

Ward 103 & 114 Edinburgh Royal Infirmary Tel: 0131 242 1031/1141		NURSING TRANSFER SUMMARY		NHS Lothian	
Patient Name: Alan Soave		Date of Birth: 29/11/1957			
800183063V M SOAVE Alan 29-Nov-57 CHI: 291 157 1495 78010 AF Stephen 12 Morrison Way West Lothian EH54 8LJ 		Next of Kin Name: Maureen Soave Relationship: Spouse Address: 12 Morrison way Livingston. EH54 8LJ Telephone: Mobile: 07391 665 064 Work: Aware of Transfer: ☐ Yes ☐ No P45			
Reason for Admission: Inferior STEMI					
Treatment: PPCI - DES to Circumflex			Taking Medication: ☒ Yes ☐ No		
Medical History: Smoker					
Mobility: Independent			A.D.L Assessment: Independent		
Personal Hygiene: Independent					
Nutrition: No issues					
Elimination: No issues					
Pressure Care Area: No issues					
Communication: ☒ Alert & Orientated ☐ Disorientated					
Sleeping: No issues					
Additional Nursing Care Requirements: N/A					
Nurse: H. COWIE			Consultant: Dr Gibson		
Transfer From: RIE 114					
Transfer Date:					

Ward: 103		Site: 21E		Date: 09/10/21		Addressograph, or	
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency. 1hrly 2 hrly 3 hrly ____ hrly (please circle/complete) Print name and sign _____						Name	
						DOB	
						Unit no. / CHI	
						NHS Lothian	
						ALAN SOUVE 29/11/57.	
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent (NW) not on ward, (TH) Theatre,							
Time of Care Rounding							
Document the exact time care rounding took place e.g. 0830							
08.00 am ← 24 hour period → 07.00 am							
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review						
	Waterlow 10+ - Visual Skin Check (tick)						
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister						
	Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....						
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan						
Elimination	Have you changed position since last CR? Y Y Y						
	Positioning (R) or (L) side (B) Back (C) Chair C R B						
	Mattress type / Cushion type please state type:						
	Do you need the toilet? 10 AS 2						
	Is the patient continent of urine? (at time of Care Rounding) Y Y Y						
Food, Fluid & Nutrition	Continence product changed/offered? - - -						
	Catheter care performed? - - -						
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact						
	Is patient continent of faeces? (at time of Care Rounding) Y Y Y						
	Bowel function monitored Observe bowel function and update daily						
Falls	Would you like a drink? Y AS 2						
	Ensure fluids are within easy reach - - -						
	Fluid Balance Chart (if clinically indicated) - - -						
	When did you last eat? D D D						
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required						
Pain	Oral Hygiene Performed (ref to risk assessment) 10 AS 2						
	Appropriate Footwear? Y Y Y						
	Walking aid available(and within reach) - - -						
	Area de-cluttered? Y Y Y						
	Chair and bed height assessed? Y Y Y						
General	Falls alarm in use and attached? Y - -						
	Glasses available for use? (if worn) Y Y Y						
	Hearing aid available for use? (if worn) Y - -						
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐						
	Are you in pain? 2 2 AS						
Analgesia Given? 2 2 2							
Peripheral Venous Cannula observed? 2 2 2							
Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily							
Are you comfortable? Y/N Y 10 2							
Anything else I can do for you? Y AS 2							
Buzzer within easy reach Y Y Y							
Personal Care Type _____ (specify) Time Given _____							
Initials - document at time of care delivery							
D 2 2 2							

PRESCRIPTION AND ADMINISTRATION RECORD

including the Warfarin Chart



Hospital/Ward: R1E 114 Consultant: Dr Bing Weight: Height: If re-written, date: DISCHARGE PRESCRIPTION Date completed: Completed by:	Name of Patient: SOAVE Alan CHI Number: 29-Nov-57 CHI: 291 157 1495 78010 AF Stephen 12 Morrison Way West Lothian D.O.B. 29 EH54 8LJ
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OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known (tick box) ☒			
		Medicine / Agent / Food / Other	Description of reaction		

Risk assessment for Venous Thromboembolism (VTE) has been completed ☐

Outcome: No action required ☐ TEDS ☐ LMWH/heparin (please prescribe) ☐

- Write clearly in block capitals, using a black ballpoint pen
 - Use approved names for medicines
 - Never alter a prescription
 - Route of administration
- The only acceptable abbreviations are:
- | | | |
|--------------------|-----------------|------------------|
| IV - intravenous | SL - sublingual | NG - nasogastric |
| IM - intramuscular | PR - per rectum | ID - intradermal |
| SC - subcutaneous | PV - per vagina | TOP - topical |
| INHAL - inhaled | NEB - nebulised | |
- Never abbreviate ORAL or INTRATHECAL
Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
- The only acceptable abbreviations are:
- g - gram mg - milligram ml - millilitre
 - all other doses must be written out in full eg. micrograms
 - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
 - Prescribe liquids by writing the dose in mg
 - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
 - Write units as 'units' not 'iu'

ONCE ONLY

Date	Time	Medicine (Approved Name)	Dose	Route	Prescriber - Sign + Print	Time Given	Given By
08/10	0710	Heparin	4000 units	IV	<i>[Signature]</i>	0710	CM/
		Tirofiban	80mg	IV	<i>[Signature]</i>	0735	CM/
8/10	post tirofiban infusion	PRASUGREL	60mg	ORAL	<i>[Signature]</i>	21:15	PS.
09/10	1030	Levofloxacin	75mg	PO	<i>[Signature]</i>	1040	R

REGULAR THERAPY

Name of Patient: _____

CHI Number: _____

D.O.B.: _____

(Attach printed label here)

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 shown below. Inform the responsible doctor in the appropriate timescale.

- | | |
|---|---|
| 1. Patient refuses | 6. Vomiting / nausea |
| 2. Patient not present | 7. Time varied on doctor's instructions |
| 3. Medicines not available - CHECK ORDERED | 8. Once only / as required medicine given |
| 4. Asleep / drowsy | 9. Dose withheld on doctor's instructions |
| 5. Administration route not available - CHECK FOR ALTERNATIVE | 10. Possible adverse reaction / side effect |

	Start		Route		Prescriber - Sign + Print	Administered by	Stop	
	Date	Time	Mask (%)	Prongs (l/min)			Date	Time
O X Y G E N								

PRESCRIPTION		Patient's Own Medicine	Date →	8/10	9/10	10/10												
			Time →	8/10	9/10	10/10												
Medicine (Approved Name)	For Use	Date	6															
Tirolfiban			8															
Dose	Route	Quantity	12															
144 ml/hr	IV																	
Notes/Indication for antibiotic	Start Date	Stop Date	14															
	08/10																	
Prescriber - sign + print	Pharmacy		18															
			22															
Medicine (Approved Name)	For Use	Date	6															
Aspirin			8															
Dose	Route	Quantity	12															
75	✓																	
Notes/Indication for antibiotic	Start Date	Stop Date	14															
	6/10																	
Prescriber - sign + print	Pharmacy		18															
			22															
Medicine (Approved Name)	For Use	Date	6															
Amidex			8															
Dose	Route	Quantity	12															
75	✓																	
Notes/Indication for antibiotic	Start Date	Stop Date	14															
	8/10																	
Prescriber - sign + print	Pharmacy		18															
			22															
Medicine (Approved Name)	For Use	Date	6															
ATORVASTATIN			8															
Dose	Route	Quantity	12															
80mg	ORAL																	
Notes/Indication for antibiotic	Start Date	Stop Date	14															
	8/10																	
Prescriber - sign + print	Pharmacy		18															
			22															

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine	Date →	8/10	9/10	10/10														
			Time →																	
Medicine (Approved Name) <i>Atorvastatin</i>		For Use	6																	
Dose <i>40mg</i>		Route <i>oral</i>	Date 8																	
Notes/Indication for antibiotic		Start Date <i>8/10/21</i>	Stop Date	12																
Prescriber - sign + print <i>Plkibin</i>		Pharmacy	14																	
			18																	
			22																	
Medicine (Approved Name) <i>Ramipril</i>		For Use	6																	
Dose <i>2.5mg</i>		Route <i>oral</i>	Date 8																	
Notes/Indication for antibiotic		Start Date <i>9/10/21</i>	Stop Date	12																
Prescriber - sign + print <i>Plkibin</i>		Pharmacy	14																	
			18																	
			22																	
Medicine (Approved Name) <i>PRASUGREL</i>		For Use	6																	
Dose <i>10mg</i>		Route <i>ORAL</i>	Date 8																	
Notes/Indication for antibiotic		Start Date <i>09/10</i>	Stop Date	12																
Prescriber - sign + print <i>KB</i>		Pharmacy	14																	
			18																	
			22																	
Medicine (Approved Name) <i>Bupropion</i>		For Use	6																	
Dose <i>1.25</i>		Route <i>5</i>	Date 8																	
Notes/Indication for antibiotic		Start Date	Stop Date	12																
Prescriber - sign + print <i>3</i>		Pharmacy	14																	
			18																	
			22																	
Medicine (Approved Name) <i>Levetiracetam</i>		For Use	6																	
Dose <i>750mg</i>		Route <i>PO</i>	Date 8																	
Notes/Indication for antibiotic		Start Date	Stop Date	12																
Prescriber - sign + print <i>-BUOTE</i>		Pharmacy	14																	
			18																	
			22																	
Medicine (Approved Name) <i>Nicotine Patch</i>		For Use	6																	
Dose <i>21mg/14hr</i>		Route <i>Top</i>	Date 8																	
Notes/Indication for antibiotic		Start Date	Stop Date	12																
Prescriber - sign + print <i>-BUOTE</i>		Pharmacy	14																	
			18																	
			22																	

AS REQUIRED
THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine
Medicine (Approved Name)	For Use	Date
<i>GTN spray</i>		Time
Dose + frequency + max	Route	Quantity
	<i>5/100</i>	Dose
Indication + notes	Start Date	Initials
<i>chest pain</i>	<i>8/10</i>	Date
Prescriber - sign + print	Pharmacy	Time
<i>[Signature]</i>		Dose
		Initials
Medicine (Approved Name)	For Use	Date
<i>Paracetamol</i>		Time
Dose + frequency + max	Route	Quantity
<i>1 gram</i>	<i>oral</i>	Dose
Indication + notes	Start Date	Initials
	<i>8/10</i>	Date
Prescriber - sign + print	Pharmacy	Time
<i>[Signature]</i>		Dose
		Initials
Medicine (Approved Name)	For Use	Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
Indication + notes	Start Date	Initials
		Date
Prescriber - sign + print	Pharmacy	Time
		Dose
		Initials
Medicine (Approved Name)	For Use	Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
Indication + notes	Start Date	Initials
		Date
Prescriber - sign + print	Pharmacy	Time
		Dose
		Initials
Medicine (Approved Name)	For Use	Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
Indication + notes	Start Date	Initials
		Date
Prescriber - sign + print	Pharmacy	Time
		Dose
		Initials
Medicine (Approved Name)	For Use	Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
Indication + notes	Start Date	Initials
		Date
Prescriber - sign + print	Pharmacy	Time
		Dose
		Initials

**REGULAR
THERAPY**

Name of Patient: _____

CHI Number: _____

D.O.B.: _____

(Attach printed label here)

Page 4 of 6

Intravenous Infusion Chart

Consultant		Name of Patient	
Hospital/Ward		Patient Number	Or affix patient label
Weight		DOB	

Refer to Preparation and Administration of Parenteral Medicines manual (or manufacturer's package insert) for details of infusion fluid, concentration of final solution and rate of administration.

Medicine (Approved Name)	Total Dose	Infusion Fluid	Final Concentration	Route	Prescribed / Transcribed By Sign + Print

Infusion Rate Instructions					
	Date	Time	Rate ml/hr	Prescribed / Transcribed By Sign + Print	Comment / Reason for Change
Initial Rate					
Change 1					
Change 2					
Change 3					
Change 4					
Change 5					
Change 6					
Change 7					
Change 8					

If required, continue on a separate sheet.

Variable Rate Infusion Instructions
e.g. insulin sliding scale (must be prescribed, or protocol to be followed stated) Prescribed / Transcribed By Sign + Print: Date:

Other Instructions e.g. blood pressure parameters, APPT check	
Prescribed / Transcribed By Sign + Print: Date:	

Intravenous Infusion Chart

Consultant	Dr Bing	Name of Patient	Allan soave.
Hospital/Ward	RIE 114.	Patient Number	Or affix patient label
Weight	80kg	DOB	29/11/57.

Refer to Preparation and Administration of Parenteral Medicines manual (or manufacturer's package insert) for details of infusion fluid, concentration of final solution and rate of administration.

Medicine (Approved Name)	Total Dose	Infusion Fluid	Final Concentration	Route	Prescribed / Transcribed By Sign + Print
Tirofiban				IV	

Infusion Rate Instructions					
	Date	Time	Rate ml/hr	Prescribed / Transcribed By Sign + Print	Comment / Reason for Change
Initial Rate	8/10	0735	80ml/h.		Bolus
Change 1	8/10	0740	14.4ml/h		maintenance
Change 2					
Change 3					
Change 4					
Change 5					
Change 6					
Change 7					
Change 8					

If required, continue on a separate sheet.

Variable Rate Infusion Instructions
e.g. insulin sliding scale (must be prescribed, or protocol to be followed stated)
Prescribed / Transcribed By Sign + Print: Date:

Other Instructions e.g. blood pressure parameters, APPT check
Prescribed / Transcribed By Sign + Print: Date:

MI AUDIT FORM

DATE: 8/10/21

Affix Addressograph

Name: Alan ~~Boyle~~ Soave

D.o.B. 29/11/57

CHI No: 1495



PPCI DATA

INCIDENT NO:	FIRST CALL FOR HELP:
ONSET OF SYMPTOMS:	CREW ON SCENE:
1 ST ECG __: __	GP/SAS/A&E/DGH
RIE ADMISSION __: __	CCU/LAB/A&E/WARD/OTHER
DIAGNOSTIC ECG __: __	INF/ANT/SEPT/POST/LAT
TEAM CALLED 06:13	TEAM ARRIVES 06:40
PATIENT ETA 06:45	PATIENT ARRIVAL 06:55
PATIENT SENT FOR __: __	PATIENT IN LAB 06:55
TIME OF THERAPY 07:15	DOOR TO THERAPY: 23 mins
ECG TO THERAPY:	PAIN TO THERAPY:
CALL FOR HELP TO THERAPY:	
DELAYS PPCI>30 MINS (DOOR)	DELAYS PPCI> 90 MINS (ECG)
Team -	Team-
Lab-	Lab-
Sas-	Sas-
Transfer-	Transfer-
Other-	Other-

DRUGS

ASPIRIN	
CLOPIDOGREL	
HEPARIN	
TIROFIBAN/INTEGRILLIN	
MORPHINE	
METOCLOPRAMIDE	

NO PCI/TNK

ESTABLISHED	
CONSERVATIVE MANAGEMENT	
OTHER	

TNK

BGH/FVH/VHK/QMH/WGH
TIME OF LYSIS - __: __
A&E/CCU/SAS
CALL TO NEEDLE __: __
PAIN TO NEEDLE __: __
ECG TO NEEDLE __: __
DOOR TO NEEDLE __: __
DELAYS D-N >30 MINS:

GRACE SCORE <24 HOURS POST ADMISSION

****THERAPY – BALLOON OR ASPIRATION CATHETER****

SIGNATURE

K. McKel

PRIMARY PCI CATH LAB CARE PLAN



Affix Addressograph

Name: Alan

D.o.B. 29/11/57

CHI No:

Date of Procedure: 08/10/21

Named Nurse: Ciaran

Consultant: Dr Bing

Pre-Procedure

Aspirin	300	Morphine/Anti-emetic	10mg/4mg
Clopidogrel	600	Oxygen Therapy	RA
Heparin	5000	NOK aware	Y/N
Tirofiban		Diagnostic ECG	Time-
Diabetic	Y/N	Area of Infarct	Inferior

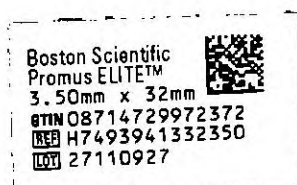
VERBAL CONSENT TAKEN BY Dr Bing

Peri-Procedure

Ensure patient is secured and comfortable on table.	✓
Ensure patient dignity at all times.	✓
Monitor vital signs and react appropriately.	✓
Reassure patient and offer pain relief if appropriate.	✓
Adverse events and actions taken documented.	✓

Post Procedure

Drugs prescribed and infusion charts complete.	✓
ECG performed in lab?	Y/N
Patient monitored for transfer	yes
Clopidogrel card completed.	Y/N
Vessel Treated - CX	DES/BMS
Tirofiban for hours.	
Procedure discussed with patient?	Y/N



Signed [Signature] Date 08/10/21

CARE OF SHEATH

Sheath Removal

Radial

Radial pulse present:

Yes No

If NO details

Haematoma:

Yes No

If YES details

TR Band care plan completed

Yes No

Femoral

Posterior tibial or pedal pulses present

Yes No

If NO details

Patient informed of post sheath removal care

Digital pressure applied for minimum of 10mins

Haemostasis achieved

Femoral or angioseal care plan completed

Sheath Insitu

Sheath with obturator sutured in place

Cap secured to 3-way-tap on side arm of sheath

Sheath clearly labelled

Haematoma or oozing from sheath site

Yes No

If YES details

Sheath to be removed after 4 hours:

Yes No

If NO details

Signature.....

Print:

Cardiology Ward 114 – 24 hour chart

Date : 8/10/21.

800183063V M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
12 Morrison Way West Lothian
EH54 8LJ

date of admission 8/10/2
Consultant DR GIBSON

[illegible]

Continuation

		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7	Ward Name
		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA					RA					RA		Coronary Care Unit RIE
		95	94	94						94	93	94	93	93										95		Name
		16								15	12	20	13	17					18					14		DOB
																										CHI
		36.4								36.9		36.9		37.0										37.0		
																										BLOOD RESULTS
		SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR					SR				SR	SR		Time
																										O2
																										H+
																										pCO2
																										pO2
																										HCO3 stand
																										BE
																										Urea
																										Na
																										K+
																										creatinine
																										egfr
																										magnesium
																										glucose
																										Troponin
																										Hb
																										WCC
																										Platelets
																										APTT
																										INR

		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7	Ward Name
		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA					RA					RA		Coronary Care Unit RIE
		95	94	94						94	93	94	93	93										95		Name
		16								15	12	20	13	17					18					14		DOB
																										CHI
		36.4								36.9		36.9		37.0										37.0		
																										BLOOD RESULTS
		SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR					SR				SR	SR		Time
																										O2
																										H+
																										pCO2
																										pO2
																										HCO3 stand
																										BE
																										Urea
																										Na
																										K+
																										creatinine
																										egfr
																										magnesium
																										glucose
																										Troponin
																										Hb
																										WCC
																										Platelets
																										APTT
																										INR

Cardiology Ward 114 – 24 hour chart

Date : 09/10/21

Name: Alan Souve

d.o.b: 29/11/57

CHI: -1495

Affix addressograph here

date of admission 8/10/21

Consultant: Dr Gibson

[illegible]

		8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7	Ward Name
		Coronary Care Unit RIE																								
		Name																								
		DOB																								
		CHI																								
		BLOOD RESULTS																								
		Time																								
		O2																								
		H+																								
		pCO2																								
		pO2																								
		HCO3 stand																								
		BE																								
		Urea																								
		Na																								
		K+																								
		creatinine																								
		egfr																								
		magnesium																								
		glucose																								
		Troponin																								
		Hb																								
		WCC																								
		Platelets																								
		APTT																								
		INR																								
		Pacemaker																								
		Mode																								
		Rate																								
		Threshold																								
		Output																								
		Underlying rhythm and rate:																								
TOTAL IN																										
Urine																										
TOTAL URINE																										
Other (specify)																										
TOTAL OUT																										
BALANCE																										
Circulation checks																										
PP L/R																										
Colour																										
Temp																										
Wound site																										
TR band																										
Femstop																										
COMMENTS																										

10

LOT 1651

Continuation

CHI: DATE:

TIME		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	
RESPIRATORY	FiO ₂																28	75	70	60	50	50	50	50		
	SpO ₂																92	92	98	95	93	95	93	92	91	Secretions
	ETCO ₂																									
	Mode																NHF	HFV	HFV	HFV	HFV	HFV	HFV	HFV	HFV	Mucoid MPucopurulent Purulent Bloodstained
	Set Respiratory Rate																	18	24	17	27	26	12	17	27	28
	Total Respiratory Rate																									
	Set Tidal Volume																									
	Expired Tidal Volume																									
	Minute Volume																									
	Peak Pressure / P High																									
	ASB / PS																									
	PEEP / CPAP / P Low																									
	I:E Ratio																									
	T high / T low																									
	HFNC Flow Rate																									
	30° Head Up																									
	Humidifier temp																									
	Inner tube change																									
	Cough / deep breath																									
	Suction																									
Subglottic drainage																										
Air Entry (R/L)																										
ETT Length																										
ETT pressure areas																										
Anchorfast (R/M/L)																										
IPPB / Cough assist																										
Fine bore suction/oral																										
TPR	Temp																									
	HR																									
	MAP																									
	ABP																									
	NIBP																									
	Cardiac Rhythm																									
	CVP																									
	PAP																									
	CCO																									
	Cardiac Index																									
SV / PPV																										
Peripheral Circulation																										
Angioseal check (L/R)																										
E	Blood Glucose																									
	Pain Score																									
	R.A.S.S																									
	GCS Eyes																									
	GCS Verbal																									
	GCS Motor (L/R)																									
	Total GCS																									
	CAM-ICU (+/-)																									
	Pupil size/reaction R																									
	Pupil size/reaction L																									
NEURO	NPI (R/L)																									
	ICP																									
	CPP																									
	ICP Treatment																									
	CSF (ml/hr)																									
	CSF Drain Set (cmH ₂ O)																									
	Brain PbO ₂ (mmHg)																									
	Brain Temp (°C)																									
	Lower Limb Power (L/R)																									
	CARE	Pressure care																								
Oral care (4 hourly)																										
Limb physiotherapy																										
Eye Care																										
Bloods sent (stickers)																										
Specimens sent																										
Drug Levels Required																										

Soave, Alan
28/11/1987 0019003V
SHCT4281985 SJH Red ITU - No
Green cap blood trace SJH

Soave, Alan
28/11/1987 0019003V
SHCT4281985 SJH Red ITU - No
Green cap blood trace SJH

Soave, Alan
28/11/1987 0019003V
SHCT4281985 SJH Red ITU - No
Green cap blood trace SJH

22 23 24 01 02 03 04 05 06 07

no admission
bloody urine, etc.

cool drugg
w/ab meds

22 23 24 01 02 03 04 05 06 07

Chest Drains
Swinging
Static
Bubbling
Bloodstained
H5
Haemoserous
Serous

CHI:		DATE:																									
Peripheral or Central (circle as appropriate)		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07		
D R U G I N F U S I O N S	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
	Pump No:	Volume Infused																									
	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
	Pump No:	Volume Infused																									
	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
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	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
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	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
	Pump No:	Volume Infused																									
	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
	Pump No:	Volume Infused																									
	Drug	Rate (ml/hr)																									
	Peripheral/Central Concentration:	Level																									
Pump No:	Volume Infused																										
TPN	Rate (ml/hr)																										
Peripheral/Central Concentration:	Level																										
Pump No:	Volume Infused																										
Hourly infusion Checks (initial)																											
Sub Total infusions																											
F L U I D S I N	Crystalloids																										
	Colloids																										
	Blood Products	W/Drawn																							25 25		
	IV Medication																										
	PCA																										
	Epidural																										
	Flush Bag (0.9% NaCl)																3	3	3	3	3	3	3	3	3		
	NG / NJ / Jejunal																										
	Gastric Aspirate pH																										
	Oral Medication																										
Oral																	200						200				
Total Intake																	263	259	212	215	218	221	544	469			
O U T P U T	Urine																230	100	140	160	200	180	120	80	40		
	Net UF CVVHD (reset hourly)																										
	Drain 1	Observations																									
	Location:	Level																									
	Hourly Amount Drained																										
	Drain 2	Observations																									
	Location:	Level																									
	Hourly Amount Drained																										
	Drain 3:	Observations																									
	Location:	Level																									
	Hourly Amount Drained																										
	Drain 4:	Observations																									
	Location:	Level																									
	Hourly Amount Drained																										
	Drain 5:	Observations																									
	Location:	Level																									
	Hourly Amount Drained																										
CSF drain output (hourly)																											
Nasogastric aspirates/drained																											
Blood Loss																											
Bowels																											
Cumulative balance (72hours)		Total Output															230	330	470	630	830	1010	1130	1210	1250		
mls		Balance																									
C V V H D	Blood Flow (mls/min)																										
	Dialysate flow (mls/hr)																										
	Access Pressure (mmHg)																										
	Return Pressure (mmHg)																										
	Pre-filter pressure (mmHg)																										
	Citrate Infusion (mmol/L)																										
	Calcium Infusion (mmol/L)																										
	Post filter iCa (6 hrly Blue port)																										
	Systemic iCa (6 hrly A-Line)																										
	Total Ca (check daily- <3mmol)																										
	T:I ratio (Total Ca ÷ Ionised Ca) (check daily - < 2.5)																										
	Changes made																										
	Initials																										
Totals reset hourly (initial)																											
		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07		

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen
800183063V M 29/11/1957

Ward: **mk100**

Date: **02/12/23**

Day No:

Consultant:

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patient's clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

- 0 None**
Continue to assess pain at least daily
- 1-3 Mild**
Continue to assess pain with routine observations, must be at least daily
- 4-5 Moderate**
Assess, administer and review analgesia as appropriate for patient
- 6-10 Severe**
Assess, administer and review analgesia as appropriate for patient

Using appropriate Lothian Guidelines

Nausea Score

- 0 - No Nausea**
- 1 - Nausea**
Consider anti-emetic
- 2 - Nausea / Vomiting**
Administer anti-emetic
- 3 - Persistent Nausea &/or Vomiting**
Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

- A** - The patient is **awake**
- V** - The patient responds to **verbal** stimulation
- P** - The patient responds to **painful** stimulation
- U** - The patient is **completely unresponsive**



NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.

