate lower	
Crowns	specify

Eleven teeth extracted over 2-3 weeks

On Examination

Build Bm

Jaundice X

Pallor X

Lymphadenopathy X

Clubbing X

Oedema X

Xanthelasma X

Thyroid swelling X

Cyanosis X

Areus X

Cardiovascular

Pulse 56 reg/irreg
Blood pressure 100/50 mm Hg

JVP $\hookleftarrow \rightarrow$

Carotid Bruits nil

Apex non displaced

Heaves nil

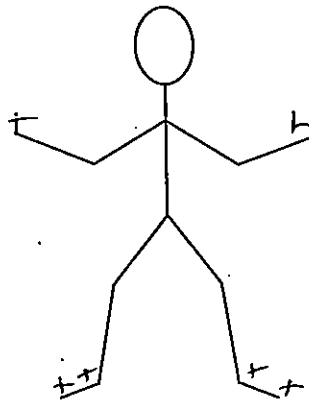
Thrills nil

Heart sound and murmurs I + II + Psm

Varicose Veins nil

Oedema nil

Peripheral Pulses



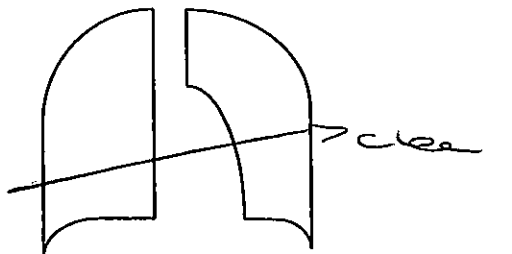
Respiratory

Trachea \perp

Expansion R = L

Percussion N/A

Auscultation NAD



Abdomen

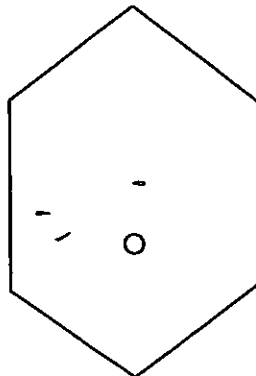
Soft Yes

Tender no

LKKS nil

Masses

Bowel Sounds yes



Tattoos

R + L Arms

(L) Ant chest

Neurological

Alert and Oriented Yes

GCS 15

Cranial Nerves

PERL

FROEM

V & VII

VIII

XII

NAD

Prev cholecystectomy via laparoscope

Tone

Power

Sensation

Reflexes

	Arms		Legs		
	R	L	R	L	
Tone	\sim				N
Power	5/5	5/5	5/5	5/5	
Sensation	\sim				N
Reflexes	Biceps	Triceps	Knee	Ankle	Plantars

Pati 700629263X M 17/01/1957
 Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 Dat 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 Ho: CHI 1701570130
 13975 L.J. Compton

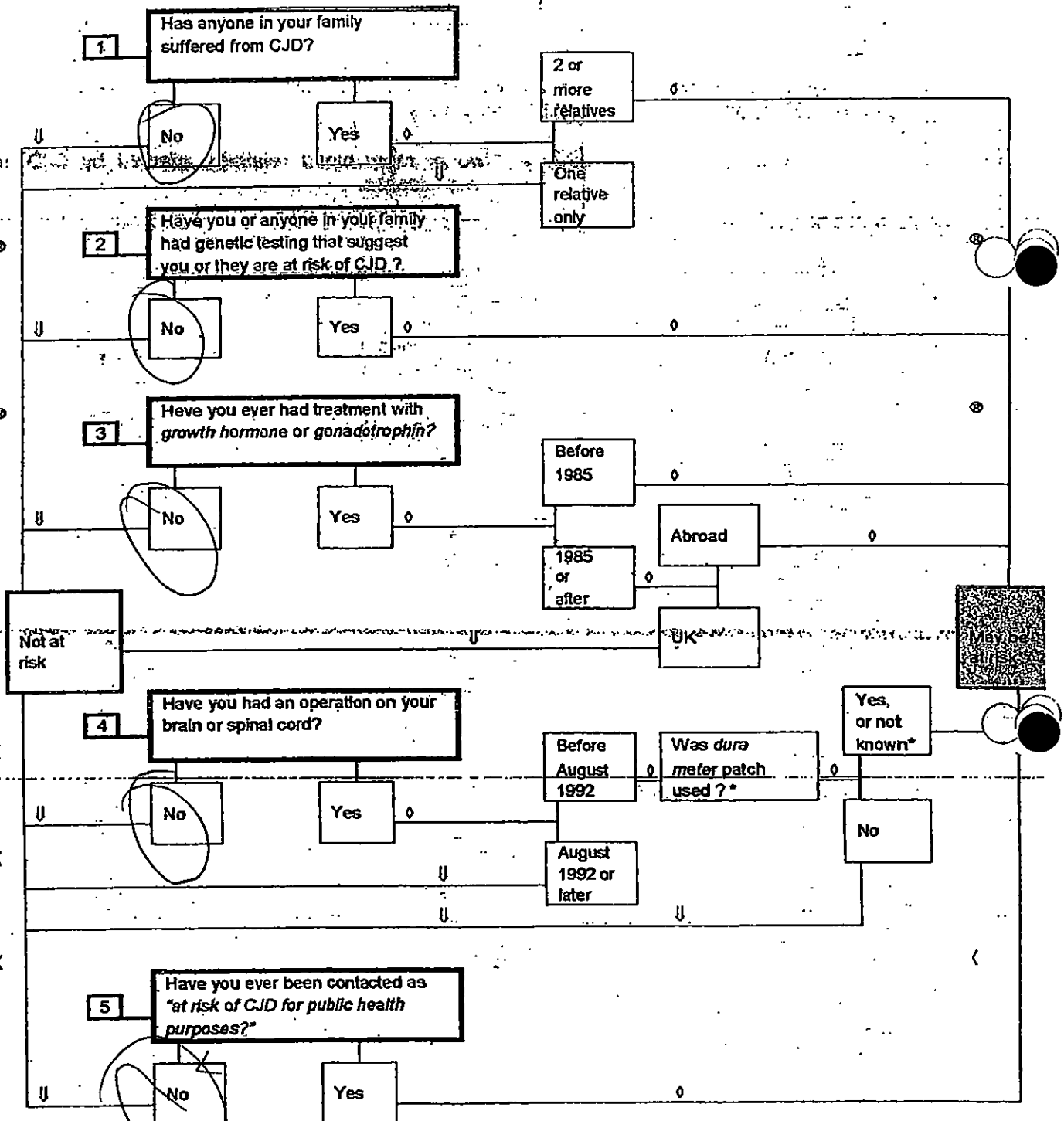
	Question	Notes to clinician
1	Has anyone in your family suffered from CJD?	A patient should be considered to be at risk from familial forms of CJD if they have: <ul style="list-style-type: none"> two or more blood relatives affected by CJD or other prion disease.
2	Have you or anyone in your family had genetic testing that suggest you, or they, are at risk of CJD?	A patient should be considered to be at risk from familial forms of CJD if they have: <ul style="list-style-type: none"> had genetic testing which has indicated that they are at significant risk of developing CJD or other prion disease. or: <ul style="list-style-type: none"> a blood relative known to have a genetic mutation indicative of familial CJD
3	Have you ever received growth hormone or gonadotrophin treatment? If yes, do you know if this was derived from human pituitary glands?	Patients have been identified as potentially at risk of CJD if they have: <ul style="list-style-type: none"> received hormone derived from human pituitary glands, e.g. growth hormone or gonadotrophin. In the UK, the use of human-derived growth hormone was discontinued in 1985 but human-derived products may have continued to be used in other countries.
4	Did you have an operation on your brain or spinal cord before August 1992?	People who <ul style="list-style-type: none"> underwent neuro-surgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of <i>dura mater</i>, and should be treated as at risk (unless evidence can be provided that <i>dura mater</i> was not used).
5	Have you ever been contacted as "at-risk of CJD for public health purposes?" If yes, please specify.	The CJD Incidents Panel has identified a number of individuals who are potentially at risk of CJD or vCJD for public health purposes

Patient name:


Date of birth / CHI number:

Hospital number:

Please ask each of the 5 questions in the bold boxes, follow the flow chart and ring each the patient's answers which will lead to the box indicating risk, or otherwise. (Only approximately 1 in 10,000 patients will be classified as 'maybe at risk')



The patient is unlikely to know the answer to this question. Please ask the patient the type and date of operation and record the answer. Neurosurgery will be able to offer an estimate of the likelihood that *dura mater* was used – (Dawn Lowe, Clinical Nurse Manager WGH xt 31202)

Patient L_a 700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130 
13975 LJ Comason

DVT PROPHYLAXIS:

Assessed risk Low

Medium

High

PROPHYLAXIS REQUIRED

TED stocking(s)

Heparin

Other- Specify

REASON FOR DEVIATION FROM PROTOCOL

Signature CHE

Name (print) C HERPICH NIP.

PRE-OP ISSUES / PLANNING

- 1/ Sister in law - cancer in SR 1
- 2/ Youngest sister will help post op
son & daughter will help
- 3/ Smoking cessation 1 - doesn't think he'll be
requiring patches.
- 4/ moving home tomorrow & will
return us with addresses & postcode.
- 5/ Recent bereavement - father died 2
wks ago.
Mid alcoholic.

Signature

CHE

CHE
C HERPICH

CHE
C HERPICH

CHE
C HERPICH

MRSA - Klebsiella oxytoca -
Sensitive to Trimethoprim,
Spoke with Patient / RF collecting
Prescription from GP Practice, mK
Wanted happy RF - SAFE + HAPPY to
Proceed with surgery
Jim
Devereux

2/5/12 1st today 1.6. 2/4 Dr Downes - day with given

John
SCW

Discharge

Discharged to

- ☐ Home
- ☐ Convalescence
- ☐ Same hospital, other specialty
- ☐ Other hospital

Follow up

- ☐ 6 week clinic
- ☐ For review by cardiologist

Rehabilitation

- ☐ DGH rehabilitaion
- ☐ Location to be confirmed

Hb at Discharge _____ g/l

If Dead:

Date of death _____

Date GP notified of Death _____

Primary cause of death _____

Underlying cause of death _____

Contributory but not causal conditions _____

Procurator Fiscal informed

- ☐ Yes
- ☐ No

700629263X M 17/01/1957

Atkinson, Alexander D

Skinnergate Resettlement Unit,

16 Skinnergate,

Perth,

Perthshire, PH1 5JH

CHI 1701570130 

13975 LJ Compton

Complications

Multi-System Failure

☐ Yes

☐ No

Cardiac Complications

☐ Atrial fibrillation

☐ Cardiac arrest

☐ Cardioversion

☐ Complete heart block

☐ Defibrillated

☐ Drainage of pericardial effusion

☐ Dressler syndrome

☐ Iatrogenic aortic dissection

☐ Left ventricular wall dysfunction

☐ Low cardiac input

☐ Myocardial infarction

☐ VT/VF

MI Diagnosis

☐ CKMB

☐ ECG only

☐ Enzymes

☐ Tnl

☐ TnT

Other Vascular Complications

☐ Amputation

☐ Deep vein thrombosis

☐ Fasciotomy

☐ Femoral artery embolectomy

☐ Foot drop

☐ Ischaemic limb

☐ Other

Respiratory Complications

☐ Adult respiratory distress syndrome

☐ CPAP required

☐ Empyema

☐ Haemothorax requiring drain

☐ Mini tracheostomy

☐ Pneumothorax requiring drain

☐ Pulmonary embolus

☐ Pulmonary infection requiring antibiotics

☐ Reventilated

☐ Tracheostomy

☐ Other

700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compson

GI Tract Complications

- ☐ Acute cholecystitis
- ☐ Acute pancreatitis
- ☐ Bleeding peptic ulceration
- ☐ Hepatic failure
- ☐ Jaundice
- ☐ Laparotomy
- ☐ Mesenteric infarction
- ☐ Perforated peptic ulceration
- ☐ Prolonged ileus
- ☐ Other GI tract complication

Renal Complications

- ☐ Acute renal failure – frusemide infusion
- ☐ Acute renal failure – haemodialysis
- ☐ Acute renal failure – peritoneal dialysis
- ☐ Acute renal failure – ultrafiltration
- ☐ Post-operative elevated creatinine
- ☐ Urinary retention
- ☐ Urinary tract infection
- ☐ Other

Neurological Complications

- ☐ Brachial plexus injury
- ☐ CVA with no residual deficit
- ☐ CVA with mild residual deficit
- ☐ CVA with severe residual deficit
- ☐ Paraplegia
- ☐ Peripheral neuropathy
- ☐ Transient ischaemic attack
- ☐ Psychosis requiring treatment
- ☐ Other

Infection

- ☐ Chest infection
- ☐ Leg wound infection
- ☐ Mediastinitis
- ☐ Septicaemia
- ☐ Sternal wound infection
- ☐ Thigh wound infection
- ☐ Tracheostomy wound infection
- MRSA

Other Complications

--

Highest creatinine _____ $\mu\text{mol/l}$

700629263X M 17/01/1957

Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH

Name

dob

CHI number

attach printed label

CHI 1701570130

13975

LJ Compson

acic Critical Care Admission

Date

Surgeon

Anaes. Con

Procedure

02/05/2013

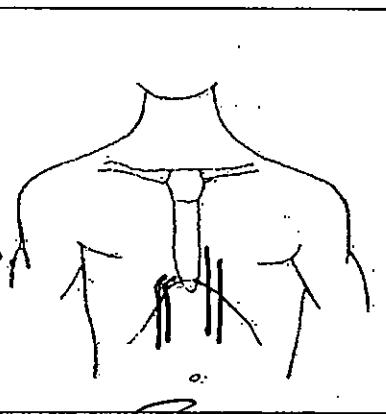
WW

Dr Dornay

MVR (mechanical)

Surgical Admission Note

Mediastinotomy.
Aortic, bicaval cannulation
Antegrade cardioplegia
Findings: Diastolic dysfunction
Atriotomy. Appearance of mitral
valve: thickened, calcified leaflets
probably rheumatic aetiology.
Excision of the anterior leaflet.
Posterior leaflet preserved



Implant: Mechanical No 27 Sorin
Weaning of CPB unremarkable
No one of the pleural spaces has been opened.
Pericardium Semi-closed
Drain: Two Mediastinal
Pacing wire: One ventricular West wall coil
Standard Closure

Please complete Daily orders on ICU chart

Signature

Print Name and Designation

Time:

Date:

Anaesthetic Admission Note

57 mechanical mitral valve today
unremarkable anaesthetic



long hx of aortic mitral disease ? rheumatic
mild Aortic stenosis
preserved LV
chronic AF - currently sinus

ex heavy smoker
good gas exchange

Please complete Daily orders on ICU chart and write plan in Daily Goals

Signature

Print Name and Designation

Time:

Date:


Dr Dornay


1900, 2/5/13

barrett's oesophagus

PMH : 1 on methadone never used IV drugs
HepC + HIV -ve; PMH diazepam abuse
2 back pain

Name:	GAY	Ward No
Date		Sig
	Mr Andrew Ashwin	
	1100 AFOLM Indurial MUR	
	CUS. 50-64 BP 150/60 mm Hg 110	
	Ref on PSCAT Ref 5 155 Fio2 90%	
	Sig 1007	
	102 20 102 5,7 60-72,7	
	Hb 11,2	
	VO - 15 - 70	
	Th: Ref also / chest xray /	
	Physio / complete routine	
	<i>[Signature]</i>	

Cardiac Surgery	SpR -	Fix label	700629263X M 17/01/1957
Inpatient progress notes	NP -	Patient name	Atkinson, Alexander D
STB Dan	CN -	Hospital no	Skinnergate Resettlement Unit, 16 Skinnergate, Perth, Perthshire, PH1 5JH
	FY2 -	DOB:	CHI 1701570130 
Consultant WV - Operation	MVA (m)	PQ da,	13975 LJ Compson

Saturation <u>100</u> <u>O2</u> <u>21</u>	Investigations:
Temp <u>36.5</u> BP <u>111/58</u>	Abnormal Bloods: _____
Rate <u>62</u> Rhythm <u>reg.</u>	ECG : <u>SB 2555 315 PM 201</u>
Weight difference : <u>67kg per cp</u>	CXR : <u>31r</u> <u>ST elevation</u> <u>thin myocard.</u>
Pacing wires <u>weaned out</u>	Examination:
Renal: <u>NPV since catheters out</u>	Heart sounds: <u>1+11 + mechanical sound</u>
GI <u>Bowel not moved</u>	Peripheral Oedema: <u>-Nil</u> <u>redness axilla</u>
CNS: <u>Alert - oriented</u>	Wounds: <u>slight stroke mark</u>
Reviews:	Respiratory: <u>reduced bilaterally</u>
Bloods: <input checked="" type="checkbox"/> 4K <u>3/5</u> <u>U 7.0</u>	
Drug Kardex: <input type="checkbox"/>	
Others:	

Plan:

pain score 0 rest 10-11 on morphine
check urine.

bloods more in check

Medicines:
review bisoprolol / bumetanide + disoxin

Completed by: STB Designation: NP Date: 3/13 Time: 1700

Drugs	PMH
- morphine 40mg	Bumetanide 0.5mg
Clozapine 910g	low back pain
Bumetanide 375 x 1 3mg	drug abuse
Lansoprazole 30mg	AF 2010
Damperolone (PRN)	Pulodan 2012
Bisoprolol 10mg	herpes simplex
Disoxin 125mg	cholesterol
Warfarin 2mg/3mg	
Heroin - smoked	

[illegible]

Atkinson, Alexander D
Skinnergate Resettlement Unit,Patient: 16 Skinnergate,
Perth,

Hospital: Perthshire, PH1 5JH

CHI 1701570130

DOB: 13975 LJ Compson

Cardiac Surgery

SpR -

Inpatient progress notes

NP -

CN -

FY2-

Fix label

Consultant WH Operation (M) MVR

PO day

(3)

Medical/Nurse Practitioner

Saturation

98 O2 (A)

Temp

35.6 BP 94 / 57

Rate

83 Rhythm irregular

Weight difference:

69.9kg (67kg)

Pacing wires

in

Renal:

PU OK.