NEWS $\geq$ 3 AND SIRS 2
(see observation chart for details)

Time:

With clinical signs of infection:

THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Voice/Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Weight (kg)

Essential

Addressograph

Name:

DOB:

CHI:

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
Fluid Balance																								
IVI 1																								
IVI 2																								
Tot Drugs									100															
Drugs																								
Naso Gastric / PEG																								
Oral		200	200	150	200	200		50	150	100		150												
Hourly Total																								
Cumulative Input						750	950		1100	1250	1350		1500											
Urine	3		300			320		200	200	210	100	200		150				340						
Gastric																								
Bowels																								
Other																								
Cumulative Output						670			1020	1230	1330	1550		1730										
Cumulative Balance																								

Fluid Balance:

Today:

Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started: _____ Date and time discontinued: _____
 Mask size: _____ Target SpO₂: _____
 Is BiPAP/CPAP ceiling of care? Y / N _____ DNA CPR in place Y / N _____

Date/Time	ABG/CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Weight (kg)

Essential

800183065 V M 29/11/1951

Soave, Alan

34 Southpark Place,

Livingston,

West Lothian, EH54 6FG

CHI 2911571495

78010 AF Stephen

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤ 132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥ 75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
IVI 1																								
IVI 2																								
Co-amoxicillin IV Drugs			100						20								20							
Clarithromycin IV Drugs				250													250							
Naso Gastric / PEG																								
Oral	0	0	300	0	100	100	150	100	150	300	150	300	150	60			100	500						250
Hourly Total	0	100	550	550	100	100	150	100	170	300	150	200	150	60										
Cumulative Input	0	100	650	650	750	850	1000	1100	1270	1570	1720	2020	2170	2230			2600	3100						3350
Urine			150	80	50	150	100	80	150	50	90	85	120	60	70	90	85	240	60	60	100	100	100	250
Gastric																								
Bowels																								
Other																								
Cumulative Output			150	230	280	430	530	610	760	810	900	985	1105	1165	1235	1325	1410	1650	1710	1770	1870	1970	2070	
Cumulative Balance																								

Fluid Balance: INTAKE - 3350 OUTPUT - 2070 +ve 1280

Today: Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started:

Mask size:

Is BiPAP/CPAP ceiling of care? Y / N

Date and time discontinued:

Target SpO2:

DNA CPR in place Y / N

Date/ Time	ABG/ CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

- Setting Ti max
1. Measure the patient's respiratory rate during assisted ventilation
 2. Refer to table column entitled COPD Ti max
 3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
 4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitats a Ti max <1.2 seconds, the back-up rate should be increased
 5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO ₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO ₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO ₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart

Ward: mhd4

Date: 29/11/23

Consultant:

Day No: 2



800183063 V M 29/11/1957
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of or individual parameter of is acceptable for this patient because

Please escalate if

Print Sign Designation
Date Time (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patient's clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart



NEWS of 5 or more?
Think Sepsis!

In a patient with a NEWS of 5 or more and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and escalate care immediately.

NEWS >=3 AND SIRS 2
(see observation chart for details)

Time:

With clinical signs of infection:
THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

- 0 None**
Continue to assess pain at least daily
- 1-3 Mild**
Continue to assess pain with routine observations, must be at least daily
- 4-5 Moderate**
Assess, administer and review analgesia as appropriate for patient
- 6-10 Severe**
Assess, administer and review analgesia as appropriate for patient

Using appropriate Lothian Guidelines

Nausea Score

- 0 - No Nausea**
- 1 - Nausea**
Consider anti-emetic
- 2 - Nausea / Vomiting**
Administer anti-emetic
- 3 - Persistent Nausea &/or Vomiting**
Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

- A - The patient is awake**
- V - The patient responds to verbal stimulation**
- P - The patient responds to painful stimulation**
- U - The patient is completely unresponsive**

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4+ on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



800183063V
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen

Ward: **M40V**

Date: **28/11/23**

Consultant: **HRG**

Day No:

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____ is acceptable for this patient because

AM SaO₂ 71.92%

Please escalate if

Print **Gruber** Sign **Heuer** Designation **CONS**
Date **28/11/23** Time **1530** (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patient's clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart



NEWS of 5 or more?
Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.

NEWS $\geq$ 3 AND SIRS 2
(see observation chart for details)

Time:

With clinical signs of infection:
THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

- 0 None**
Continue to assess pain at least daily
- 1-3 Mild**
Continue to assess pain with routine observations, must be at least daily
- 4-5 Moderate**
Assess, administer and review analgesia as appropriate for patient
- 6-10 Severe**
Assess, administer and review analgesia as appropriate for patient
- Using appropriate Lothian Guidelines**

Nausea Score

- 0 - No Nausea**
- 1 - Nausea**
Consider anti-emetic
- 2 - Nausea / Vomiting**
Administer anti-emetic
- 3 - Persistent Nausea &/or Vomiting**
Contact Doctor
- Using guidelines prescribe / give anti-emetics and review**

AVPU

- A - The patient is awake**
- V - The patient responds to verbal stimulation**
- P - The patient responds to painful stimulation**
- U - The patient is completely unresponsive**

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO ₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

NEWS2 Key 0 1 2 3

Date: 28/11/23 Time: 15:20

Respirations 25-30

Breaths/min 15-17

SpO2 Scale 1 92

SpO2 Scale 2 92

Air or Oxygen? A = Air

Blood Pressure mmHg 126/78

Pulse Beats/min 113

Consciousness Alert

Temperature 37.3

NEWS TOTAL 10

Monitoring frequency 10

Escalation of care Y/N Y

Heart rate: Rhythm ST

C.V.P. -

Suction Y/N -

Secretions (see scale) -

Pain score (0-10) 0

Nausea score (0-3) 0

Blood Glucose level or N/A -

GLASGOW COMA SCALE

Eyes Open 4

Verbal Response 5

Motor Response 6

GCS TOTAL 15

PUPILS

R Size Reaction

L Size Reaction

ARMS

LEGS

Pupil Scale (mm)

1 2 3 4 5 6 7 8

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)
PLASMAlyte	1000	IV	100	16:20		JHNSTON	

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation							

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

Fluid Balance		06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
PLASMAlyte	IVI 1												100	100	100	100	100		100	100	100	100	100		
abx	IVI 2																	270							
	Drugs																								
	Drugs																								
	Naso Gastric / PEG																								
	Oral												350		200										
	Hourly Total												450				50								
	Cumulative Input												500		650	950									
	Urine										330		210	80	100	70	70	100	120	100	220				
	Gastric																								
	Bowels																								
	Other																								
	Cumulative Output												540	620	720										
	Cumulative Balance																								

Fluid Balance:	
Today:	Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started: _____ Date and time discontinued: _____
 Mask size: _____ Target SpO₂: _____
 Is BiPAP/CPAP ceiling of care? Y / N _____ DNA CPR in place Y / N _____

Date/Time	ABG/CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



Addressograph
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG
CHI 2911571495
78010 AF Stephen
8/00183063V M 29/11/1957

Ward: MHDU

Date: 30/11/23

Day No:

Consultant:

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of or individual parameter of is acceptable for this patient because

Please escalate if

Print Sign Designation
Date Time (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

REMEMBER

- Record all observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - CALL FOR HELP

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to Scottish Palliative Care Guidelines

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to Acute Pain Guidelines

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

- 0 None
Continue to assess pain at least daily
- 1-3 Mild
Continue to assess pain with routine observations, must be at least daily
- 4-5 Moderate
Assess, administer and review analgesia as appropriate for patient
- 6-10 Severe
Assess, administer and review analgesia as appropriate for patient
- Using appropriate Lothian Guidelines

Nausea Score

- 0 - No Nausea
- 1 - Nausea
Consider anti-emetic
- 2 - Nausea / Vomiting
Administer anti-emetic
- 3 - Persistent Nausea &/or Vomiting
Contact Doctor
- Using guidelines prescribe / give anti-emetics and review

AVPU

- A - The patient is awake
- V - The patient responds to verbal stimulation
- P - The patient responds to painful stimulation
- U - The patient is completely unresponsive



NEWS of 5 or more?
Think Sepsis!

In a patient with a NEWS of 5 or more and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and escalate care immediately.

NEWS $\geq$ 3 AND SIRS 2
(see observation chart for details)

Time:

With clinical signs of infection:
THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO ₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

Department of Physics, National Tsing-Tung University, Hsinchu, Taiwan 300, Republic of China

Pupil Scale
(mm)

1 •

2 ●

3 ●

4.

10

7 ●

8

IV fluids for adults: for more details, see pocket guideline or App
 Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless $K^+ > 5.0$)
ml	mmol	mmol

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤ 132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥ 75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines

Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)
② NORMAL SALINE	1000ml	IV	100ml/hr	1550		Alan NBE	Alan

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation							
① PLASMA-LYTE	1000ml	IV	200ml/hr	1000	1215	Alan NBE	Alan

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
 Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
Plasmalyte IVI 1					200	200	200	200	200															
0.9% NaCl IVI 2																								
CD ALIX Drugs			20										100	100	100	100	/	100	100	100	100	100	100	100
CLARITHROMYCIN Drugs			250														20							
Naso Gastric / PEG																	250							
Oral	200	200	80	40					150	100			50			50		150				200		
Hourly Total																								
Cumulative Input	200	670	750	790	990	1190	1390	1740	1940	2040	2140	2240	2390	2490	2590	2740	3010	3260	3360	3460	3760	3860	3860	3860
Urine	180	180	120	100	100	100	100				500	280	100				280	175			400	70	80	110
Gastric																								
Bowels																								
Other																								
Cumulative Output	280	360	480	580			880				1380	1660	1760				2040	2215			2615	2685	2765	2875
Cumulative Balance																	970				1175		985	

Fluid Balance:

Today:

Previous 24hrs: +VE 1280

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started: _____ Date and time discontinued: _____
 Mask size: _____ Target SpO₂: _____
 Is BiPAP/CPAP ceiling of care? Y / N _____ DNA CPR in place Y / N _____

Date/Time	ABG/CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

24 hour Observation Chart - Level 1 / Level 2 Beds
National Early Warning Score 2 (NEWS2) Chart



Addressograph
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG
CHI 2911571495
78010 AF Stephen
800183063V M 29/11/1957

Ward: MHOU
Date: 1/12/23 Day No:
Consultant:

Special Instructions:
Only to be completed under the direction of a senior member of the medical team
A total NEWS of _____ or individual parameter of _____
is acceptable for this patient because _____
Please escalate if _____
Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.

NEWS >=3 AND SIRS 2 (see observation chart for details)	
Time: _____	
With clinical signs of infection: THINK SEPSIS	
Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE
Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE
Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score	
0 None Continue to assess pain at least daily	
1-3 Mild Continue to assess pain with routine observations, must be at least daily	
4-5 Moderate Assess, administer and review analgesia as appropriate for patient	
6-10 Severe Assess, administer and review analgesia as appropriate for patient	
Using appropriate Lothian Guidelines	
Nausea Score	AVPU
0 - No Nausea	A - The patient is awake
1 - Nausea Consider anti-emetic	V - The patient responds to verbal stimulation
2 - Nausea / Vomiting Administer anti-emetic	P - The patient responds to painful stimulation
3 - Persistent Nausea &/or Vomiting Contact Doctor	U - The patient is completely unresponsive
Using guidelines prescribe / give anti-emetics and review	

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO ₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Verbal/Abnormal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤ 132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥ 75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)
Plasmalyte	1000	IV	85 ml/hr	07-10		Sam PAIN 315	NCC / ly

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
Plasmalyte IVI 1		85																						
IVI 2																								
Clarithromycin Drugs		250															250							
Co-amoxiclav Drugs		20														100								
Naso Gastric / PEG																								
Oral		20	150		100	150	100		200															
Hourly Total		290	150		100	150	100		200															
Cumulative Input		290	440		540	690	790		990							1090	1340							
Urine		110	100	80	140	130	150	150	340				350		140	140	140	110		160	200			380
Gastric																								
Bowels																								
Other																								
Cumulative Output		110	210	290	430	560	710	860	1200			1550			1690	1830	1970	2080		2240	2440			2820
Cumulative Balance		180	230		110			130				560												OUT 2880 -1290

Fluid Balance:

Today: -1,290

Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started: _____

Date and time discontinued: _____

Mask size: _____

Target SpO₂: _____

Arm > 92%

Is BiPAP/CPAP ceiling of care? Y (N) _____

DNA CPR in place Y (N) *full escalation*

Date/Time	ABG/CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max < 1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

Lothian University Hospitals NHS Trust
ADULT UNITARY PATIENT RECORD

ADMITTING HOSPITAL: St John's Hospital at Howden

TYPE OF ADMISSION: Emergency

PRESENTING COMPLAINTS/REASON FOR ADMISSION

- 1 Short of breath / Difficulty breathing, FEVER, COUGH, BROWN PHLEGM SOB 1 WEEK TACHY, CHEST CRACKLES, CHES
- 2 T PAIN WHEN COUGHING HX STENT 2021, HYPOTHYROIDISM, OBS T 36.6, HR 121, SATS 79-81, BP 101/69, RR 36 N
- 3 EWS 9 ON 15hrs OXYGEN, ? INFECTION ? CLOT
- 4

Patient wishes to be known as:

NAME & ADDRESS (PATIENT LABEL)		ADMISSION WARD	DESTINATION WARD - 1st	DESTINATION WARD - 2nd
Hospital No	100183063V F/M: M	Ward No.	SJHHDU	
DOB:	29/11/1957 Age: 65	Admission Date	28/11/2023	
Name:	Alan Soave	Admission Time to Ward	14:41	
Address:	34 Southpark Place	Admitting Nurse		
	Livingston	Consultant	Dr HR Gillett	
	West Lothian	G.P. Details	6166118/78010	78010/3
	EH54 6FG	AF Stephen	Carnondean Medical Group, Carn	
Telephone No:		EH54 8PY		
Title - Mr / Mrs / Miss / Ms:	Mr	Tel No:	01506 836300	
Marital Status:				
Religion:	Unknown - No Rel Aff.			
Ethnic Origin:				

NEXT OF KIN: Soave (wife), Maureen
RELATIONSHIP: Unknown
Address: 12 MORRISON WAY

FIRST CONTACT
RELATIONSHIP
Address:

LIVINGSTON
EH54 8LJ
Contact No. 01811 07341665004

Patients Relative / Next of Kin Present on Admission Y/N

Signature:

Other comments: eg Night Call

Allergies / Sensitivities

CARDIO PULMONARY RESUSCITATION Resuscitate / DO NOT Attempt Resuscitation (DNAR) (Delete as appropriate)

Rationale if DNAR:

Signature: Print Name: Designation: Date & Time:

Consultant Signature (Within 24 hrs) Print Name: Date & Time

	Date/Time	DNAR Status	Signature	Print Name	Designation	Consultant Signature
Change (1)						
Change (2)						

Please document rationale for change in the progress notes.

pvc green
CARE ACP
SRCD

↑ SOB. / 2/2 sputum. Brown / Green.

- Cond tre. / CAP.

- lives = daughter.. (24 South Park Place)

WMTM
phoe
family
Indep
Grand kids

- Alan Indep with ADL'S

- Normally Indep with no falls.

- 4A50.

- Normally Good Appetite / drinks. &

off food few days

false teeth - top

- Glasses

- no issue with hearing

- Daily - Bow. no laxative.

- Continent - once - haematuria past
couple of days.

- STEPS were normal.

-

NHS Lothian – Directorate of Critical Care: Patient Admission

800183063V 29/11/1957 Soave, Alan 34 Southpark Place Livingston, West Lothian, EH54 6FG CHI 2911571495 78010 AF Stephen	Date & Time of Admission: 4/12/23 Admitted from: HHDA. @ 2345. Critical Care Consultant: Referring Consultant:
Reason for admission: Covid +ve. A O₂ requirements T1RF	Next of Kin/ Significant Other: Relationship: Wife. - Nameen. Contact details (address/telephone number): 073 9166 5054 GP: AF Stephen Carmondeen Health Rochice GP Telephone: 01506 836 300 GP Address:
Alcohol: Smoker: Yes 10 a day	Admission: Initial MRSA screen: YES/NO Pregnancy test +ve -ve N/A
Medications:	HAI Surveillance Form started: YES/NO Initials:
Allergies: NKDA.	Valuables checked and stored: YES/NO Belongings listed and stored : YES/NO Initials:
Details of valuables stored or given to N.O.K:	
Likes to be known as: Alan. Relevant Social History Independent - Retired electrician. Relevant Past Medical History: MI 2021, Hypothyroidism.	

A&E TO MHDU HANDOVER

A&E NURSE:- AJ

PATIENTS NAME:- Alan Soave 65

Presenting complaint CAP	7 days ↑ SOB new O2 req 15L ^{o2} whited out lung (R) COVID +ve
NEWS/GCS	8 RR 32, 94 SATS 15L ^{o2} Tachy 115 GCS 15
Medical History	Smoker, MI ↑ thyroid
Swallow assessment within 4 hrs	Nil
DNACPR STATUS	for
Any history of violence & aggression	nil
PVC/SRC on trak	on trak ✓
Drugs/Fluids prescribed	Co-amox IV Clari - oral Co-codamol - chest + back Pain
Any Infection	COVID +ve
Known Allergies	nil

high flo
FTU RV ✓
will review later

dex 6mg
back Pain

Patient Name
SOAVE ALAN

CHI
2911571495

Date of Birth
29/11/2007

Age

GP
Stephen, Alexandra

GP Practice
Medical Group

GP Practice Code
78010

Allergies

Description	Date Recorded	Comments
No ECS data exists		

Sources:

☒ ECS

☐ Patient's Drugs

☐ Referrer Kardex

☐ GP Practice

☐ TRAK

☐ Patient

☐ Relative / Carer

☐ Referrer Letter

☐ Comm Pharmacy

☒ Other - Specify HEALTH

Actions:

C: Continue

W: Withhold

S: Stop

Acute Medication (including those greater than 30 days)

Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Source 1° 2° 3°	Action C W S	Comments
No ECS data exists								

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source 1° 2° 3°	Action C W S	Comments
GP practice	Melatonin 2mg modified-release tablets	30 tablet	1 TABLET ONCE A DAY		26/01/2023	12/05/2023		1		
GP practice	Levothyroxine sodium 100microgram tablets	56 tablet	1 TABLET ONCE A DAY		20/04/2023	03/10/2023		1		
GP practice	Aspirin 75mg dispersible tablets	56 tablet	TAKE ONE DAILY		12/10/2021	01/09/2022		1		
GP practice	Atorvastatin 80mg tablets	56 tablet	TAKE ONE DAILY		12/10/2021	12/05/2023		1		
GP practice	Lansoprazole 15mg gastro-resistant capsules	56 capsule	TAKE ONE DAILY FOR 6 MONTHS (WHILST ON ASPIRIN + PRASUGREL)		12/10/2021	12/05/2023		1		↑ Dose ↑ Dose 2x
GP practice	Ramipril 5mg capsules	56 capsule	TAKE ONE CAPSULE ONCE DAILY. STOP TEMPORARILY WHEN		22/12/2022	12/05/2023		1		

Patient Name
SOAVE ALAN

CHI
2911571495

Date of Birth
29/11/1957

Age
65

GP
Stephen, Alexandra

GP Practice
Carmondean Medical Group

GP Practice Code
78010

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Source	Action	Comments
			UNWELL WITH VOMITING, DIARRHOEA OR FEVER. RESTART WHEN WELL AGAIN. Notes for patient: Bloods fine jan 2022					1° 2° 3°	C W S	
GP practice	Glyceryl trinitrate 400micrograms/dose pump sublingual spray	200 dose	1 - 2 SPRAYS UNDER THE TONGUE WHEN REQUIRED AS DIRECTED		12/10/2021	24/01/2023		1		

Compliance Device

Name and telephone number for community pharmacy

Completed by

Designation

Grade

Date

Time

Contact Number

Reviewed by

Designation

Grade

Date

Time

Contact Number

Key Information Summary

No KIS data recorded

PRESCRIPTION AND ADMINISTRATION RECORD

Date of Admission: 02/12/23 (ITU)		Critical Care and Cardiothoracic Surgery		1 of 1	
Hospital/Ward: ITU		Consultant:		800183063V M	
Weight:		Height:		SOAVE Alan	
If re-written, date:				29-Nov-57 CHI: 291 157 1495	
DISCHARGE PRESCRIPTION				78010 AF Stephen	
Date completed:		Completed by:		34 Southpark Place West Lothian	
				EH54 6FG	

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS - This section must be completed before any medicine is given except in exceptional circumstances			None known ☐
Date	Type of Chart	Medicine / Agent	Description of reaction	Completed by (sign, print & designation)	Date
		NWGA		<i>R. Guespie</i>	

- Write clearly in block capitals, using a black ballpoint pen
 - Use approved names for medicines
 - Never alter a prescription
 - Route of administration

The only acceptable abbreviations are:

IV - intravenous	SL - sublingual	NG - nasogastric
IM - intramuscular	PR - per rectum	ID - intradermal
SC - subcutaneous	PV - per vagina	TOP - topical
INHAL - inhaled	NEB - nebulised	

Never abbreviate ORAL or INTRATHECAL
Specify RIGHT or LEFT for eye and ear preparations

- Write the medicine dose clearly
 - The only acceptable abbreviations are:
g - gram mg - milligram ml - millilitre
all other doses must be written out in full eg. micrograms
 - Avoid decimal points eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
 - Prescribe liquids by writing the dose in mg
 - For 'as required' medicines, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
 - Write units as 'units' not 'iu'

- 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 shown below. Inform the responsible doctor in the appropriate timescale.
- | | |
|---|---|
| 1. Patient refuses | 6. Vomiting / nausea |
| 2. Patient not present | 7. Time varied on doctor's instructions |
| 3. Medicines not available - CHECK ORDERED | 8. Once only / as required medicine given |
| 4. Asleep / drowsy | 9. Dose withheld on doctor's instructions |
| 5. Administration route not available - CHECK FOR ALTERNATIVE | 10. Possible adverse reaction / side effect |

CONTENTS:	PAGE	CONTENTS:	PAGE
Once Only Prescriptions	2 - 5	Warfarin Chart	28
 Regular Therapy	6 - 17		
 Continuous Drug Infusions	18 - 23		
 As Required Therapy	24 - 27		

O X Y G E N	Start		Route		Prescriber - Sign + Print	Administered by	Stop	
	Date	Time	Mask (%)	Prongs (l/min)			Date	Time

Once Only Medication

[illegible]

Once Only Medication

[illegible]

Once Only Medication

[illegible]

Once Only Medication

[illegible]

Name: ALAN JOANE D.O.B. 29/11/57 CHI Number: 2911571495

Regular
Therapy

			Date/ Time	2/12/23	3/12/23	4/12/23	5/12/23	6/12/23
Medicine (Approved Name)	For Use		06		us	us	u	u
Dose / Amount	Route	Quantity	10					
1 PMA	3-4 leg							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22			u		ml
Prescriber - sign + print			24	us	HW			
Medicine (Approved Name)	For Use		06	x	us	us	u	u
Dose / Amount	Route	Quantity	10					
5000 UNITS	sc							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14				RV	
Comments/Indication/Review Date			18	x	unac	thunter	thunter	thunter
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)	For Use		06	x	us	us	u	u
Dose / Amount	Route	Quantity	10					
30 mg	oral							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22				0	
Prescriber - sign + print			24					
Medicine (Approved Name)	For Use		06	DS X	us	us	us	noise
Dose / Amount	Route	Quantity	10		Day 6	Day 7	Day 8	Day 9
6 mg	oral							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					

Name: D.O.B.: CHI Number:

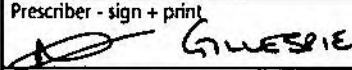
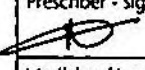
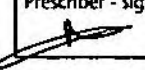
Regular
Therapy

Date/ Time									
7/12/23									
06	HW								
10									
12									
14									
18									
22									
24									
06	HW								
10									
12									
14									
18									
22									
24									
06	HW								
10									
12									
14									
18									
22		0							
24									
06	HW								
10	Day 10								
12	HW								
14									
18									
22									
24									

Regular Therapy

Name: ALAN SCOVE D.O.B. 29/11/57 CHI Number: 2911571495

Regular
Therapy

			Date/Time	2/12/23	3/12/23	4/12/23	5/12/23	6/12/23
Medicine (Approved Name)	For Use		06					
NICOTINE PATCH 21mg								
Dose / Amount	Route	Quantity	(10)	X	MAC	Hunter	Hunter	Hunter
1 PATCH	100 PATCH							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
	2/12							
Comments/Indication/Review Date			18					
24 hours			22					
Prescriber - sign + print			24					
								
Medicine (Approved Name)	For Use		(06)	X	MR. J. WESPIE	Le.	Le.	
LEVODOPA								
Dose / Amount	Route	Quantity	10					
100 micrograms	ORAL							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
	28/11							
Comments/Indication/Review Date			18					
OA			22					
Prescriber - sign + print			24					
								
Medicine (Approved Name)	For Use		(06)	X	MR. J. WESPIE	U.	U.	
ASPIRIN								
Dose / Amount	Route	Quantity	10					
75mg	ORAL							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
	28/11							
Comments/Indication/Review Date			18					
OA - IND			22				0	
Prescriber - sign + print			24					
								
Medicine (Approved Name)	For Use		06					
ATORVASTATIN								
Dose / Amount	Route	Quantity	10					
80mg	ORAL							
Diluent/Undiluted + Volume	Date		12					
Rate/Duration	Start Date	Pharmacy	14					
	28/11							
Comments/Indication/Review Date			18					
OK - IND			(22)	given in hospital	X	J. WESPIE	U.	U. J. WESPIE
Prescriber - sign + print			24					
								

Name: D.O.B.: CHI Number:

Regular
Therapy

Date/ Time									
06	7/11/23								
10									
12									
14									
18									
22									
24									
06	HW								
10									
12									
14									
18									
22									
24									
06	HW								
10									
12									
14									
18									
22									
24									
06									
10									
12									
14									
18									
22									
24									

Regular Therapy

Name: ALAN SOAVE D.O.B. 29/11/57 CHI Number: 2911571493

Regular
Therapy

			Date/ Time	2/12/23	3/12/23	4/12/23	5/12/23	6/12/23
Medicine (Approved Name)		For Use	06	- X -	Ab/c	int	EL	u
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14	- X -	LMAC	Ab/c	EL	Ab/c
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular
Therapy

Date/ Time									
06	7/12/23 HW								
10									
12	rw								
14									
18									
22									
24									
06									
10									
12									
14									
18									
22									
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22									
24									
06									
10									
12									
14									
18									
22									
24									

Regular Therapy

Name:..... D.O.B.:..... CHI Number:.....

Regular
Therapy

Regular Therapy

			Date/ Time					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular
Therapy

Date/ Time									
06									
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Regular
Therapy

Name:..... D.O.B.:..... CHI Number:.....

Regular
Therapy

			Date/ Time					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B.:..... CHI Number:.....

Regular
Therapy

Date/ Time									
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Regular
Therapy

Name:..... D.O.B.:..... CHI Number:.....

Regular
Therapy

Regular Therapy

			Date/ Time					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					
Medicine (Approved Name)		For Use	06					
Dose / Amount	Route	Quantity	10					
Diluent/Undiluted + Volume		Date	12					
Rate/Duration	Start Date	Pharmacy	14					
Comments/Indication/Review Date			18					
			22					
Prescriber - sign + print			24					

Name:..... D.O.B:..... CHI Number:.....

Regular
Therapy

Date/ Time									
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Regular Therapy

Name:..... D.O.B.:..... CHI Number:.....

Continuous Drug
Infusions

Medicine (Approved Name)			Date				
			Time				
Dose / Amount	Total Volume	Route	Signatures				
Glucose 5%	Sodium Chloride 0.9%		Date				
Water for Injections	Undiluted		Time				
Rate/Duration	Start Date	Pharmacy	Signatures				
Comments/Indication/Review Date			Date				
			Time				
Prescriber - sign + print			Signatures				
Medicine (Approved Name)			Date				
			Time				
Dose / Amount	Total Volume	Route	Signatures				
Glucose 5%	Sodium Chloride 0.9%		Date				
Water for Injections	Undiluted		Time				
Rate/Duration	Start Date	Pharmacy	Signatures				
Comments/Indication/Review Date			Date				
			Time				
Prescriber - sign + print			Signatures				
Medicine (Approved Name)			Date				
			Time				
Dose / Amount	Total Volume	Route	Signatures				
Glucose 5%	Sodium Chloride 0.9%		Date				
Water for Injections	Undiluted		Time				
Rate/Duration	Start Date	Pharmacy	Signatures				
Comments/Indication/Review Date			Date				
			Time				
Prescriber - sign + print			Signatures				
Medicine (Approved Name)			Date				
			Time				
Dose / Amount	Total Volume	Route	Signatures				
Glucose 5%	Sodium Chloride 0.9%		Date				
Water for Injections	Undiluted		Time				
Rate/Duration	Start Date	Pharmacy	Signatures				
Comments/Indication/Review Date			Date				
			Time				
Prescriber - sign + print			Signatures				
Medicine (Approved Name)			Date				
			Time				
Dose / Amount	Total Volume	Route	Signatures				
Glucose 5%	Sodium Chloride 0.9%		Date				
Water for Injections	Undiluted		Time				
Rate/Duration	Start Date	Pharmacy	Signatures				
Comments/Indication/Review Date			Date				
			Time				
Prescriber - sign + print			Signatures				

Continuous Drug Infusions

Date									
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Name:..... D.O.B.:..... CHI Number:.....