GI

Bones not moved yet.

CNS:

all.

Reviews:

Bloods:

L

Drug Kardex:

L

Others:

Investigations:

Abnormal Bloods:

WCC 14.2.

ECG : 3/5 SR

CXR : 3/5 clear.

Examination:

Heart sounds:

① - ② metallic click

Peripheral Oedema:

Nil.

Wounds:

Stable clear

Respiratory:

A → clear.

Plan:

- 1) ECG
- 2) regular dihydropyridine
- 3) PW in today - ? on more.
- 4) ? PRI Tuesday.
- 5) BP ↓↓. ? ↓ Bumetanide.

Completed by:

K Hux

Designation:

FY2

Date:

5/5/13.

Time:

0845

MR VG

WCC 14.

(P) 1) change WCC

2) septic screen - sputum & urine

3) ↓ Bumetanide to 1mg

Jup Hux
(FY2)

WE MP

(P) I will not be


Signature

Plan: INR today ? need reversal
Pw out today?

Completed by: *[Signature]* Designation: *F42* Date: *7/5/13* Time: *0800*

Current Rx
methadone
Dihydrocodeine
gabapentin
Lamotrigine
Bupropion
Nizorin

PNH
 B. melanocephalus
 how been pni
 AF 2010
 Phil m. adena
 WRLUM 7/11/13 0900
 INR. 3
 PW out today
 looking well - next 48h.
 (H) none? of shuble
 INR none - 9P to necken. + unit for
 usually 2/3 ult.

Cardiac Surgery Inpatient progress notes	SpR -	Fix label	700629263X M 17/01/1957
	NP -	Patient name:	Atkinson, Alexander D
	CN -	Hospital numt	Skinnergate Resettlement Unit, 16 Skinnergate, Perth, Perthshire, PH1 5JH
	FY2- <i>monnn</i>	DOB: /	CHI 1701570130 
Consultant <i>W</i> Operation <i>(M) NUR</i>		PO day <i>6</i>	Medical/Nurse Practitioner

Saturation <u>99%</u> O2 <u>RA</u> Temp <u>36.5</u> BP <u>105</u> / <u>62</u> Rate <u>69</u> Rhythm <u>reg.</u> Weight difference: <u>68.4 ↓ (67)</u> Pacing wires <u>out</u> Renal: <u>M✓</u> GI <u>to ECG</u> CNS: <u>Best anesthetic</u> Reviews: Bloods: <input type="checkbox"/> Drug Kardex: <input type="checkbox"/> Others:	<u>Investigations:</u> Abnormal Bloods: <u>INR 3.1</u> ECG: <u>AF 4/2/13</u> CXR: <u>3/5 clear</u> <u>Examination:</u> Heart sounds: <u>1 H1 + clear</u> Peripheral Oedema: <u>nil</u> Wounds: <u>clean</u> Respiratory: <u>[H]</u>
--	---

Plan: *monitor INR + K*
signed peroxide.
A feels well today.

Completed by: *monnn* Designation: *NUR* Date: *8/5/13* Time: *221*

8/5/13
20/6

8/5/13 RUP Entry

ATOP cp: pain in mouth.

→ apparently had "gum infection" pre-op and was on "antibiotics"

→ Jx has always been there but subsided slightly

→ more aware of it today ⊕ read information leaflet about mouth care. ∴ worried about infection.

O/E & oral thrush

& many great discharged inflammation / erythema

① upper gum → cavity initiated.

Does not look swollen.

② if for dental in mane if possible

③ I've looked through his notes ⇒ & abx?

[Signature] HOP

[Signature] CUP

Hb	103
Wcl	6.8
Plt	270
INR	1.7

15715 L. Compson

700629263X M - 17/01/1957

Patient Name: Atkinsnn, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
 DOB: Perth,
Perthshire, PH1 5JH

Unit No: CHI 1701570130

Operation: MNR

Consultant: NW

Date: 2/3/13

Pre-operative checklist	Yes	No	Signature	Comments
1. Fasted from 1/5/13 1700	✓		CH	
2. Consent form signed	✓		CH	
3. Allergies		✓	CH	
4. Numb for theatre	✓		CH	
5. Ur empty	✓		CH	
6. ID Bands on & correct	✓		CH	
7. Name & DOB marked on R.arm	✓		CH	
8. Dentures removed / crowns/ etc	✓		CH	
9. Prosthesis-removed		✓	CH	NIL
10. Glasses / contact lenses removed	✓		CH	
11. Hearing aid removed / insitu	✓		CH	
12. Nail varnish/make-up removed	✓		CH	
13. Jewellery SPECIFY Ring: removed / taped Other: removed / taped	✓		CH	Specify "other" items
14. Pacemaker (Type)		✓	CH	
15. Operation site marked (eg. Radial)		✓	CH	
16. Case notes / X-Ray present	✓		CH	
17. Premed 1 st TEMAZEPAM 1030 2 nd	✓		CH	
18. Hep B & MRSA status				
19. Diabetes (type)		✓	CH	
20. Chest pain prior to theatre		✓	CH	
21. Infusions		✓	CH	
22. High risk for CJD?				

Personal items accompanying patient to theatre : NIL

Problems in 24 hours prior to theatre (eg. Treatment of chest pain / anticoagulants) NIL

Relevant Past Medical History : AF-warfarin, Previous Drug abuse -
Metnadone, pulmonary oedema

Word Staff: Signature

Print



D. MACARTHUR

WHO Surgical Safety Checklist

(adapted for Cardiac Surgery NHS Lothian)

NHS
Lothian

Patient Details or Addressograph label	
First Name	ATKINSON
Last Name	ALXANDER
Date of Birth	17/01/57
CHI Number	1701570130

*DATE

02/05/13

CONSULTANT

MR WILKINSON

*THEATRE

5

*PROCEDURE

*SITE

RIE

Please complete ALL boxes

SIGN IN (To be read out loud)

Before commencement of anaesthesia

Member verbally confirms with the team:

Patient confirmed his/her identity, site, procedure and consent

Yes ☒ No ☐

Specialised equipment required

Yes ☐ No ☒

Surgical site/site marked

Are prophylactic antibiotics required?

Yes ☒ No ☐ N/A ☒

Does the patient have a:

Known Allergy?

Anticipated airway issues?

Yes ☐ No ☒

Complete case notes available?

Patient details entered in monitor?

Yes ☒ No ☐

Blood results available?

Known infection risk?

Is blood available?

On electronic release?

Yes ☒ No ☐ N/A ☐

Coordinated by Name:

Signature:

Dr. J. J. J.

[Signature]

TIME OUT (To be read out loud)

Before start of surgical intervention

Member verbally confirms with the team:

Team members known to each other, otherwise unknown members introduced

Yes ☒ No ☐

Correct patient?

Correct procedure/consent?

Correct site/site marked?

Correct positioning?

Yes ☒ No ☐ N/A ☒

Does the patient have a known allergy?

Known infection risk?

Essential imaging displayed

Yes ☐ No ☒ N/A ☒

Antibiotic prophylaxis administration complete?

Yes ☒ No ☐ N/A ☐

Diathermy plates on

Specific Instruments / Equipment / Prostheses required

Yes ☒ No ☐ N/A ☐

Pump present

Pump primed

Perfusionist available

Myocardial protection strategy discussed

Yes ☒ No ☐ N/A ☐

Any anticipated difficulties expected by?

Surgeon

Anaesthetist

Theatre Practitioners

Perfusionist

Yes ☐ No ☒ N/A ☐

Coordinated by Name:

Signature:

[Signature]

[Signature]

SIGN OUT (To be read out loud)

Before patient leaves operating room

Member verbally confirms with the team:

Have the specimens been labelled correctly

Yes ☐ No ☐ N/A ☐

Have blood tests been completed?

Yes ☐ No ☐ N/A ☐

Record printed from monitor?

TEGs printed?

Patient discharged from monitor

Yes ☐ No ☐

Coordinated by Name:

Signature:

Questions with yellow background for when induction in theatre is rapidly followed by the procedure.

THEATRE STAFF

DATE

02/05/13

Venue

Theatre 4
Theatre 5
Theatre 6Theatre 7
Theatre 8
Other

Anaesthetic start time

13:50

Surgery start time

14:52, 15:11

Surgery finish time

18:40

Leave theatre time

18:50

Anaesthetist:

① DR R. DENMAN

Grade:

Year (1-6 if SpR):

② DR B. FUNK

Grade:

Year (1-6 if SpR):

3.

Grade:

Year (1-6 if SpR):

ODP

1. DENNIS MCKENNA

2. ELAINA SCIBBARD

Perfusionist

1.

2.

IV Infusion

Site (2) HAND

Cannula 16G

Comment

Anaesthetist

(2)

CVP

Site R.F.J.

Type 3umen

Anaesthetist

(2)

A-Line

Site (2) RADIAL

Type 20G ARROW

Anaesthetist

(2)

PA Catheter

Site

Type

Anaesthetist

TOE Probe

Yes / No

Remote defib pad

Dermis Pad

On

Off

Comments

Position

(C) + (2)

BORDER

Urinary Catheter

Type

Inserted by

Comments

DENNIS MCKENNA

Position of patient

Supine

Pressure care

Gel pads

Pillows

Cell saver used

Yes / No

Signature

Print

DENNIS MCKENNA

DENNIS MCKENNA

Surgeons:

1. MR WALKER

Grade:

Year (1-6 if SpR):

2. MR PATONIS

Grade:

Year (1-6 if SpR):

3.

Grade:

Year (1-6 if SpR):

ROtrak

Pack Name **Pack Cardiac**

Cat No **RMT4428-REVC**

Lot No **W126855**

Date **2013/02**

Expiry Date: **2016/02**

Roclaile, Wales
Tel: +44 (0) 1443 471300
Fax: +44 (0) 1443 471301
www.rocaille.com

DO NOT USE if wrap damaged
for its intended purpose.

racic Th 4-8

COSGROVE S/R



ID No: A010194

Edinburgh Royal Infirmary
Sterile Services
0131 5381000

This Pack has been manufactured in accordance with article
12 of council directive 93/42/EEC concerning medical devices

RETRACTOR MITRAL COSGROVE S/R

ID: A0101942013/04/25 CT022
Edinburgh Royal Infirmary



ID No: A000363

Edinburgh Royal Infirmary
Sterile Services
0131 5381000

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CARDIO BYPASS

ID: A0003832013/04/30 CT018
Edinburgh Royal Infirmary



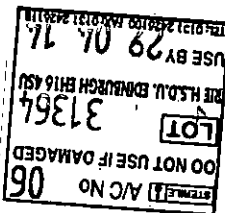
CT047



ID No: A019822

Edinburgh Royal Infirmary
Sterile Services
0131 5381000

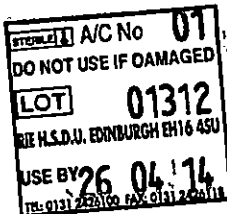
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93/42/EEC concerning medical devices



ID No: A021205

Edinburgh Royal Infirmary
Sterile Services
0131 5381000

Manufactured in accordance with article
93/42/EEC concerning medical devices



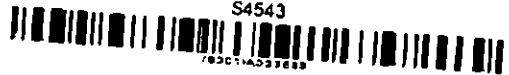
Wt 0 Kg

Store in clean dry conditions. DO NOT USE if wrap damaged.
ONLY for use by trained personnel - for its intended purpose.

RIE - Cardio Thoracic Th 4-8

SORIN BICARBON GAUGES & HOLDERS

S4543



ID No: A023883

Edinburgh Royal Infirmary
Sterile Services
0131 5381000

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12 of council directive 93/42/EEC concerning medical devices

SORIN BICARBON GAUGES & HOLDERS

ID: A0236832013/03/26 S4543
Edinburgh Royal Infirmary



700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13075 11 Compson

Circulating Nurse

1. H. GARDNER
2. K. GUNTER
3. S. Waite

ODR

1. JAMES M. MCGHEE
2. PAUL SWANSON

Perfusionist

1. S. Anderson
- 2.

Scrub Nurse

1. K. LEMMON
- 2.
- 3.

Closure	Chest	Closure	Legs	Closure	Arms
Drains	X	Drains		Drains	
Sternal	Wire	Skin	NA	Skin	NA
Skin	Mono coil	Dressing		Dressing	
Dressing	1/2 inch	Bandage		Bandage	

Intra-op counts	Intra	Intra	Intra	Intra	Intra
Signature	[Signature]		SA		[Signature]
Print	M. Gardner		S. Waite		S. Waite

Comments

Operation Performed

Mitral Valve Replacement

Implant labels



Surgical instrument labels

Pacing Wires

Pacing on return to ward

Variance in working practice

Specimens, additional comments, incidents, information, incident form.

Signature

Date 2/5/13

Print

Time 1940

Surgical Training – Birmingham Training Data

Please enter operators initials against procedure

All major cardiac cases

	Staff Initials
Sternotomy	WW
Thoracotomy	
Cannulation	WW
Weaning	WW
Sternal closure	WW
Thoracotomy closure	

700629263X M 17/01/1957

Atkinson, Alexander D

Skinnergate Resettlement Unit,

16 Skinnergate,

Perth,

Perthshire, PH1 5JH

CHI 1701570130

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CABG cases

Target	Distal anas done by	Prox anas done by
Graft 1		
Graft 2		
Graft 3		
Graft 4		
Graft 5		
Graft 6		

Graft harvest	Done by
LIMA	
RIMA	
LSV	
SSV	
Radial artery	
Cephalic vein	
Rt gastro-epiploic artery	
Other	

Aortic valve cases

	Staff Initials
Aortotomy	
Excision of valve	
Decalc of annulus	
Implant of valve	
Closure aortotomy	
De-airing of heart	

Mitral valve cases

	Staff Initials
Bi-caval cannulation	WW
Access to mitral valve	WW
Assessment of suitability for repair of valve	WW
Excis of valve and annular debridement	WW
Repair of valve	
Ring	
Implant of valve	WW
Atrial closure	WW
De-airing of heart	WW

Preoperative status and Support

IV nitrates of any kind

- ☒ No
- ☐ Until operation
- ☐ Within one week

Heparin of any kind

- ☒ No
- ☐ Until operation
- ☐ Within one week

Cardiogenic Shock

- ☐ Yes
- ☒ No

Ventilated

- ☐ Yes
- ☒ No

IV inotropes prior to anaesthesia

- ☐ Yes
- ☒ No

IABP support

- ☒ No
- ☐ Pre-operation
- ☐ Intra-operation
- ☐ Post-operation

Reason for IABP use

- ☐ Haemodynamic instability
- ☐ Unstable angina
- ☐ Prophylactic

Pre-operative heart rhythm

- ☐ Sinus Rhythm
- ☒ Atrial fibrillation/flutter
- ☐ VT/VF
- ☐ Complete heart block/paced
- ☐ Other abnormal rhythm

Primary incision

- ☒ Sternotomy
- ☐ Left thoracotomy
- ☐ Right thoracotomy
- ☐ Heart port

Other incision

- ☐ Laparotomy
- ☐ Left arm
- ☐ Right arm
- ☐ Left groin
- ☐ Right groin
- ☐ Left leg
- ☐ Right leg

Procedures carried out : tick all relevant boxes

- ☐ CABG
- ☒ Valve
- ☐ Surgery on aorta
- ☐ Other major cardiac

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Graft procedure data

Graft 1

Graft site	Size (mm):
Findings	Calcified / Diseased / Dissected / Healthy / Thrombus
Conduit	
Anastomosis	End to side / Side to side
Local procedures	None / Endarterectomy / Vein patch
Prox anastomosis	N/a / Aorta / LIMA / RIMA / SV / Other
Quality of vessel	Diffuse disease / Discrete lesion
Shunt used	Yes / No Size (mm):

Graft 2

Graft site	Size (mm):
Findings	Calcified / Diseased / Dissected / Healthy / Thrombus
Conduit	
Anastomosis	End to side / Side to side
Local procedures	None / Endarterectomy / Vein patch
Prox anastomosis	N/a / Aorta / LIMA / RIMA / SV / Other
Quality of vessel	Diffuse disease / Discrete lesion
Shunt used	Yes / No Size (mm):

Graft 3

Graft site	Size (mm):
Findings	Calcified / Diseased / Dissected / Healthy / Thrombus
Conduit	
Anastomosis	End to side / Side to side
Local procedures	None / Endarterectomy / Vein patch
Prox anastomosis	N/a / Aorta / LIMA / RIMA / SV / Other
Quality of vessel	Diffuse disease / Discrete lesion
Shunt used	Yes / No Size (mm):

Graft 4

Graft site	Size (mm):
Findings	Calcified / Diseased / Dissected / Healthy / Thrombus
Conduit	
Anastomosis	End to side / Side to side
Local procedures	None / Endarterectomy / Vein patch
Prox anastomosis	N/a / Aorta / LIMA / RIMA / SV / Other
Quality of vessel	Diffuse disease / Discrete lesion
Shunt used	Yes / No Size (mm):

Graft 5

Graft site	Size (mm):
Findings	Calcified / Diseased / Dissected / Healthy / Thrombus
Conduit	
Anastomosis	End to side / Side to side
Local procedures	None / Endarterectomy / Vein patch
Prox anastomosis	N/a / Aorta / LIMA / RIMA / SV / Other
Quality of vessel	Diffuse disease / Discrete lesion
Shunt used	Yes / No Size (mm):

Valve Procedure Data

Number of valves replaced/repaired _____

	Aortic Valve	Mitral Valve	Tricuspid Valve	Pulmonary Valve
Haemodynamic pathology	<input type="checkbox"/> Regurgitation <input type="checkbox"/> Stenosis <input type="checkbox"/> Mixed	<input checked="" type="checkbox"/> Regurgitation <input checked="" type="checkbox"/> Stenosis <input type="checkbox"/> Mixed	<input type="checkbox"/> Regurgitation <input type="checkbox"/> Stenosis <input type="checkbox"/> Mixed	<input type="checkbox"/> Regurgitation <input type="checkbox"/> Stenosis <input type="checkbox"/> Mixed
Explant Valve Type	<input type="checkbox"/> Native Valve <input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft <input type="checkbox"/> Ring	<input checked="" type="checkbox"/> Native Valve <input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft <input type="checkbox"/> Ring	<input type="checkbox"/> Native Valve <input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft <input type="checkbox"/> Ring	<input type="checkbox"/> Native Valve <input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft <input type="checkbox"/> Ring
Native Valve Pathology (See codes at end of table)		5, 7		
Other native valve pathology (Free Text)				
Reason for Repeat Valve Surgery	<input type="checkbox"/> Thrombosis <input type="checkbox"/> Dehiscence <input type="checkbox"/> Embolism <input type="checkbox"/> Infection <input type="checkbox"/> Intrinsic Valve failure <input type="checkbox"/> Haemolysis <input type="checkbox"/> Other	<input type="checkbox"/> Thrombosis <input type="checkbox"/> Dehiscence <input type="checkbox"/> Embolism <input type="checkbox"/> Infection <input type="checkbox"/> Intrinsic Valve failure <input type="checkbox"/> Haemolysis <input type="checkbox"/> Other	<input type="checkbox"/> Thrombosis <input type="checkbox"/> Dehiscence <input type="checkbox"/> Embolism <input type="checkbox"/> Infection <input type="checkbox"/> Intrinsic Valve failure <input type="checkbox"/> Haemolysis <input type="checkbox"/> Other	<input type="checkbox"/> Thrombosis <input type="checkbox"/> Dehiscence <input type="checkbox"/> Embolism <input type="checkbox"/> Infection <input type="checkbox"/> Intrinsic Valve failure <input type="checkbox"/> Haemolysis <input type="checkbox"/> Other
Other reason for repeat valve surgery (free text)				
Valve procedures	<input type="checkbox"/> Replacement <input type="checkbox"/> Repair	<input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Repair	<input type="checkbox"/> Replacement <input type="checkbox"/> Repair	<input type="checkbox"/> Replacement <input type="checkbox"/> Repair
Implant Type	<input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft	<input checked="" type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft	<input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft	<input type="checkbox"/> Mechanical <input type="checkbox"/> Biological <input type="checkbox"/> Homograft <input type="checkbox"/> Autograft
Implantprosthesis (Heart Valve Registry Code)				
Valve or Ring Serial Number				
Valve or Ring Model Number				
Valve or ring size (mm)		27		

Codes for native pathology

0 = Native Valve not present 1 = congenital 2 = Degenerative 3 = Active endocarditis
 4 = Previous endocarditis 5 = Rheumatic 6 = Annuloaortic ectasia
 7 = calcific degeneration 8 = Ischaemic 9 = Functional
 10 = Other native valve pathology

Aorta Procedure Data

Presentation

- Acute aortic syndrome
- Size criteria
- Ischaemia
- Compression syndrome
- Trauma
- Aortic fistula
- Concomitant with other procedure
- Eg. AVR
- Other

Aetiology

- Hypertension
- Atherosclerosis
- Marfan syndrome
- Bicuspid valve
- Other connective tissue disorder
- Trauma
- Coarctation
- Other congenital
- Infection
- Aortitis
- Previous aortic surgery

Aortic pathology
Please tick one pathology for each relevant aortic section

	Root	Ascending	Arch	Descending	Abdominal
Aneurysm					
Dissection					
Acute dissection					
Trauma					
Penetrating atheromatous ulcer					
Pseudoaneurysm					
Intramural haematoma					
Other					

Procedure

Root

- Autograft root replacement (Ross procedure)
- Homograft root replacement
- Root replacement with preservation of native valve + coronary reimplantation
- Root replacement with composite valve graft + coronary reimplantation
- Sinus of valsalva repair

Ascending

- Aortic patch graft
- Autograft root replacement (Ross procedure)
- Homograft root replacement
- Reduction aortoplasty
- Root replacement with preservation of native valve + coronary reimplantation
- Root replacement with composite valve graft + coronary reimplantation
- Tube graft + separate AVR
- Concomitant endovascular aortic procedure
- Extra anatomic bypass
- Interposition tube graft

Arch

- Aortic patch graft
- Reduction aortoplasty
- Interposition tube graft with reimplantation of major vessels
- Concomitant endovascular aortic procedure
- Extra-anatomic bypass

Descending

- Aortic patch graft
- Interposition tube graft
- Concomitant endovascular aortic procedure

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Abdominal

- ☐ Interposition tube graft
- ☐ Interposition tube graft with reimplantation of major vessels
- ☐ Concomitant endovascular aortic procedure
- ☐ Extra-anatomic bypass

Neuroprotection

- ☐ Deep hypothermic circulatory arrest
- ☐ Selective antegrade cerebral perfusion
- ☐ Non-selective antegrade cerebral perfusion (rt. Subclavian)
- ☐ Retrograde cerebral perfusion
- ☐ Spinal CSF drainage

Other Cardiac Procedures

- ☐ None
- ☐ LV aneurysmectomy
- ☐ Acquired VSD
- ☐ Atrial myxoma
- ☐ ASD Closure
- ☐ Pulmonary embolectomy
- ☐ Pulmonary transplant
- ☐ Cardiac Trauma
- ☐ Cardiac Transplant
- ☐ Epicardial pacemaker
- ☐ Pericardectomy
- ☐ Other procedures for congenital condition
- ☐ Other procedures not listed above

Other thoracic and vascular procedures

- ☐ None
- ☐ Aorta and peripheral vascular
- ☐ Carotid endarterectomy
- ☐ Other thoracic

Continuation

Post-Procedure

Outcome

- ☒ Alive
☐ Died in theatre

Rhythm on weaning

- ☒ Sinus
☐ Atrial fibrillation
☐ Complete heart block
☐ Not applicable

Mechanical support

- ☐ IABP
☐ LVAD
☒ None

Closure

Delayed closure

- ☐ Yes
☒ No

Sternum closure

- ☒ Wire
☐ Ethibond
☐ Other

Skin closure

- ☐ Surgical clips
☒ Vicryl
☐ Other

No. of chest drains: 2

Pacing wires

Site	Number of wires
Right atrium	
Right ventricle	
Indifferent	

Weaning off-bypass

- ☐ Eventful
☒ Uneventful
☐ Not applicable

Rhythm on leaving theatre

- ☒ Sinus
☐ Atrial fibrillation
☐ Complete heart block

Reason for mechanical support

- ☐ Haemodynamic instability
☐ Prophylactic

Pericardium

- ☐ Open
☒ Closed

Semi closed

Sternum Drains Used

- ☒ Yes
☐ No

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Royal Infirmary Edinburgh Clinical Perfusion Record

Name	700629263X M 17/01/1957	Case No.	
D.O.B	Atkinson, Alexander D	Height	171 cm
Hospital No.	Skinnergate Resettlement Unit,	Weight	69 kg
Address	16 Skinnergate,	BSA	1.8 m ²
	Perth,	Flow Rate @ 2.4 l/m ²	4.32 l/m
	Perthshire, PH1 5JH		
	CHI 1701570130		
	13975 LJ Compson		

Date	02/05/13	Surgeon	WW
Perfusionist	SIMON ANDERSON	Anaesthetist	JD
Procedure	MNR		

Pre Heparin ACT	153 secs	Times	
Heparin Administered	1542 hrs	CPB On	15:50
Post Heparin ACT	680 secs	CPB Off	17:23
		CPB On	
		CPB Time	95 mins
		X-Clamp On	15:54
		X-Clamp Off	17:03
		X-Clamp On	
		X-Clamp Time	70 mins
		Total Circ. Arrest	X mins

Prime and Fluids	
Hartmann's	1000 ml
8.4% Sodium Bicarb	50 ml
Mannitol 20%	200 ml
Heparin	10,000 i.u.
Aprotinin	= i.u.
Blood Unit No.	=
Total Prime Volume	1250 ml
Fluid Added on CPB	3700 ml
Volume Filtered	2000 ml
Urine Pre-Bypass	100 ml
Urine Post Bypass	800 ml
Urine Output	700 ml
Fluid Balance	250 ml

TOMCAT Data (delete as appropriate)	
Cardiac Preservation	Cardioplegia/Non-cardioplegia
Cardioplegic Solution	Blood/Crystalloid
Infusion Temperature	Cold/Warm
Infusion Regime	Single Shot/Intermittent/Cont.
Infusion Route	Antegrade/Retrograde/Both
Non-Cardioplegia	X-Clamp w. fibrillation/Beating Heart
Cardiopulmonary Bypass	Yes/No/Conversion
Arterial Cannulation Site	Artery
Venous Cannulation Site	VC + SVC

Equipment	
Oxygenator	QAD
Cardioplegia	SOLAN
Tubing Set	MAQUET
Haemofilter	MAQUET
Cold Circuit	
Arterial Cannula	
Venous Cannula	2 x 10mm
Retrograde Cannula	
Coronary Cannula	

Intra-Operative Notes and Stickers	
1554 - WW AWARE OF LOW PLEWA PRESSURE 1650 - REWARM	
Priming Fluid Check	Signature

Pre-Bypass Checklist		
Gas Line Connected and Checked	Suckers Checked	HCU Connected and Checked
Pump Primed and Deaired	Occlusion Checked	Isoflurane Vapouriser Filled
Alarms and Interventions Set	Recirculation Lines Clamped	ACT above 400 seconds

Signature	Print
SIMON ANDERSON	SIMON ANDERSON

Royal Infirmary Edinburgh Clinical Perfusion Record

[illegible]

HDU transfer summary

700629263X M 17/01/1957

Atkinson, Alexander D

Skinnergate Resettlement Unit,

Patient 16 Skinnergate,

Perth,
Perthshire, PH1 5JH

CHI 1701570130



Diagnosis

Procedure

Operation Date

Transfer date

Cardiovascular system

Heart rate _____ Rhythm _____ Blood Pressure _____

Temperature _____ Hb _____ K+ _____ Treated Yes/ No _____

Requires : Cardiac monitoring Yes / No _____

Pacing Yes / No _____

Pacing Wires: Atrial / Ventricular / Indifferent

Respiratory System

Respiratory rate _____ PO2 _____ PCO2 _____ SpO2 _____ % on _____ l O2 / Air

Coughing and expectorating Yes / No _____ Sputum clear / purulent

Renal System

Fluid intake _____ litres/day

Infusions _____

Urinary catheter: removed / maintained

Blood glucose _____ mmol/L

Central Nervous System

Orientated / Confused

Sedation score 0 1 2 3

Nausea Score _____

Last analgesia _____ hrs

Pain Score 0 1 2 3

Treatment _____

Epidural / Paravertebral Yes/No

Sternotomy / Thorocotomy

Drains Yes / No

Drainage _____ mls

Secure area score _____

Nutritional assessment score _____

Other wounds _____

Pleural / Mediastinal / Pericardial / other

Bubbling Yes/No Suction Yes/No

Grade _____ Intervention _____

Nutrition: oral () Enteral () Parenteral ()

Mobility: Full / with 1 nurse / with 2 nurses / immobile - requires _____ (hoist / stand aid)

TED Stockings Yes/No

Medications administered prior to transfer : Yes / No

Comments : Uncomplicated recovery Yes / No

(Please tick when complete)

Audit sheet TPR/Fluid balance Chart

Filing

Ward contacted

Ward aware of equipment needed to be set up

Signature

Name (print)

Designation

HDU Stay Record

Into HDU from ICU/theatre _____ (Date)

_____ (Time)

Transferred to ward _____ (Date)

_____ (Time)

Blood products transfused (in HDU) _____

Number of blood units _____

FFP

☐ Yes

☐ No

Platelets

☐ Yes

☐ No

Total drainage (from all drains) _____

Destination	Nurse	Sign	Doctor	Sign	Ward Clerk	Sign	Pharmacist	Sign
HOME	Confirm discharge		Confirm discharge		Arrange transport		Analgesia effective	
	Discuss with patient & family		Complete D/C letter		Sick certificate if required		Unnecessary drugs removed	
	Discharge meeting attended		Prescription sheet		Photocopy discharge information		Warfarin Advice given	
	Notes filed		Warfarin D/C dose		Packed lunch if needed		Prescription sheet checked	
	File copies of all letters in notes		prescribed & pt informed				and signed	
	In two envelopes (for GP & DN)		Warfarin chart copied					
	Drs discharged letter		for GP					
	Patient summary +copy Warfarin chart							
	Prescription sheet (GP only-blue)							
	Nursing Discharge letter							
	For patient							
	Prescription sheet (White)							
	Information leaflets							
	Warfarin booklet							
	Rehab Nurse Referral							
	Nursing Discharge letter							
	Drs Discharge letter							
	Patient summary							
	See Guideline on ward							
INTER-HOSPITAL TRANSFER	Confirm discharge		Confirm discharge		Arrange transport		Analgesia effective	
	Discuss with patient & family		Liaise with medical staff		confirm bed.		Unnecessary drugs removed	
	Discharge meeting attended		of receiving hospital		photocopy discharge information		Warfarin Advice given	
	Notes filed		Complete discharge letter		packed lunch if needed		Prescription sheet checked	
	Liaise with receiving ward (CN)		Prescription sheet		Ensure parent hospital notes go		and signed	
	File copies of all letters in notes		include Diabetic chart &		with patient			
	In two envelopes (for GP & Ward)		Warfarin chart					
	Drs discharged letter		Recent CXR & ECG					
	Patient summary+ copy warfarin chart		Blood result flow sheet					
	Prescription sheet (Ward only - blue)							
	Nursing Discharge letter							
	For patient							
	Prescription sheet (white)							
	Information leaflets							
	Warfarin booklet							
	Rehab Nurse							
	Nursing Discharge letter							
	Drs Discharge letter							
	Patient summary							
for as above								

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WARDS 102/

DISCHARGE CHECKLIST

CHI 1701570130

PATIENT'S NAME 13975

LJ Compson

DATE OF DISCHARGE

	TICK		TICK
PACING WIRES REMOVED		REHAB. PACK GIVEN	
VENFLON REMOVED		REHAB. CENTRE CONTACTED	
TED STOCKINGS SUPPLIED		ATTENDED DISCHARGE MEETING	
BOWELS OPEN		PHYSIO ADVICE SHEET GIVEN	
DISCHARGE DRUGS GIVEN		INR CHECK ORGANISED	
CLOTHES, VALUABLES RETURNED		WEEKEND D/N REFERRAL FORM	
MRSA SCREEN (DATE)			

WOUNDS:	DRESSING	SUTURES	DATE FOR REMOVAL
STERNOTOMY/THORACOTOMY	YES/NO	YES/NO	*
DONOR R/L LEG	YES/NO	YES/NO	*
R/L ARM	YES/NO	YES/NO	*
DRAIN SITES	YES/NO	YES/NO	*
OTHER	YES/NO	YES/NO	*

**REFER TO DISTRICT NURSE (COMPLETE D/N REFERRAL FORM FOR COMPLEX DRESSINGS) - WILL VISIT ON*

SIGNATURE OF NURSE

PRINT

DATE

Please file in notes on completion

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Own Transport - Discharge Lounge Direct Booking Form

First Name	Surname	Date of Fax	CHI Number
Hospital	Ward	Time Ready	Ward Contact + EXT
Destination Address		City	Postcode
Background			
Patient Condition			
Clinically Fit		Infection Status	
DNAR Form		Mental Status	
POC		Behavioural Issues	
Falls Risk		O2	
Pharmacy Status		Wanderer	
Allergies		Mobility	
Dietary Issues			
Transport Date	Transport Time	Patient Weight	
Transport			
Family Aware			
Any Equipment			
Keys/Keysafe			
Transport Required	OWN		
Comments			
<p style="text-align: right;"><u>Fax Number</u> RIE 0131 2421913</p>			

ICU TRANSFER SUMMARY

700629263X M 17/01/1957

Patient de Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,

Perthshire, PH1 5JH

CHI 1701570130

13975 I.J. Compton

Diagnosis Severe MR

Procedure MVR (mechanical)

Operation Date 2/5/13

Transfer date 3.5.13

Cardiovascular system

Heart rate 40-58 Rhythm SB Blood Pressure 140/80

Temperature Hb 108 K+ 4.5 Treated Yes/No (No)

Requires: Cardiac monitoring Yes/No (No)

Pacing Yes/No (No)

Pacing Wires: Atrial / Ventricular / Indifferent

West Med coil

Respiratory System

Respiratory rate 10-15 PO2 23 PCO2 6.1 SpO2 97% on 3L O2 / Air

Coughing and expectorating Yes/No (No)