Continuous Drug Infusions

Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures					
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures					
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures					
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures					
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures					
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures					
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures					
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures					
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures					
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures					
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures					
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures					
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures					
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures					
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures					

Continuous Drug Infusions

OWN TRANSPORT (S.B.A.R.)

Discharge Lounge

No notes

S SITUATION

Nurse _____

Ward 21Accepted By _____ Time 1312Patient Name Alan Dave CHI 2911571495Onward Address 34 Southpark Place
Livingston EH54 6FGTime Patient Ready 4**B** BACKGROUNDPatient Condition Pneumonia Cardio VET endedPMH: Stemi 2021 - LVSD, Hypotension, CholesterolBehavioural Issues YES/NO (NO) Wanderer YES/NO (NO) Falls Risk YES/NO Score:Mental Status: Alert + orientated ☒ Confused ☐Mobility + Aids INDMRSA/Infection Status NA O2 NAMedication: with patient ☐ awaiting pharmacy* ☐ awaiting script* ☐ none required ☒

*Has the medication been reconciled by the ward? YES/NO

DNACPR Form: YES/NO (NO) Travelling with Patient: YES/NO**A** ASSESSMENT

Is further assessment required prior to discharge? YES/NO

R RECOMMENDATION

OWN Transport

Access to Home - Keys/Key Safe/Someone at home

Approx Time for Transport:

Await wife.

SIGNED:

DESIGNATION:

DATE:

Following evaluation, this patient will receive care rounding at the following frequency.

Circle Yes No Not Applicable where shown: Y N NA Use codes if otherwise indicated

Care Plan	Ward: SJH Discharge Lounge	Date:											
		30 minutes 1 hrly 2 hrly (please circle)				Nurse planning planning care rounding							
		Signature Print											
	Time of care rounding (24hr)												
Food, fluid & nutrition	Would you like a drink? (Y Yes, N No, Within reach W, Nil by mouth NBM)												
	Fluid balance chart updated if in use?	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA
	When did you last eat? (Breakfast B, Lunch L, Dinner D, Snack S, Assist A, Feed F, Nil by mouth NBM)												
	Oral care performed recently? (Y, N, Assist A)												
PAC	Have you moved/ walked since last round? (Y, N, Asleep AS)												
Falls	Appropriate footwear?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
	Walking aid available if required?	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA
	Area de-cluttered?	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
Continence	Do you need the toilet? (Y, N, Asleep AS)												
	Continent of urine? (at time of rounding) (Y, N)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
	Continent of faeces? (at time of rounding) (Y, N)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
	Catheter care performed?	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA	Y N NA
	Bag checked (Position below bladder, no more the 2/3 full, connections intact)	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N
General	Are you in pain? Are you comfortable? (P, C, AS)												
	Anything else I can do for you? (Y, N, AS)												
	Someone will be back in hrs (Y, N, AS)												
	Check IV Cannulation	Y N	Removed			Yes							
	Initials												

Continuation

Continuation

Name:..... D.O.B.:..... CHI Number:.....

Continuous Drug Infusions

Continuous Drug Infusions

Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-

Name:..... D.O.B.:..... CHI Number:.....

Continuous Drug Infusions

Continuous Drug Infusions

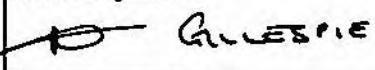
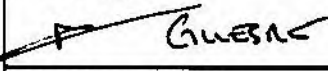
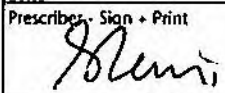
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-
Medicine (Approved Name)			Date					
			Time					
Dose / Amount	Total Volume	Route	Signatures	-	-	-	-	-
Glucose 5% Sodium Chloride 0.9%			Date					
Water for Injections Undiluted			Time					
Rate/Duration	Start Date	Pharmacy	Signatures	-	-	-	-	-
Comments/Indication/Review Date			Date					
			Time					
Prescriber - sign + print			Signatures	-	-	-	-	-

Continuous Drug Infusions

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Name:..... D.O.B.:..... CHI Number:.....

As Required
Therapy

Medicine (Approved Name) PARACETAMOL		For Use	Date				
			Time				
Dose + Frequency + Maximum 1 gram + 4 to 6 x 4	Route ORAL	Quantity	Dose				
			Signature(s)				
Indication + Notes Pain	Start Date 2/12	Date	Date				
			Time				
Prescriber - Sign + Print 		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name) GLUCERIL TENINATE 400 mg tablets		For Use	Date				
			Time				
Dose + Frequency + Maximum 2 tablets + chest pain	Route S/L	Quantity	Dose				
			Signature(s)				
Indication + Notes CA - IMA	Start Date 2/12	Date	Date				
			Time				
Prescriber - Sign + Print 		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name) Sulbutamol		For Use	Date				
			Time				
Dose + Frequency + Maximum 5mg PRN	Route Neb	Quantity	Dose				
			Signature(s)				
Indication + Notes SUBJ Wheeze	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print 		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)				
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)				
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)				

As Required Therapy

Name:..... D.O.B.:..... CHI Number:.....

As Required
Therapy

Date									
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Dose									
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As Required
Therapy

Name:..... D.O.B.:..... CHI Number:.....

**As Required
Therapy**

Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)	_____	_____	_____	_____
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)	_____	_____	_____	_____
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)	_____	_____	_____	_____
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)	_____	_____	_____	_____
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)	_____	_____	_____	_____
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)	_____	_____	_____	_____
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)	_____	_____	_____	_____
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)	_____	_____	_____	_____
Medicine (Approved Name)		For Use	Date				
			Time				
Dose + Frequency + Maximum	Route	Quantity	Dose				
			Signature(s)	_____	_____	_____	_____
Indication + Notes	Start Date	Date	Date				
			Time				
Prescriber - Sign + Print		Pharmacy	Dose				
			Signature(s)	_____	_____	_____	_____

Name:..... D.O.B.:..... CHI Number:.....

**As Required
Therapy**

Date									
Time									
Dose									
Signature(s)									
Date									
Time									
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Date									
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Dose									
Signature(s)									

**As Required
Therapy**

WARFARIN CHART

- 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) and mechanical prosthetic heart valves.

Yellow anticoagulant booklet completed and issued:

Date _____

28

ADULT FLUID PRESCRIPTION CHART



Name _____

Date of Birth _____

CHI/Unit No _____

Date _____ Sheet no _____

Ward _____

IV fluids for adults: for more details, see pocket guideline or App

Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic

Does your patient need IV fluids? If so, are they needed for:

Maintenance, Replacement, or Resuscitation?

Write in Maintenance requirements in next 24 hours:

Weight (kg) _____

Essential _____

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Estimated oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100 ml/hr of 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If Sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances

Weight (kg)	Maintenance Fluid Requirement in 24hr	Rate (ml/hr)	Equivalent to 1000 ml over:
35-44	1200 ml	50	20 hr
45-54	1500 ml	65	16 hr
55-64	1800 ml	75	14 hr
65-74	2100 ml	85	12 hr
≥75	2400 ml	100 (max)	10 hr

Prescribe Maintenance fluids and diabetic fluids here.

Max rate is 100ml/hr.

Prescribe subcutaneous fluids using SC guidelines

Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV/ SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (Sign and Print)	Set up by (Sign and Print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250 to 500ml Plasmalyte 148 over 5 to 15 min. Stop and assess before repeat. Request senior / ICU opinion if 2000ml insufficient

CHI/Unit No.

ADULT FLUID BALANCE CHART

Total Input Goal: _____ ml in 24hr

Fluid Restriction: _____ ml in 24hr

Today's PEG/NG Feed:

ml/24hr

TPN

ml/24hr

Total Input Goal:

Fluid Restriction:

ml in 24hr

ml in 24hr

	IV FLUIDS or SC FLUIDS IV MEDICATION	Line 1	ORAL INPUT		ENTERAL: NG/ PEG / RIG	TPN/Other Line 2	URINE		GASTRIC	DRAIN 1	DRAIN 2 OTHER
	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100 ml	Volume	Volume	Volume	Running Total	Volume	Volume	Volume
06.00							/				
07.00							/				
08.00			Coffee	100			150	150			
09.00							/				
10.00			Water	330			498	648			
11.00							/				
12.00			Water	330			/				

Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print

13.00						236	'	884		
14.00	Tazocin	120(30)					'			
15.00		(30)					'			
16.00		(30) water	500(1260)			269	'	1153		

Stop and review. Escalate any concern to senior staff and document. Tick box to show review conducted, ☐ and Sign/Print

17.00		(30)				/				
18.00						/				
19.00						183	'	1336		
20.00			COFFEE	200	(1460)	182	'	1411		
21.00	IV ABX + FLUSH	125	WATER	50	(1510)					
22.00						278	'	1696		
23.00						/				
24.00						/				
01.00			WATER	100	(1610)	/				
02.00						/				
03.00			COFFEE	100	(1710)	/				
04.00			WATER	100	(1810)	240	'	1936		
05.00	IV ABX, FLUSH	125	.							
Totals		A		B	C	D	E	F	G	H
	Total input and output			A+B+C+D	Total in	2180		E+F+G+H	Total out	1936

NOTES

24 Hr Balance

(+249

AIRVO CARE PLAN

Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

MEDICAL HIGH DEPENDENCY

Date: 30/11/23 Resus Status: FOR

Named Nurse GMM

Patient ID CHI 2911571495
78010 AF Stephen
800183063V M 29/11/1957

Ceiling Of Care/For Escalation to ICU

Named Nurse

Weaning Plan aim Sat > 92%

MEDICAL STAFF TO PRESCRIBE FLOW SETTINGS +FIO2 REQUIREMENTS - TRAK/CHART

Time	ABGs PH/H+	PO2	PCO2	HC03	FLOW LPM 10-70	OXYGEN% 21-100	RR	SP02	MEDICAL SIGNATURE	COMMENTS
0800					60L	80%	30	94%		check EP
17:00	7.482	12.5	4.75	26.3	60L	80%	30	95%		ES
18:10					60L	70%	32	94%		4/80
0730	7.7	12.7	2.17	22.0	60L	75%	33	90%		EBG ✓
20:45					60L	75%	33	93%		check W

MEDICAL HIGH DEPENDENCY

Patient label

Date: 2/17/23 Resus Status: FOR

Named Nurse Emma

Ceiling Of Care/For Escalation to ICU

Named Nurse

Weaning Plan

MEDICAL STAFF TO PRESCRIBE FLOW SETTINGS +FIO2 REQUIREMENTS - TRAK/CHART

[illegible]

High Flow Nasal Oxygen Algorithm

ESCALATION PLAN

Must be discussed with ITU

The appropriateness and plan for initiation or ceasing of therapy must be clearly documented in notes prior to or upon initiation or ceasing.

Initial settings

Consult with medical staff and establish targets and parameters of therapy

Flow rate 30 L/min

FiO₂ 21-100% to achieve initial SpO₂ 88-92% unless otherwise stated

Switch to humidifier as per policy

Ensure prongs are 1/2 the size of patient's nares for comfort

Continuously monitor and document SpO₂, respiratory rate and heart rate
ABG when practical, and alter therapy as needed

Has the work of breathing eased?
Is respiratory rate improved? Is there use of accessory muscles?

NO

YES

SpO₂ or PaO₂ at target levels

NO

YES

If clinical improvement maintained for at least 2 hours

1. Decrease FiO₂ gradually in increments of 10%

THEN

2. Decrease flow rate in 10 L/min steps to 30 L/min

Once on 10% and at 30 L/min, can try alternative oxygen delivery system for wearing periods

1. Consider extend wearing periods of HFO until completely weaned from HFO

INFORM MEDICAL STAFF

Increase flow rate to 40 L/min
Increase FiO₂ to 100% if needed

Increase FiO₂ to achieve target SpO₂ or PaO₂

IN CASE OF DETERIORATION

Inform ITU/HDU immediately
Register immediately

Increase FiO₂ to 100% and flow rate to 50 L/min

Consider reversible causes (ACX/RT)

Follow up with ITU/HDU as per policy

Set up for intubation if appropriate

CHI 2911571495
78010 AF Stephen

MEDICAL HIGH DEPENDENCY

Weaning Plan aim stgs 79%.[illegible]

High Flow Nasal Oxygen Algorithm

ESCALATION PLAN

Must be discussed with ITU

The appropriateness and plan for initiation or ceasing of therapy must be clearly documented in notes prior to or upon initiation of treatment

Initial settings

Consult with medical staff and establish targets and parameters of therapy

Flow rate 30 L/min

FiO₂ 24-100% to achieve initial SaO₂ 88-92% if possible

Flow rate otherwise stated

Switch to humidifier if was 24-30 L/min

Ensure prongs are 7-10mm size of patient's nares for comfort

Continuously monitor and document SaO₂, respiratory rate and heart rate

Adjust when it is possible and alter every 4 hours

Has the work of breathing reduced?

Has respiratory improved? Less use of accessory muscles

NO

YES

SaO₂ or PaO₂ at target level?

NO

YES

If clinical improvement maintained for at least 2 hours

1) Decrease FiO₂ gradually to minimum of 40%

THEN

2) Decrease flow rate in 10 L/min steps to 30 L/min

Once on 40% and 30 L/min flow can try alternative oxygen delivery system for weaning period

1) plan to extend weaning period for HFNO until completely weaned from HFNO

INFORM MEDICAL STAFF

INCREASE flow rate in 10 L/min

increments to reach 30 L/min

Check for nasal cannula fit

Check for nasal cannula patency

Check for nasal cannula position

Check for nasal cannula size

Check for nasal cannula type

Check for nasal cannula material

Check for nasal cannula color

Check for nasal cannula shape

Check for nasal cannula texture

Check for nasal cannula weight

Check for nasal cannula length

Check for nasal cannula width

Check for nasal cannula depth

Check for nasal cannula height

Check for nasal cannula diameter

Check for nasal cannula circumference

Check for nasal cannula area

Check for nasal cannula volume

Check for nasal cannula mass

Check for nasal cannula density

Check for nasal cannula specific gravity

Check for nasal cannula refractive index

Check for nasal cannula thermal conductivity

Check for nasal cannula electrical conductivity

Check for nasal cannula magnetic permeability

Check for nasal cannula dielectric constant

Check for nasal cannula loss tangent

Check for nasal cannula phase shift

Check for nasal cannula time delay

Check for nasal cannula group delay

IN CASE OF DETERIORATION

Inform ITU/HDU Consultant or Registrar immediately

Increase FiO₂ to 100% and flow rate to 60 L/min

Consider reversible causes (COPD)

Follow documented escalation plan

Stop HFNO from initiation of escalation

Reassess patient

AIRVO CARE PLAN

MEDICAL HIGH DEPENDENCY

Date: 28/11/23

Resus Status: FOR RESUS

Named Nurse: LEANNE

Patient label: ALAN SOAVE

Ceiling Of Care/For Escalation to ICU: 92% H_g

Named Nurse:

Weaning Plan: AIM SAT₂ > 92%

MEDICAL STAFF TO PRESCRIBE FLOW SETTINGS + FIO2 REQUIREMENTS - TRAK/CHART

Time	ABGs PH/H+	PO2	PCO2	HC03	FLOW LPM 10-70	OXYGEN% 21-100	RR	SP02	MEDICAL SIGNATURE	COMMENTS
15.20					60	60%	34	87%	[Signature]	
15.30	45	10.5	5.3		60	80%	26	93%	[Signature]	DOCTORS AWARE OF ↑
19.20	43	10.3	5.3		↓ 50	80%	29	93%	SEE TRAK - DE HVA (ITU)	
21.00					50L	80%	30	93%		check Jm
00.00					60L	85	32	93		

800183063V M 29/11/1957

Soave, Alan

34 Southpark Place;

Livingston,

West Lothian, EH54 6FG

CHI 2911571495

78010 AF Stephen

Directorate Clinical Care High Flow Nasal Oxygen Algorithm

ESCALATION PLAN

Must be discussed with ITU

The appropriateness and plan for initiation or ceasing of therapy must be clearly documented in notes prior to or upon initiation of treatment

Initial settings

Consult with medical staff and establish targets and parameters of therapy

Flow rate 30 L/min

FIO₂ 1.00 to achieve initial SaO₂ 88-92% in ITU

otherwise 21-24%

Switch humidifier to passive setting

Ensure prongs are 1/2 the size of patients nose for comfort

Continuously monitor and document: SaO₂, respiratory rate and heart rate
ABG within 30 minutes if possible and after every change

Has the work of breathing eased?

1. Respirate more easily
2. Less use of accessory muscles
3. AD

NO

INFORM MEDICAL STAFF

increase flow rate to 40 L/min
increments to reach 40 L/min

YES

SaO₂ or PaO₂ stable or level is?

NO

increase FIO₂ to achieve target
SaO₂ 88-92%

YES

Clinical improvement maintained for at least 2 hours

1. Decrease FIO₂ gradually to minimum of 21%

THEN

2. Decrease flow rate in 10 L/min steps to 30 L/min

Once on 21% and 30 L/min flow, can try alternate oxygen delivery system in wearing periods

1. tolerate extend wearing periods of HFO until completely weaned from HFO

IN CASE OF DETERIORATION

Inform ITU/ITU Consultant or Registrar immediately

increase FIO₂ to 100% and flow rate to 60 L/min

Consider reversible causes (ACUTE?)

Follow determined escalation plan

Refer to the escalation of care template

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)	Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface	Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)	Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid	Reproduced by kind permission of Dr KW Heaton, Reader in Medicine at the University of Bristol		

Date	Time	Colour	Type	Amount	Blood	Mucous	Comments	Initials
29/11/23		BNO	d/s					NS
30/11/23		BNO	d/s					ES
30/11/23		NIS						
30/11/23		BNO	overnight					
1/12/23	1030	Brown	6 large		N	N	Commence	4/6 Cep

Emergency Department SJH Care Rounding

/a 800183063V /E5536575 M
SOAVE Alan
N: 29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
Dt 34 Southpark Place West Lothian
EH54 6FG
Ht 

NURSING ADMISSION CHECKLIST

Standard Admission Procedures				Initials
Vital signs recorded	☒ YES	☐ NO	☐ N/A	
NEWS 2 score recorded	☒ YES	☐ NO	☐ N/A	
Name band attached	☒ YES	☐ NO		
Relatives	☒ IN ED	☐ AT HOME	☐ NOT AWARE	
Clothing and valuables - Labelled	☐ YES	☒ NO		
Clothing and valuables - Documented	☐ YES	☒ NO		
Falls risk assessment - Completed	☒ YES	☐ NO		
Falls risk assessment - Documented	☒ YES	☐ NO		
4 AT assessment completed	☐ YES	☐ NO	☐ N/A	
Swallow screen completed (within 4 hours of arrival)	☐ YES	☐ NO	☐ N/A	
Resus Status	For CPR ☒	DNACPR ☐		

Procedures	Initials
ECG completed	☒ YES ☐ NO ☐ N/A

Presenting Complaint: SOB ? PE.

Date/time	Progress Notes	Signature/print name
12.05	Brought in Resus 1 on charts	
	News 10 ECG done - blood e	
	access obtained Cepheid running	KE
12.15	Obs checked News 10 pt on	
	Continuous monitoring	KE
12.35	Obs continue to be monitored	
	News 9.	
12.45	Obs continue to be monitored w fluids	KE

[illegible]

CARE ROUNDING

HOURLY FREQUENCY	☐ 1	☒ 2	☐ 3	☐ 4
------------------	----------------------------	---------------------------------------	----------------------------	----------------------------

Review frequency every 12 hours or if the patient's clinical condition requires

Print name of nurse reviewing: Kelley Date: 28/11/23

Time of Round	<u>12.20</u>	<u>14.15</u>			
Clinical Area	<u>Resus 1</u>	<u>Resus 1</u>			
Care Round Leader's Initials	<u>KE</u>	<u>AM</u>			

Review Frequency of Vital Signs & Cardiac Monitoring

Vital Signs Frequency	<u>Cont</u>	<u>15 mins</u>			
Cardiac Monitoring required?	☒ Y ☐ N	☒ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Pain score (0-10)	<u>0</u>	<u>0/2</u>			
Analgesia provided	☐ Y ☒ N	☒ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Is the person due any routine medication?	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Ability - tick one option per care rounding

Fully weight bearing	☒	☒	☐	☐	☐
Requires some assistance/uses walking aid	☐	☐	☐	☐	☐
Non weight bearing- needs full assistance	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐
Ask patient if they require the toilet	☒	☒	☐	☐	☐
Patient is self-caring and can walk to toilet	☐	☐	☐	☐	☐
Patient has issues with incontinence - assist with personal care as needed	☐ Reviewed	☐ Reviewed	☐ Reviewed	☐ Reviewed	☐ Reviewed
Personal care	☐ Given	☐ Given	☐ Given	☐ Given	☐ Given
Personal care	☒ Not required	☒ Not required	☐ Not required	☐ Not required	☐ Not required
Patient has catheter in situ- assist patient as needed (THINK FLUID BALANCE CHART)	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?
Personal care	☐ Offered	☐ Offered	☐ Offered	☐ Offered	☐ Offered
Personal care	☐ Given	☐ Given	☐ Given	☐ Given	☐ Given
Personal care	☒ Declined/Not required	☒ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required

Nutrition and Hydration (tick one option) *THINK SWALLOW

Patient is self-caring (ensure nutrition and hydration needs are still being met)	☒	☒	☐	☐	☐
Patient needs assistance with feeding/drinks and have been given help	☐	☐	☐	☐	☐
Patient for fluids only- ensure signage appropriate above bed/trolley	☐	☐	☐	☐	☐
Patient is NBM* (are background fluids required? Review signage is appropriate above the bed/trolley)	☐	☐	☐	☐	☐
Patient has IVI in situ	☐	☐	☐	☐	☐
Fluid balance chart updated?	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A

Refreshments - Provided (P) Declined (D)

Drink	☐ P ☒ D	☒ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D
Snack	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D
Catered meal	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D

Emergency Department Care Rounding

800183063V /E5536575 M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG



CARE ROUNDING

Time of Round	12.20	1415			
Clinical Area	Resus 1	Resus 1			
Care Round Leader's Initials	Ke	Am			
Review Frequency of Vital signs and Cardiac Monitoring					
Vital signs frequency monitoring	15	15			
Visual Skin Inspection - tick one option per care rounding					
Patient is healthy - no concerns		pt still healthy			
Visible areas of redness					
Broken skin and evidence of pressure ulcers					
Is a Waterlow assessment required (AND COMPLETED)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Is pressure relieving equipment/mattress required?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Invasive Devices - please circle device used and tick if device in situ					
PVC/PVC Insertion bundle completed	☒	☒	☐	☐	☐
Urinary catheter/catheter insertion bundle completed	☐	☐	☐	☐	☐
Infusion device	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐
Other:					
Vulnerable person/cognitive impairment					
Is a 4AT required?	☐ Y	☒ N			
Family Communication					
Patient and relatives present, and have been made aware	☒	☒			
Cubicle Tidy					
Ensure area is tidy and free of obstructions	☒	☒			

EMERGENCY DEPARTMENT TO WARD HANDOVER

NEWS	
Outstanding jobs	
Medications administered?	☐ Y ☐ N
Diagnosis and relevant information	

800183063V M 29/11/1957 Soave, Alan 34 Southpark Place, Livingston, West Lothian, EH54 6FG CHI 2911571495  M / F 78010 AF Stephen	NHS Lothian Blood Glucose Monitoring and Subcutaneous Insulin Prescription Chart If on intravenous insulin, please document hourly blood glucose readings on the intravenous insulin chart Never omit insulin without consulting with medical staff	Usual insulin regime: _____ Usual device: _____
---	--	--

Date	Blood Glucose (mmol/l)				Insulin (Units)								Additional glucose readings and blood ketones
	Before breakfast	Before lunch	Before evening meal	Before bed	Before breakfast type / units	Prescribed by Given by	Before lunch type / units	Prescribed by Given by	Before evening meal type / units	Prescribed by Given by	Before bed type / units	Prescribed by Given by	
				5	units		units		units		units		
29/11/23	4.4 6.20AM	8.6 @ 14.10		9.4	units		units		units		units		
30/11/23	2.1		8.2		units		units		units		units		
1/12/23	6.2	7.1	7.1	6.6	units		units		units		units		
2/12/23	6.5		7.4		units		units		units		units		
					units		units		units		units		
					units		units		units		units		

Management of Hypoglycaemia / Hyperglycaemia - dose adjustment

To adjust insulin doses for a twice daily fixed insulin mixture (e.g. Novomix 30 / Humulin M3 / Humalog Mix 25)

- If glucose high / low **before breakfast**, increase / decrease **EVENING** insulin dose
- If glucose high / low **before evening meal**, increase / decrease **MORNING** insulin dose

For dosage adjustment with a basal-bolus regimen (e.g. Novorapid / Humalog and Insulatard / Levemir / Lantus)

- If glucose high / low **before breakfast**, increase / decrease **EVENING** long-acting insulin
- If glucose high / low **before lunch**, increase / decrease **MORNING** short-acting insulin
- If glucose high / low **before evening meal**, increase / decrease **LUNCHTIME** short-acting insulin
- If glucose high / low **before bed**, increase / decrease **EVENING** short-acting insulin

Other adjustments may necessitate a change of the mixture. For further advice please contact the Diabetes Team (Diabetes SPR or Diabetes Specialist Nurse) via switchboard.