Sputum clear / purulent

Renal System

Fluid intake 2.25 litres/day Urinary catheter: removed / maintained

Nausea score 0 Treatment Blood glucose 7.6 mmol/L

Central Nervous System

Orientated / Confused

Sedation score 0 1 2 3

Last analgesia hrs PCA Yes/No

Score 0 1 2 3

Sternotomy / Thorocotomy

Drains Yes/No (No)

6hrly drainage mls

Pressure area score

Nutritional assessment score 0

Other wounds

Pleural / Mediastinal / Pericardial

Grade 0 Intervention

eating light diet

Comments: Uncomplicated recovery Yes/No (Yes)

(Please tick when complete)

Audit sheet ☐

TPR Chart ☒

Filing ☒

Signature

Name (print)

Designation

U. Russell
J. PENDLEBURY
SN

ICU Stay Record

Into ICU from theatre 2/5/13 (Date)

18.10 (Time)

Extubated at 06.15

Transferred to HDU/ward _____ (Date)

(Time)

Vasoconstrictor

☐ Yes

☐ No

~~Inotropes~~

☐ Yes

☐ No

Blood products transfused (in ICU) 0

Blood _____ units

FFP

☐ Yes

☐ No

Platelets

☐ Yes

☐ No

Total drainage (from all drains) 600

NHS Lothian - University Hospitals Division

Department of Therapy & Rehabilitation

Physiotherapy CTSU Guideline

Consultant Surgeon Mr Walker

Surgery and Date of Operation

mme 02/5/13

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Therapy handling RA

considered. Consent

PMH COPD
Diabetic
Chronic AF
MSK issues

previous IVAD
currently on metoprolol

LFT Fev1
VC %

LVF preserved

Caution if Hb < 80
Drains over 360/6 Hrs

Caution if K+ out with 4.5 to 5.5
Consistent drain loss 60ml / Hr for a period of 6 Hrs. actively bleeding

CNS Sedation on/off Propofol Alfentanil Midazolam

alert & orientated / drowsy / distressed / paralysed / in acute pain Pain site sternotomy

Analgesia PCA morphine Fentanyl

CVS Stable yes/no, then BP 146/54 M 81 CVP 14 HR 47 Rhythm AF

If unstable check these parameters: Max Syst BP / MP / and HR / as required by Consultant

PAP M CO CI PCWP SVR

Pacing wires A V I Fixed / On demand set at /mn U/L underlying rhythm

Inotropes Support Adren mmL/hr mg Norad mmL/hr mg Dopamine mmL/hr

GTN IABP LVAD

If this patient is unstable and requires MHI, please discuss with anaesthetist

Respiratory System

FiO2 3 l/mn- Resp Rate 10 /mn- SaO2 99 % O2-

Breathing Pattern Shallow Apical Abdominal / Paradoxical / Distressed

Ventilated FiO2 % O2 Mode of Ventilation

ABGs Pre-op on air. PCO2 6.2 PO2 8.3 Sat 99%

O830 FiO2 3L H+ 42.8 PCO2 6.1 PO2 23.4 HCO3 24.8 SBE 0.3

Auscultation Breath sounds bilateral

Added sounds scattered crackles upper zones

Expansion (R) = (L)

Palpation NIL

SUCTION during last 24hrs

Nil (M) (P) B (1) 2 3

COUGH

Spontaneous
On command

Effective Ineffective

Nil (M) (P) B 1 2 3
Nil (M) (P) B 1 2 (3) Plus

RENAL Check fluid balance

+598mls U/O: 20, 150, 150. Check U and Cr

CXR

DATE	NO.	PROBLEM LIST			DATE INACTIVE	Initials
030513	2	Secretion retention				
"	1	Decrease lung volume				
		Pain				
		Agitated / confused / non compliant / sedated / drowsiness				
		Anxiety				
		Decreased mobility due to IABP / Hypotension / unstable AF				

DATE	NO.	GOALS	GOAL TIME	DATE ACHIEVED	Initials
030513	↓	Transfer to chair	Day 1 pm		
		Start mobilising to improve dynamic balance	Day 2		
		Clear Breath sounds throughout	Day 2		
		Start increasing exercise tolerance	Day 3		
		Independent chest clearance	Day 3		
		Stair assessment	Day 4		
		Discharge advice booklet explained	Day 5		

DATE	NO.	PLAN	Initials
		MHI / VHI / suction / suction with saline / lavage	
		IPPB intermittent NIV continuous NIV	
030513	1,2	Incentive spirometer with inspiratory hold	LW.
"	2	TEE / inspiratory holds / diaphragmatic breathing / supported cough and sips of water / cough lock / Saline Nebs (to be prescribed)	LW.
		Reposition Up sitting in bed - Transfer to arm chair / with hoist / stand aid / with assistance	
		Mobilisation - with stand aid / WZF / with assistance of..... with supervision	
		Stairs assessment	
		Advice booklet explained	

Treatment IS. = 1750mls + ACST. Expectated MP3 large
A... plug. Pain 11/10s - RDA morphine ineffective
ause post fix - clear chest.
P... Review later 1 pm / tomorrow / IABP removed. Do not treat please. SPOB - Chest clear.
Continue IS 1/2ly when awake.

Name	Designation	Date	Time	Signature
L Winn / K Dempster	Senior PT	030513	1140	LW
Gerard Knecht	Clinical Specialist			

700629263X M 17/01/1957
 Patient 1a1 Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 CHI 1701570130
 13975 LJ Comoson

Ward 102
 Date of admission
 Consultant

Date & Time	IN-PATIENT PROGRESS/COMMUNICATION SHEET (State action taken after exception reporting)	Signature (print name & designation)
04/05/13 12:00	Physiotherapy ③ pt well. c/o brownish sputum, up & mobile within room, consent ① SV RA SpO ₂ 98% obs stable Ausc: BSto ↓ bibasally, few fine insp creps bibasally RA IS ~ 15000 x 5 breaths ① Sit test mob & sup ~ 50m A) SpO ₂ 99% post mob, ① infect P) advised helix IS regular mob 3x external steps at home	
05/05/13 11:20	Physiotherapy ③ Verbal consent. c/o pain + when coughing, not expectorating, feeling sick when coughing ② TH 1a + 5 + 7. Rx considered. Obs stable SpO ₂ 97% on RA Ausc: BSto ↓ BS bases crackles (R) L2 Rx: Mob ~ 60m & sup // Tolerated well SpO ₂ 99% post mob 2 Huff technique + IS (vol to ~ 750 & insp hold) n/c cough + expectoration dry ① Ind mobile ↓ vol good technique & IS + ① mobilising ② Continue ↑ ET. U - rlv am.	
06/05/13 10:20	Physiotherapy S/ consent to PTV. PE reports ① mobilising + using IS. ③ TH 1a S 7 considered. SEWS = 1 ↓ temp = pts normal. Ausc - BSto ↓ bibasally Palpn - nil. Cough - dry, strong. Rx / Mob 100m & supervision IS. 1750 ~ 1 & insp hold x 6. A/ Re - ausc ↑ BS bibasally. P. RIV more pt has 3 steps.	R. Lyle Ruth BSPT. CUFF G. D. BSPT

	Royal Infirmary of Edinburgh Cardiac and Thoracic Surgery	University Hospitals Division																							
700 Atk Skin 16 Per Per CH 139 Date	<p>ARTERIAL BLOOD GASES O₂ sat 98% Sy... SpO₂ 98% Patient ... T_a 36.5°C P_aO₂ 101 mmHg P_aCO₂ 42 mmHg Operator JTB</p> <p>ACID-BASE STATUS H⁺ 7.42 nmol/L pCO₂ 6.1 kPa PO₂ 23.4 kPa HCO₃⁻ 24.8 mmol/L BE(8) 0.3 mmol/L</p> <p>CO-OXIMETRY tHb 10.6 g/dL SO₂ 98.7 % FO₂Hb 97.8 % FCOHb 0.3 % FMeHb 0.6 % FHhb 1.3 %</p> <p>OXYGEN SATURATION ctO₂(a) 15.0 mL/dL</p> <p>ELECTROLYTES Na⁺ 139.6 mmol/L K⁺ 4.51 mmol/L Ca⁺⁺ 1.08 mmol/L Mg⁺⁺ 1.09 mmol/L</p> <p>ABOLITES Glu 7.61 mmol/L Lac 1.071 mmol/L</p> <p>UNITS pH 7.42 - 7.45 pO₂ 10.00 - 13.33 Na⁺ 135.0 - 145.0 K⁺ 3.50 - 5.30 Ca⁺⁺ 1.13 - 1.32 Cl⁻ 98 - 106 Glucose 3.7 - 5.2 Lactate 0.00 - 1.00 tHb 10.0 - 18.0 FO₂Hb 94.0 - 97.0 FCOHb 0.5 - 1.5 FMeHb 0.0 - 1.5 FHhb 0.0 - 5.0</p> <p>↓, ↑ = Out of range</p>	<p>Age 55</p> <p>Weight 67kg</p> <p>Height 5' 2"</p>	<p>Date 3/5/13</p> <p>Date of ICU admission 2/5/13</p> <p>Day number 1</p> <p>Initial procedure MVR (mechanical)</p> <p>Surgeon Mr Walker</p> <p>ICU Anaesthetist</p>	<table border="1"><thead><tr><th>Daily Goals</th><th>Timescale</th><th>Achieved ? (Y/N/comment)</th></tr></thead><tbody><tr><td>1 Rpt CXR → ? drain out signature [initials]</td><td>Time set: Time to be Achieved by:</td><td></td></tr><tr><td>2 signature</td><td>Time set: Time to be Achieved by:</td><td></td></tr><tr><td>3 signature</td><td>Time set: Time to be Achieved by:</td><td></td></tr><tr><td>4 signature</td><td>Time set: Time to be Achieved by:</td><td></td></tr><tr><td>5 signature</td><td>Time set: Time to be Achieved by:</td><td></td></tr><tr><td>6 signature</td><td>Time set: Time to be Achieved by:</td><td></td></tr></tbody></table>	Daily Goals	Timescale	Achieved ? (Y/N/comment)	1 Rpt CXR → ? drain out signature [initials]	Time set: Time to be Achieved by:		2 signature	Time set: Time to be Achieved by:		3 signature	Time set: Time to be Achieved by:		4 signature	Time set: Time to be Achieved by:		5 signature	Time set: Time to be Achieved by:		6 signature	Time set: Time to be Achieved by:	
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5 signature	Time set: Time to be Achieved by:																								
6 signature	Time set: Time to be Achieved by:																								

Note insensible losses approximately 7ml/per kg lean body mass

Airway and breathing		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	
FIO ₂		4L	4L	4L	3L	3L	3L	3L												
Mode		SV	SV	SV	SV	SV	SV	SV												
Tidal volume / Pressure control																				
Set Resp Rate																				
Pressure support																				
PEEP																				
Peak AP/plateau AP																				
Total Resp Rate		12	9	10	12	10	12													
Minute Vol Expired																				
Tidal Vol Expired																				
SpO ₂		99	99	100	99	99	99	99												
etCO ₂		3.4	3.8	2.9	2.8															
30 head up tilt		✓	✓	✓	✓	✓	✓	✓												
Humidification/ temp		✓	✓	✓	✓	✓	✓	✓												
Suction		✓	✓	✓	✓	✓	✓	✓												
Circulation		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	
Rhythm		SB	SB	SB	SB	SB	SB	SB												
CVP		+2	+2	+7		+2														
PAP																				
CO / PCWP																				
Augmented press																				
Radial(IABP)																				
<div>● Temp</div> <div>● HR</div> <div>X MAP</div> <div>V Art BP</div> <div>V NIBP</div>		40																		
		39																		
		38																		
		37																		
		36																		
		35																		
		34																		
		200																		
		180																		
		160																		
		140																		
		120																		
		100																		
		80																		
		60																		
		40																		
		20																		
Toe Temp/pulse R																				
Toe Temp/pulse L																				
Fluid balance & infusions		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	

Daily orders

AIRWAY & BREATHING

Airway

Intubation grade	Distance at lips	Tube details
1 2 3 4	cm	Size mm
Intubation date	Last tube change	Murphy eye oral
		Low pres cuff trachy

Respiratory parameters

PaO ₂	>8 kPa	Or	>		kPa
SpO ₂	>89%	Or	>		%
PaCO ₂	4.5 to 6.0 kPa	Or		to	kPa
Resp Rate (if Spont vent)	10 to 30 per min	Or		to	per min

Ventilation prescription

Time				
FiO2				
Mode				
TV/PC				
Rate				
PS				
Peep				
Sign				

CIRCULATION

Pacing

Indifferent wire	Mode
one two	Off fixed demand sequential
Atrial wire	set threshold
one two	mA
Ventricular wire	set threshold
one two	mA

Cardiovascular parameters

Heart Rate		to		Per min
Mean arterial pressure		to		mmHg
Systolic pressure		to		mmHg
Central venous pressure		<		mmHg
PCWP		<		mmHg
Urine output greater than 0.5ml/kg	Or	>		ml/Hr

Drains

1	Pericardial	Suction?	Yes	No
2	Mediastinal	Suction?	Yes	No
3	Right pleural	Suction?	Yes	No
4	Left pleural	Suction?	Yes	No
5	Other	Suction?	Yes	No
Sign				

INFUSION PRESCRIPTIONS

Drug	Amount	Dilution	Rate	Signature
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	
	mg	ml D5W	ml/hr	

Metabolic requirements (see relevant protocol/prescription)

5% Dextrose with or without 20mmol KCl for total rate		ml/hr	Sign
Additional Potassium?	<input type="checkbox"/> Maintain K+ at 4.5 to 5 (cardiac protocol)		
	<input type="checkbox"/> Range to	mmol/l	Sign
Insulin infusion?	<input type="checkbox"/> As per protocol		
	<input type="checkbox"/> As per prescription		Sign
Nasogastric feeding?	<input type="checkbox"/> As per protocol		
	<input type="checkbox"/> 24 hour volume	ml	Sign
TPN?	<input type="checkbox"/> As per protocol		
	<input type="checkbox"/> 24 hour volume	ml	Sign

Crystalloid/colloid balance

Aim for total daily balance of	ml
Maintain Hb?	<input type="checkbox"/> As per protocol
	<input type="checkbox"/> at >

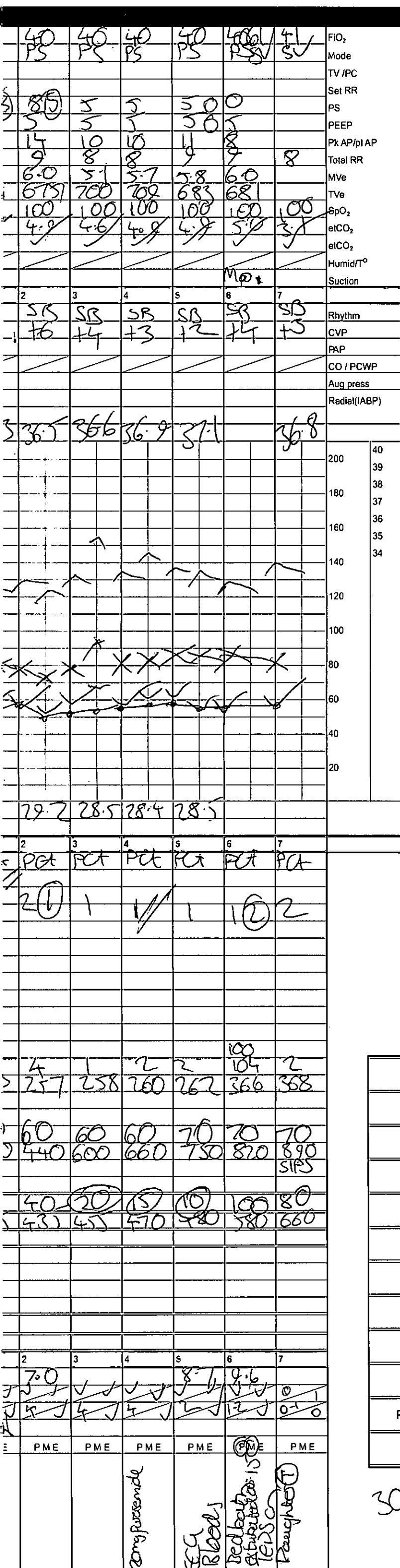
Fluid Prescription

Fluid	Volume	Duration	Sign	Given by	Time

Potassium

mmol															
Start Time															
End Time															
Ordered by															
Given by															

Potassium chloride infusion dilute to at least 40ml administer over 30 minutes give via central line ONLY



700629263X M 17/01/1957
Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compton

Procedure
MVR Replacement (Meltal valve)
Date 2/5/13

Past Medical history
AF - on warfarin
mild aortic incompetence
Barrett's Oesophagus
Back pain
Ex smoker & substance abuse - on methadone
Pulmonary oedema
Cholecystectomy

NKDA

ABG		19	21	24	25	26	27
Time	Preop	19	21	24	25	26	27
FiO ₂	21	40	40	40	40	40	40
Mode	SV	PS	PS	PS	PS	PS	PS
H ⁺	38.5	46.5	46.8	46.0	45.2	45.2	45.2
pCO ₂	6.7	5.56	6.46	5.91	5.7	5.7	5.7
pO ₂	8.3	20.48	19.95	23.13	20.2	20.2	20.2
HCO ₃	22.1	21.1	22.3	22.3	22.2	22.2	22.2
SBE	3.7	-4.1	-2.6	-2.4	-2.7	-2.7	-2.7
Hb	146	12.6	12.6	12.1	11.3	11.3	11.3
K ⁺	3.7	4.36	5.07	4.71	4.32	4.32	4.32
Ca ⁺⁺	1.13	1.05	1.12	1.14	1.14	1.14	1.14
Cl ⁻		114	108	110	110	110	110
Lactate		8.2	3.08				
ACT		156					

ABG cont		28	29	30	31	32	33
Time	0500	0600	0630	0700	0730	0800	0830
FiO ₂	40	60	60	60	60	60	60
Mode	SV	SV	SV	SV	SV	SV	SV
H ⁺	43.8	42.3					
pCO ₂	5.6	6.12					
pO ₂	19.9	21.66					
HCO ₃	22.6	25.0					
SBE	-2.2	0.6					
Hb	11.8	10.9					
K ⁺	5.34	4.84					
Ca ⁺⁺	1.13	1.11					
Cl ⁻	106	108					
Lactate	1.43	1.42					
ACT							

ABG cont		34	35	36	37	38	39
Time							
FiO ₂							
Mode							
H ⁺							
pCO ₂							
pO ₂							
HCO ₃							
SBE							
Hb							
K ⁺							
Ca ⁺⁺							
Cl ⁻							
Lactate							
ACT							

Colloid Balance											
Drain Code					Pneumonectomy 5/60 = release/ clamp						
swing bubble static											
Time	drain1	drain2	drain3	total out	colloid up	colloid given	net	balance	comments	Drain code	
18:50	40			40			-40	-40		-	
19:00	40			0			-40	-40		-	
19:15	40			0			0			-	
19:30	40			100			-100	-140		-	
19:45	140			0			0			-	
20:00	150			10			-10	-150	Pump blocked	-	
20:15	190			40			-40	-190		-	
20:30	230			40			-40	-230		X	
20:45	300			70			-70	-300		X	
21:00	320			20			-20	-320		X	
21:15	320			0			0	-320		X	
21:30	360			40			-40	-360		X	
21:45	400			40			-40	-400		X	
22:00	420			20			-20	-420		X	
22:15	420			0			0	-420		X	
22:30	430			10			-10	-430		X	
22:45	440			10			-10	-440			
23:00	460			20			-20	-460		-	
23:15	460			0			0	-460		-	
23:30	460			0			0	-460		-	
23:45	460			0			0	-460		-	
00:00	460			0		500	+500	+40		-	
00:15	460			0	500			+40	gelled	-	
00:30	460			0				+40		X	
00:45	460			0				+40		X	
01:00	460			0				+40		X	
01:15	460			20			-20	+20		X	
01:30	480			10			-10	+10		X	
01:45	500			10		500	+490	+500		-	
02:00	520			20			-20	+480		-	
02:15	520			0			0	+480		-	
02:30	520			0	500		-20	+480	gelled	-	
02:45	540			20			-20	+460		-	
03:00	540			0			0	+460		-	
03:15	540			0			0	+460		-	
03:30	540			0			0	+460		-	
03:45	540			0		500	+460	+920		-	
04:00	580			0			0	+920		-	
120ml/6											
24hr TOTAL drain loss					ml						

[illegible]

Daily orders

AIRWAY & BREATHING

Airway

Intubation grade

1234

Distance at lips

cm

Tube details

Size 9 mm

Intubation date

Last tube change

Murphy eye

oral

Low pres cuff

trachy

Respiratory parameters

PaO₂

>8 kPa

Or

>

kPa

SpO₂

>89%

Or

>

%

PaCO₂

4.5 to 6.0 kPa

Or

to

kPa

Resp Rate

(if Spont vent)

10 to 30 per min

Or

to

per min

Ventilation prescription

Time

FiO₂

PS

Mode

40%

TV/PC

Rate

PS

12

Peep

5

Sign

CIRCULATION

Pacing

Indifferent wire

one two

Mode

Off fixed demand sequential

Atrial wire

set

threshold

Underlying rhythm

one two

mA

Ventricular wire

set

threshold

Set Rate

one two

mA

Westmed coil

Cardiovascular parameters

Heart Rate

to

Per min

Mean arterial pressure

to

mmHg

Systolic pressure

to

mmHg

Central venous pressure

<

mmHg

PCWP

<

mmHg

Urine output greater than 0.5ml/kg

Or

>

ml/Hr

Drains

1

Pericardial

Suction?

Yes

No

2

Mediastinal

Suction?

Yes

No

3

Right pleural

Suction?

Yes

No

4

Left pleural

Suction?

Yes

No

5

Other

Suction?

Yes

No

Sign

INFUSION PRESCRIPTIONS

Drug

Amount

Dilution

Rate

Signature

If required for agitation

propofol 1%

mg

ml D5W

0-25 ml/hr

mg

ml D5W

ml/hr

mg

ml D5W

ml/hr

mg

ml D5W

ml/hr

mg

ml D5W

ml/hr

mg

ml D5W

ml/hr

mg

ml D5W

ml/hr

mg

ml D5W

ml/hr

Metabolic requirements (see relevant protocol/prescription)

5% Dextrose with or without 20mmol KCl for total rate

ml/hr

Sign

Additional Potassium?

☒

Maintain K+ at 4.5 to 5 (cardiac protocol)

Range

to

mmol/l

Sign

Insulin infusion?

☐

As per protocol

As per prescription

Sign

Nasogastric feeding?

☐

As per protocol

24 hour volume

ml

Sign

TPN?

☐

As per protocol

24 hour volume

ml

Sign

Crystalloid/colloid balance

Aim for total daily balance of

ml

Maintain Hb?

☐

As per protocol

☐

at >

g/dl

Fluid Prescription

Fluid

Volume

Duration

Sign

Given by

Time

Geloflasma

500

15/15 2015

Geloflasma

500

15/15 2015

Geloflasma

500

15/15 2015

Potassium

mmol

10

Start Time

End Time

Ordered by

Given by

Potassium chloride infusion dilute to at least 40ml administer over 30 minutes give via central line ONLY

RAPIDPoint® 500

ARTERIAL SAMPLE

03.05.2013 05:28

System Name RP 30615

System ID 0500-30615

Patient ID 1701570130

Lst Name AITKINSON

1st Name ALEXANDER

Operator FENDICK

ACID/BASE 37.0 °C

H ⁺	43.8	nmol/L
pCO ₂	5.60	kPa
pO ₂	19.97↑	kPa
HCO ₃ ⁻ std	22.6	mmol/L
BE (6)	-2.2	mmol/L

CO-OXIMETRY

tHb	11.8	g/dL
sO ₂	98.6	%
FO ₂ Hb	97.8↑	%
FCOHb	0.3↓	%
FMetHb	0.5	%
FHHb	1.4	%

OXYGEN STATUS 37.0 °C

ctO ₂ (a)	16.5	mL/dL
----------------------	------	-------

ELECTROLYTES

Na ⁺	137.1	mmol/L
K ⁺	5.34↑	mmol/L
Ca ⁺⁺	1.13	mmol/L
Cl ⁻	106	mmol/L

METABOLITES

Glu	8.7↑	mmol/L
Lac	1.43↓	mmol/L

PATIENT RANGES

H ⁺	35.0 - 45.0
pCO ₂	4.67 - 6.00
pO ₂	10.00 - 13.33
Na ⁺	135.0 - 148.0
K ⁺	3.50 - 5.30
Ca ⁺⁺	1.13 - 1.32
Cl ⁻	98 - 106
Glu	3.7 - 5.2
Lac	0.00 - 1.00
tHb	10.0 - 18.0
FO ₂ Hb	94.0 - 97.0
FCOHb	0.5 - 1.5
FMetHb	0.0 - 1.5
FHHb	0.0 - 5.0

↓, ↑ = Out of range

RAPIDPoint[®] 500

ARTERIAL SAMPLE
03.05.2013 00:25
System Name 300035
System ID 0500-30035
Patient ID 1701570130
Lst Name ATKINSON
1st Name ALEXANDER
Operator FENDICK

ACID/BASE 37.0 °C
H⁺ 46.01 nmol/L
pCO₂ 5.95 kPa
pO₂ 23.131 kPa
HCO₃⁻ std 22.5 mmol/L
BE(B) -2.4 mmol/L

CO-OXIMETRY
tHb 12.1 g/dL
sO₂ 98.5 %
FO₂Hb 97.41 %
FCOHb 0.31 %
FMetHb 0.8 %
FHHb 1.5 %

OXYGEN STATUS 37.0 °C
ctO₂(a) 16.9 mL/dL

ELECTROLYTES
Na⁺ 139.0 mmol/L
K⁺ 4.71 mmol/L
Ca⁺⁺ 1.14 mmol/L
Cl⁻ 1101 mmol/L

METABOLITES
Glu 9.11 mmol/L

PATIENT RANGES
H⁺ 35.0 - 45.0
pCO₂ 4.67 - 6.00
pO₂ 10.00 - 13.33
Na⁺ 135.0 - 148.0
K⁺ 3.50 - 5.30
Ca⁺⁺ 1.13 - 1.32
Cl⁻ 98 - 106
Glu 3.7 - 5.2
tHb 10.0 - 18.0
FO₂Hb 94.0 - 97.0
FCOHb 0.5 - 1.5
FMetHb 0.0 - 1.5
FHHb 0.0 - 5.0

↓, ↑ = Out of range

.....

RAPIDPoint[®] 500

ARTERIAL SAMPLE

02.05.2013 21:44
System Name RP 30615
System ID 0500 30615
Patient ID 1701570130
Lst Name ATKINSON
1st Name ALEXANDER
Operator FENDICK

ACID/BASE 37.0 °C
H⁺ 48.81 nmol/L
pCO₂ 6.461 kPa
pO₂ 19.951 kPa
HCO₃⁻ std 22.3 mmol/L
BE(B) -2.6 mmol/L

CO-OXIMETRY

tHb 12.6 g/dL
sO₂ 98.4 %
FO₂Hb 97.51 %
FCOHb 0.31 %
FMetHb 0.6 %
FHb 1.6 %

OXYGEN STATUS 37.0 °C
ctO₂(a) 17.5 mL/dL

ELECTROLYTES

Na⁺ 140.2 mmol/L
K⁺ 5.07 mmol/L
Ca⁺⁺ 1.121 mmol/L
Cl⁻ 1091 mmol/L

METABOLITES

Glu 11.41 mmol/L
Lac 3.081 mmol/L

PATIENT RANGES

H⁺ 35.0 - 45.0
pCO₂ 4.67 - 6.00
pO₂ 10.00 - 13.33
Na⁺ 135.0 - 148.0
K⁺ 3.50 - 5.30
Ca⁺⁺ 1.13 - 1.32
Cl⁻ 98 - 106
Glu 3.7 - 5.2
Lac 0.00 - 1.00
tHb 10.0 - 18.0
FO₂Hb 94.0 - 97.0
FCOHb 0.5 - 1.5
FMetHb 0.0 - 1.5
FHb 0.0 - 5.0

↓, ↑ = Out of range

FHHb 0.0

↓,↑=Out of range

.....

RAPIDPoint™ 500

ARTERIAL SAMPLE

02.05 2013 19 01

System Name: RP 30614

System ID 0500 30615

Patient ID 1701570130

Lst Name: AITKINSON

1st Name: ALEXANDER

Operator 0411

ACID/BASE 37.0 °C

H⁺ 46.51 nmol/L

pCO₂ 5.56 kPa

pO₂ 20.48↑ kPa

HCO₃⁻ std 21.1 mmol/L

BE(8) -4.1 mmol/L

CO-OXIMETRY

tHb 12.6 g/dL

sO₂ 98.4 %

FO₂Hb 97.31 %

FCOHb 0.41 %

FMetHb 0.7 %

FHHb 1.6 %

OXYGEN STATUS 37.0 °C

ctO₂(a) 17.5 mL/dL

ELECTROLYTES

Na⁺ 141.2 mmol/L

K⁺ 4.36 mmol/L

Ca⁺⁺ 1.051 mmol/L

Cl⁻ 1141 mmol/L

METABOLITES

Glu 8.21 mmol/L

Lac 1.791 mmol/L

F_IO₂ 40.0 %

PATIENT RANGES

H⁺ 35.0 - 45.0

pCO₂ 4.67 - 6.00

pO₂ 10.00 - 13.33

Na⁺ 135.0 - 148.0

K⁺ 3.50 - 5.30

Ca⁺⁺ 1.13 - 1.32

Cl⁻ 98 - 106

Glu 3.7 - 5.2

Lac 0.00 - 1.00

tHb 10.0 - 18.0

FO₂Hb 94.0 - 97.0

FCOHb 0.5 - 1.5

FMetHb 0.0 - 1.5

FHHb 0.0 - 5.0

↓,↑=Out of range

.....

RAPIDPoint[®] 500

ARTERIAL SAMPLE

05/05/2013 02:41

System Name: RPT 10

System ID: 0500 100

Patient ID: 1701570130

1st Name: ALEX NSON

1st Name: ALEXANDER

Operator: FENDICK

ACID-BASE 57 0 °C

pH 7.45 21 mmol/L

pCO₂ 5.75 kPa

pO₂ 20.21 kPa

HCO₃⁻ std 22.2 mmol/L

BE(B) 2.7 mmol/L

CO-OXIMETRY

tHb 11.3 g/dl

SO₂ 98.4 %

FO₂Hb 97.61 %

FCOHb 0.31 %

FMethHb 0.5 %

FHHb 1.6 %

OXYGEN STATUS 37.0 °C

cIO₂(a) 15.8 mL/dL

ELECTROLYTES

Na⁺ 140.1 mmol/L

K⁺ 4.52 mmol/L

Ca⁺⁺ 1.14 mmol/L

Cl⁻ 110.1 mmol/L

METABOLITES

Glu 7.01 mmol/L

Lac 1.571 mmol/L

PATIENT RANGES

pH 7.35 - 7.45

pCO₂ 4.67 - 6.00

pO₂ 10.00 - 13.33

Na⁺ 135.0 - 148.0

K⁺ 3.50 - 5.30

Ca⁺⁺ 1.13 - 1.32

Cl⁻ 98 - 106

Glu 3.7 - 5.2

Lac 0.00 - 1.00

tHb 10.0 - 18.0

FO₂Hb 94.0 - 97.0

FCOHb 0.5 - 1.5

FMethHb 0.0 - 1.5

FHHb 0.0 - 5.0

1.1=Out of range

.....

OPIOID INFUSION AND PCA CHART – Cardiothoracic unit

700629263X M 17/01/1957

Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH

CHI 1701570130

CONSULTANT SURGEON: WALLER

ANAESTHETIST: DORNAN

WARD: III

OPERATION: MVR

DATE: 2/5/13

3975 Drug	LJ Comnson Morphine	mg/ml 100	mg/ml 50	ml	Concentration 2 mg/ml
Diluent 0.9% Sodium Chloride / 5% Dextrose				Antiemetic added Cyclizine 100	
Bolus dose	Lockout	Signature	Print Name	Date/time	
2 mg	5 mins	BSR/FUNKE		2/5/13 15:30	
1 mg	5 mins	Sh	Brown	3/5/13	
Infusion rate		mg/mcg/hr			
Amended to		mg/mcg/hr			
Landing dose	Signature	Time Given	Given By	Checked By	
Intrathecal or Epidural opioid	Signature	Time Given	Given By		

All patients require oxygen therapy, 4l/min by face mask or 2-4l/min via nasal canulae. Oxygen therapy whilst sleeping particularly important

TREATMENT OF PROBLEMS

1. If respiratory rate is 8/min or less, or if the patient is very difficult to rouse (sedation score of 3) STOP PUMP, and inform resident or anaesthetist on call (bleep 2140). Ensure naloxone is available.
2. Nausea refer to PONV algorithm
3. Inadequate pain relief – check adjuvants prescribed -inform resident, or anaesthetist on call (bleep 1669).

Anaesthesia SpR	Page No.
Anaesthesia Consultant	Page No.

SCORE	PAIN	SEDATION	NAUSEA
0	No pain	None, patient alert	None
1	Mild pain, it does not distress me	Mild, occasionally drowsy, easy to rouse	Mild nausea, no treatment required
2	Moderate pain, it distresses me a bit	Moderate, frequently drowsy, easy to rouse	Nausea/vomiting helped by treatment
3	Severe pain, it distresses me a lot	Severe, somnolent, difficult to rouse	Persistent nausea/vomiting despite treatment
V	Ventilated, or otherwise unable to give pain score		
S	Sleeping normally	Normal sleep, stirs to light touch	Sleeping normally

Pain Service

DATE 2/5/13 OPIOID AND PCA MONITORING CHART (DAY 1)
OBSERVATIONS MUST BE CARRIED OUT HOURLY
Shaded sections are recorded on 24-hour chart in ICU/EDU

Time	Set infusion rate	Volume left in syringe	Delivered dose each hour	Total volume infused	Sedation score	Resp. Rate	Pain score rest	Pain score movement	Nausea score	IV Site Check	Initials
0800											
0900											
1000											
1100											
1200											
1300											
1400											
1500											
1600											
1700											
1800											
1900	PCA	746									10/15
2000	PCA	46	0	0			see ICU chart				15
2100	PCA	40	6ml	6ml/12hrs				"			15
2200	PCA	39	1ml	7ml/14hrs				"			15
2300	PCA	39	0	7ml							15
2400	PCA	37	2ml	2ml				"			15
0100	PCA	35	4ml	8/13ml				"			15
0200	PCA	45	2ml	15ml				"			15
0300	PCA	45	0	15ml				"			15
0400	PCA	43	2ml	17ml				"			15
0500	PCA	41	2ml	19ml				"			15
0600	PCA	37	4ml	23ml				"			15
0700	PCA	31	0	23ml				"			15

TOTAL DOSE IN 24 HOURS =

23ml/46mg

Preparation Details

Date	Time	Prepared by	Checked by	Pump No	Batch no. drugs	Batch no. diluent
1. 2/5	1410	Kabir	Jah		20445	F0068
2. 3/5	00:30	Lira	Jah		20445	
3.						
4.						