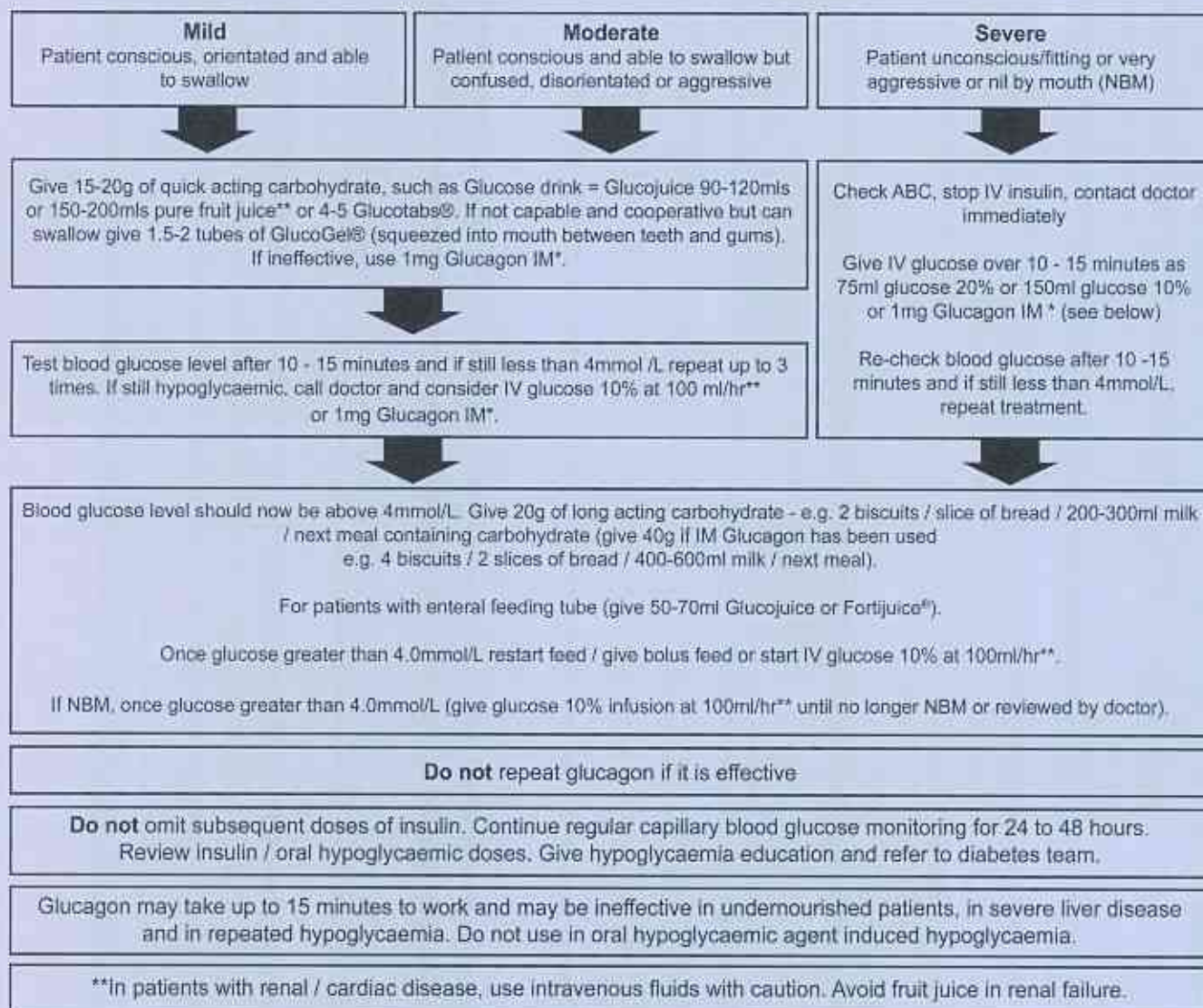
Management of Acute Hypoglycaemia

Note: You will find - 1) Glucojuice, Glucotabs and GlucoGel in the ward Hypo box. 2) Glucagon IM in the ward fridge. 3) IV fluids in the ward treatment room 4) Biscuits, Bread and Forti juice in the ward kitchen.

Algorithm for the Treatment and Management of Hypoglycaemia in Adults with Diabetes Mellitus in Hospital

Hypoglycaemia is a serious condition and should be treated as an emergency regardless of level of consciousness. Hypoglycaemia is defined as blood glucose of less than 4mmol/L (if not less than 4mmol/L but symptomatic give a small carbohydrate snack for symptom relief).

For further information: NHS Lothian Intranet > Healthcare > Diabetes > Metabolic Unit Handbook.



If hypoglycaemia occurs, DO NOT omit insulin injection if due, treat hypoglycaemia and review the insulin dose and reduce if necessary

PATIENT PROGRESS NOTES
/COMMUNICATION SHEET

Name **Soave, Alan**
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

DOB **CHI 2911571495**
78010 AF Stephen

Unit No **800183063V M 29/11/1957**

Ward/Clinical Area: **MHDU**

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)
29/11/23 9:30	CCM 1. CAP 2. COVID +ve ABC: resp alkalosis CRP 418 NEWS: 7 - BP 109/71, EOX. O₂/60L sat's 93% rr 28, afebrile. Imp: pneumonia with right sided parapneumonic effusion. Plan: 1. Repeat bloods today ☒ ? what bloods 2. Review radiology ☐ BCV - ? gas aspiration ? TAP ☐ imaging foot 3. Continue co-amox + clav ☒ 4. Send sputum M+C+S - already sent ☒ * CRPA pneum. & effusion	
	* Blood results CRP 405 today URES also HPS2 slightly improved ↓ improved renal function ✓ fbc - 113 HB ✓ WCC ↑ 20.6 ✓ neuts ↑ 20.21	

[illegible]

National Early Warning Score 2 (NEWS2) Chart

[illegible]

NEWS of 5 or more? Think Sepsis!



In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately.**

Signs of Infection

- Temperature $<36^{\circ}\text{C}$ or $>38^{\circ}\text{C}$
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name: _____

DOB: _____

CHI: _____

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter*	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

Date		Time																		
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4																	Eyes closed by swelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	Best Verbal Response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropriate words	3																	
		Incomprehensible sounds	2																	
		None	1																	
	Best Motor Response	Obey commands	6																	Always record the best arm response
Localise to pain		5																		
Flexion to pain		4																		
Abnormal flexion		3																		
Extension to pain		2																		
None		1																		
Total GCS Score			5																	
Right Pupil	Size																			
	Reaction																			
Left Pupil	Size																			
	Reaction																			
LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		
LEGS	Normal power																			
	Mild weakness																			
	Severe weakness																			
	Extension																			
	No response																			
Initials																				

Pupil Scale mm

1 •

2 •

3 •

4 •

5 •

6 •

7 •

8 •

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished
12:35	PlasmaLyte	500ml	STAT		12:35	KE	JG.	
13:00	PLASMAlyte	500	STAT		13:05	KE	JG.	
13:50	PLASMAlyte	500	STAT		13:50	KE	APA	
14:05	PLASMAlyte	500	30 mins		14:15	APA	KE	

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time										
	Rate (ml/hr)										
	Volume in Syringe										
Pump No	Total amount Infused										

Drug Name:

	Time										
	Rate (ml/hr)										
	Volume in Syringe										
Pump No	Total amount Infused										

Ward: <u>21</u>	Site: <u>SYH</u>	Date: <u>7/12/23</u>	Addressograph, or 800183063V M 29/11/1957	
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.			Name: Soave, Alan 34 Southpark Place, Livingston, West Lothian, EH54 6FG	
1hrly 2 hrly <u>(3 hrly)</u> hrly (please circle/complete)			CHI 2911571495 Unit: 78010 AF Stephen	
Print name and sign _____				
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined, (AS) Asleep, (I) Independent, (NW) not on ward, (TH) Theatre.				
Time of Care Rounding Document the exact time care rounding took place e.g. 0830			<u>0800</u> 08.00 am 24 hour period <u>1417</u> <u>2023</u> <u>2</u> <u>5</u> <u>0700</u> 07.00 am	
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review			
	Waterlow 10+ - Visual Skin Check (tick)		NS NS ✓ ✓ ✓ ✓	
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister		NS NS H H H H	
	Vulnerable areas? (circle areas of damage)		Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....	
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan			
Elimination	Have you changed position since last CR?		Y Y Y Y Y Y	
	Positioning (R) or (L) side (B) Back (C) Chair		B B B B B B	
	Mattress type / Cushion type		please state type:	
	Do you need the toilet?		I I Y Y Y Y	
	Is the patient continent of urine? (at time of Care Rounding)		Y Y Y Y Y Y	
Food, Fluid & Nutrition	Continence product changed/offered?		NA NA N N N N	
	Catheter care performed?		NA NA N N N N	
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact			
	Is patient continent of faeces? (at time of Care Rounding)		Y Y Y Y Y Y	
	Bowel function monitored		Observe bowel function and update daily	
Falls	Would you like a drink?		I I I I I I	
	Ensure fluids are within easy reach			
	Fluid Balance Chart (if clinically indicated)		NA NA N N N N	
	When did you last eat?		B B B D D D	
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required			
Pain	Oral Hygiene Performed (ref to risk assessment)		I I I I I I	
	Appropriate Footwear?		Y Y Y Y Y Y	
	Walking aid available (and within reach)		NA NA N N N N	
	Area de-cluttered?		Y Y Y Y Y Y	
	Chair and bed height assessed?		Y Y Y Y Y Y	
General	Falls alarm in use and attached?		NA NA N N N N	
	Glasses available for use? (if worn)		Y Y Y Y Y Y	
	Hearing aid available for use? (if worn)		NA NA N N N N	
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐			
	Are you in pain?		N N N N N N	
Analgesia Given?		N N N N N N		
Peripheral Venous Cannula observed?		Y Y Y Y Y Y		
Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily				
Are you comfortable? Y/N		Y Y Y Y Y Y		
Anything else I can do for you?		N N N N N N		
Buzzer within easy reach		Y Y Y Y Y Y		
Personal Care Type _____ (specify)			Time Given _____	
Initials – document at time of care delivery		BC BC <u>W W W W</u>		

Ward: <u>21</u>	Site: <u>SYM</u>	Date: <u>8/12/23</u>	Addressograph, or 800183063V M 29/11/1957 Name <u>Soave, Alan</u> 34 Southpark Place, Livingston, West Lothian, EH54 6FG DOB Unit no. <u>CHI 2911571495</u> <u>78010 AF Stephen</u>	
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.				
1hrly 2 hrly <u>3 hrly</u> hrly (please circle/complete)				
Print name and sign _____				
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,				
Time of Care Rounding Document the exact time care rounding took place e.g. 0830 <u>08.11</u> 08.00 am ← 24 hour period → 07.00 am				
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review. Use codes for outcome of skin review.			
	Waterlow 10+ - Visual Skin Check (tick) <u>X</u>			
	Outcome of skin review: (H) Healthy (R) Red (P) Purple (B) Broken (BL) Blister <u>NS</u>			
	Vulnerable areas? (circle areas of damage) <u>Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....</u>			
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan			
Elimination	Have you changed position since last CR? <u>Y</u>			
	Positioning (R) or (L) side (B) Back (C) Chair			
	Mattress type / Cushion type <u>please state type:</u>			
	Do you need the toilet?			
	Is the patient continent of urine? (at time of Care Rounding)			
Food, Fluid & Nutrition	Continence product changed/offered?			
	Catheter care performed?			
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact			
	Is patient continent of faeces? (at time of Care Rounding)			
	Bowel function monitored <u>Observe bowel function and update daily.</u>			
Falls	Would you like a drink?			
	Ensure fluids are within easy reach			
	Fluid Balance Chart (if clinically indicated)			
	When did you last eat?			
	(B) Breakfast (L) Lunch (D) Dinner (S)Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required			
Pain	Oral Hygiene Performed (ref to risk assessment)			
	Appropriate Footwear?			
	Walking aid available (and within reach)			
	Area de-cluttered?			
	Chair and bed height assessed?			
General	Falls alarm in use and attached?			
	Glasses available for use? (if worn)			
	Hearing aid available for use? (if worn)			
	Requires close observation for commode, toilet, bathing or showering <u>Y</u> ☐ <u>N</u> ☐			
	Are you in pain?			
Personal Care	Analgesia Given?			
	Peripheral Venous Cannula observed?			
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily			
	Are you comfortable? <u>Y/N</u>			
	Anything else I can do for you?			
Buzzer within easy reach				
Personal Care Type <u>IND wash</u> (specify) Time Given _____				
Initials — document at time of care delivery				

Ward: MHPU Site: STA Date: 30/11/23
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

Addressograph, or



Na Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6PG

CHI 2911571495
Unit 78010 AF Stephen
800183063V M 29/11/1957

1hrly 2 hrly **3 hrly** _____ hrly (please circle/complete)

Print name and sign

E. Dick E. Dick

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NV) not on ward, (TH) Theatre,

Time of Care Rounding

Document the exact time care rounding took place e.g. 0830

0830 1130 1430 1630 1930 2230 0100 0400 0700
08.00 am ← 24 hour period → 07.00 am

Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review									
	Use codes for outcome of skin review									
	Waterlow 10+ - Visual Skin Check (tick) ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓									
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....									
Elimination	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan									
	Have you changed position since last CR? Y Y Y Y Y Y Y Y Y Y									
	Positioning (R) or (L) side (B) Back (C) Chair B B B C B B B B B									
	Mattress type / Cushion type please state type:									
Food, Fluid & Nutrition	Do you need the toilet? N N N N N N N N N N									
	Is the patient continent of urine? (at time of Care Rounding) SRC SRC SRC SRC SRC SRC SRC SRC SRC									
	Continence product changed/offered? No									
	Catheter care performed? N N N N N N N N N N									
Falls	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact									
	Is patient continent of faeces? (at time of Care Rounding) Y Y Y Y Y Y Y Y Y Y									
	Bowel function monitored Observe bowel function and update daily									
	Would you like a drink? Y Y N N N N N N N N									
Pain	Ensure fluids are within easy reach Y Y Y Y Y Y Y Y Y Y									
	Fluid Balance Chart (if clinically indicated) Y Y Y Y Y Y Y Y Y Y									
	When did you last eat? B B L L D D D D D									
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required									
General	Oral Hygiene Performed (ref to risk assessment) N N N Y N N N N N									
	Appropriate Footwear? N N N N N N N N N									
	Walking aid available (and within reach) NA NA NA NA NA NA NA NA NA									
	Area de-cluttered? Y Y Y Y Y Y Y Y Y									
Personal Care	Chair and bed height assessed? NA NA NA NA NA NA NA NA NA									
	Falls alarm in use and attached? NA NA NA NA NA NA NA NA NA									
	Glasses available for use? (if worn) Y Y Y Y Y Y Y Y Y									
	Hearing aid available for use? (if worn) N N N N N N N N N									
Initials	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐									
	Are you in pain? N N N N N N N N N									
	Analgesia Given? N N N N N N N N N									
	Peripheral Venous Cannula observed? Y Y Y Y Y Y Y Y Y									
Initials	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily									
	Are you comfortable? Y/N Y Y Y Y Y Y Y Y Y									
	Anything else I can do for you? N N N N N N N N N									
	Buzzer within easy reach Y Y Y Y Y Y Y Y Y									
Personal Care Type Baon (specify) Time Given 1630										
Initials — document at time of care delivery										
C. Dick E. Dick M. Medo M. Medo										

Ward: mhdca Site: slh Date: 28/11/23

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2hrly 3hrly _____ hrly (please circle/complete)

Print name and sign One CMKIE

Addressograph, or
800183063V M 29/11/1957
Name: Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG
DOB
Unit no: CHI 2911571495
78010 AF Stephen

IHS
othian

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding
Document the exact time care rounding took place e.g. 0830 1530 1830 2130 0030 0330 0630

08.00 am ← 24 hour period → 07.00 am

Waterlow score less than 10 low risk requires only a daily skin review
Use codes for outcome of skin review

Pressure Area Care

Waterlow 10+ - Visual Skin Check (tick) ✓ n N N N

Outcome of skin review: (H) Healthy h n states n ns NS NS
(R) Red, (P) Purple (B) Broken (BL) Blister
Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....

If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan

Have you changed position since last CR? Y Y Y Y Y Y

Positioning (R) or (L) side (B) Back (C) Chair B B b B B B

Mattress type / Cushion type please state type: SoftFoam

Elimination

Do you need the toilet? Y N n N N N

Is the patient continent of urine? (at time of Care Rounding) Y SLC SLC SLC SLC SLC

Continence product changed/offered? na na na na na na

Catheter care performed? na Y na na na na

Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact

Is patient continent of faeces? (at time of Care Rounding) Y Y Y Y Y Y

Bowel function monitored Observe bowel function and update daily

Food, Fluid & Nutrition

Would you like a drink? Y Y Y I I I

Ensure fluids are within easy reach Y Y Y Y Y Y

Fluid Balance Chart (if clinically indicated) Y Ref Y Y Y Y

When did you last eat? ? Ref Small Small Small Small

(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required

Oral Hygiene Performed (ref to risk assessment) na I N N N N

Appropriate Footwear? Y Y Y Y Y Y

Walking aid available (and within reach) gl na na na na na

Area de-cluttered? Y Y Y Y Y Y

Chair and bed height assessed? na na na na na na

Falls alarm in use and attached? Y Y N N N N

Glasses available for use? (if worn) Y Y Y Y Y Y

Hearing aid available for use? (if worn) N N Y N N N

Requires close observation for commode, toilet, bathing or showering Y N

Pain

Are you in pain? N N n N N N

Analgesia Given? N N n N N N

General

Peripheral Venous Cannula observed? Y Y Y Y Y Y

Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily

Are you comfortable? Y/N Y Y Y Y Y Y

Anything else I can do for you? Y Y n N N N

Buzzer within easy reach Y Y Y Y Y Y

Personal Care Type _____ (specify) Time Given _____

Initials — document at time of care delivery ap GP nm nm nm nm

Ward: MNDU Site: SWH Date: 29/11/23

Addressograph, or



This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

800183063V /E5536575 M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG

1hrly 2 hrly 3 hrly _____ hrly (please circle/complete)

Print name and sign NCON NCON



Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre

Time of Care Rounding

Document the exact time care rounding took place e.g. 0830

08.00 am 11.00 14 17 20.00 23.00 02.00 05.00
24 hour period 07.00 am

Waterlow score less than 10 low risk requires only a daily skin review

Use codes for outcome of skin review

Waterlow 10+ - Visual Skin Check (tick)

Outcome of skin review: (H) Healthy

(R) Red, (P) Purple (B) Broken (BL) Blister

Vulnerable areas? (circle areas of damage)

If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan

Have you changed position since last CR?

Positioning (R) or (L) side (B) Back (C) Chair

Mattress type / Cushion type

Do you need the toilet?

Is the patient continent of urine?

(at time of Care Rounding)

Continence product changed/offered?

Catheter care performed?

Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact

Is patient continent of faeces?

(at time of Care Rounding)

Bowel function monitored

Would you like a drink?

Ensure fluids are within easy reach

Fluid Balance Chart (if clinically indicated)

When did you last eat?

(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance

Oral Hygiene Performed (ref to risk assessment)

Appropriate Footwear?

Walking aid available (and within reach)

Area de-cluttered?

Chair and bed height assessed?

Falls alarm in use and attached?

Glasses available for use? (if worn)

Hearing aid available for use? (if worn)

Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐

Are you in pain?

Analgesia Given?

Peripheral Venous Cannula observed?

Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily

Are you comfortable? Y/N

Anything else I can do for you?

Buzzer within easy reach

Personal Care Type Basic Care (specify)

Time Given 9:10

Initials - document at time of care delivery

Ward:	Site:	Date:	Addressograph, or	
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.			Name DOB Unit no. / CHI	
1hrly 2 hrly 3 hrly ____ hrly (please circle/complete)				
Print name and sign _____				
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre.				
Time of Care Rounding Document the exact time care rounding took place e.g. 0830				
08.00 am ← 24 hour period → 07.00 am				
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review Use codes for outcome of skin review			
	Waterlow 10+ - Visual Skin Check (tick)			
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister			
	Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other,			
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan			
	Have you changed position since last CR? Positioning (R) or (L) side (B) Back (C) Chair Mattress type / Cushion type <i>please state type:</i>			
Elimination	Do you need the toilet?			
	Is the patient continent of urine? (at time of Care Rounding)			
	Continence product changed/offered?			
	Catheter care performed? Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact			
	Is patient continent of faeces? (at time of Care Rounding) Bowel function monitored Observe bowel function and update daily			
Food, Fluid & Nutrition	Would you like a drink? Ensure fluids are within easy reach Fluid Balance Chart (if clinically indicated)			
	When did you last eat?			
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required			
	Oral Hygiene Performed (ref to risk assessment)			
Falls	Appropriate Footwear?			
	Walking aid available (and within reach)			
	Area de-cluttered?			
	Chair and bed height assessed?			
	Falls alarm in use and attached?			
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)			
Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐				
Pain	Are you in pain?			
	Analgesia Given?			
General	Peripheral Venous Cannula observed?			
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily			
	Are you comfortable? Y/N			
	Anything else I can do for you? Buzzer within easy reach			
Personal Care Type _____ (specify) Time Given _____				
Initials – document at time of care delivery				

SAS Handover Sheet

Date

Time

Crew no 4272

Standby

Alert

Courtesy

Age 65

Male

Female

Symptoms

? PE

SOB, Chest Pain

Onset time

GCS-15

3.9-BM

RR-36

Observations

SAT 91%

MF

HR-108

GCS

102/78

Medications given

ETA 5

Signed

Destination

800183063V
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen

29/11/23

2911571495



Directorate of Critical Care

Date: 6/12/23

Date of admission: 2/12/23

Day number: 5

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O ² Cylinder Check	LA	✓ HW	
Tracheostomy box check (If applicable)	N/A	N/A	
C-Circuit	LA	✓ HW	
Laerdal AMBU bag	Unit	IN UNIT	
Suction	LA	HW	
MONITORING CHECKS			
Invasive lines - Check and zero	LA	N/A	
NIBP	LA	✓ HW	112/73 (SB) 117/73 (DB)
Alarm limits - Checked/Set	LA	✓ HW	
Glucometer QC	Unit	✓ HW	IN UNIT
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	LA	✓ HW	
Infusions and Lines in date	LA	✓ HW	
Air entry assessed	LA	✓ HW	✓✓✓
Name band in situ with CHI	LA	✓ HW	
ETT Cuff pressure check	N/A	N/A	
Skin bundle check		✓ HW	
Allergy band check	NKDA	NKDA	
PROPHYLAXIS			
FLOWTRONS	LA	✓ HW	TEOS
DVT/PE	LA	✓ HW	Dalteparin
Gastric Ulcer		✓ HW	LANOOPRACOL
Eye care (prescribed)	N/A	N/A	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On:	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On:	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

SEDATION AND WEANING	
Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☒
Ready to wean	
Yes	☐
No	☐
Not appropriate	☒

Infection Status	
MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	(COVID) TVE
Patient neutropaenic?	Y ☐ N ☒
Isolation Required?	Y ☒ N ☐

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

Admission Weight (kg)

Predicted Weight (kg)

Admission BMI

Latest Weight (kg) 79kg

Bowels last opened (Date) 4/12/23

If >72hrs aperients considered Y ☐ N ☐

NOTES	

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoïd	0 Nil	✓ Cough & expectorate	SW Swinging	P Pink	W Warm	R Right side	0 No pain	0 Full power in legs
MP Mucopurulent	1 Minimal	✗ Cough & No expectorate	ST Static BUB Bubbling	WH White	C Cool	L Left side	1 Mild (Doesn't distress me)	1 Weak but can move legs
P Purulent	2 Moderate	Ø No cough	B Bloodstained	M Mottled	CO Cold	B Back	2 Moderate (Distresses me a bit)	2 Able to move knees
B Bloodstained	3 Large	BG Bagging BD Bird	HS Haemoserous S Serous	✓ Pulse present	✗ Pulse absent	Ch In Chair Pr Proned	3 Severe (Distresses a lot) S Sleeping	3 Minimal movement 4 Paralysed

Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
•	•	•	•	•	•	•	•	4 Spontaneous 3 To speech 2 To pain 1 None 1 Eyes swollen	5 Orientated 4 Confused 3 Inappropriate words 2 Incomprehensible 1 None/ETT/Trach	6 Obeys commands 5 Localises pain 4 Normal flexion 3 Abnormal flexion 2 Extension 1 None

Continuation

TIME	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
FiO ₂	31%	31%	2L																					
SpO ₂	93	95	94																					
ETCO ₂																								
Mode	SVT	SVT	SVT																					
Set Respiratory Rate	18	24	17																					
Total Respiratory Rate																								
Set Tidal Volume																								
Expired Tidal Volume																								
Minute Volume																								
Peak Pressure / P High																								
ASB / PS																								
PEEP / CPAP / P Low																								
I:E Ratio																								
T high / T low																								
HFNC Flow Rate																								
30° Head Up	✓	✓	✓																					
Humidifier temp																								
Inner tube change																								
Cough / deep breath																								
Suction																								
Subglottic drainage																								
Air Entry (R/L)		✓	✓																					
ETT Length																								
ETT pressure areas																								
Anchorfast (R/M/L)																								
IPPB / Cough assist																								
Fine bore suction/oral																								
Temp	40°																							
HR	39																							
MAP	37°																							
ASP	35°																							
NIBP	33°																							
Cardiac Rhythm	SR																							
CVP																								
PAP																								
CCO																								
Cardiac Index																								
SV / PPV																								
Peripheral Circulation	N / N / W																							
Angio seal check (L/R)																								
Blood Glucose																								
Pain Score	0	0	0																					
R.A.S.S																								
GCS Eyes	4																							
GCS Verbal	5																							
GCS Motor (L/R)	6																							
Total GCS	15																							
CAM-ICU (+/-)	15																							
Pupil size/reaction R	3+																							
Pupil size/reaction L	3+																							
NPI (R/L)																								
ICP																								
CPP																								
ICP Treatment																								
CSF (ml/hr)																								
CSF Drain Set (cmH ₂ O)																								
Brain PbO ₂ (mmHg)																								
Brain Temp (°C)																								
Lower Limb Power (L/R)																								
Pressure care																								
Oral care (4 hourly)																								
Limb physiotherapy																								
Eye Care																								
Swinging																								
Static																								
Bubbling																								
Bloodstain																								
HS																								
Haemorrhage																								
Serous																								

Soave, Alan
28/11/1987 600103063V
SHCT47230637 SJH Red
SH

Soave, Alan
28/11/1987 600103063V
SHCT47230637 SJH Red
SH

Soave, Alan
28/11/1987 600103063V
SHCT47230637 SJH Red
SH

DATE: 6/12/23

[illegible]

DATE: _____

DATE:		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
DRUG INFUSIONS	Peripheral or Central (circle as appropriate)																								
	Drug	Rate (ml/hr)																							
	Peripheral/Central Concentration:	Level																							
	Pump No:	Volume Infused																							
	Drug	Rate (ml/hr)																							
	Peripheral/Central Concentration:	Level																							
	Pump No:	Volume Infused																							
	Drug	Rate (ml/hr)																							
	Peripheral/Central Concentration:	Level																							
	Pump No:	Volume Infused																							
	Drug	Rate (ml/hr)																							
	Peripheral/Central Concentration:	Level																							
	Pump No:	Volume Infused																							
	TPN	Rate (ml/hr)																							
Peripheral/Central Concentration:	Level																								
Pump No:	Volume Infused																								
Hourly infusion Checks (initial)																									
Sub Total infusions																									
FLUIDS IN	Crystalloids																								
	Colloids																								
	Blood Products																								
	IV Medication	30	30					30	30	30	30														
	PCA																								
	Epidural																								
	Flush Bag (0.9% NaCl)	3	3	3																					
	NG / NJ / Jejunal																								
	Gastric Aspirate pH																								
	Oral Medication																								
Oral	100	330		330						500		500	200	50											
Total Intake		133	169	532		862		892	922	1452		1452	1982												
OUTPUT	Urine	150	498			236				269			183	182			278								
	Net UF CVVHD (reset hourly)																								
	Drain 1	Observations																							
	Location:	Level																							
	Hourly Amount Drained																								
	Drain 2	Observations																							
	Location:	Level																							
	Hourly Amount Drained																								
	Drain 3:	Observations																							
	Location:	Level																							
	Hourly Amount Drained																								
	Drain 4:	Observations																							
	Location:	Level																							
	Hourly Amount Drained																								
Drain 5:		Observations																							
Location:		Level																							
Hourly Amount Drained																									
CSF drain output (hourly)																									
Nasogastric aspirates/drained																									
Blood Loss																									
Bowels																									
Cumulative balance (72hours)	Total Output	150	648			884				1153			1336	1418											
	Balance	-17	-116							-291			-646												
CVVHD	Blood Flow (mls/min)																								
	Dialysate flow (mls/hr)																								
	Access Pressure (mmHg)																								
	Return Pressure (mmHg)																								
	Pre-filter pressure (mmHg)																								
	Citrate Infusion (mmol/L)																								
	Calcium Infusion (mmol/L)																								
	Post filter iCa (6 hrly Blue port)																								
	Systemic iCa (6 hrly A-Line)																								
	Total Ca (check daily- <3mmol)																								
	T:I ratio (Total Ca + Ionised Ca) (check daily - < 2.5)																								
	Changes made																								
	Initials:																								
	Totals reset hourly (initial)																								

CHI:

DATE: 5/12/23

[illegible]

800183063V M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG



abel



Directorate of Critical Care

Date: 5/12/23

Date of admission: 2/12/23

Day number: 4

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O ² Cylinder Check	LH	✓ U	
Tracheostomy box check (If applicable)	-	N/A	
C-Circuit	LH	✓ U	
Laerdal AMBU bag	Unit	N/A	ununit
Suction	LH	✓ U	
MONITORING CHECKS			
Invasive lines - Check and zero	LH	✓ U	
NIBP	UA	✓ U	Arm: 122/83 (44)
Alarm limits - Checked/Set	LH	✓ U	
Glucometer QC	Unit	N/A	ununit
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	UA	N/A	
Infusions and Lines in date	UA	✓ U	
Air entry assessed	UA	✓ U	
Name band in situ with CHI	UA	✓ U	
ETT Cuff pressure check	-	N/A	
in bundle check	LH	✓ U	
Allergy band check	NKDA	N/A	NKDA
PROPHYLAXIS			
FLOWTRONS	TDS	✓ U	
DVT/PE	UA	✓ U	Daltapanna
Gastric Ulcer	UA	N/A	
Eye care (prescribed)	N/A	N/A	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On:	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On:	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)

Predicted Weight (kg)

Admission BMI

Latest Weight (kg) 79

Bowels last opened (Date) 4/12/23

If >72hrs aperients considered Y ☐ N ☒

SEDATION AND WEANING

Sedation Hold (please tick)

Yes ☐

No ☐

Not appropriate ☒

Ready to wean

Yes ☐

No ☐

Not appropriate ☒

Infection Status

MRSA Negative

C. Difficile

VRE

ESBL (e.g. E Coli or Klebsiella)

CRE/CPE

Other: Covid +ve

Patient neutropaenic? Y ☐ N ☒

Isolation Required? Y ☒ N ☐

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	0 Nil	✓ Cough & expectorate	SW Swinging	P Pink	W Warm	R Right side	0 No pain	0 Full power in legs
MP Mucopurulent	1 Minimal	✗ Cough & No expectorate	ST Static BUB Bubbling	WH White	C Cool	L Left side	1 Mild (Doesn't distress me)	1 Weak but can move legs
P Purulent	2 Moderate	Ø No cough	B Bloodstained	M Mottled	CO Cold	B Back	2 Moderate (Distresses me a bit)	2 Able to move knees
B Bloodstained	3 Large	BG Bagging	HS Haemoserous	✓ Pulse present	✗ Pulse absent	Ch In Chair	3 Severe (Distresses a lot)	3 Minimal movement
		BD Bird	S Serous			Pr Proned	S Sleeping	4 Paralysed

Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8	4 Spontaneous 3 To speech 2 To pain 1 None 1 Eyes swollen	5 Orientated 4 Confused 3 Inappropriate words 2 Incomprehensible 1 None/ETT/Trach	6 Obeys commands 5 Localises pain 4 Normal flexion 3 Abnormal flexion 2 Extension 1 None
•	•	•	•	•	•	•	•			

CHI:

DATE:

Peripheral or Central
(circle as appropriate)

08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 01 02 03 04 05 06 07

D
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N
S

(circle as appropriate)			08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
Drug	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									
TPN	Rate (ml/hr)	Level																								
Peripheral/Central Concentration:																										
Pump No:	Volume Infused																									

F
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Sub Total Infusions																									
Crystalloids																									
Colloids																									
Blood Products																									
IV Medication	30	30						25	25	25	25				30	30	30	30							
PCA																									
Epidural																									
Flush Bag (0.9% NaCl)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
NG / NJ / Jejunal																									
Gastric Aspirate pH																									
Oral Medication																									
Oral	330	330						330							200										

Total Intake

33 366 399 732 735 738 766 794 1152 1180 1183 1186 1189 1222 1260 1273 1276 1279 1282 1285 1288 1291 1294 1297 1300 1303 1306 1309 1312 1315 1318 1321 1324 1327 1330 1333 1336 1339 1342 1345 1348 1351 1354 1357 1360 1363 1366 1369 1372 1375 1378 1381 1384 1387 1390 1393 1396 1399 1402 1405 1408 1411 1414 1417 1420 1423 1426 1429 1432 1435 1438 1441 1444 1447 1450 1453 1456 1459 1462 1465 1468 1471 1474 1477 1480 1483 1486 1489 1492 1495 1498 1501 1504 1507 1510 1513 1516 1519 1522 1525 1528 1531 1534 1537 1540 1543 1546 1549 1552 1555 1558 1561 1564 1567 1570 1573 1576 1579 1582 1585 1588 1591 1594 1597 1600 1603 1606 1609 1612 1615 1618 1621 1624 1627 1630 1633 1636 1639 1642 1645 1648 1651 1654 1657 1660 1663 1666 1669 1672 1675 1678 1681 1684 1687 1690 1693 1696 1699 1702 1705 1708 1711 1714 1717 1720 1723 1726 1729 1732 1735 1738 1741 1744 1747 1750 1753 1756 1759 1762 1765 1768 1771 1774 1777 1780 1783 1786 1789 1792 1795 1798 1801 1804 1807 1810 1813 1816 1819 1822 1825 1828 1831 1834 1837 1840 1843 1846 1849 1852 1855 1858 1861 1864 1867 1870 1873 1876 1879 1882 1885 1888 1891 1894 1897 1900 1903 1906 1909 1912 1915 1918 1921 1924 1927 1930 1933 1936 1939 1942 1945 1948 1951 1954 1957 1960 1963 1966 1969 1972 1975 1978 1981 1984 1987 1990 1993 1996 1999 2002 2005 2008 2011 2014 2017 2020 2023 2026 2029 2032 2035 2038 2041 2044 2047 2050 2053 2056 2059 2062 2065 2068 2071 2074 2077 2080 2083 2086 2089 2092 2095 2098 2101 2104 2107 2110 2113 2116 2119 2122 2125 2128 2131 2134 2137 2140 2143 2146 2149 2152 2155 2158 2161 2164 2167 2170 2173 2176 2179 2182 2185 2188 2191 2194 2197 2200 2203 2206 2209 2212 2215 2218 2221 2224 2227 2230 2233 2236 2239 2242 2245 2248 2251 2254 2257 2260 2263 2266 2269 2272 2275 2278 2281 2284 2287 2290 2293 2296 2299 2302 2305 2308 2311 2314 2317 2320 2323 2326 2329 2332 2335 2338 2341 2344 2347 2350 2353 2356 2359 2362 2365 2368 2371 2374 2377 2380 2383 2386 2389 2392 2395 2398 2401 2404 2407 2410 2413 2416 2419 2422 2425 2428 2431 2434 2437 2440 2443 2446 2449 2452 2455 2458 2461 2464 2467 2470 2473 2476 2479 2482 2485 2488 2491 2494 2497 2500 2503 2506 2509 2512 2515 2518 2521 2524 2527 2530 2533 2536 2539 2542 2545 2548 2551 2554 2557 2560 2563 2566 2569 2572 2575 2578 2581 2584 2587 2590 2593 2596 2599 2602 2605 2608 2611 2614 2617 2620 2623 2626 2629 2632 2635 2638 2641 2644 2647 2650 2653 2656 2659 2662 2665 2668 2671 2674 2677 2680 2683 2686 2689 2692 2695 2698 2701 2704 2707 2710 2713 2716 2719 2722 2725 2728 2731 2734 2737 2740 2743 2746 2749 2752 2755 2758 2761 2764 2767 2770 2773 2776 2779 2782 2785 2788 2791 2794 2797 2800 2803 2806 2809 2812 2815 2818 2821 2824 2827 2830 2833 2836 2839 2842 2845 2848 2851 2854 2857 2860 2863 2866 2869 2872 2875 2878 2881 2884 2887 2890 2893 2896 2899 2902 2905 2908 2911 2914 2917 2920 2923 2926 2929 2932 2935 2938 2941 2944 2947 2950 2953 2956 2959 2962 2965 2968 2971 2974 2977 2980 2983 2986 2989 2992 2995 2998 3001 3004 3007 3010 3013 3016 3019 3022 3025 3028 3031 3034 3037 3040 3043 3046 3049 3052 3055 3058 3061 3064 3067 3070 3073 3076 3079 3082 3085 3088 3091 3094 3097 3100 3103 3106 3109 3112 3115 3118 3121 3124 3127 3130 3133 3136 3139 3142 3145 3148 3151 3154 3157 3160 3163 3166 3169 3172 3175 3178 3181 3184 3187 3190 3193 3196 3199 3202 3205 3208 3211 3214 3217 3220 3223 3226 3229 3232 3235 3238 3241 3244 3247 3250 3253 3256 3259 3262 3265 3268 3271 3274 3277 3280 3283 3286 3289 3292 3295 3298 3301 3304 3307 3310 3313 3316 3319 3322 3325 3328 3331 3334 3337 3340 3343 3346 3349 3352 3355 3358 3361 3364 3367 3370 3373 3376 3379 3382 3385 3388 3391 3394 3397 3400 3403 3406 3409 3412 3415 3418 3421 3424 3427 3430 3433 3436 3439 3442 3445 3448 3451 3454 3457 3460 3463 3466 3469 3472 3475 3478 3481 3484 3487 3490 3493 3496 3499 3502 3505 3508 3511 3514 3517 3520 3523 3526 3529 3532 3535 3538 3541 3544 3547 3550 3553 3556 3559 3562 3565 3568 3571 3574 3577 3580 3583 3586 3589 3592 3595 3598 3601 3604 3607 3610 3613 3616 3619 3622 3625 3628 3631 3634 3637 3640 3643 3646 3649 3652 3655 3658 3661 3664 3667 3670 3673 3676 3679 3682 3685 3688 3691 3694 3697 3700 3703 3706 3709 3712 3715 3718 3721 3724 3727 3730 3733 3736 3739 3742 3745 3748 3751 3754 3757 3760 3763 3766 3769 3772 3775 3778 3781 3784 3787 3790 3793 3796 3799 3802 3805 3808 3811 3814 3817 3820 3823 3826 3829 3832 3835 3838 3841 3844 3847 3850 3853 3856 3859 3862 3865 3868 3871 3874 3877 3880 3883 3886 3889 3892 3895 3898 3901 3904 3907 3910 3913 3916 3919 3922 3925 3928 3931 3934 3937 3940 3943 3946 3949 3952 3955 3958 3961 3964 3967 3970 3973 3976 3979 3982 3985 3988 3991 3994 3997 4000 4003 4006 4009 4012 4015 4018 4021 4024 4027 4030 4033 4036 4039 4042 4045 4048 4051 4054 4057 4060 4063 4066 4069 4072 4075 4078 4081 4084 4087 4090 4093 4096 4099 4102 4105 4108 4111 4114 4117 4120 4123 4126 4129 4132 4135 4138 4141 4144 4147 4150 4153 4156 4159 4162 4165 4168 4171 4174 4177 4180 4183 4186 4189 4192 4195 4198 4201 4204 4207 4210 4213 4216 4219 4222 4225 4228 4231 4234 4237 4240 4243 4246 4249 4252 4255 4258 4261 4264 4267 4270 4273 4276 4279 4282 4285 4288 4291 4294 4297 4300 4303 4306 4309 4312 4315 4318 4321 4324 4327 4330 4333 4336 4339 4342 4345 4348 4351 4354 4357 4360 4363 4366 4369 4372 4375 4378 4381 4384 4387 4390 4393 4396 4399 4402 4405 4408 4411 4414 4417 4420 4423 4426 4429 4432 4435 4438 4441 4444 4447 4450 4453 4456 4459 4462 4465 4468 4471 4474 4477 4480 4483 4486 4489 4492 4495 4498 4501 4504 4507 4510 4513 4516 4519 4522 4525 4528 4531 4534 4537 4540 4543 4546 4549 4552 4555 4558 4561 4564 4567 4570 4573 4576 4579 4582 4585 4588 4591 4594 4597 4600 4603 4606 4609 4612 4615 4618 4621 4624 4627 4630 4633 4636 4639 4642 4645 4648 4651 4654 4657 4660 4663 4666 4669 4672 4675 4678 4681 4684 4687 4690 4693 4696 4699 4702 4705 4708 4711 4714 4717 4720 4723 4726 4729 4732 4735 4738 4741 4744 4747 4750 4753 4756 4759 4762 4765 4768 4771 4774 4777 4780 4783 4786 4789 4792 4795 4798 4801 4804 4807 4810 4813 4816 4819 4822 4825 4828 4831 4834 4837 4840 4843 4846 4849 4852 4855 4858 4861 4864 4867 4870 4873 4876 4879 4882 4885 4888 4891 4894 4897 4900 4903 4906 4909 4912 4915 4918 4921 4924 4927 4930 4933 4936 4939 4942 4945 4948 4951 4954 4957 4960 4963 4966 4969 4972 4975 4978 4981 4984 4987 4990 4993 4996 5000

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Total Intake		53	366	399	732	735	738	766	794	1152	1180	1183	1186	1189	1232	1260	1273	1296	1349	1352	1353	1358	1361	2317	2352
Urine		180	300	400	181	341	187	234	240		276		292		291	308		340	342		242			503	
Net UF CVVHD (reset hourly)	Observations																								
Drain 1	Observations																								
Location:	Level																								
	Hourly Amount Drained																								
Drain 2	Observations																								
Location:	Level																								
	Hourly Amount Drained																								
Drain 3:	Observations																								
Location:	Level																								
	Hourly Amount Drained																								
Drain 4:	Observations																								
Location:	Level																								
	Hourly Amount Drained																								
Drain 5:	Observations																								
Location:	Level																								
	Hourly Amount Drained																								
CSF drain output (hourly)																									
Nasogastric aspirates/drained																									
Blood Loss																									
Bowels																									

DATE:

Intravenous Fluid Prescription Chart

[illegible]

Enteral Feed/NG Water Prescription

Enteral	Type	Volume	Rate	Prescribed by	Given By	Time Started	Batch Number
NG Water		1000ml					

Haemofiltration Recording & Fluid Prescription

[illegible]

800183063V M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG

el

800183063V M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG



Directorate of Critical Care

Date: 4/12/23
Date of admission: 2/12/23
Day number: 3

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O ² Cylinder Check	UA	✓	
Tracheostomy box check (If applicable)	N/A	✓	
C-Circuit	UA	✓	
Laerdal AMBU bag	N/A	NA	ununit
Suction	UA	✓	
MONITORING CHECKS			
Invasive lines - Check and zero	UA	✓	
NIBP	UA	✓	131/86 (99)
Alarm limits - Checked/Set	UA	✓	
Glucometer QC	ununit	N/A	ununit
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	UA		
Infusions and Lines in date	UA		
Air entry assessed		✓	
Name band in situ with CHI	UA	✓	
ETT Cuff pressure check	N/A	N/A	
Skin bundle check	UA	✓	
Allergy band check	NKDA	NA	NKDA
PROPHYLAXIS			
FLOWTRONS	TODS	✓	
DVT/PE	UA	✓	neutropaenic
Gastric Ulcer	N/A	N/A	
Eye care (prescribed)	N/A	NA	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On: N/A	DAILY
Pressure bag fluid	Change On:	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On: 9/12/23	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On: N/A	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	79
Bowels last opened (Date)	1/1
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING	
Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☒
Ready to wean	
Yes	☐
No	☐
Not appropriate	☒

Infection Status	
MRSA	neg
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	Covid +ve.
Patient neutropaenic? Y ☐ N ☒	
Isolation Required? Y ☒ N ☐	

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

NOTES	

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	0 Nil	✓ Cough & expectorate	SW Swinging	P Pink	W Warm	R Right side	0 No pain	0 Full power in legs
MP Mucopurulent	1 Minimal	X Cough & No expectorate	ST Static BUB Bubbling	WH White	C Cool	L Left side	1 Mild (Doesn't distress me)	1 Weak but can move legs
P Purulent	2 Moderate	Ø No cough	B Bloodstained	M Mottled	CO Cold	B Back	2 Moderate (Distresses me a bit)	2 Able to move knees
B Bloodstained	3 Large	BG Bagging BD Bird	HS Haemoserous S Serous	✓ Pulse present	X Pulse absent	Ch In Chair Pr Proned	3 Severe (Distresses a lot) S Sleeping	3 Minimal movement 4 Paralysed

Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
								4 Spontaneous 3 To speech 2 To pain 1 None 1 Eyes swollen	5 Orientated 4 Confused 3 Inappropriate words 2 Incomprehensible 1 None/ETT/Trach	6 Obeys commands 5 Localises pain 4 Normal flexion 3 Abnormal flexion 2 Extension 1 None

DATE: 4/12/23

[illegible]

DATE: 4/12/23.

DATE: 4/2/16		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	
DRUG INFUSIONS	Peripheral or Central (circle as appropriate)																									
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	TPN	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
Pump No:	Volume Infused																									
Hourly infusion Checks (initial)																										
Sub Total infusions																										
FLUIDS IN	Crystalloids																									
	Colloids																									
	Blood Products																									
	IV Medication	25	25	25				25	25	25	25					25	25	25	25					30	30	
	PCA																									
	Epidural																									
	Flush Bag (0.9% NaCl)	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
	NG / NJ / Jejunal																									
	Gastric Aspirate pH																									
	Oral Medication																									
Oral	150	50	150				150								330								330	225		
Total Intake		178	256	434	437	440	593	160	649	677	705	708	711	714	1047	1075	1103	1131	1159	1162	1165	1168	1501	1534	1792	
OUTPUT	Urine	140	100	380	160	160	200	160	160	OPEN	180	180	220	180	180	300	480	260	200	180	160	150	200	150	140	
	Net UF CVVHD (reset hourly)																									
	Drain 1 Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 2 Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 3: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 4: Observations																									
	Location: Level																									
	Hourly Amount Drained																									
	Drain 5: Observations																									
Location: Level																										
Hourly Amount Drained																										
CSF drain output (hourly)																										
Nasogastric aspirates/drained																										
Blood Loss																										
Bowels	✓																									
Cumulative balance (72hours)	Total Output	140	240	620	780	940	1140	1300	1460		1640	1820	2040	2220	2400	2700	3100	3440	3640	3820	3960	4130	4330	4460	4620	
	Balance				343	547	781				1112							-2071	-2307		-2805			-2916	-2828	
CVVHD	Blood Flow (mls/min)																									
	Dialysate flow (mls/hr)																									
	Access Pressure (mmHg)																									
	Return Pressure (mmHg)																									
	Pre-filter pressure (mmHg)																									
	Citrate Infusion (mmol/L)																									
	Calcium Infusion (mmol/L)																									
	Post filter iCa (6 hrly Blue port)																									
	Systemic iCa (6 hrly A-Line)																									
	Total Ca (check daily- <3mmol)																									
T:I ratio (Total Ca ÷ Ionised Ca) (check daily - < 2.5)																										
Changes made																										
Initials																										
Totals reset hourly (initial)																										

DATE:

Intravenous Fluid Prescription Chart

[illegible]

Enteral Feed/NG Water Prescription

Enteral	Type	Volume	Rate	Prescribed by	Given By	Time Started	Batch Number
NG Water		1000ml					

Haemofiltration Recording & Fluid Prescription

[illegible]

Hospital Number

800183063V

Name

Soave, Alan

D.O.B.

29/11/1957

Admission Date

CHI 2911571495

Address

34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

Barcode

78010 AF Stephen

ent label

*Day 1 = Day of insertion *Score through box and date when line removed

Intubation - Endotracheal

DateTimeOperator

Grade of View (circle appropriate): I II III IV

Tube Size:Tube Type:

Distance @ Lip:Distance @ Teeth:

Procedure Checklist:Difficulties/Adjuncts/Complications:

Preoxygenation☐

Cricoid☐

Capnography☐

Auscultation☐

CXR☐

Operator's Signature:

Days in situ123456789101112

Cuff Pressure

Distance@lip

Dressing/tapes

Tracheostomy

DateTimeOperator

Tube Size:

Tube Type:

Procedure Checklist:Difficulties/Adjuncts/Complications:

Preoxygenation☐

Capnography☐

Auscultation☐

CXR☐

Securing method used:

Bed head sign completed and safety box by bedside☐

Operator's Signature:

Days in situ123456789101112

Cuff Pressure

Tapes/Device

Dressing

Invasive Line

Line Type (circle): CVCArterialCVVH PA Cath

Date:2/12/15Time:1350Operator (print & sign):S. Davi

Site: L radial

USS:Anatomy CheckVisualised insertionNot used

Procedure ChecklistDifficulties/Adjuncts/Complications

Antiseptic hand scrub☒

Gown/gloves/hat/mask☒

CHG skin prep☒

Aseptic insertion☒

Stitched to secure☒

Lines transduced☒

Line saved for TPN☒

Operators Signature:

Post insertion CXRYesN/AReviewed by:

Days in situ123456789101112

Site CleanY/N

Dressing ChangedY/N

Flush Set ChangedY/N

Still RequiredY/N

Invasive Line

Line Type (circle): CVCArterialCVVH PA Cath

Date:Time:Operator (print & sign):

Site:

USS:Anatomy CheckVisualised insertionNot used

Procedure ChecklistDifficulties/Adjuncts/Complications

Antiseptic hand scrub☐

Gown/gloves/hat/mask☐

CHG skin prep☐

Aseptic insertion☐

Stitched to secure☐

Lines transduced☐

Line saved for TPN☐

Operators Signature:

Post insertion CXRYesN/AReviewed by:

Days in situ123456789101112

Site CleanY/N

Dressing ChangedY/N

Flush Set ChangedY/N

Still RequiredY/N

Invasive Line

Line Type (circle): CVCArterialCVVH PA Cath

Date:Time:Operator (print & sign):

Site:

USS:Anatomy CheckVisualised insertionNot used

Procedure ChecklistDifficulties/Adjuncts/Complications

Antiseptic hand scrub☐

Gown/gloves/hat/mask☐

CHG skin prep☐

Aseptic insertion☐

Stitched to secure☐

Lines transduced☐

Line saved for TPN☐

Operators Signature:

Post insertion CXRYesN/AReviewed by:

Days in situ123456789101112

Site CleanY/N

Dressing ChangedY/N

Flush Set ChangedY/N

Still RequiredY/N

Invasive Line

Line Type (circle): CVCArterialCVVH PA Cath

Date:Time:Operator (print & sign):

Site:

USS:Anatomy CheckVisualised insertionNot used

Procedure ChecklistDifficulties/Adjuncts/Complications

Antiseptic hand scrub☐

Gown/gloves/hat/mask☐

CHG skin prep☐

Aseptic insertion☐

Stitched to secure☐

Lines transduced☐

Line saved for TPN☐

Operators Signature:

Post insertion CXRYesN/AReviewed by:

Days in situ123456789101112

Site CleanY/N

Dressing ChangedY/N

Flush Set ChangedY/N

Still RequiredY/N

Peripheral Venous catheter

Date:1/12/15Time:Operator:MAU

Size (circle): BluePinkGreen Brown Grey

Site:RightLeftHandACFForearmFoot

Procedure Checklist:Difficulties/Complications:

Hand hygiene☐

CHG skin prep☐

Aseptic insertion☐

Needle free port☐

Dressing dated☐

Days in situ123456789101112

Site Clean Y/N

Still req'd Y/N

Peripheral Venous catheter

Date:Time:Operator:

Size (circle): BluePinkGreen Brown Grey

Site:RightLeftHandACFForearmFoot

Procedure Checklist:Difficulties/Complications:

Hand hygiene☐

CHG skin prep☐

Aseptic insertion☐

Needle free port☐

Dressing dated☐

Days in situ123456789101112

Site Clean Y/N

Still req'd Y/N

☐ Complete risk assessment on Trak (PCCP)

Trak

Peripheral Venous catheter										Peripheral Venous catheter														
Date:		Time:		Operator:						Date:		Time:		Operator:										
Size (circle): Blue Pink Green Brown Grey										Size (circle): Blue Pink Green Brown Grey														
Site: Right Left Hand ACF Forearm Foot										Site: Right Left Hand ACF Forearm Foot														
Procedure Checklist:					Difficulties/Complications:					Procedure Checklist:					Difficulties/Complications:									
Hand hygiene ☐										Hand hygiene ☐														
CHG skin prep ☐										CHG skin prep ☐														
Aseptic insertion ☐										Aseptic insertion ☐														
Needle free port ☐										Needle free port ☐														
Dressing dated ☐										Dressing dated ☐														
Days in situ		1	2	3	4	5	6	7	8	9	Days in situ		1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N											Site Clean Y/N													
Still req'd Y/N											Still req'd Y/N													

☐ Complete risk assessment on Trak (PCCP)

Peripheral Venous catheter														Peripheral Venous catheter													
Date:		Time:		Operator:										Date:		Time:		Operator:									
Size (circle): Blue Pink Green Brown Grey														Size (circle): Blue Pink Green Brown Grey													
Site: Right Left Hand ACF Forearm Foot														Site: Right Left Hand ACF Forearm Foot													
Procedure Checklist:							Difficulties/Complications:							Procedure Checklist:							Difficulties/Complications:						
Hand hygiene ☐														Hand hygiene ☐													
CHG skin prep ☐														CHG skin prep ☐													
Aseptic insertion ☐														Aseptic insertion ☐													
Needle free port ☐														Needle free port ☐													
Dressing dated ☐														Dressing dated ☐													
Days in situ		1	2	3	4	5	6	7	8	9	10	11	12	Days in situ		1	2	3	4	5	6	7	8	9	10	11	12
Site Clean Y/N														Site Clean Y/N													
Still req'd Y/N														Still req'd Y/N													

Nasogastric intubation														Nasogastric intubation													
Date:		Time:		Operator:										Date:		Time:		Operator:									
Size:		Type (circle): Standard 7day Fine bore 31 days										Nostril: R / L		Size:		Type (circle): Standard 7day Fine bore 31 days										Nostril: R / L	
Post Procedure Checklist:														Post Procedure Checklist:													
Aspirate Yes ☐ No ☐ pH confirms placement? Yes ☐ No ☐														Aspirate Yes ☐ No ☐ pH confirms placement? Yes ☐ No ☐													
CXR required? Yes ☐ No ☐														CXR required? Yes ☐ No ☐													
External cables/wires removed pre CXR ☐														External cables/wires removed pre CXR ☐													
Length at Nostril:							Aspirate pH:							Length at Nostril:							Aspirate pH:						
Bridle ☐														Bridle ☐													
Senior Doctor confirming tube safe to use:														Senior Doctor confirming tube safe to use:													
Length at nostril- record each day/prn														Length at nostril- record each day/prn													
1	2	3	4	5	6	7*	8	9	10	1	2	3	4	5	6	7*	8	9	10								
11	12	13	14	15	16	17	18	19	20	11	12	13	14	15	16	17	18	19	20								
21	22	23	24	25	26	27	28	29	30	21	22	23	24	25	26	27	28	29	30								

Indwelling Urinary Catheter														Indwelling Urinary Catheter													
Date:		Time:		Operator:										Date:		Time:		Operator:									
Catheter - Size:		10fg 12fg 14fg										Catheter - Size:		10fg 12fg 14fg													
Type:		PTFE Silicone Male Female Suprapubic										Type:		PTFE Silicone Male Female Suprapubic													
Volume in balloon:		Catheter expiry date: 28days										Volume in balloon:		Catheter expiry date: 28days 12 weeks													
Procedure Checklist:							Difficulties/complications							Procedure Checklist:							Difficulties/complications						
Hand hygiene ☐														Hand hygiene ☐													
Aseptic insertion ☐														Aseptic insertion ☐													
Catheter secured ☐														Catheter secured ☐													
Lubricant used, expiry date/batch number														Lubricant used, expiry date/batch number													
Operator Signature:														Operator Signature:													
Days in situ		1	2	3	4	5	6	7	8	9	10	11	12	Days in situ		1	2	3	4	5	6	7	8	9	10	11	12
BD cath care Y/N														BD cath care Y/N													
Still required Y/N														Still required Y/N													
Drain bag dated														Drain bag dated													

☐ Complete risk assessment on Trak (PCCP)

GENERIC DEVICE RECORD

Use for other invasive devices i.e. ICP bolts, intercostal, wound, rectal & CSF drains.