Syringe No. 1	Total drug given	Signed	Date	Time
	11			
Total drug discarded	35	Witnessed	3/5/13	0030
Syringe No. 2				
Total drug given		Signed		
Total drug discarded		Witnessed		

Cyclizine added

DATE _____ OPIOID AND PCA MONITORING CHART (DAY _____)

OBSERVATIONS MUST BE CARRIED OUT HOURLY

Shaded sections are recorded on 24-hour chart in ICU/HDU

Time	Set infusion rate	Volume left in syringe	Delivered dose each hour	Total volume infused	Sedation score	Resp. Rate	Pain score rest	Pain score movement	Nausea score	IV Site Check	Initials
0800	PCA	38	0	0			See ITU chart			✓	
0900	PCA	36	2mg	1ml			↓			✓	
1000	PCA	35	2mg	2ml			↓			✓	
1100	PCA	35	0	2ml			↓			✓	
1200	PCA	34	2mg	3ml			↓			✓	
1300											
1400											
1500											
1600											
1700											
1800											
1900											
2000											
2100											
2200											
2300											
2400											
0100											
0200											
0300											
0400											
0500											
0600											
0700											

TOTAL DOSE IN 24 HOURS =

Preparation Details

Date	Time	Prepared by	Checked by	Pump No	Batch no. drugs	Batch no. diluent
1.						
2.						
3.						
4.						

Syringe No. 1	Signed	Date	Time
Total drug given	<i>[Signature]</i>	3.5.13	1303
Total drug discarded 34	Witnessed <i>[Signature]</i>	3.5.13	1300
Syringe No. 2	Signed	Date	Time
Total drug given			
Total drug discarded	Witnessed		

DATE _____ OPIOID AND PCA MONITORING CHART (DAY _____)

OBSERVATIONS MUST BE CARRIED OUT HOURLY

Shaded sections are recorded on 24-hour chart in ICU/HDU

Time	Set infusion rate	Volume left in syringe	Delivered dose each hour	Total volume infused	Sedation score	Resp. Rate	Pain score rest	Pain score movement	Nausea score	IV Site Check	Initials
0800											
0900											
1000											
1100											
1200											
1300											
1400											
1500											
1600											
1700											
1800											
1900											
2000											
2100											
2200											
2300											
2400											
0100											
0200											
0300											
0400											
0500											
0600											
0700											

TOTAL DOSE IN 24 HOURS =

Preparation Details

Date	Time	Prepared by	Checked by	Pump No	Batch no. drugs	Batch no. diluent
1.						
2.						
3.						
4.						

Syringe No. 1		Date	Time
Total drug given	Signed		
Total drug discarded	Witnessed		
Syringe No. 2			
Total drug given	Signed		
Total drug discarded	Witnessed		

Pump type:

Pump type:

Pump type:

Pump

[illegible]

Alexander Atkinson
D.O.B. 17/01/57

Pump type:

Number:

Number:					Number:					Number:					Number:					Number:					Number:				
Date:	Drug, Amount and Total Volume:				Drug, Amount and Total Volume:				Drug, Amount and Total Volume:				Drug, Amount and Total Volume:				Drug, Amount and Total Volume:				Drug, Amount and Total Volume:								
6/15/15	ACTRAPID 50:cc/ml																												
Time:	Rate ml/hr	Level	Volume Infused	Initials	Rate ml/hr	Level	Volume Infused	Initials	Rate ml/hr	Level	Volume Infused	Initials	Rate ml/hr	Level	Volume Infused	Initials	Rate ml/hr	Level	Volume Infused	Initials	Rate ml/hr	Level	Volume Infused	Initials					
6:00		35																											
7:00																													
8:00																													
9:00																													
10:00																													
11:00																													
12:00																													
13:00																													
14:00																													
15:00																													
16:00																													
17:00																													
18:00																													
19:00																													

700629263X—M—17/01/1957—
 Atkinson, Alexander/DMAASCL
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 CHI 1701570130
 13975 LJ Compson



Daily Repositioning and Skin Inspection Chart

Date:

31/5/15

- Inspect skin for evidence of change
- Reassess at every positional change and document below
- Reposition the patient/client to reduce the risk of further damage, e.g. using the 30 degree tilt
- Use manual handling aids to minimise risk of friction and shear
- Patients/clients on any form of pressure redistribution equipment still require skin inspection and regular repositioning
- Provide suitable seating including pressure redistribution cushions, if required, encourage repositioning/mobilisation where possible
- Acutely ill patients/clients should sit out for no longer than 2 hours and return to bed for no less than 1 hour.

Time	Repositioning (Using Codes) From: To:		Skin Inspection Comments	Action Taken	Signature
eg: 08:00	L	U	Left Hip Non-Blanching	Reassess at next positional change	
01:15	B	B	intact	Reassess	Wendy
06:10	B	B	intact	Reassess	Wendy
10:00	B	B	"	"	Wendy
13:30	B	B	"	"	Wendy

Code: L = left, R = right, B = back, P = prone (front), M = mobilised, U = up to sit

addressograph

Following evaluation, this patient will receive care rounding at the following frequency over the next 24 hours.
All sections should be completed for **every patient** except those on the LCP at **every planned time**.

NHS
Lothian

$$\mathcal{O}_N$$
Page 1 of 2

Patient Care Rounding Record – to be filed in Nursing section of unitary patient record.

Print this document double-sided - **P.T.O**

Version 18.2 Jan 2013 – review date Dec 2013

Use codes in each box or circle in pre written boxes / Print this document double-sided

Time of care rounding		AS																								
Falls	Appropriate footwear?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN		
	Walking aid available if required?	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA			
	Area de-cluttered?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN			
	Bed rails in use? (Up U, Down D, N/A)	NR																								
Continence	Do you need the toilet? (Y, N, AS)	N																								
	Continent of urine? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN			
	Continent of faeces? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN			
	Continence product changed if insitu?	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA				
	If catheterised, is it still required? (if NA do not complete next 2 sections)	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA				
	Catheter care performed?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN			
	Bag checked? (Position below bladder, No more than 2/3 full, Connections intact)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN			
PVC	Is the PVC / SC still req? (if NA do not complete next 3 sections)	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA				
	Insitu for > 72hrs?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN				
	Dressing intact?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN				
	Redness / swelling?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN				
General	Are you in pain? Are you comfortable? (P, C, AS)	[Handwritten line across the row]																								
	Buzzer within reach?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN				
	Anything else I can do for you? (Y, N, AS)	N																								
	Someone will be back in...hrs. Use buzzer if req (Y, N, AS)	4																								
Initials		JS																								

Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 CHI 1701570130
 13975 LJ Compson

Patient Care Rounding Record

Following evaluation, this patient will receive care rounding at the following frequency over the next 24 hours.
 All sections should be completed for every patient except those on the LCP at every planned time.

Circle Yes No where shown **(Y)N** use codes if otherwise indicated.

Care Plan		Date from: 7/5/13 to: 8/5/13												Date from: 8/5/13 to: 9/5/13														
Ward 102		1hrly 2hrly 4hrly 6hrly (please circle)				Nurse planning care rounding Signature Print R McCombe				1hrly 2hrly 4hrly 6hrly (please circle)				Nurse planning care rounding Signature Print														
Time of care rounding (24 hour)		6:00	09:00	15:30	21:00	07:00	07:00	07:00							06:30	09:30	14:00	18:00	21:00	07:00								
PAC	Personal Care? (Bedbath BB, Bath B, Shower S, Basin wash W, Shave SH, Decline D)	Care given (use codes): Date/Time..... Shower Date/Time.....												Care given (use codes): Date/Time..... Shower (Ind) Date/Time.....														
	Cavilon applied (Cream C, Spray S, N/A)	/	/	N/A	N	N	N							/	/	N/A	N/A	N/A	N/A									
	Visual skin check	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
	Outcome of skin check (NAD, Red R, Broken B- wound chart)	-	NAD	/	NAD	/	/								Verbal NAD			/	/									
	Vulnerable areas? (Circle areas if red or broken skin)	Heel (L) (R) Hips (L) (R) Sacrum Spine Other.....												Heel (L) (R) Hips (L) (R) Sacrum Spine Other.....														
	Positioning (Right R, Left L, Back B, Chair C)	B	C	B	B	B	B							C	C	C	C	C	B									
	Have you moved / walked since last round? (Y, N, Asleep AS)	Y	Y	Y	Y	Y	AS							Y	Y	Y	Y	Y	AS									
	Mattress type	Pentaflex - if other type please state:												Pentaflex - if other type please state:														
Seat/Cushion type	Reflexion - if other type please state:												Reflexion - if other type please state:															
Food, Fluid & Nutrition	Would you like a drink? (Y, N, Within reach W, Nil by mouth NBM, Prompt, P, assist A) Remember FBC	W	W	W	W	W	W							W	W	Y	N	W	W									
	Oral Care performed recently? (Y, N, Assist A)	N	Y	N	N	N	N							N	Y	N	N	N	N									
	Does IVI need reconnected?	(N)	(N)	(N)	(N)	(N)	(N)	Y	N	Y	N	Y	N	Y	(N)	(N)	(N)	(N)	(N)	Y	(N)	Y	N	Y	N	Y	N	

Time of care rounding		6:00	09:00	13:30	16:45	21:00	02:00								06:00	09:30	14:00	17:00	21:00	02:00						
Falls	Appropriate footwear?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Walking aid available if required?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Area de-cluttered?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Bed rails in use? (Up U, Down D, N/A)	D	D	D	D	NA	NA								NA	NA	NA	D	NA	NA						
Continence	Do you need the toilet? (Y, N, AS)	N	N	N	N	N	AS								N	N	N	N	N	AS						
	Continent of urine? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Continent of faeces? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Continence product changed if insitu?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	If catheterised, is it still required? (if NA do not complete next 2 sections)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Catheter care performed?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Bag checked? (Position below bladder, No more than 2/3 full, Connections intact)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
PVC	Is the PVC / SC still req? (if NA do not complete next 3 sections)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Insitu for > 72hrs?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Dressing intact?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Redness / swelling?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
General	Are you in pain? Are you comfortable? (P, C, AS)	C	C	C	P																					
	Buzzer within reach?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Anything else I can do for you? (Y, N, AS)	N	N	N	N	N	AS								N	N	N	N	N	AS						
	Someone will be back in...hrs. Use buzzer if req (Y, N, AS)	4	2	2	20	40	AS								40	4	4	4	4	AS						
Initials		AP	AL	AL	AL	AL									AP	AL	AL	AL	AL	AL						

addressograph
ALEXANDER
ATKINSON

Patient Care Rounding Record

Following evaluation, this patient will receive care rounding at the following frequency over the next 24 hours.
All sections should be completed for **every patient** except those on the LCP at **every planned time**.

Circle Yes No where shown **(Y)N** use codes if otherwise indicated.

Care Plan	Ward <u>102</u>	Date from: <u>05/05/13</u> to: <u>06/05/13</u>												Date from: <u>6/5/13</u> to: <u>7/5/13</u>												
		1hrly (please circle) (4hrly) 2hrly 6hrly				Nurse planning care rounding Signature <u>K. Burgess</u> Print								1hrly (please circle) (4hrly) 2hrly 6hrly				Nurse planning care rounding Signature <u>[Signature]</u> Print								
	Time of care rounding (24 hour)	200	0600	1100	1600	2100	0200							600	1000	1400	1800	2000								
PAC	Personal Care? (Bedbath BB, Bath B, Shower S, Basin wash W, Shave SH, Dedline D)	Care given (use codes): Date/Time..... Date/Time.....												Care given (use codes): Date/Time..... <u>Shower Independent</u> Date/Time..... <u>0900</u>												
	Cavilon applied (Cream C, Spray S, N/A)		/	/	/	/	/							/	/	/	/	/	/							
	Visual skin check	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA	YN NA
	Outcome of skin check (NAD, Red R, Broken B- wound chart)	NAD	Verb NAD	NAD	NAD	NAD	/							/	Verb verb.	/	/	Verb oil. foul	AS							
	Vulnerable areas? (Circle areas if red or broken skin)	Heel (L) (R) Hips (L) (R) Sacrum Spine Other.....												Heel (L) (R) Hips (L) (R) Sacrum Spine Other.....												
	Positioning (Right R, Left L, Back B, Chair C)	B	B	C	C	B	B							C	C	C	C	B	B							
	Have you moved / walked since last round? (Y, N, Asleep AS)	N	Y	Y	Y	Y	AS							Y	Y	Y	Y	Y	Y							
	Mattress type	Pentaflex – if other type please state:												Pentaflex – if other type please state:												
Seat/Cushion type	Reflexion – if other type please state:												Reflexion – if other type please state:													
Food, Fluid & Nutrition	Would you like a drink? (Y, N, Within reach W, Nil by mouth NBM, Prompt, P, assist A) Remember FBC	AS	W	W	W	W	W							W	W	W	W	W	W							
	Oral Care performed recently? (Y, N, Assist A)	AS	N	Y	Y	Y	AS							N	Y	Y	Y	Y	Y	N						
	Does IVI need reconnected?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN

Time of care rounding		0200	0600	1100	1600	2100	0200								0600	1000	1400	1800	2100	0200						
Falls	Appropriate footwear?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Walking aid available if required?	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN (NA)	YN	YN	YN	YN	YN	
	Area de-cluttered?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Bed rails in use? (Up U, Down D, N/A)	D	D	D	D	D	D								D	N/A	N/A	N/A	D	D						
Continence	Do you need the toilet? (Y, N, AS)	N	N	N	N	N	AS								N	N	N	N	N	AS						
	Continent of urine? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Continent of faeces? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Continence product changed if insitu?	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN (NA)	YN	YN	YN	YN	YN	
	If catheterised, is it still required? (if NA do not complete next 2 sections)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN (NA)	YN	YN	YN	YN	YN	
	Catheter care performed?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Bag checked? (Position below bladder, No more than 2/3 full, Connections intact)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
PVC	Is the PVC / SC still req? (if NA do not complete next 3 sections)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN (NA)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN (NA)	YN	YN	YN	YN	YN	
	Insitu for > 72hrs?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Dressing intact?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Redness / swelling?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
General	Are you in pain? Are you comfortable? (P, C, AS)	AS	C	C	C	C	AS								C				Sec	Sens						
	Buzzer within reach?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Anything else I can do for you? (Y, N, AS)	AS	N	N	N	N	AS								N	N	N	N	N	AS						
	Someone will be back in...hrs. Use buzzer if req (Y, N, AS)	2 ⁰	4 ⁰	4 ⁰	4 ⁰	4 ⁰	4 ⁰								6 ⁰	4 ⁰	4 ⁰	4 ⁰	4 ⁰	4 ⁰	4 ⁰					
Initials		KK	LN	DS	DI	AP																				

700629263X M 17/01/1957
 Atkinson, Alexander D
 Skinnergate Resettlement Unit,
 16 Skinnergate,
 Perth,
 Perthshire, PH1 5JH
 CHI 1701570130
 13975 LJ Compson

Patient Care Rounding Record

Following evaluation, this patient will receive care rounding at the following frequency over the next 24 hours.
 All sections should be completed for every patient except those on the LCP at every prescribed time.



Circle Yes No where shown **(Y)** N use codes if otherwise indicated.

Care Plan		Date from: 3/5/13 to: 4/5/13												Date from: 4/5/13 to: 5/5/13											
Ward 102		1hrly (please circle) 4hrly				2hrly 6hrly				Nurse prescribing care rounding Signature: [Signature] Print: [Print]				1hrly (please circle) 4hrly				2hrly 6hrly				Nurse prescribing care rounding Signature: [Signature] Print: [Print]			
Time of care rounding (24 hour)		21												07 08 10 14 18 22											
PAC	Personal Care? (Bedbath BB, Bath B, Shower S, Basin wash W, Shave SH, Decline D)	Care given (use codes): Date/Time: Date/Time:												Care given (use codes): Date/Time: S..... Date/Time:											
	Visual skin check	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N		
	Outcome of skin check (NAD, Red R, Broken B-wound chart)	NAD												AS	NAD	NAD	NAD	NAD							
	Vulnerable areas? (Circle areas if red or broken skin)	Heel (L) (R) Hips (L) (R) Sacrum Spine Other.....												Heel (L) (R) Hips (L) (R) Sacrum Spine Other.....											
	Positioning (Right R, Left L, Back B, Chair C)	B												B	B	C	C	C	C						
	Have you moved / walked since last round? (Y, N, Asleep AS)	N												AS	Y	Y	Y	Y	Y						
	Mattress type	Pentaflex – if other type please state:												Pentaflex – if other type please state:											
Seat/Cushion type	Reflexion – if other type please state:												Reflexion – if other type please state:												
Food, Fluid & Nutrition	Would you like a drink? (Y, N, Within reach W, Nil by mouth NBM)	Y											AS	W	W	N	N	W							
	Fluid balance chart updated if in use?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N		
	When did you last eat? (Breakfast B, Lunch L, Dinner D, Snack S, Assist A, F Feed, Nil by mouth NBM)	S												AS	D	B	L	D	S						
	Oral Care performed recently? (Y, N, Assist A)	N												AS	N	S	V	V	N						

[illegible]

CHI 1701570130

Patient Care Rounding Record

Following evaluation, this patient will receive care rounding at the following frequency over the next 24 hours.