Device:														Device:													
Insertion Date:		Time:												Insertion Date:		Time:											
Size:		Type:												Size:		Type:											
Insertion details:														Insertion details:													
Monitoring requirements:														Monitoring requirements:													
Operator Signature:														Operator Signature:													

Day one = Day of insertion

Every device in situ should be recorded - If device inserted elsewhere please note
Record removal by scoring through box and dating

Draft Oct13 RIE CCQIT

800183063V M 29/11/1957

Soave, Alan

34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495

78010 AF Stephen



Directorate of Critical Care

Date: 03/12/23

Date of admission: 02/12/23

Day number: 2

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O ² Cylinder Check	Lmac	✓HW	
Tracheostomy box check (if applicable)	NA	IN UNIT	
C-Circuit	Lmac	✓HW	
Laerdal AMBU bag	IN UNIT	IN UNIT	
Suction	Lmac	✓HW	
MONITORING CHECKS			
Invasive lines - Check and zero	Lmac	✓HW	
NIBP	Lmac	✓HW	129/77(PM)
Alarm limits - Checked/Set	Lmac	✓HW	
Glucometer QC	Lmac	✓IN UNIT	
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions	Lmac	✓HW	
Infusions and Lines in date	Lmac	✓HW	
Air entry assessed		✓HW	
Name band in situ with CHI	Lmac		☐
ETT Cuff pressure check	NA	NIA	
Skin bundle check	ON TRAK	HW	
Allergy band check	NKDA	NKDA	
PROPHYLAXIS			
FLOWTRONS	Teds	✓HW	
DVT/PE	Lmac	✓HW	DALEPARIN
Gastric Ulcer	NA	✓HW	LANOOPRAC
Eye care (prescribed)	NA	NIA	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On: —	DAILY
Pressure bag fluid	Change On: —	EVERY 4 DAYS
Dry Circuit	Change On: —	EVERY 7 DAYS
Flexiseal (If in situ)	Change On: —	EVERY 29 DAYS
Urinary Drainage Bag	Change On: new 02/12	EVERY 7 DAYS
HMEF	Change On: —	DAILY
Closed Suction	Change On: —	DAILY
Wet Circuit	Change On: —	EVERY 14 DAYS
Bacterial Filter	Change On: —	DAILY
Anchorfast	Change On: —	EVERY 7 DAYS
Stoma bag	Change On: —	DAILY

Admission Weight (kg)	
Predicted Weight (kg)	
Admission BMI	
Latest Weight (kg)	79
Bowels last opened (Date)	03/12/23
If >72hrs aperients considered	Y ☐ N ☐

SEDATION AND WEANING	
Sedation Hold (please tick)	
Yes	☐
No	☐
Not appropriate	☒
Ready to wean	
Yes	☐
No	☐
Not appropriate	☒

BRISTOL STOOL CHART	
Type 1	Separate hard lumps, like nuts. Hard to pass
Type 2	Sausage shaped but lumpy
Type 3	Like a sausage but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed early)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces. Entirely liquid

Infection Status	
MRSA	
C. Difficile	
VRE	
ESBL (e.g. E Coli or Klebsiella)	
CRE/CPE	
Other:	COVID +ve.
Patient neutropaenic?	Y ☐ N ☐
Isolation Required?	Y ☐ N ☐

NOTES

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	0 Nil	✓ Cough & expectorate	SW Swinging	P Pink	W Warm	R Right side	0 No pain	0 Full power in legs
MP Mucopurulent	1 Minimal	✗ Cough & No expectorate	ST Static BUB Bubbling	WH White	C Cool	L Left side	1 Mild (Doesn't distress me)	1 Weak but can move legs
P Purulent	2 Moderate	Ø No cough	B Bloodstained	M Mottled	CO Cold	B Back	2 Moderate (Distresses me a bit)	2 Able to move knees
B Bloodstained	3 Large	BG Bagging	HS Haemoserous	✓ Pulse present	✗ Pulse absent	Ch In Chair	3 Severe (Distresses a lot)	3 Minimal movement
		BD Bird	S Serous			Pr Proned	S Sleeping	4 Paralysed

Pupil Size								Eye Opening (E)	Best Verbal (V)	Best Motor (M)
1	2	3	4	5	6	7	8			
•	•	•	•	•	•	•	•	4 Spontaneous 3 To speech 2 To pain 1 None 1 Eyes swollen	5 Orientated 4 Confused 3 Inappropriate words 2 Incomprehensible 1 None/ETT/Trach	6 Obeys commands 5 Localises pain 4 Normal flexion 3 Abnormal flexion 2 Extension 1 None

DATE: 3/12/23

[illegible]

CHI: 2911571495

DATE: 3/12/23

DATE:		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	
Peripheral or Central (circle as appropriate)																										
DRUG INFUSIONS	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
	Drug	Rate (ml/hr)																								
	Peripheral/Central Concentration:	Level																								
	Pump No:	Volume Infused																								
TPN	Rate (ml/hr)																									
Peripheral/Central Concentration:	Level																									
Pump No:	Volume Infused																									
Hourly infusion Checks (initial)																										
Sub Total infusions																										
FLUIDS IN	Crystalloids																									
	Colloids																									
	Blood Products																									
	IV Medication	25	25	25					25	25	25	25				25	25	25	25	/						
	PCA																									
	Epidural	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
	Flush Bag (0.9% NaCl)																									
	NG / NJ / Jejunal																									
	Gastric Aspirate pH																									
	Oral Medication																									
Oral		150	200	50	100	200	100	50	0	100	50	50	0		100	100										
Total Intake		28	206	434	487	590	793	896	1174	1002	1130	1208	1261	1269	1267	1139	1150	1531	1559	1562	1565	1568	1571	1574	1577	
Urine		100	240	180	120	200	180	150	120	240	100	120	160	120	160	220	180	190	180	200	100	→ 3600 3745 3905				
Net UF CVVHD (reset hourly)																										
Drain 1	Observations																									
Location:	Level																									
Hourly Amount Drained																										
Drain 2	Observations																									
Location:	Level																									
Hourly Amount Drained																										
Drain 3:	Observations																									
Location:	Level																									
Hourly Amount Drained																										
Drain 4:	Observations																									
Location:	Level																									
Hourly Amount Drained																										
Drain 5:	Observations																									
Location:	Level																									
Hourly Amount Drained																										
CSF drain output (hourly)																										
Nasogastric aspirates/drained																										
Blood Loss																										
Bowels																										
Cumulative balance (72hours)	Total Output	100	340	520	640	840	1020	1170	1270	1530	1630	1750	1910	2086	2190	2410	2590	2770	2903	3150	3250	→ 3600 3745 3905				
	Balance							-274				-542								-1588		-2070	-2328			
CVVHD	Blood Flow (mls/min)																									
	Dialysate flow (mls/hr)																									
	Access Pressure (mmHg)																									
	Return Pressure (mmHg)																									
	Pre-filter pressure (mmHg)																									
	Citrate Infusion (mmol/L)																									
	Calcium Infusion (mmol/L)																									
	Post filter iCa (6 hrly Blue port)																									
	Systemic iCa (6 hrly A-Line)																									
	Total Ca (check daily- <3mmol)																									
	T:I ratio (Total Ca + Ionised Ca) (check daily - < 2.5)																									
	Changes made																									
Initials																										
Totals reset hourly (initial)																										
		08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06	07	

U

800183063V

M

29/11/1957

Name:

Soave, Alan

34 Southpark Place,

Livingston,

West Lothian, EH54 6FG

D.O.B.:

CHI:

CHI 2911571495



78010 AF Stephen



Directorate of Critical Care

Date:

2/12/23

Date of admission:

2/12/23

Day number:

1

Routine Shift Checks	Day Initial	Night Initial	Comment if N/A or not achieved
EQUIPMENT CHECKS			
O ² Cylinder Check		Ut	
Tracheostomy box check (If applicable)		NA	
C-Circuit		Ut	
Laerdal AMBU bag		In Ut	
Suction		Ut	
MONITORING CHECKS			
Invasive lines - Check and zero		Ut	
NIBP		Ut	
Alarm limits - Checked/Set		Ut	
Glucometer QC		NA	
PATIENT ASSESSMENT			
Infusions/fluids match prescriptions		NA	
Infusions and Lines in date		NA	
Air entry assessed		Ut	
Name band in situ with CHI		Ut	
ETT Cuff pressure check		NA	
Skin bundle check		Ut	
Allergy band check		NA	
PROPHYLAXIS			
FLOWTRONS		Ut	techs
DVT/PE		Ut	
Gastric Ulcer		NA	
Eye care (prescribed)		NA	

Routine Changes		Frequency of routine change
NG Tube tapes:	Change On:	DAILY
Pressure bag fluid	Change On:	EVERY 4 DAYS
Dry Circuit	Change On:	EVERY 7 DAYS
Flexiseal (If in situ)	Change On:	EVERY 29 DAYS
Urinary Drainage Bag	Change On:	EVERY 7 DAYS
HMEF	Change On:	DAILY
Closed Suction	Change On:	DAILY
Wet Circuit	Change On:	EVERY 14 DAYS
Bacterial Filter	Change On:	DAILY
Anchorfast	Change On:	EVERY 7 DAYS
Stoma bag	Change On:	DAILY

Admission Weight (kg)

Predicted Weight (kg)

Admission BMI

Latest Weight (kg)

Bowels last opened (Date)

1/1

If >72hrs aperients considered

Y ☐ N ☐

SEDATION AND WEANING

Sedation Hold (please tick)

Yes

☐

No

☐

Not appropriate

☒

Ready to wean

Yes

☐

No

☐

Not appropriate

☒

Infection Status

MRSA

Sent

C. Difficile

VRE

ESBL (e.g. E Coli or Klebsiella)

CRE/CPE

Other:

Covid + re

Patient neutropaenic? Y ☐ N ☒

Isolation Required? Y ☒ N ☐

BRISTOL STOOL CHART

Type 1

Separate hard lumps, like nuts. Hard to pass

Type 2

Sausage shaped but lumpy

Type 3

Like a sausage but with cracks on its surface

Type 4

Like a sausage or snake, smooth and soft

Type 5

Soft blobs with clear cut edges (passed early)

Type 6

Fluffy pieces with ragged edges, a mushy stool

Type 7

Watery, no solid pieces. Entirely liquid

NOTES

Secretions		Physiotherapy	Chest Drains	Circulation		Pressure Care	Pain Scoring	Motor Block
M Mucoid	0 Nil	✓ Cough & expectorate	SW Swinging	P Pink	W Warm	R Right side	0 No pain	0 Full power in legs
MP Mucopurulent	1 Minimal	✗ Cough & No expectorate	ST Static BUB Bubbling	WH White	C Cool	L Left side	1 Mild (Doesn't distress me)	1 Weak but can move legs
P Purulent	2 Moderate	Ø No cough	B Bloodstained	M Mottled	CO Cold	B Back	2 Moderate (Distresses me a bit)	2 Able to move knees
B Bloodstained	3 Large	BG Bagging	HS Haemoserous	✓ Pulse present	✗ Pulse absent	Ch In Chair	3 Severe (Distresses a lot)	3 Minimal movement
		BD Bird	S Serous			Pr Proned	S Sleeping	4 Paralysed

Pupil Size

1

2

3

4

5

6

7

8

•

•

•

•

•

•

•

•

Eye Opening (E)

4 Spontaneous

3 To speech

2 To pain

1 None

1 Eyes swollen

Best Verbal (V)

5 Orientated

4 Confused

3 Inappropriate words

2 Incomprehensible

1 None/ETT/Trach

Best Motor (M)

6 Obeys commands

5 Localises pain

4 Normal flexion

3 Abnormal flexion

2 Extension

1 None

ADULT UNITARY PATIENT RECORD

ADMITTING HOSPITAL	St John's Hospital at Howden
TYPE OF ADMISSION	Emergency

PRESENTING COMPLAINTS/REASON FOR ADMISSION	
1	Rash, PC, REALLY UNWELL IN HSP DISCHARGED 2 WEEKS AGO FOLLOWING COVID AND PNEUMONIA MUCH IM
2	PROVIDE FOLLOWING D/C LAST NIGHT HOWEVER SPIKED A FEVER AND FELT TERRIBLE T 41 HOME READING P
3	ARACETAMOL AND IBPROFEN AND FELT BETTER TODAY HAS DEVELOPED A MASSIVE RASH NON BLANCHING
4	RASH, PITYRIASIS RASH VERY WIDESPREAD LEGS TORSO ? BLOODS AND INVESTIGATION Triage temp 36.5 HR
5	79 BP 94/54 Resps 16 Sats 93, not feeling short of breath JL 18.43

Patient wishes to be known as:

NAME & ADDRESS (PATIENT LABEL)	ADMISSION WARD	DESTINATION WARD - 1st	DESTINATION WARD - 2nd
Hospital No: 800183063V F/M: M DOB: 29/11/1957 Age: 66 Name: Alan Soave Address: 34 Southpark Place Livingston West Lothian EH54 6FG Telephone No:	Ward No. Admission Date Admission Time to Ward Admitting Nurse Consultant	SJHHDU 16/12/2023 01:40 Dr Maria Corret ge	
Title - Mr / Mrs / Miss / Ms : Mr Marital Status: Religion: Unknown Ethnic Origin:	G.P.Details 6166118/78010 78010/3 AF Stephen Carmondean Medical Group, Carm EH54 8PY Tel No: 01506 836300		

NEXT OF KIN Relationship: Soave (wife), Maureen Address: 12 MORRISON WAY LIVINGSTON EH54 8LJ Contact No: 491811 Patients Relative / Next of Kin Present on Admission Y/N IF NO: Date & Time of Notification: Signature:	FIRST CONTACT Relationship: Address: Contact No:
--	--

Other comments or Night Call

Allergies / Sensitivities

CARDIO PULMONARY RESUSCITATION	Resuscitate / DO NOT Attempt Resuscitation (DNAR) (Delete as appropriate)
Rationale if DNAR:	
Signature:	Print Name: Designation: Date & Time:
Consultant Signature: (Within 24 hrs)	Print Name: Date & Time

	Date/Time	DNAR Status	Signature	Print Name	Designation	Consultant Signature
Change (1)						
Change (2)						

Please document rationale for change in the progress notes.

Emergency Department SJH Care Rounding

800183063V / E5552696 M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG



NURSING ADMISSION CHECKLIST

Standard Admission Procedures				Initials
Vital signs recorded	☒ YES	☐ NO	☐ N/A	
NEWS 2 score recorded	☒ YES	☐ NO	☐ N/A	
Name band attached	☒ YES	☐ NO		
Relatives	☒ IN ED	☐ AT HOME	☐ NOT AWARE	
Clothing and valuables - Labelled	☐ YES	☒ NO		
Clothing and valuables - Documented	☐ YES	☒ NO		
Falls risk assessment - Completed	☒ YES	☒ NO		
Falls risk assessment - Documented	☒ YES	☒ NO		
4 AT assessment completed	☒ YES	☐ NO	☒ N/A	
Swallow screen completed (within 4 hours of arrival)	☐ YES	☐ NO	☒ N/A	
Resus Status	For CPR ☒	DNACPR ☐		

Procedures	Initials
ECG completed	☐ YES ☐ NO ☒ N/A

Presenting Complaint:

RASH / TEMP

Date/time	Progress Notes	Signature/print name
15/12/2023 @ 2135	Pt in rm M3. NEWS and care rounding updated. No clo pain. GCS=15.	
21:45	Ceph running. Awaiting medical bed. Sandwich, coffee and water provided	<i>[Signature]</i> L. Weir
01:05	pt moved on to hospital bed. obs taken.	Alyneen
		Alyneen

[illegible]

CARE ROUNDING

HOURLY FREQUENCY

☐ 1

☐ 2

☒ 3

☐ 4

Review frequency every 12 hours or if the patient's clinical condition requires

Print name of nurse reviewing:

L. WEIR

Date: 15/12/2023

Time of Round	2/25	0100			
Clinical Area	rm M3	M3 AGE			
Care Round Leader's Initials	aw	AL			

Review Frequency of Vital Signs & Cardiac Monitoring

Vital Signs Frequency	10				
Cardiac Monitoring required?	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Pain score (0-10)	0				
Analgesia provided	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Is the person due any routine medication?	☐ Y ☒ N	☐ Y ☒ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

Mobility - tick one option per care rounding

Fully weight bearing	☒	☒	☐	☐	☐
Requires some assistance/uses walking aid	☐	☐	☐	☐	☐
Non weight bearing- needs full assistance	☐	☐	☐	☐	☐
Identified as at risk of falls	☐	☐	☐	☐	☐
Ask patient if they require the toilet	☐	☐	☐	☐	☐
Patient is self-caring and can walk to toilet	☒	☒	☐	☐	☐
Patient has issues with incontinence - assist with personal care as needed	☐ Reviewed	☐ Reviewed	☐ Reviewed	☐ Reviewed	☐ Reviewed
Personal care	☐ Given	☐ Given	☐ Given	☐ Given	☐ Given
Personal care	☒ Not required	☒ Not required	☐ Not required	☐ Not required	☐ Not required
Patient has catheter in situ- assist patient as needed (THINK FLUID BALANCE CHART)	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?	☐ Patent & draining?
Personal care	☐ Offered	☐ Offered	☐ Offered	☐ Offered	☐ Offered
Personal care	☐ Given	☐ Given	☐ Given	☐ Given	☐ Given
Personal care	☐ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required	☐ Declined/Not required

Nutrition and Hydration (tick one option) *THINK SWALLOW

Patient is self-caring (ensure nutrition and hydration needs are still being met)	☒	☒	☐	☐	☐
Patient needs assistance with feeding/drinks and have been given help	☐	☐	☐	☐	☐
Patient for fluids only- ensure signage appropriate above bed/trolley	☐	☐	☐	☐	☐
Patient is NBM* (are background fluids required? Review signage is appropriate above the bed/trolley)	☐	☐	☐	☐	☐
Patient has IVI in situ	☐	☐	☐	☐	☐
Fluid balance chart updated?	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A	☐ Y ☐ N ☐ N/A

Refreshments - Provided (P) Declined (D)

Drink	☒ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D
Snack	☒ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D
Catered meal	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D	☐ P ☐ D

Emergency Department Care Rounding

(addressograph, or handwritten)

Name:

DOB:

Hospital no/CHI:

CARE ROUNDING

Time of Round	2125	0105			
Clinical Area	im M3	M3			
Care Round Leader's Initials	aw	AL			
Review Frequency of Vital signs and Cardiac Monitoring					
Vital signs frequency monitoring	10	10			
Visual Skin Inspection - tick one option per care rounding					
Patient is healthy - no concerns	pr status healthy	✓			
Visible areas of redness					
Broken skin and evidence of pressure ulcers					
Is a Waterlow assessment required (AND COMPLETED)?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Is pressure relieving equipment/mattress required?	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
Invasive Devices - please circle device used and tick if device in situ					
PVC/PVC insertion bundle completed	☐	☐	☐	☐	☐
Urinary catheter/catheter insertion bundle completed	☐	☐	☐	☐	☐
Infusion device	☐	☐	☐	☐	☐
NG tube / PEG tube / Tracheotomy	☐	☐	☐	☐	☐
Other:					
Vulnerable person/cognitive impairment					
Is a 4AT required?		☐ Y		☒ N	
Family Communication					
Patient and relatives present, and have been made aware	✓	✓			
Cubicle Tidy					
Ensure area is tidy and free of obstructions	✓	✓			

EMERGENCY DEPARTMENT TO WARD HANDOVER

NEWS		
Outstanding jobs		
Medications administered?	☐ Y	☐ N
Diagnosis and relevant information		

A&E TO MHDU HANDOVER

A&E NURSE:- Mhare

PATIENTS NAME:- Alan Soave, 66,

Presenting complaint	recent dc CAP Covid +	Sob.
NEWS/GCS		Sats 95 on air
Medical History		m. hypothyroid itu
Swallow assessment within 4 hrs		n/a
DNACPR STATUS		full esc
Any history of violence & aggression		no
PVC/SRC on trak		✓
Drugs/Fluids prescribed		amox - oral iv fluids Paracetamol
Any Infection		Covid + - barrier
Known Allergies		n/kda.

Sputum

WARD 21-HANDOVER-SHEET

NAME	Alan Soave	66
CONSULTANT		
ADMISSION DIAGNOSIS	Recent PIC COVID prev ITU CAP	7 MHDV
PMH	LUSD	
MOBILITY	IND	
SOCIAL		
PLAN	Oral ABX Bic & Sputum sent Wean O2	
INFECTION	Covid - Able to Step down	
RISK ASSESSMENTS:- MUST/WT 4AT BEDRAILS WATERLOW FALLS		
OXYGEN	3L O2 NC	
IV'S	N/A	
SKIN CONDITION	Intact	
SRC	SRC	
REFERRALS		

Name of nurse handing patient over.....

Completed by Kirsty

Date.....

VANCOMYCIN DOSE CALCULATOR FOR ADULT PATIENTS

Produced by: NHS Lothian AMT (Using GG&C Template designed by A.Thomson)
Contact: AMT Administrator Version 2.9b 2023



ENTER DETAILS IN BLUE BOXES

Fields marked * are mandatory; height can be recorded in either cm or feet & inches.

Patient name* Alan Soave

Patient CHI* 2911571495

Indication 7empyema

Planned duration

Target trough levels* Select either 10-15 or 15-20. See Note 1. 15-20

Age* (years) 66

Height* (cm) 170

OR Height* (feet)

(Inches)

Actual Body Weight* (kg) 70.5

Sex* (m/f) m

Creatinine* (μmol/L) 71

Creatinine CL (ml/min) 90

STAT vancomycin IV loading dose date & time: 16/12/2023 06:48

If loading dose is calculated as lower than maintenance dose then give the maintenance dose as a loading dose instead.

Dose 1500 mg

Volume 500 ml

Duration of infusion 3 hours

Rate 166 ml/hr

REGULAR VANCOMYCIN IV MAINTENANCE DOSE

Mode of administration Intermittent Infusion

Time of first maintenance dose at 6pm on 16/12/2023, then every 12 hours

Dose 1500 mg

Volume 500 ml

Duration of infusion 3 hours

Rate 166 ml/hour

Dosage interval 12 hours

PHARMACY CHECK (Signature/Date)

VANCOMYCIN MONITORING FORM

	Date of level	Time sample taken	Level	Creatinine	Action taken (circle)	Name	Signature
1 st LEVEL	17/12/23	17:00	9	65	INCREASE / DECREASE / NO CHANGE	Rahul	76
2 nd LEVEL					INCREASE / DECREASE / NO CHANGE		
3 rd LEVEL					INCREASE / DECREASE / NO CHANGE		
4 th LEVEL					INCREASE / DECREASE / NO CHANGE		
5 th LEVEL					INCREASE / DECREASE / NO CHANGE		
6 th LEVEL					INCREASE / DECREASE / NO CHANGE		
7 th LEVEL					INCREASE / DECREASE / NO CHANGE		

FOR PATIENTS ON VANCOMYCIN FOR PROLONGED PERIODS, FURTHER MONITORING CHARTS CAN BE FOUND ON THE ANTIMICROBIAL MANAGEMENT INPATIENT PAGE

CLICK HERE

NOTE 1. RECOMMENDED TARGET TROUGH LEVELS

10-15

- Skin soft tissue infection (cellulitis, diabetic foot infection (no osteomyelitis))
- Wound infection
- Respiratory tract infection (HAP, CAP, aspiration pneumonia)
- Line infection without bacteraemia
- Urinary tract infection
- Intra-abdominal infection

15-20

- Typically "deep seated" infections
- Bone and joint infections including prosthetic joint infection
- Endocarditis and other intravascular infections
- Any abscess or collection (liver/diverticular/appendix/brain)
- Any prosthetic material infection
- Staph aureus bacteraemia

NOTE 2. WHEN TO CHECK VANCOMYCIN LEVELS

Blood levels should be taken up to 1 hour before the dose. Do not wait for level to return before administering the next dose.

12 hourly maintenance When dose changed re-check trough level before 3rd NEW dosing MAINTENANCE dose if remains on 12 hourly dosing.

24 hourly maintenance When dose changed re-check trough level before 2nd NEW dosing MAINTENANCE dose if remains on 24 hourly dosing.

48 hourly maintenance When dose changed re-check trough level before every dosing MAINTENANCE dose if remains on 48 hourly dosing.

When therapeutic levels achieved continue to monitor levels every 48 hours

STEP 1. STARTING VANCOMYCIN

- Check contraindications.
- Decide on a target trough level
NOTE 1.
- Use the calculator and print off the calculator page and notes and file with current patient monitoring forms.
- If unable to print immediately prescribe the recommended loading and maintenance doses in the drug chart/HEPMA. Be aware that if you print the calculator at a later date, given the change in date/time, the recommended timing of the maintenance doses may change.
- Prescribe the loading dose as close to the time recorded on the calculator (top right of chart).
- Prescribe maintenance doses only at recommended times.
- Use the \vanc code to document in the electronic patient record (TRAK) the indication and when the vancomycin level should be taken
NOTE 2.
- Check U+E daily.

STEP 2. GETTING TO THERAPEUTIC LEVELS

- Document the date and time that the vancomycin level was taken on the monitoring form.
- Ensure that vancomycin is administered after the level is taken. DO NOT WAIT FOR THE LEVEL TO RETURN.
- Review the result of the level within 12 hours of it being taken.
- Document the result of the level on the monitoring form.
- Based on the target trough level chosen and information in NOTE 3 circle the required action - INCREASE/DECREASE/NO CHANGE.
- If a change in dose is required use the dose banding table NOTE 4 to choose subsequent doses as recommended.
- Prescribe the new recommended doses on the drug chart/HEPMA.
- Use the \vanc in TRAK to document when the next vancomycin level should be taken (typically every 48 hours or more frequently if renal function unstable).

STEP 3. REVIEW AND REVISE @72 HOURS

- Review IV antibiotics daily.
- At 48-72 hours review need for ongoing IV therapy and available microbiology results.
- Complete the \antibreview.
- If vancomycin level not therapeutic by 72 hours after ward pharmacist review discuss with microbiology (review antibiotic choice).
- If vancomycin is to be continued continue to monitor trough levels every 48-72 hours or as advised by the pharmacist.
- See NOTE 5 if a dose is unintentionally missed or delayed.

NOTE 5. MANAGING MISSED OR DELAYED DOSES

A DOSE DELAYED LESS THAN 1 HOUR AFTER THE PRESCRIBED TIME CAN BE ADMINISTERED WITHOUT BEING RE-WRITTEN OR OTHER ACTIONS TAKEN

Length of delay	Recommended action
More than 1 hour but less than half the maintenance dosing interval (i.e. if on 12 hourly dosing <6 hours delay, if on 24 hourly dosing <12 hours delay etc.)	Re-prescribe missed dose as once only/STAT. Give the next vancomycin dose at the ORIGINALLY PRESCRIBED TIME.
More than half the maintenance dosing interval (i.e. if on 12 hourly dosing >6 hours delay, if on 24 hourly dosing >12 hours delay etc.)	Re-prescribe missed dose as once only/STAT. Seek advice from pharmacy for further dosing.

NOTE 4. VANCOMYCIN DOSE BANDS (Sodium chloride 0.9% or glucose 5%)

DOSE, VOLUME, DURATION AND RATE

500 mg in 250 ml over 1 hour = 250ml/hr
500 mg in 250 ml over 1 hour = 250ml/hr
750 mg in 250 ml over 1.5 hours = 166ml/hr
500 mg in 250 ml over 1 hour = 250ml/hr
750 mg in 250 ml over 1.5 hours = 166ml/hr
1000 mg in 250 ml over 2 hours = 125ml/hr
1250 mg in 250 ml over 2.5 hours = 100ml/hr
1500 mg in 500 ml over 3 hours = 166ml/hr
1000 mg in 250 ml over 2 hours = 125ml/hr
1250 mg in 250 ml over 2.5 hours = 100ml/hr
1500 mg in 500 ml over 3 hours = 166ml/hr

DOSING INTERVAL

48 hours
24 hours
24 hours
12 hours
12 hours
12 hours
12 hours
12 hours
8 hours
8 hours



NOTE 3. ALTERING THE DOSE BASED ON THE TROUGH (PRE-DOSE) LEVELS

Trough (pre-dose) level	Guidance for target trough level 10-15mg/L	Guidance for target trough level 15-20mg/L
4.9mg/L or less	Increase 2 dose bands - consider discussing with a pharmacist	Increase 3 dose bands - consider discussing with a pharmacist
5.0-9.9mg/L	Increase 1 dose band	Increase 2 dose bands
10.0-14.9mg/L	Continue	Increase 1 dose band
15.0-19.9mg/L	Decrease 1 dose band Do not omit a dose	Continue
20.0-24.9mg/L	Decrease 2 dose bands Do not omit a dose	Decrease 1 dose band Do not omit a dose
25.0mg/L or more	Omit next dose and check level every 24 hours. Restart when level < 20mg/L and decrease 2 dose bands.	Omit next dose and check level every 24 hours. Restart when level < 25mg/L and decrease 1 dose band.
If a level of 25mg/L or more is recorded, review the timing of when the sample was taken, and ensure it is a true trough (up to 1 hour BEFORE the dose was administered) and discuss with your pharmacist.		

Gentamicin dosing calculator and monitoring chart for adult patients

Use for patients aged 16 and over. THIS IS NOT A PRESCRIPTION. ALL PRESCRIBING AND ADMINISTRATION SHOULD BE RECORDED ON HEPMA OR PRESCRIPTION CHART.

Exclusions: Dialysis patients, myasthenia gravis patients, synergistic use, prophylaxis unless 5mg/kg recommended.

Produced by NHS Lothian Antimicrobial Management Team antimicrobial.stewardship@nhslothian.scot.nhs.uk



Enter details in the boxes below:	
Patient name	Alan Soave
Patient CHI	2911571495
Age	66
Height (cms)	170
OR Height (feet)	
(& inches)	
Actual body weight (kg)	70.5
Sex (m/f)	m
Creatinine (μmol/L)	71
CrCl result (ml/min)	90

Gentamicin dosing recommendations	Date and time: 16/12/2023 06:45
Gentamicin dose (mg)	360
Predicted dosing interval, based on data entered	24 hourly, confirm by measuring levels
HEPMA prescribing interval recommendation	XH24
Confirm dosing interval with levels	
Recommended date and time first gentamicin level to be taken - range between	16/12/2023 12:45 & 16/12/2023 20:45

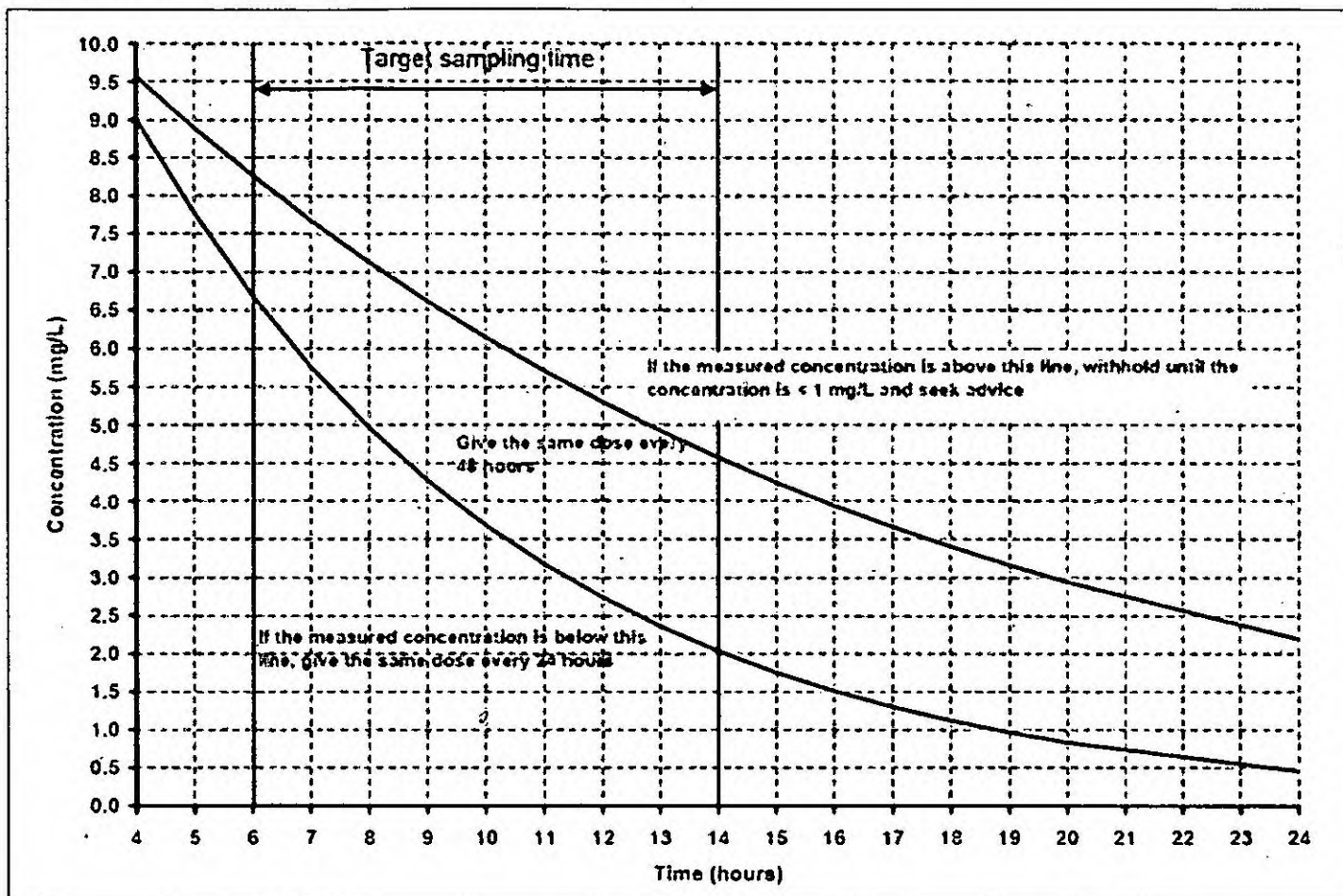
Pharmacy check	

PREPARATION: Dilute dose in 100ml of sodium chloride 0.9% or glucose 5% and infuse over 30 minutes

PRESCRIBING GENTAMICIN IN HEPMA
CHOOSE: Gentamicin 80mg/2ml solution for injection ampoules
Prescribe the calculator recommended dose.
Frequency:
• XH24: if 24 hourly dosing recommended
• XH48: if 48 hourly dosing recommended
• STAT order: if not to give further dose

Administration record - complete each time gentamicin is given									
Step 1. Nursing staff to record when dose was administered. Whoever takes the level should record the date and time it was taken.		Step 2. Clinical team: document the gentamicin level and renal function and complete Step 3 BEFORE the next dose of gentamicin is due.		Step 3. Clinical team: Plot the gentamicin level on the monitoring chart to confirm the dosing interval. Nursing staff should NOT ADMINISTER the next dose of gentamicin if this section is not completed unless instructed to by clinical team. If not completed discuss with clinical team/H@N.					
	Date and time dose administered	Date and time level taken	Gentamicin level mg/L	Creatinine μmol/L	Does the dosing interval need to change?	Has the dosing interval been amended on HEPMA?	Confirm date and time of next gentamicin dose	Name	Signature
Dose 1	16/12/23 07:00	16/12/23 16:40	1.1	66	Yes / ☒ No	Yes, amended / ☒ No change required	17/12/23 07:00	R SHEPPARD	R Sheppard
Dose 2	17/12/23 07:00	17/12/23 17:00	1.1	65	Yes / ☒ No	Yes, amended / ☒ No change required	18/12/23 07:00	R Sheppard	R Sheppard
Dose 3	18/12/23 07:00				Yes / No	Yes, amended / ☒ No change required			
@72 hours review need for ongoing antibiotics - stop or justify continue. Document outcome of review using Iantibreview Continued IV gentamicin is acceptable after 72 hours, for up to 5 days in total, where the patient is improving, oral route is not available, and there is no deterioration in renal function or hearing. Look at the Antimicrobial Companion for IV to oral switch options. CLICK HERE FOR GENTAMICIN - HOW TO USE IT WELL NOTES									
Dose 4					Yes / No	Yes, amended / ☒ No change required			
					Yes / No	Yes, amended / ☒ No change required			

GENTAMICIN MONITORING CHART



SIGNS OF GENTAMICIN TOXICITY

RENAL

- Decreased urine output/oliguria
- Increasing serum creatinine

OTO/VESTIBULAR - development of new:

- Tinnitus or hearing loss
- Dizziness or poor balance
- Oscillating vision

MONITORING GENTAMICIN

- Take a gentamicin level (and U&Es) at the time suggested on the calculator:
 - If $\text{CrCl} \geq 21$ @ 6-14 hours after the start of the infusion
 - if $\text{CrCl} < 21$ @ 24 hours after the start of the infusion
- Record the exact date and time the sample was taken.
- Record the serum concentration.
- Determine appropriate dosing interval from the chart. The plot will indicate one of 3 options:
 1. Continue present dosage regimen (either 24 hourly or 48 hourly)
 2. Change dosing interval (calculator predicted 24 or 48 hourly but levels indicate need to change interval on HEPMA or prescription chart)
 3. Withhold any further dose until level < 1 mg/L
- If the concentration falls exactly on the line, choose the option above the line and seek advice from pharmacy. Also seek advice from pharmacy if the concentration is exceptionally high or low.
- Continue to take gentamicin levels after each administration and daily U&Es.

DOB

Unit N **CHI 2911571495** 
78010 AF Stephen

[illegible]

OTHER MEDICINE CHARTS IN USE		PREVIOUS ADVERSE REACTIONS This section must be completed before any medicine is given		Completed by (sign & print)	Date
Date	Type of Chart	None known ☒			
		Medicine / Agent	Description of reaction		

- **Write the medicine dose clearly**
 - **The only acceptable abbreviations are:**
g - gram mg - milligram ml - millilitre
all other doses must be written out in full eg. micrograms
 - **Avoid decimal points** eg. 100 micrograms (not 0.1mg). If unavoidable, write zero in front of the decimal point
 - **Prescribe liquids** by writing the dose in mg
 - **For 'as required' medicines**, state the symptoms to be relieved, the minimum time interval between doses and the maximum daily dose
 - **Write units as 'units'** not 'iu'

[illegible]

REGULAR THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

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 shown below. Inform the responsible doctor in the appropriate timescale.

- | | |
|---|---|
| 1. Patient refuses | 6. Vomiting / nausea |
| 2. Patient not present | 7. Time varied on doctor's instructions |
| 3. Medicines not available - CHECK ORDERED | 8. Once only / as required medicine given |
| 4. Asleep / drowsy | 9. Dose withheld on doctor's instructions |
| 5. Administration route not available - CHECK FOR ALTERNATIVE | 10. Possible adverse reaction / side effect |

O X Y G E N	Start Date	Time	Mask (%)	Route Prongs (l/min)	Prescriber - Sign + Print	Administered by	Stop Date	Time

PRESCRIPTION		Patient's Own Medicine	Date	Time																
Medicine (Approved Name) ATORVASTATIN		For Use	6		✓	W/H	-	CLAR												
Dose 80mg	Route ORAL	Date	8																	
		Quantity	12																	
Notes/Indication for antibiotic	Start Date 16/12	Stop Date	14																	
Prescriber - sign + print <i>Abb</i>	Pharmacy	18																		
			22																	
Medicine (Approved Name) LANSOPRAZOLE		For Use	6																	
Dose 15mg	Route ORAL	Date	8																	
		Quantity	12																	
Notes/Indication for antibiotic	Start Date 16/12	Stop Date	14																	
Prescriber - sign + print <i>Abb</i>	Pharmacy	18																		
			22																	
Medicine (Approved Name) LEVOTHYROXINE		For Use	6																	
Dose 100 MICROGRAMS	Route ORAL	Date	8																	
		Quantity	12																	
Notes/Indication for antibiotic	Start Date 16/12	Stop Date	14																	
Prescriber - sign + print <i>Abb</i>	Pharmacy	18																		
			22																	
Medicine (Approved Name) RAMIPRIL		For Use	6		✓	H/W	unwell													
Dose 5mg	Route	Date	8																	
		Quantity	12																	
Notes/Indication for antibiotic	Start Date	Stop Date	14																	
Prescriber - sign + print	Pharmacy	18																		
			22																	

REGULAR THERAPY

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine
		Date → Time →
Medicine (Approved Name) ASPIRIN		For Use Date
Dose 75mg	Route ORAL	Quantity (8)
Notes/Indication for antibiotic	Start Date 16/12	Stop Date 14
Prescriber - sign + print Ato		Pharmacy 18
		22
Medicine (Approved Name) CLO-AMOXICLAV		For Use Date
Dose 1.2g	Route IV	Quantity (8)
Notes/Indication for antibiotic	Start Date 16/12	Stop Date (14)
Prescriber - sign + print Ato		Pharmacy 18
		(22)
Medicine (Approved Name) CLARITHROMYCN		For Use Date
Dose 500mg	Route ORAL	Quantity (8)
Notes/Indication for antibiotic	Start Date 16/12	Stop Date 14
Prescriber - sign + print Ato		Pharmacy 18
		(22)
Medicine (Approved Name)		For Use Date
Dose	Route	Quantity 8
Notes/Indication for antibiotic	Start Date	Stop Date 14
Prescriber - sign + print		Pharmacy 18
		22
Medicine (Approved Name)		For Use Date
Dose	Route	Quantity 8
Notes/Indication for antibiotic	Start Date	Stop Date 14
Prescriber - sign + print		Pharmacy 18
		22
Medicine (Approved Name)		For Use Date
Dose	Route	Quantity 8
Notes/Indication for antibiotic	Start Date	Stop Date 14
Prescriber - sign + print		Pharmacy 18
		22

**AS REQUIRED
THERAPY**

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

[illegible]

Continuation

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



Addressograph

800183063V / E5552696 M
SOAVE Alan
29-Nov-57 CHI: 291 157 1495
78010 AF Stephen
34 Southpark Place West Lothian
EH54 6FG

Ward: **MH DU**Date: **17/12/23**

Day No:

Consultant:

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart



NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.

NEWS $\geq$ 3 AND SIRS 2 (see observation chart for details)

Time:

With clinical signs of infection:

THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

0 None

Continue to assess pain at least daily

1-3 Mild

Continue to assess pain with routine observations, must be at least daily

4-5 Moderate

Assess, administer and review analgesia as appropriate for patient

6-10 Severe

Assess, administer and review analgesia as appropriate for patient

Using appropriate Lothian Guidelines

Nausea Score

0 - No Nausea

1 - Nausea
Consider anti-emetic

2 - Nausea / Vomiting

Administer anti-emetic

3 - Persistent Nausea &/or Vomiting

Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

A - The patient is awake

V - The patient responds to verbal stimulation

P - The patient responds to painful stimulation

U - The patient is completely unresponsive

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Voice/Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

NEWS2 Key 0 1 2 3

Date: 11/12/14 Time: 10:00

Respirations 26

Breaths/min 15

SpO2 Scale 1 96

SpO2 Scale 2* 96

Air or Oxygen? A = Air

Blood Pressure 113/93

Pulse 90

Consciousness Alert

Temperature 36.1

NEWS TOTAL 7

Monitoring frequency 1

Escalation of care Y/N N

Initials DR

Heart rate: Rhythm 100

C.V.P. 1

Suction Y/N 1

Secretions (see scale) 1

Pain score (0-10) 0

Nausea score (0-3) 0

Blood Glucose level or N/A 1

GLASGOW COMA SCALE

Eyes Open 4

Best Verbal Response 5

Best Motor Response 6

GCS TOTAL 15

PUPILS

R 4

L 4

ARMS

LEGS

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS). Updated report of a working party. London: RCP 2017.

①

Pupil Scale (mm)

1 •

2 •

3 •

4 •

5 •

6 •

7 •

8 •

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Weight (kg)

Essential

800183063V /E5552696 M
 SOAVE Alan
 29-Nov-57 CHI: 291 157 1495
 78010 AF Stephen
 34 Southpark Place West Lothian
 EH54 6FG

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines

Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
 Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
Plasmalyte	75	75	75	75	75																			
IVI 2																								
Gentamycin																								
Vancomycin																								
Naso Gastric / PEG																								
Oral	50		200		100	100	200	50	100	80	150	100	150	100		200								
Hourly Total	125	341	441	241	175	100	200	50	100	80	150	100	316	266										
Cumulative Input	125	466	907	1148	1323	1423	1623	1673	1773	1853	2003	2103	2419	2685										
Urine			250				200			125		370		450	430	250	400				541			
Gastric																								
Bowels																								
Other																								
Cumulative Output			250				450			575		945		1395										
Cumulative Balance							1173			1278		1158		1290										

Fluid Balance:

Today:

Previous 24hrs:

BiPAP/CPAP - Non-invasive Ventilation Care Plan

Date and time started:

Date and time discontinued:

Mask size:

Target SpO₂:

Is BiPAP/CPAP ceiling of care? Y / N

DNA CPR in place Y / N

Date/Time	ABG/CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	muroid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



Ward: **MHDO**

Date: **18/12/23**

Consultant: **Wright**

Day No:

800183063V M 29/11/1957

Soave, Alan

34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495

(78010 AF Stephen

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

0 None

Continue to assess pain at least daily

1-3 Mild

Continue to assess pain with routine observations, must be at least daily

4-5 Moderate

Assess, administer and review analgesia as appropriate for patient

6-10 Severe

Assess, administer and review analgesia as appropriate for patient

Using appropriate Lothian Guidelines

Nausea Score

0 - No Nausea

1 - Nausea

Consider anti-emetic

2 - Nausea / Vomiting

Administer anti-emetic

3 - Persistent Nausea &/or Vomiting

Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

A - The patient is awake

V - The patient responds to verbal stimulation

P - The patient responds to painful stimulation

U - The patient is completely unresponsive



NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.

NEWS ≥ 3 AND SIRS 2

(see observation chart for details)

Time:

With clinical signs of infection:

THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO ₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Voice Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

NEWS2 Key

0 1 2 3

A+B

Respirations

Breaths/min

SpO2 Scale 1

Oxygen saturation (%)

SpO2 Scale 2*

Oxygen saturation (%)

Air or Oxygen?

O2 L/min or %

Device

Blood Pressure

mmHg

If manual BP mark as M

Pulse

Beats/min

Manual pulse

Consciousness

Alert

New Confusion

V

P

U

Temperature

°C

NEWS TOTAL

Monitoring frequency

Escalation of care Y/N

Initials

Heart rate: Rhythm

C.V.P.

Suction Y/N

Secretions (see scale)

Pain score (0-10)

Nausea score (0-3)

Blood Glucose level or N/A

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute illness severity in the primary care setting. London: RCP, 2017.

GLASGOW COMA SCALE

E

Spontaneously

To speech

To pain

None

V

Orientated

Confused

Inap. words

Incomp. sounds

None

M

Obeys

Localises

Flexion to pain

Abnormal flexion

Extension to Pain

None

GCS TOTAL

PUPILS

R

Size

Reaction

L

Size

Reaction

ARMS

Normal power

Mild weakness

Severe weakness

Extension

No response

LEGS

Normal power

Mild weakness

Severe weakness

Extension

No response

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Always record the best arm response

s = sluggish
+ = reacts
- = no reaction
c = eyes closed

Record right (R) & left (L) separately if there is a difference between the two sides

Rm 1

Pupil Scale (mm)

1 •

2 •

3 •

4 •

5 •

6 •

7 •

8 •

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Weight (kg)

Essential

Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤ 132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥ 75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines

Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰	
Fluid Balance																									
IVI 1																									
IVI 2																									
Drugs																									
IV Vanc Drugs									250								250								
Naso Gastric / PEG																									
Oral			285				200	400		500	400	350	200	200		200		200		200			200	150	350
Hourly Total																									
Cumulative Input							485	885	1185	1635	2035	2385	2585	2785	3185	3235	3435		3635			3835	3985	4335	
Urine			410		470	560	220			510		330		430			1050				850			630	
Gastric																									
Bowels																									
Other																									
Cumulative Output					880	1440	1660			2170	2500	2930		3480						4830				5460	
Cumulative Balance														-145											

Fluid Balance: IN - 4335 OUT - 5460

Today: NEA - 1125

Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started:

Date and time discontinued:

Mask size:

Target SpO₂:

Is BiPAP/CPAP ceiling of care? Y / N

DNA CPR in place Y / N

Date/ Time	ABG/ CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	muroid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

24 hour Observation Chart - Level 1 Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart

Ward: **MINDU**Date: **19/12/23**

Consultant:

Day No:



800183063V M 29/11/1957

Soave, Alan

34 Southpark Place,

Livingston,

West Lothian, EH54 6FG

CHI 2911571495

78010 AF Stephen

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

NEWS of 5 or more?
Think Sepsis!In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.NEWS ≥ 3 AND SIRS 2
(see observation chart for details)

Time:

With clinical signs of infection:

THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines****Acute Pain:** Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines****Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines**

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

0 None

Continue to assess pain at least daily

1-3 Mild

Continue to assess pain with routine observations, must be at least daily

4-5 Moderate

Assess, administer and review analgesia as appropriate for patient

6-10 Severe

Assess, administer and review analgesia as appropriate for patient

Using appropriate Lothian Guidelines

Nausea Score

0 - No Nausea

Consider anti-emetic

2 - Nausea / Vomiting

Administer anti-emetic

3 - Persistent Nausea &/or Vomiting

Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

A - The patient is awake

V - The patient responds to verbal stimulation

P - The patient responds to painful stimulation

U - The patient is completely unresponsive

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Voice/Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

NEWS2 Key
0 1 2 3
A+B
Respirations
Breaths/min
A+B
SpO2 Scale 1
Oxygen saturation (%)
Use Scale 1 if target range is 94-98%
SpO2 Scale 2*
Oxygen saturation (%)
Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure
* ONLY use Scale 2 under the direction of a qualified clinician
Tick box if using SpO2 Scale 2
Sign:
Air or Oxygen?
A = Air
O2 L/min or %
Device
Blood Pressure
mmHg
Score uses Systolic BP only
If manual BP mark as M
Pulse
Beats/min
Manual pulse
Consciousness
Score for new onset of confusion (no score if chronic)
Temperature
°C
NEWS TOTAL
Monitoring frequency
Escalation of care Y/N
Initials
Heart rate: Rhythm
C.V.P.
Suction Y/N
Secretions (see scale)
Pain score (0-10)
Nausea score (0-3)
Blood Glucose level or N/A

GLASGOW COMA SCALE
E
Eyes Open
V
Best Verbal Response
M
Best Motor Response
GCS TOTAL
PUPILS
R
L
ARMS
LEGS
Limb Movement

Pupil Scale (mm)
1
2
3
4
5
6
7
8

Reproduced from: Royal College of Physicians. National Early Warning Score (NEWS) 2: Standardising the assessment of acute illness severity in the NHS. Updated report of a working party. London: RCP, 2017.