All sections should be completed for **every patient** except those on the LCP at **every planned time**.



Circle Yes No where shown (Y)N use codes if otherwise indicated.

=13975 LJ Compson

[illegible]

Time of care rounding		02 ⁰⁰	02 ³⁰	06 ⁰⁰																					
Falls	Appropriate footwear?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Walking aid available if required?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Area de-cluttered?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Bed rails in use? (Up U, Down D, N/A)	D	D	D																					
Continence	Do you need the toilet? (Y, N, AS)	N	N	N																					
	Continent of urine? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Continent of faeces? (at time of rounding) (Y, N)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Continence product changed if insitu?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	If catheterised, is it still required? (if NA do not complete next 2 sections)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Catheter care performed?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Bag checked? (Position below bladder, No more than 2/3 full, Connections intact)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
PVC	Is the PVC / SC still req? (if NA do not complete next 3 sections)	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Insitu for > 72hrs?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Dressing intact?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Redness / swelling?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
General	Are you in pain? Are you comfortable? (P, C, AS)	C	sleep	C																					
	Buzzer within reach?	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	YN	
	Anything else I can do for you? (Y, N, AS)	N	N	N																					
	Someone will be back in...hrs. Use buzzer if req (Y, N, AS)	4	4	4																					
Initials		S	BN	BN																					

Documentation for Transfusion of Blood Components

This is a formal record of transfusion and **must** be filed in the appropriate healthcare records
Please use a new document for each hospital admission

Patient Details

Hospital: <u>R.I.E</u>	700629263X M 17/01/1957 Atkinson, Alexander D Skinnergate Resettlement Unit, 16 Skinnergate, Perth, Perthshire, PH1 5JH CHI 1701570130 13975 LJ Compson
Ward/Dept: <u>102</u>	Date of birth: CHI number:
Consultant: <u>Mr Waugh</u>	

Accountability Statement

Only staff who have completed the learnbloodtransfusion package relevant to their role can participate in the clinical transfusion process

TRAIN or REVALIDATE online at
www.learnbloodtransfusion.org.uk (also available via NHS Learnpro)

Consent for Transfusion

THIS SECTION SHOULD BE COMPLETED BY THE PERSON PRESCRIBING THE TRANSFUSION

- | | |
|---|---|
| • Reasons for transfusion and possible alternatives discussed with patient? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| • Was the patient offered a Transfusion Patient Information Leaflet? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| • Does this patient agree to have a blood transfusion? | Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| • Is an advanced decision (refusal of transfusion) document in place? | Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

If it is not possible to discuss transfusion with the patient, please give reason / details below:

.....

.....

.....

Signature: C. Waugh Name & Designation: Mr Alexander D Atkinson Date: 17/01/13

Before prescribing blood or blood components:

- Please be familiar with the NHS Lothian Blood Transfusion Policy and Procedures on NHS Lothian intranet > healthcare > clinical guidance. Local transfusion threshold guidance for specific patient groups is also available in some departments.
- Check if patient has any previous transfusion history or has had any previous transfusion reactions (this may not be possible in an emergency situation)

RIGHT BLOOD → RIGHT PATIENT @ RIGHT TIME

Patient Name:

Date of birth:

CHI:

Prescription

- It is the responsibility of the prescriber and requester of the blood component(s) to ensure that any special transfusion requirements are met (e.g. irradiated/CMV negative units, use of blood warmer)
- Medications related to transfusion (e.g. diuretics, antipyretics) must be prescribed on the patient's Drug Prescription chart/kardex.
- Most routine red cell transfusions can be given over approximately 2 hours per unit. Where volume overload is a problem, consider slower transfusion and use of furosemide

UNIT 1	Blood component	Unit/ mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here	
	RCC	①	Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>	Donation No: G101 613 248 128 M Component: 04333 Red Cells in Additive Solution(CPD/SAGM) Signature 1: <i>[Signature]</i> Date Given: 5/5/13 Signature 2: <i>[Signature]</i> Time Given: 16 ³⁰	
	Reason for transfusion				
	Date 5/5/13	Duration 3 hours	Prescriber signature <i>[Signature]</i>		

Reassess before you progress!

UNIT 2	Blood component	Unit/ mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here	
	RCC	①	Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>	Donation No: G101 613 248 162 I Component: 04333 Red Cells in Additive Solution(CPD/SAGM) Signature 1: <i>[Signature]</i> Date Given: 5/5/13 Signature 2: <i>[Signature]</i> Time Given: 17 ²⁰	
	Reason for transfusion				
	Date 5/5/13	Duration 3 hours	Prescriber signature <i>[Signature]</i>		

Reassess before you progress!

UNIT 3	Blood component	Unit/ mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here	
			Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>		
	Reason for transfusion				
	Date	Duration	Prescriber signature		

Reassess before you progress!

UNIT 4	Blood component	Unit/ mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here	
			Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>		
	Reason for transfusion				
	Date	Duration	Prescriber signature		

RIGHT BLOOD → RIGHT PATIENT @ RIGHT TIME

Patient Name:

Date of birth:

CHI:

Transfusion Checklist - Please initial each box as checks are completed

	Pre-Collection Checks below to be completed before removing component from temperature controlled storage			Pre-administration			At Bedside		Post Transfusion		
Unit No.	Patient's ID band insitu?	Patent IV access?	Blood prescribed? (check consent (p1) and if any special requirements (p2))	Date/Time component removed from temperature controlled storage	Inspect bag (condition & expiry date)	Baseline Obs (clearly show as 'baseline' obs on SEWS or agreed alternative observation chart)	Verbal ID (if patient able)	Check patient's ID band against component tag – all identification details	Date/Time Transfusion completed	Completion Observations: TPR & BP within 60 minutes of completion of last unit	Tag Completed & Returned to laboratory
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Transfusion must be completed within 4 hours of removing component from temperature controlled storage

If blood is not used / no longer required please return to transfusion laboratory or satellite blood fridge within 30 minutes of removal to prevent wastage

RIGHT BLOOD → RIGHT PATIENT @ RIGHT TIME

Observations

All blood transfusion observations must be marked as blood transfusion observations, utilising patient's current observation chart, for example SEWS chart.

The **minimum** observations of Temperature, Blood Pressure, Respiratory Rate & Pulse that **must** be recorded for **each unit** are:

- Baseline observations must be recorded **no more than 60 minutes** prior to transfusion commencing
- 15 minutes **after** the start
- Thereafter **hourly** until completion
- At **end** of each transfusion episode, **within 60 minutes of completion of transfusion**

NB if any of these measurements have altered significantly from baseline values, consider the possibility of a transfusion reaction: increase frequency of the observations and inform a member of medical staff.

A simple pyrexia on baseline should not prevent a transfusion if this is clinically imperative but the patient must be monitored closely throughout the transfusion – paying particular attention to any temperature rise above baseline and / or changes to other vital signs.

Management of a Transfusion Reaction

Mild (ie non-haemolytic febrile reaction, allergic reaction)

- **Stop** the transfusion
(check the patient and component compatibility)
- Seek medical advice
- Assess patient
- Commence appropriate treatment
- Monitor patient closely for 30 minutes:
 - If signs and symptoms respond to treatment, transfusion may be recommenced. It may be appropriate to recommence at a slower rate.
 - If there is no improvement within 15 minutes, or if any deterioration occurs do not restart transfusion and treat as a severe reaction

Severe (ie acute haemolytic reaction, septic reaction, anaphylaxis, respiratory complications)

- **Stop** the transfusion
 - Disconnect and take down blood component and blood administration set
 - Commence IV 0.9% saline infusion (using new administration set)
- Call medical staff to see the patient urgently
- Assess patient – resuscitate as required
- Inform the hospital transfusion laboratory and return the component

The incident/event must also be reported in the patient's healthcare record and through DATIX.

Post Transfusion

- It is recognised that adverse reactions may manifest many hours after the transfusion is completed. It is recommended that patients discharged within 24 hours of transfusion be issued with a contact card giving 24-hour access to clinical advice
- When pre-transfusion discussion has not taken place, the reasons for transfusion should be discussed with the patient and written information offered retrospectively

Best Practice Points

- Positive patient identification is essential at all stages of the blood transfusion process
- A patient identification band (or risk assessed equivalent) must be worn by all patients receiving a blood transfusion and include first name, surname, date of birth, CHI / emergency number and gender
- It is the responsibility of the healthcare professional administering the blood component to perform the final patient identification check, before administering the blood component
- All staff who collect blood components are required by law to be competency assessed
- It is a legal requirement to complete the blue traceability label and return it to the hospital transfusion laboratory to ensure traceability from donor to recipient.

All blood component transfusions in NHS Lothian must be given in accordance with the NHS Lothian Blood Transfusion Policy and Procedures which can be found on the **NHS Lothian intranet > healthcare > clinical guidance**

Document for Transfusion of Blood Components Continuation Sheet

Patient Name:

Date of birth:

CHI:

Continuation Sheet No:

Main transfusion record must be used for initial transfusion. Continuation sheet is only for use when patient requires more than 4 units

Prescription

- It is the responsibility of the prescriber/requester of the blood component(s) to ensure that any special transfusion requirements are met (e.g. irradiated/CMV negative units, use of blood warmer)
- Medications related to transfusion (e.g. diuretics, antipyretics) must be prescribed on a Drug Prescription chart/kardex.
- Most routine red cell transfusions can be given over approximately 2 hours per unit. Where volume overload is a problem, consider slower transfusion and use of furosemide

UNIT 1	Blood component	Unit/mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here
			Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>	
	Reason for transfusion			
	Date	Duration	Prescriber signature	

Reassess before you progress!

UNIT 2	Blood component	Unit/mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here
			Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>	
	Reason for transfusion			
	Date	Duration	Prescriber signature	

Reassess before you progress!

UNIT 3	Blood component	Unit/mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here
			Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>	
	Reason for transfusion			
	Date	Duration	Prescriber signature	

Reassess before you progress!

UNIT 4	Blood component	Unit/mls	Special Requirements / Instructions (please tick)	Affix completed pink portion of compatibility label here
			Irradiated <input type="checkbox"/> CMV negative <input type="checkbox"/> Blood warmer <input type="checkbox"/> Other medication <input type="checkbox"/>	
	Reason for transfusion			
	Date	Duration	Prescriber signature	

RIGHT BLOOD → RIGHT PATIENT @ RIGHT TIME

Patient Name:

Date of birth:

CHI:

Transfusion Checklist - Please initial each box as checks are completed

	Pre-Collection Checks below to be completed before removing component from temperature controlled storage			Pre-administration			At Bedside		Post Transfusion		
Unit No.	Patient's ID band insitu	Patent IV access?	Blood prescribed? (check consent (p1) and if any special requirements (p2))	Date/Time component removed from temperature controlled storage	Inspect bag (condition & expiry date)	Baseline Obs (clearly show as 'baseline' obs on SEWS or agreed alternative observation chart)	Verbal ID (if patient able)	Check patient's ID band against component tag – all identification details	Date/Time Transfusion completed	Completion Observations: TPR & BP within 60 minutes of completion of last unit	Tag Completed & Returned to laboratory
1	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Transfusion must be completed within 4 hours of removing component from temperature controlled storage

If blood is not used / no longer required please return to transfusion laboratory or satellite blood fridge within 30 minutes of removal to prevent wastage

RIGHT BLOOD → RIGHT PATIENT @ RIGHT TIME



27/5/20

Observation Chart

NHS

Lothian

Consultant: _____

Date chart commenced: _____

This is chart number _____ this admission

Actual or estimated patient weight _____ kgs

ASU: _____

700629263X M 17/01/1957

Atkinson, Alexander D

Skinnergate Resettlement Unit,

16 Skinnergate,

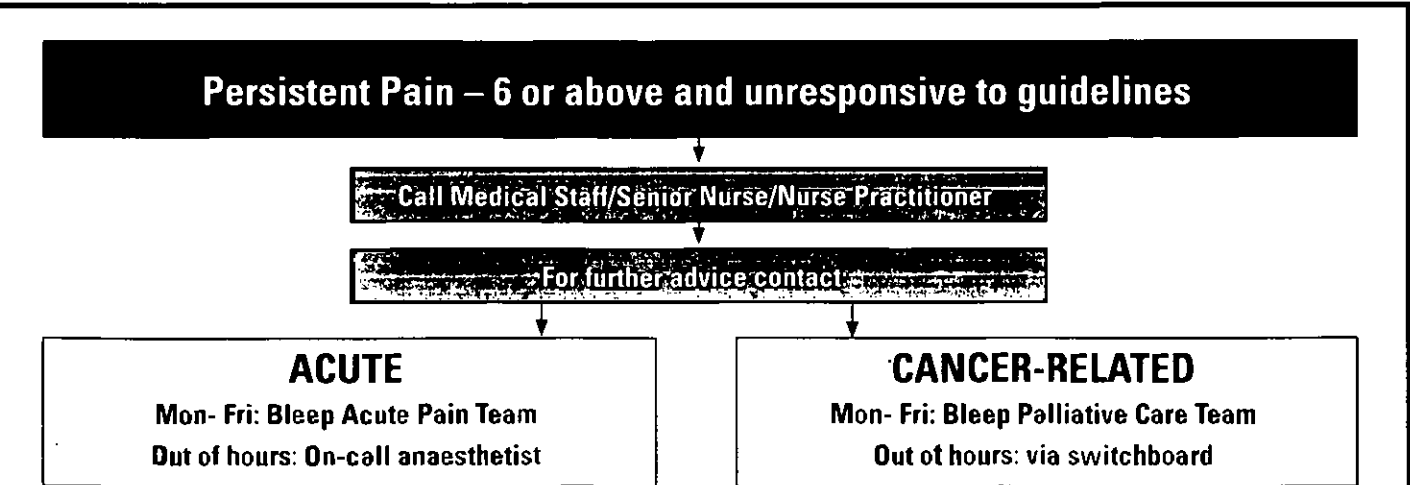
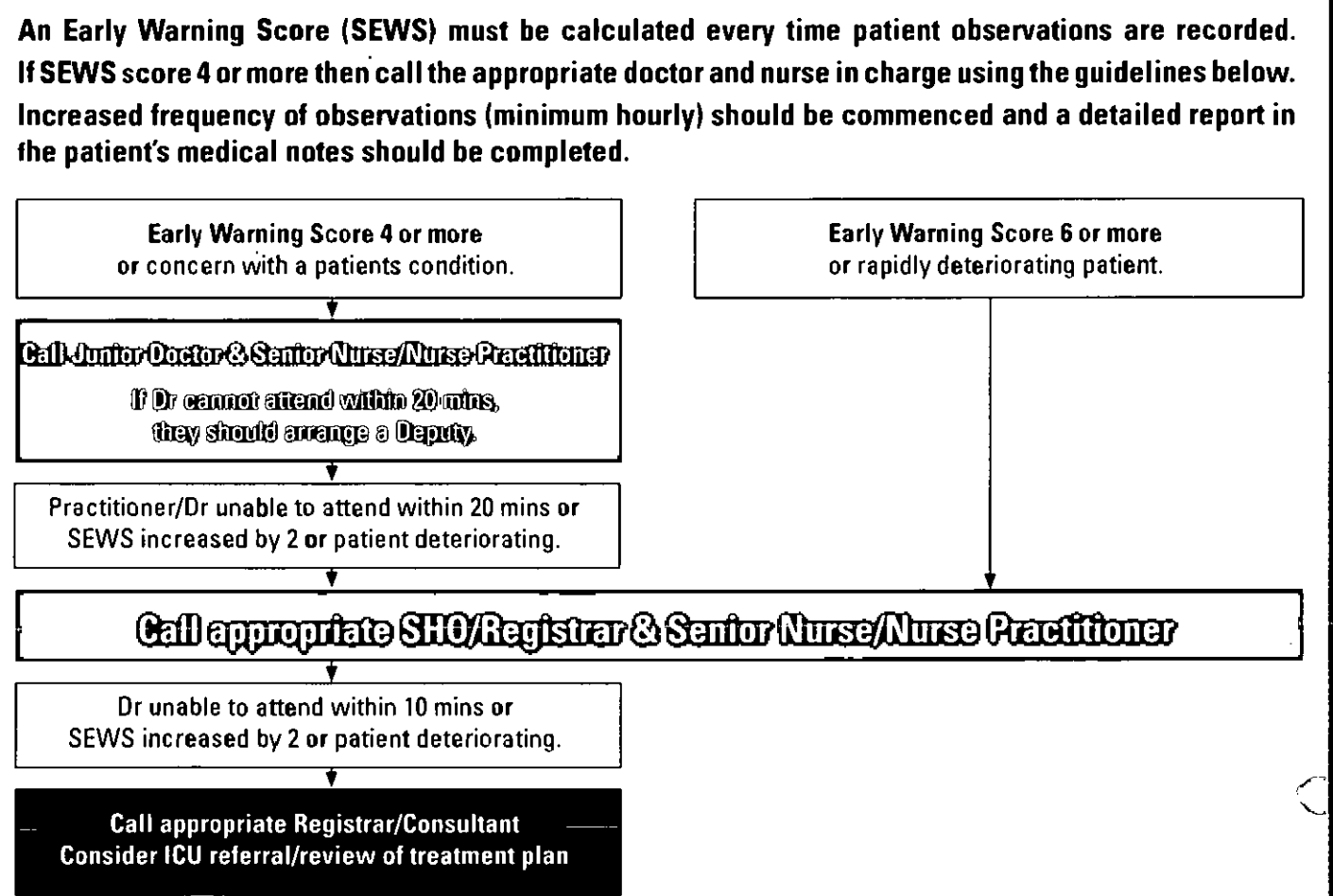
Perth,

Perthshire, PH1 5JH

CHI 1701570130

13975 LJ Compson

in here



How to calculate SEWS Score

- Do not add pain score to SEWS Score.
- Record standard observations (RR, SpO₂, Temp, BP, HR, AVPU).
- Note whether observation falls in shaded "At Risk Zone". Score as per SEWS key.
- Add points scored and record total "SEWS Score" in bottom row of chart.
- Action as per guidelines on front of chart.

If RR >24

Review patient / CXR +/- gases / PEF (Peak Expiratory Flow) etc → Definitive Therapy

If SpO₂ sats <93%

Review probe ? accurate

Review patient → prescribe oxygen on drug chart if indicated, consider ABGs.

If Temp >38

Blood cultures Other cultures Early antibiotic therapy if sepsis suspected.

If Systolic BP <100

Review monitoring (cardiac / oximetry / urine output / invasive BP etc).

IV Access

Review patient / drug kardex.

Consider:

IV fluid bolus and reassess.

TREAT UNDERLYING CAUSE

Consider:

Hypovolaemia Obstructive Distributive Cardiac

Dehydration PE Sepsis Arrhythmia

Blood loss Tamponade Anaphylaxis Pump failure

If Pulse >130

Review monitoring (cardiac monitor indicated)

IV Access

Review patient / ECG / electrolytes → Definitive Therapy

If responds to pain only or unresponsive

Assess airway, BM, GCS, neuro observation chart, review patient / kardex.

If BM <4

Give Oral Carbohydrate / IV Dextrose. Consider checking urgent laboratory blood glucose.

Pain Assessment & Management Guidelines

How to score pain:

Cancer-related pain:

Always score worst pain in last 24 hours or since last assessment.

Acute pain:

Score current pain on movement e.g. deep breathing.

Pain Score:

0 NDNE

1-3 MILD

4-5 MODERATE

6-10 SEVERE

Action:

Continue to assess pain with every set of observations (must be at least daily).

Continue to assess pain with every set of observations (must be at least daily).

Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

Assess. Using guidelines, prescribe/give analgesia as appropriate for the patient. Review.

PERSISTENT SEVERE PAIN (6 OR ABOVE), WHICH DISTRESSES THE PATIENT: REFER.

SEE FLOW CHART OVER.

Lothian Guidelines

Cancer-related pain:

Initiate Edinburgh Pain Assessment Tool (EPAT®) for pain score of 4 or above.

Use Palliative Care Guidelines.

Acute pain:

Use Acute Pain Guidelines.

Nausea Score (0-3)

0 = No Nausea

2 = Nausea/Vomiting (administer anti-emetic)

1 = Nausea (consider anti-emetic)

3 = Persistent Nausea &/or Vomiting (contact Dr).

PERSISTENT NAUSEA &/OR VOMITING: USING GUIDELINES PRESCRIBE/GIVE ANTI-EMETICS. REVIEW.

SEWS KEY 0 1 2 3			DATE:
RESP. RATE	≥36		
	31-35		
	21-30		
	9-20		
	≤8		
SpO ₂	≥93		
	90-92		
	85-89		
	<85		
Inspired O ₂ %	%		
Humidifier Temp	>39°		
TEMP	38°		
	37°		
	36°		
	35°		
	34°		
	210		
	200		
	190		
	180		
	170		
	160		
BLOOD PRESSURE	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
HEART RATE	>140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
	40		
SEDATION / NEURO SCORE	S Sleep		
	0 Alert		
	1 Verbal		
	2 Pain		
	3 Unresp		
UO<30mls/hr (3 hrs+)			
SEWS SCORE (with all obs)			
PAIN	Severe	9-10	
	Moderate	4-5	
	Mild	1-3	
	None	0	
	Nausea Score (0-3)		
BM			
Weight			
Bowels			
Orin Type -			
Wound			
Circulation			
Sensation			
Movement			

ECS - Live - Patient Report

Patient

Patient Name	CHI	Date Of Birth	Age	GP	GP Practice	GP Practice Code
Alexander Atkinson	1701570130	17/01/1957	56	COMPSON, LINDSEY	DRUMHAR HEALTH CENTRE	13975

Clinical Data

Last Emergency Care Summary received 24 April 2013

Allergy

Description	Date Recorded	Comments
-------------	---------------	----------

Acute Medication (within 30-days) Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date
	Trimethoprim 200mg tablets	14 tablet	1 TABLET TWICE A DAY	In Dose		22-Apr-2013
	Loperamide 2mg capsules	30 capsule	AS DIRECTED	In Dose		10-Apr-2013
	Ensure Plus Commence liquid assorted (Abbott Laboratories...	4400 ml	TWO CARTONS DAILY	In Dose		10-Apr-2013

Repeat Medication Medicines Reconciliation Report

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
✓	Bumetanide 1mg tablets	84 tablet	THREE TABLETS IN THE MORNING	In Dose	21-Jan-2013	03-Apr-2013		
✓	Warfarin 1mg tablets	60 tablet	2 ALTERNATE NIGHTS EVERY OTHER DAY NIGHTS	In Dose	03-Dec-2012	03-Apr-2013		
✓	Warfarin 3mg tablets	60 tablet	OTHER DAY NIGHTS	In Dose	03-Dec-2012	03-Apr-2013		
✓	Gabapentin 600mg tablets	28 tablet	1 TABLETS AT NIGHT	In Dose	28-Nov-2012	03-Apr-2013		
✓	Bisoprolol 10mg tablets	28 tablet	1 TABLET ONCE A DAY	In Dose	28-Nov-2012	03-Apr-2013		
✓	Lansoprazole 15mg gastro-resistant capsules	28 capsule	1 EVERY DAY	In Dose	05-Nov-2012	03-Apr-2013		
✓	Gabapentin 300mg capsules	56 capsule	1 CAPSULE TWO TIMES DAILY	In Dose	05-Nov-2012	03-Apr-2013		
	Digoxin 125microgram tablets	28 tablet	ONE EVERY DAY	In Dose	05-Nov-2012	03-Apr-2013		
	Bumetanide 1mg tablets	28 tablet	1 TABLET ONCE A DAY	In Dose	28-Nov-2012	07-Jan-2013		

☐ Patient does not want their GP to know about this access.

[Show All Medication Information](#)

PRESCRIPTION AND ADMINISTRATION RECORD

700629263X M. 17/01/1957

Hospital/Ward:	Consultant:	Nan
Weight:	Height:	CHI
DISCHARGE PRESCRIPTION		D.C.
Date completed:	Completed by:	

Atkinson, Alexander D
Skinnergate Resettlement Unit,
16 Skinnergate,
Perth,
Perthshire, PH1 5JH
CHI 1701570130
13975 LJ Compson

CODES FOR NON-ADMINISTRATION OF PRESCRIBED MEDICINE

If a dose is not administered as prescribed, initial and enter a code in the column with a circle drawn round the code according to the reason as follows:

Patient Refuses.....	1	Vomiting/nausea.....	8
Patient not present on ward.....	2	Time varied on Dr's instructions.....	9
Medicines not available.....	3	Once only/prn medication given.....	10
Instructions not clear or legal.....	4	Dose withheld on Dr's instructions.....	11
Nil by mouth.....	5	Possible drug reaction/side effect.....	12
Asleep/drowsy.....	6	Self administered by patient.....	13
Unable to swallow/Route not available.....	7	Other reasons.....	14

ONCE ONLY

Date	Time	Drug (Approved Name)	Dose	Method of Administration	Doctor's Signature	Time Given	Given By
1/5/13	2305	2081CLONE	3.75mg	PO		2330	OS
2/5/13	1000	Methadone	40mg	p.o.		1055	SL
2/5/13	1000	Gasapentia	300mg	p.o.		1055	SL
2/5/13	1000	Bumetranide	3mg	p.o.	SE/FUNKE	1055	SL
2/5/13	1000	Lamotopazole	15mg	p.o.		1055	SL
2/5/13	1030	Tenaxepam	60mg	p.o.		1055	SL
2/5/13	1220	VITAMIN JK	2mg	ORAL IV	DR. LUNDHISE DR. DE. DORHAN	1240	SL
2/5/13	2000	Paracetamol	1g	i.v.		2000	JP
3/5/13	0000	Paracetamol	1g	i.v.		0000	JP
3/5/13	0600	Paracetamol	1g	IV		0510	JP
3/5/13	0900	Furazem	20mg	PO		0930	JP
3/5/13	1030	Methadone	40mg	O		1200	SL
4/5/13	1430	DIGOXIN	125mcg	oral		1445	SL
6/5/13	2230	VITAMIN K	2mg	PO		2230	SL
7/5/13		Digoxin	125mcg	P.O		0500	SL
2/5/13	1105	DIGOXIN	100mg	SLC			SL

OTHER MEDICINE CHARTS IN USE

Date	Type of Chart
2/5/13	MORPHINE PCA

DRUG SENSITIVITIES

NIL KNOWN

Name: ALEXANDER ATKINSON B.O.B.: 170157 CHI Number: 0130

REGULAR THERAPY

Date →		1/5/13	2/5/13	3/5/13	4/5/13	5/5/13	6/5/13	7/5/13	8/5/13	9/5/13	10/5/13						
Time →																	
Drug (Approved Name) Paracetamol		6															
Dose 1 gram	Route PO	8		X	X	12	12	AP	AP	12	12						
Signature <i>[Signature]</i>	Start Date 8/5/13	14															
Notes	Pharmacy 3/5/13	18		X	X	12	12	AP	AP	12	12						
		22		X	X	12	12	AP	AP	12	12						
Drug (Approved Name) Senna		6															
Dose 2 Tabs	Route PO	8															
Signature <i>[Signature]</i>	Start Date 8/5/13	14															
Notes	Pharmacy 3/5/13	18															
		22															
Drug (Approved Name) METHADONE		6															
Dose 40mg	Route oral	8															
Signature <i>[Signature]</i>	Start Date 11/5/13	14															
Notes	Pharmacy 3/5/13	18															
		22															
Drug (Approved Name) GABAPENTIN		6															
Dose 300mg	Route oral	8															
Signature <i>[Signature]</i>	Start Date 11/5/13	14															
Notes back pain	Pharmacy 3/5/13	18															
		22															
Drug (Approved Name) GABAPENTIN		6															
Dose 600mg	Route oral	8															
Signature <i>[Signature]</i>	Start Date 11/5/13	14															
Notes	Pharmacy 3/5/13	18															
		22															
Drug (Approved Name) BUPRENORPHINE		6															
Dose 3mg	Route oral	8															
Signature <i>[Signature]</i>	Start Date 11/5/13	14															
Notes	Pharmacy 3/5/13	18															
		22															

prepack
41313

prepack

Phone
on Discharge
so get
Rx for
methad.

prepack

at
home

Name: ALEXANDER, ALEXANDER D.O.B.: 1/10/57 CHI Number: 0130

REGULAR THERAPY

		Date →	1/5	2/5	3/5	4/5	5/5	6/5	7/5	8/5	9/5						
		Time →															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															
Drug (Approved Name)		6															
Dose		8															
Route		10															
Signature		12															
Start Date		14															
Notes		18															
Pharmacy		22															

preparation

preparation

preparation
Dose
325
1/1/57
45-11

on 1/1/57
45-11

Name: ALEXANDER ATKINSON D.O.B.: 170157 CHI Number: 0130

WARFARIN CHART

Recommended target INRs and indications:

- INR 2-2.5 for prophylaxis of DVT including surgery on high risk patients.
- INR 2.5 for treatment of DVT and PE (or for recurrence in patients no longer receiving warfarin), AF, cardioversion, dilated cardiomyopathy, mural thrombus following MI, and for rheumatic mitral valve disease.
- INR 3.5 for recurrent DVT and PE (in patients currently receiving warfarin).

Indication	Target INR	Duration of treatment	Signature	Date
AF mechanical	2.5-3.5 ?	Lifelong	Mr HOR	1/5/13

Yellow anticoagulant booklet completed and issued: (*) on Warfarin prior to admission

Signature Wahel Date 6/5/13

[illegible]

REGULAR THERAPY

Date →	3/5	4/13	5/13	6/9	7/13	8/13	9/23
Time →	12	12	13	13	13	13	13
6	KL	KL	KL	KL	KL	KL	KL
8							
12							
14							
18							
22							
6	KL	KL	KL	KL	KL	KL	KL
8							
12							
14							
18							
22							
6	KL	KL	KL	KL	KL	KL	KL
8							
12							
14							
18							
22							
6	KL	KL	AP	AP	KL	GR	
8							
12							
14							
18							
22							
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18							
22							
6							
8							
12							
14							
18							
22							

REGULAR THERAPY

[illegible]

AS REQUIRED THERAPY

Drug (Approved Name)		Date
Morphine <i>(recw)</i>		
Dose + Frequency	Route	
2.5mg	IV	
Signature	Start Date	
<i>[signature]</i>	3/5	
Indication/Notes	Pharmacy	
For Pain		
Drug (Approved Name)		Date
Prochlorperazine		
Dose + Frequency	Route	
12.5mg 6 Hourly	IM	
Signature	Start Date	
Indication/Notes	Pharmacy	
For Nausea		
Drug (Approved Name)		Date
Morphine		
Dose + Frequency	Route	
10mg 2 Hourly	IM	
Signature	Start Date	
Indication/Notes	Pharmacy	
For Pain		
Drug (Approved Name)		Date
Dihydrocodeine		
Dose + Frequency	Route	
30mg 4 Hourly	PO	
Signature	Start Date	
<i>[signature] max 24mg/day not while on PCA</i>	3/5	
Indication/Notes	Pharmacy	
For Pain		
Drug (Approved Name)		Date
Ondansetron		
Dose + Frequency	Route	
4 - 4°	P.O.	
Signature	Start Date	
B.S.R.	2/5/13	
Indication/Notes	Pharmacy	
Nausea		
Drug (Approved Name)		Date
diazepam		
Dose + Frequency	Route	
2.5 - 5mg	IV/Po	
Signature	Start Date	
<i>[signature]</i>	2/5/13	
Indication/Notes	Pharmacy	
dormer		

PATIENT'S CASH & VALUABLES

Receipt No. 023235

Receipt for Patient's Cash & Valuables Held in Safe Custody By:-

~~*WARD~~/*CASHIERS DEPARTMENT/*~~OUT OF HOURS (NIGHT SAFE)~~

(*Circle as necessary)

Hospital R.I.E. Ward 102

Has the patient been advised that NHS Lothian cannot be held responsible for loss/damage/ theft of valuables NOT handed in for safe custody? – YES /NO (Delete as necessary)

PATIENT DETAILS

Name <u>Mr/Mrs/Ms/Miss (Delete as necessary)</u> <u>Alexander Arkinson</u>	Date of Birth <u>17.01.57</u>
Address <u>Skinnergate Rosetlement, 16 Skinnergate</u>	CHI No. <u>1701570130</u>
Post Code <u>Perth PH1 5JH</u>	Date of Admission

Line No.

1	Cash £ <u>220=00</u> = 2x £10 notes .
2	10 x £20 notes -
3	
4	
5	
6	
7	
8	

Certified that the above entries are a correct record of cash and valuables handed over for safe custody.

	Signature	Date
**Patient or Representative	<u>UNABLE TO SIGN</u>	
Nurse Receiving Property	<u>Evelyn Wynn</u>	<u>21/5/13</u>
Staff Witness	<u>[Signature]</u>	<u>21/5/13</u>

**In the event of a query please retain this copy.

Received K. Murray 02/05/13

WHITE (Top) – PATIENT COPY : GREEN (2nd) – CASHIERS COPY : PINK (3rd) – FUNDS OFFICE : YELLOW (4th) – WARD COPY

Transport Booking Form

Caller

Contact Name:	Contact Number:	Hospital	Ward	Base:
LENA	21021	RIE	102	A

Patient

First Name:	Surname:	CHI Number:	Time of Call:	Date of Call:
ALEXANDER	AITKINSON	1701570130	11:55	06/05/2013
Destination Address:	City:	Postcode:	Call Ref Number:	Out Of Area?
PERTH ROYAL INFIRMARY, WARD 6	PERTH	PH1 1NX	25463	YES

Background

Patient Diagnosis:	VALVE REPLACEMENT			
Clinically Fit for Journey:	YES	POC:	NO	DNAR Form:
Clinically Fit For Discharge Lounge:	NO	POC Start Time:		NO
Infection Status:	NONE	Mobility:	INDEPENDENT	
Falls Risk:	NO	Pharmacy Status:	WITH PATIENT	
Wanderer:	NO	Mental Status:	ALERT & ORIENTATED	
Behavioural Issues:	NO	Dietary Requirments:	NONE	
O2:	NONE	Allergies:	NO	
Domicillary O2:	NO	Allergies to		

Transport

Transport Date:	Patient Ready In Ward:	Pre-booked:	YES
09/05/2013	Time Transport Required:	Escort Needed:	NO
	09:00	Any Equipment:	NONE
Patient Weight (Kg):	67	Ambulance Transport Method:	IMC
Keys:	N/A	Transport Provider:	SAS (specify AM or PM)
Access:	RAMP	Complete For SAS:	AM
Number of Stairs:	0	Booking Reference:	5701511
Comments:	DIRECT ROUTE		
Cost Code:		Call Handlers:	ANDREW KERR
Authorising Name:		Status:	BOOKED
Clinical Management No:		Request Signed Off:	

Assessed at 0845 on reciept of booking -
SAS crew on ward at time collecting.
direct to transport nshonah clin