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Weight (kg)

Essential

Addressograph

Name: _____
 DOB: _____
 CHI: _____

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
 0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines

Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
 Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
IVI 1																								
IVI 2																								
Drugs																								
<i>lanc</i> Drugs																								
Naso Gastric / PEG																								
Oral																								
Hourly Total																								
Cumulative Input																								
Urine																								
Gastric																								
Bowels																								
Other																								
Cumulative Output																								
Cumulative Balance																								

Fluid Balance:

Today:

Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started:

Date and time discontinued:

Mask size:

Target SpO₂:

Is BiPAP/CPAP ceiling of care? Y / N

DNA CPR in place Y / N

Date/ Time	ABG/ CBG	H ⁺ /pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H⁺	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

Continuation

**REGULAR
THERAPY**

(Attach printed label here)

[illegible]

**REGULAR
THERAPY**

(Attach printed label here)

[illegible]

AS REQUIRED
THERAPY

Name of Patient:

CHI Number:

D.O.B.:

(Attach printed label here)

PRESCRIPTION		Patient's Own Medicine
Medicine (Approved Name) GTN		For Use
		Date
		Time
Dose + frequency + max 2 PUFF	Route S/C	Quantity
		Dose
		Initials
Indication + notes CHEST PAIN	Start Date 16/2	Date
		Date
		Time
Prescriber - sign + print 		Pharmacy
		Dose
		Initials
Medicine (Approved Name)		For Use
		Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
		Initials
Indication + notes	Start Date	Date
		Date
		Time
Prescriber - sign + print		Pharmacy
		Dose
		Initials
Medicine (Approved Name)		For Use
		Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
		Initials
Indication + notes	Start Date	Date
		Date
		Time
Prescriber - sign + print		Pharmacy
		Dose
		Initials
Medicine (Approved Name)		For Use
		Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
		Initials
Indication + notes	Start Date	Date
		Date
		Time
Prescriber - sign + print		Pharmacy
		Dose
		Initials
Medicine (Approved Name)		For Use
		Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
		Initials
Indication + notes	Start Date	Date
		Date
		Time
Prescriber - sign + print		Pharmacy
		Dose
		Initials
Medicine (Approved Name)		For Use
		Date
		Time
Dose + frequency + max	Route	Quantity
		Dose
		Initials
Indication + notes	Start Date	Date
		Date
		Time
Prescriber - sign + print		Pharmacy
		Dose
		Initials

Prescription, Administration & Observation Record

EH54 6FG

Previous
Adverse
Reactions

ALDA

kqs

Actual / Estimate

Date _____

15/12/23

[illegible][illegible]

NEWS Key		Date:	15/12	20/35	21/25	22/30	22/50	00/00	26/0
		Time:	20:35	21:25	22:30	00:00	26:0		
A+B Respirations Breaths/min	≥25								3
	21-24								2
	18-20	18	19	19	20	19	19		
	15-17								
	12-14								
	9-11								1
	≤8								3
A+B SpO ₂ Scale 1 Oxygen saturation (%) Use Scale 1 if target range is 94-98%	≥96								
	94-95		95	96	94	95	95		1
	92-93	92							2
SpO₂ Scale 2* Oxygen saturation (%) Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure * ONLY use Scale 2 under the direction of a qualified clinician Tick box if using SpO ₂ Scale 2 Sign:	≤91								3
	≥97 on O ₂								3
	95-96 on O ₂								2
	93-94 on O ₂								1
	≥93 on air								
88-92									
86-87								1	
84-85								2	
≤83								3	
Air or Oxygen?	A = Air	A	RA	A	A	RA	A		
O ₂ L/min or %									2
Device									
C Blood Pressure mmHg Score uses Systolic BP only If manual BP mark as M	≥220								3
	201-219								
	181-200								
	161-180								
	141-160								
	121-140								
	111-120								
	101-110		100	102	100	109	106		1
	91-100	97	↑	↓	↑	↓	↓		2
	81-90	↓	↓	↓	↓	↓	↓		
	71-80	↓	↓	↓	↓	↓	↓		
	61-70	↓	↓	65	↓	↓	↓		3
51-60	66	64		67	71	70			
≤50									
C Pulse Beats/min Manual pulse	≥131								3
	121-130								
	111-120								2
	101-110								
	91-100								1
	81-90	87							
	71-80		77	82					
	61-70						66		
51-60									
41-50								1	
31-40								3	
≤30									
D Consciousness Score for new onset of confusion (no score if chronic)	Alert	A	A	A	A	A	A		
	New Confusion								
	V								3
	P								
U									
E Temperature °C	≥39.1°								2
	38.1-39.0°								1
	37.1-38.0°								
	36.1-37.0°	36.4		37.3	36.5		36.5		
	35.1-36.0°								

NEWS of 5 or more?

Think Sepsis!



In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think **'Could this be sepsis?'** and **escalate care immediately.**

Signs of Infection

- Temperature $<36^{\circ}\text{C}$ or $>38^{\circ}\text{C}$
- Heart rate >90 beats pm
- Respiratory rate >20 breaths pm
- New confusion
- WCC <4 or >12
- Blood sugar >7.7 in non-diabetic

Addressograph

Name: _____

DOB: _____

CHI: _____

NEWS Total	Monitoring Frequency	Clinical Response
Total 0	Commence on 2 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
Total 1 - 4	Commence on 1 hourly observations	Report to Area Co-ordinator if score increases to 5 or more
3 in one parameter *	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to Nurse In Charge (NIC) and Senior Medic
Total 5 - 6	Commence on 30 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Total 7 or more	Commence on 15 minute observations	Report to Area Co-ordinator who must escalate to NIC and Senior Medic
Special Instructions		

*or increase in NEWS score of 2

Conscious Level Chart to be completed when clinically indicated

		Date	15/12/2023													
		Time	09:18													
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4													Eyes closed by swelling = C
		To speech	3													
		To pain	2													
		None	1													
	Best Verbal Response	Orientated	5													Endotracheal tube or tracheostomy = T
		Confused	4													
		Inappropriate words	3													
		Incomprehensible sounds	2													
		None	1													
	Best Motor Response	Obeys commands	6													Always record the best arm response
		Localise to pain	5													
		Flexion to pain	4													
		Abnormal flexion	3													
		Extension to pain	2													
		None	1													
Total GCS Score			15													
Right Pupil	Size														+ reacts - no reaction c. eye closed	
	Reaction															
Left Pupil	Size															
	Reaction															
LIMB MOVEMENT	ARMS	Normal power													Record right (R) and left (L) separately if there is a difference between the two sides	
		Mild weakness														
		Severe weakness														
		Extension														
		No response														
LEGS	Normal power															
	Mild weakness															
	Severe weakness															
	Extension															
	No response															
Initials			Frage													

Pupil Scale mm

1 •

2 •

3 •

4 •

5 •

6 •

7 •

8 •

IV Fluid Prescription

Time Prescribed	Fluid	Volume	Rate	Prescribers Signature	Time Started	Given by (Initials)	Checked by (Initials)	Time Finished
22 ³⁰	PLASMA-LYTE	500	2ml/hr	mykenn MP	22 ³⁰	TS	AKW	
	PLASMA-LYTE	500	4ml/hr	mykenn MP	02 ²⁰	AKW		
	PLASMA-LYTE	500	4ml/hr	mykenn MP				

Fluid Balance

INPUT						OUTPUT				
	IV Fluids or SC Fluids IV Medication	IV Line(s)	Oral Input		Input		Urine		Gastric	
Time	Type of Fluid e.g. 0.18% NaCl/4% Glucose /20mmolKCl	Volume	Type e.g. Tea	Volume e.g. 100ml	Running Total	Time	Volume	Running Total	Volume	Running Total

Drug Infusion

Drug Name:

	Time												
	Rate (ml/hr)												
	Volume in Syringe												
Pump No	Total amount Infused												

Drug Name:

	Time												
	Rate (ml/hr)												
	Volume in Syringe												
Pump No	Total amount Infused												

Ward: <u>HDL</u>	Site: <u>5TH</u>	Date: <u>16/12/23</u>	Addressograph, or 800183063V M 29/11/1957 NHS Lothian
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.			Nan Soave, Alan 34 Southpark Place, DOE Livingston, West Lothian, EH54 6FG
1hrly 2 hrly 3 hrly <u>4</u> hrly (please circle/complete)			Unit CHI 2911571495  78010 AF Stephen
Print name and sign <u>LAICKCE</u>			
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,			
Time of Care Rounding Document the exact time care rounding took place e.g. 0830 <u>02.6</u> <u>10⁰⁰</u> 08.00 am ← 24 hour period → 07.00 am			
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review		
	Waterlow 10+ - Visual Skin Check (tick)	<u>✓</u>	<u>N</u>
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	<u>H</u>	<u>skin</u>
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....	
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan		
Elimination	Have you changed position since last CR?	<u>Y</u>	<u>Y</u>
	Positioning (R) or (L) side (B) Back (C) Chair	<u>B</u>	<u>b</u>
	Mattress type / Cushion type	<u>please state type:</u>	
	Do you need the toilet?	<u>N</u>	<u>Y</u>
	Is the patient continent of urine? (at time of Care Rounding)	<u>Y</u>	<u>Y</u>
Food, Fluid & Nutrition	Continence product changed/offered?	<u>N</u>	<u>na</u>
	Catheter care performed?	<u>N</u>	<u>na</u>
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact		
	Is patient continent of faeces? (at time of Care Rounding)	<u>Y</u>	<u>Y</u>
	Bowel function monitored	Observe bowel function and update daily	
Falls	Would you like a drink?	<u>Y</u>	<u>W</u>
	Ensure fluids are within easy reach	<u>Y</u>	<u>Y</u>
	Fluid Balance Chart (if clinically indicated)	<u>Y</u>	<u>Y</u>
	When did you last eat?	<u>B</u>	<u>S</u>
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required		
Pain	Oral Hygiene Performed (ref to risk assessment)	<u>I</u>	<u>ind</u>
	Appropriate Footwear?	<u>Y</u>	<u>Y</u>
	Walking aid available (and within reach)	<u>N</u>	<u>na</u>
	Area de-cluttered?	<u>Y</u>	<u>Y</u>
	Chair and bed height assessed?	<u>Y</u>	<u>Y</u>
General	Falls alarm in use and attached?	<u>N</u>	<u>na</u>
	Glasses available for use? (if worn)	<u>Y</u>	<u>Y</u>
	Hearing aid available for use? (if worn)	<u>N</u>	<u>Y</u>
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐		
	Are you in pain?	<u>N</u>	<u>n</u>
Personal Care	Analgesia Given?	<u>N</u>	<u>n</u>
	Peripheral Venous Cannula observed?	<u>Y</u>	<u>Y</u>
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily		
	Are you comfortable? Y/N	<u>Y</u>	<u>Y</u>
	Anything else I can do for you?	<u>N</u>	<u>n</u>
Buzzer within easy reach <u>Y</u> <u>Y</u>			
Personal Care Type _____ (specify) Time Given _____			
Initials – document at time of care delivery <u>LA JM</u>			

Ward: <u>MH10V</u>	Site: <u>STH</u>	Date: <u>16/12/23</u>	800183063V <u>29/11/1951</u> Soave, Alan 34 Southpark Place, Livingston, West Lothian, EH54 6FG CHI 2911571495 78010 AF Stephen 000102062V <u>20/11/1957</u>
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.			
1hrly 2 hrly <u>3 hrly</u> hrly (please circle/complete)			
Print name and sign <u>Kframe</u>			
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,			
Time of Care Rounding Document the exact time care rounding took place e.g. 0830 <u>0800</u> <u>0850</u> <u>1400</u> <u>1700</u> <u>2000</u> <u>2300</u> <u>0200</u> <u>0500</u> 08.00 am ← 24 hour period → 07.00 am			
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review		
	Waterlow 10+ - Visual Skin Check (tick) (R) Red, (P) Purple (B) Broken (BL) Blister		
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister		
	Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other: <u>Cash on legs</u>		
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan		
Elimination	Have you changed position since last CR?		
	Positioning (R) or (L) side (B) Back (C) Chair		
	Mattress type / Cushion type <u>please state type:</u>		
	Do you need the toilet?		
	Is the patient continent of urine? (at time of Care Rounding) Continence product changed/offered? Catheter care performed? Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact		
Food, Fluid & Nutrition	Is patient continent of faeces? (at time of Care Rounding) Bowel function monitored Observe bowel function and update daily		
	Would you like a drink? Ensure fluids are within easy reach Fluid Balance Chart (if clinically indicated) When did you last eat? (B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required		
	Oral Hygiene Performed (ref to risk assessment)		
	Appropriate Footwear?		
	Walking aid available (and within reach)		
Falls	Area de-cluttered?		
	Chair and bed height assessed?		
	Falls alarm in use and attached?		
	Glasses available for use? (if worn) Hearing aid available for use? (if worn)		
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐		
Pain	Are you in pain?		
	Analgesia Given?		
General	Peripheral Venous Cannula observed?		
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily		
	Are you comfortable? Y/N		
	Anything else I can do for you? Buzzer within easy reach		
Personal Care Type <u>Basun(I)</u> (specify) Time Given <u>10845</u>			
Initials – document at time of care delivery			



Ward: MHDU Site: SGN Date: 18/12/23

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly hrly (please circle/complete)

Print name and sign [Signature]

Addressograph, or
800183063V M 29/11/1957

Name: **Soave, Alan**
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

DOB

CHI 2911571495

Unit n: 78010 AF Stephen


Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent (NW) not on ward, (TH) Theatre,

Time of Care Rounding

Document the exact time care rounding took place e.g. 0830

08.00 am 11.00 15.00 18.00 20.00 23.00 02.00 05.00
08.00 am 24 hour period 07.00 am

Waterlow score less than 10 low risk requires only a daily skin review:

Use codes for outcome of skin review

Waterlow 10+ - Visual Skin Check (tick)
Outcome of skin review: (H) Healthy

(R) Red, (P) Purple (B) Broken (BL) Blister

Vulnerable areas? (circle areas of damage)

Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.

If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan

Have you changed position since last CR?

Positioning (R) or (L) side (B) Back (C) Chair

Mattress type / Cushion type

please state type: SOFTFOAM

Do you need the toilet?

Is the patient continent of urine? (at time of Care Rounding)

Continence product changed/offered?

Catheter care performed?

Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact

Is patient continent of faeces? (at time of Care Rounding)

Bowel function monitored

Observe bowel function and update daily

Would you like a drink?

Ensure fluids are within easy reach

Fluid Balance Chart (if clinically indicated)

When did you last eat?

(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance

Update Food Chart if required

Oral Hygiene Performed (ref to risk assessment)

Appropriate Footwear?

Walking aid available (and within reach)

Area de-cluttered?

Chair and bed height assessed?

Falls alarm in use and attached?

Glasses available for use? (if worn)

Hearing aid available for use? (if worn)

Requires close observation for commode, toilet, bathing or showering Y ☐ N ☒

Are you in pain?

Analgesia Given?

Peripheral Venous Cannula observed?

Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily

Are you comfortable? Y/N

Anything else I can do for you?

Buzzer within easy reach

Personal Care Type REFUSED (specify)

Time Given

Initials - document at time of care delivery

[Initials]

Ward: MUDU Site: SH Date: 19/11/23

800183063V M 29/11/1957

Soave, Alan

34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly hrly (please circle/complete)

Print name and sign Shame

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding

Document the exact time care rounding took place e.g. 0830

8:00 11:00 14:00 17:00 20:00 23:00 02:30 05:30
08.00 am ← 24 hour period → 07.00 am

Waterlow score less than 10 low risk requires only a daily skin review.
Use codes for outcome of skin review

Waterlow 10+ - Visual Skin Check (tick)
Outcome of skin review: (H) Healthy
(R) Red, (P) Purple (B) Broken (BL) Blister

Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....

If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan

Pressure Area Care

Have you changed position since last CR?

Positioning (R) or (L) side (B) Back (C) Chair

Mattress type / Cushion type

please state type:

Elimination

Do you need the toilet?

Is the patient continent of urine?
(at time of Care Rounding)

Continence product changed/offered?

Catheter care performed?

Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact

Is patient continent of faeces?
(at time of Care Rounding)

Bowel function monitored

Observe bowel function and update daily

Food, Fluid & Nutrition

Would you like a drink?

Ensure fluids are within easy reach

Fluid Balance Chart (if clinically indicated)

When did you last eat?

(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required

Oral Hygiene Performed (ref to risk assessment)

Appropriate Footwear?

Walking aid available (and within reach)

Area de-cluttered?

Chair and bed height assessed?

Falls alarm in use and attached?

Glasses available for use? (if worn)

Hearing aid available for use? (if worn)

Requires close observation for commode, toilet, bathing or showering Y ☐ N ☐

Pain

Are you in pain?

Analgesia Given?

General

Peripheral Venous Cannula observed?

Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily

Are you comfortable? Y/N

Anything else I can do for you?

Buzzer within easy reach

Personal Care Type Basin (specify)

Time Given @ 11:00 am

Initials — document at time of care delivery

(Handwritten initials and signatures)

Ward: 21 Site: SYM Date: 20/12/23

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2 hrly 3 hrly ____ hrly (please circle/complete)

Print name and sign _____

Addressograph, or
 800183003 Y 27/11/1957
 Name Soave, Alan
 34 Southpark Place,
 Livingston,
 DOB West Lothian, EH54 6FG
 CHI 2911571495
 Unit n° 78010 AF Stephen
 800183063 V M 20/11/1057



Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding
 Document the exact time care rounding took place e.g. 0830 17:00 08.00 am 24 hour period 07.00 am

Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review	
	Waterlow 10+ - Visual Skin Check (tick)	U
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister	NS
	Vulnerable areas? (circle areas of damage)	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....
	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan	
Elimination	Have you changed position since last CR?	Y
	Positioning (R) or (L) side (B) Back (C) Chair	B
	Mattress type / Cushion type	please state type:
	Do you need the toilet?	Y
	Is the patient continent of urine? (at time of Care Rounding)	Y
Food, Fluid & Nutrition	Continence product changed/offered?	N/A
	Catheter care performed?	N/A
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact	
	Is patient continent of faeces? (at time of Care Rounding)	Y
	Bowel function monitored	Observe bowel function and update daily
Falls	Would you like a drink?	Y
	Ensure fluids are within easy reach	Y
	Fluid Balance Chart (if clinically indicated)	
	When did you last eat?	L
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance Update Food Chart if required	
Pain	Oral Hygiene Performed (rel to risk assessment)	SC
	Appropriate Footwear?	Y
	Walking aid available (and within reach)	N/A
	Area de-cluttered?	Y
	Chair and bed height assessed?	Y
General	Falls alarm in use and attached?	N/A
	Glasses available for use? (if worn)	Y
	Hearing aid available for use? (if worn)	N/A
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☒	
	Are you in pain?	N
General	Analgesia Given?	N
	Peripheral Venous Cannula observed?	N/A
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily	
	Are you comfortable? Y/N	Y
	Anything else I can do for you?	N
Buzzer within easy reach		Y
Personal Care Type _____ (specify) Time Given _____		
Initials - document at time of care delivery		W

WARD 21

Ward: MIDU Site: SJH Date: 20/11/23 Addressograph, or
 800183063V M 29/11/1957
Soave, Alan
 34 Southpark Place,
 Livingston,
 West Lothian, EH54 6FG
NHS
 Lothian

This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.

1hrly 2hrly 3hrly _____ hrly (please circle/complete)

Print name and sign Frame

CHI 2911571495 78010 AF Stephen

Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,

Time of Care Rounding
 Document the exact time care rounding took place e.g. 0830 0830 1130 1430 1700 1900 17:22 14:47
 08.00 am ← 24 hour period → 07.00 am

Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review:									
	Use codes for outcome of skin review									
	Waterlow 10+ - Visual Skin Check (tick)									
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister									
	Vulnerable areas? (circle areas of damage) Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other..... <u>HEALTHY</u>									
Elimination	If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan									
	Have you changed position since last CR?									
	Positioning (R) or (L) side (B) Back (C) Chair									
	Mattress type / Cushion type <u>please state type:</u>									
	Do you need the toilet?									
Food, Fluid & Nutrition	Is the patient continent of urine? (at time of Care Rounding)									
	Continence product changed/offered?									
	Catheter care performed?									
	Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact									
	Is patient continent of faeces? (at time of Care Rounding)									
Falls	Bowel function monitored <u>Observe bowel function and update daily</u>									
	Would you like a drink?									
	Ensure fluids are within easy reach									
	Fluid Balance Chart (if clinically indicated)									
	When did you last eat?									
Pain	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance <u>Update Food Chart if required</u>									
	Oral Hygiene Performed (ref to risk assessment)									
	Appropriate Footwear?									
	Walking aid available (and within reach)									
	Area de-cluttered?									
General	Chair and bed height assessed?									
	Falls alarm in use and attached?									
	Glasses available for use? (if worn) ✓									
	Hearing aid available for use? (if worn)									
	Requires close observation for commode, toilet, bathing or showering Y ☐ N ☒									
General	Are you in pain?									
	Analgesia Given?									
	Peripheral Venous Cannula observed?									
	Observe for signs of inflammation/swelling at every CR session. Bundle/VIP score to be updated daily									
	Are you comfortable? Y/N									
Anything else I can do for you?										
Buzzer within easy reach										
Personal Care Type <u>Basin</u> (specify) Time Given <u>10:30 am</u>										
Initials — document at time of care delivery <u>LM LM OT JC</u> <u>W et et et et</u>										

Ward: 21	Site: STH	Date: 21/12/23	Addressograph, or 000103003 Y 29/11/1931	
This care rounding document should be used in non-acute areas and should be supported by an additional person-centred care plan. Registered Nurses should use clinical judgement based on risk assessment, clinical condition and essential care needs to plan frequency.			Name Soave, Alan 34 Southpark Place, Livingston, West Lothian, EH54 6FG	
			DOB CHI 2911571495 Unit no 78010 AF Stephen 800182063 Y M 20/11/1057	
1hrly 2 hrly 3 hrly <u>4</u> hrly (please circle/complete)				
Print name and sign _____				
Codes (Y) Yes, (N) No, (N/A) not applicable, (D) Declined (AS) Asleep (I) Independent, (NW) not on ward, (TH) Theatre,				
Time of Care Rounding Document the exact time care rounding took place e.g. 0830			0800 1200 08.00 am 07.00 am ← 24 hour period →	
Pressure Area Care	Waterlow score less than 10 low risk requires only a daily skin review: Use codes for outcome of skin review			
	Waterlow 10+ - Visual Skin Check (tick)			
	Outcome of skin review: (H) Healthy (R) Red, (P) Purple (B) Broken (BL) Blister			
	Vulnerable areas? (circle areas of damage)			
	Heel (L) (R), Hips (L) (R), Sacrum, Spine, Other.....			
If changes in outcome of skin check, consider continence status, review frequency of CR and update care plan				
Elimination	Have you changed position since last CR?			
	Positioning (R) or (L) side (B) Back (C) Chair			
	Mattress type / Cushion type			
	Do you need the toilet?			
	Is the patient continent of urine? (at time of Care Rounding)			
Catheter care performed?				
Catheter bundle updated daily position catheter below the bladder / no more than 2/3 full with connections intact				
Is patient continent of faeces? (at time of Care Rounding)				
Bowel function monitored				
Food, Fluid & Nutrition	Would you like a drink?			
	Ensure fluids are within easy reach			
	Fluid Balance Chart (if clinically indicated)			
	When did you last eat?			
	(B) Breakfast (L) Lunch (D) Dinner (S) Snack (NBM) Nil by Mouth (A) Assistance			
Update Food Chart if required				
Oral Hygiene Performed (ref to risk assessment)				
Falls	Appropriate Footwear?			
	Walking aid available (and within reach)			
	Area de-cluttered?			
	Chair and bed height assessed?			
	Falls alarm in use and attached?			
	Glasses available for use? (if worn)			
	Hearing aid available for use? (if worn)			
Requires close observation for commode, toilet, bathing or showering				
Pain	Are you in pain?			
	Analgesia Given?			
General	Peripheral Venous Cannula observed?			
	Observe for signs of inflammation/swelling at every CR session.			
	Are you comfortable? Y/N			
	Anything else I can do for you?			
Buzzer within easy reach				
Personal Care Type <u>Ind wash</u> (specify) Time Given <u>0900</u>				
Initials — document at time of care delivery				

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



800183063V M 29/11/1957

Soave, Alan

34 Southpark Place,
Livingston,
West Lothian, EH54 6FGCHI 2911571495
78010 AF Stephen

Ward: HDU

Date: 16/12/23

Consultant: RXJW

Day No:

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____
is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

NEWS of 5 or more?
Think Sepsis!In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.NEWS ≥ 3 AND SIRS 2
(see observation chart for details)

Time:

With clinical signs of infection:

THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

REMEMBER

- Record **all** observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines****Acute Pain:** Score current pain on movement, e.g. deep breathing.
Refer to **Acute Pain Guidelines****Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines**

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

0 None

Continue to assess pain at least daily

1-3 Mild

Continue to assess pain with routine observations, must be at least daily

4-5 Moderate

Assess, administer and review analgesia as appropriate for patient

6-10 Severe

Assess, administer and review analgesia as appropriate for patient

Using appropriate Lothian Guidelines

Nausea Score

0 - No Nausea

Consider anti-emetic

1 - Nausea

Administer anti-emetic

2 - Nausea / Vomiting

Administer anti-emetic

3 - Persistent Nausea &/or Vomiting

Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

A - The patient is awake

V - The patient responds to verbal stimulation

P - The patient responds to painful stimulation

U - The patient is completely unresponsive

Assess

Possible Actions

AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

Ln
0

Pupil Scale (mm)

1 •

2 ●

3 ●

4 ●

5 ●

6 ●

7 ●

8 ●

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Weight (kg)

Essential

Addressograph

Name:

DOB:

CHI:

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤ 132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥ 75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation							

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰		
IVI 1																						125	125	125	125	
IVI 2																										
Drugs																										
Drugs																										
Naso Gastric / PEG																										
Oral																										
Hourly Total																										
Cumulative Input																							325	550	675	1475
Urine																										
Gastric																										
Bowels																										
Other																										
Cumulative Output																									440	
Cumulative Balance																										

Fluid Balance:

Today:

Previous 24hrs:

BiPAP / CPAP Non-invasive Ventilation Care Plan

Date and time started:

Date and time discontinued:

Mask size:

Target SpO₂:

Is BiPAP/CPAP ceiling of care? Y / N

DNA CPR in place Y / N

Date/ Time	ABG/ CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max <1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

Codes for recording oxygen delivery on the NEWS2 observations chart		Secretions		Normal Values of Arterial Blood Gases	
A	breathing air	M	mucoid	pH	7.35 - 7.45
N	nasal cannula (document in litres)	MP	mucopuvulent	H+	35 - 45 nmol/L
SM	simple mask	P	puvulent	pCO₂	4.3 - 6 kPa
V	venturi mask and percentage (e.g device = V, % = 40)	B	blood stained	pO₂	11 - 14 kPa
NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L

Continuation

National Early Warning Score 2 (NEWS2) Chart



800183063V M 29/11/1957
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG
CHI 2911571495
78010 AF Stephen

Date chart commenced: 20/12/23
This is chart number of this admission

Conscious Level Chart to be completed when clinically indicated

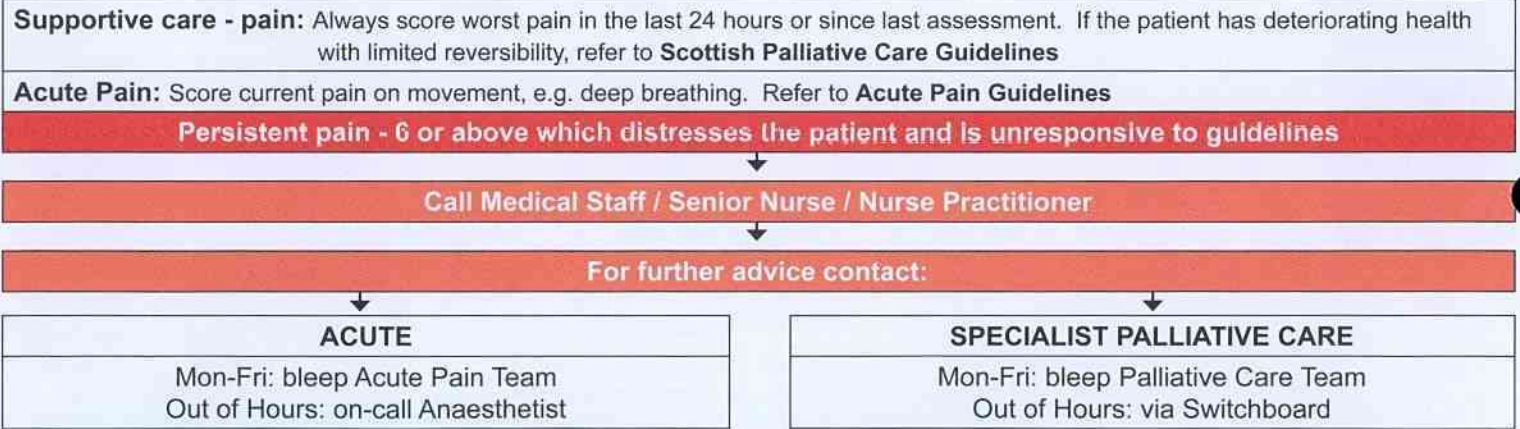
Date																												
Time																												
GLASGOW COMA SCALE	Eyes Open	Spontaneously	4																									Eyes closed by swelling = C
		To speech	3																									
		To pain	2																									
		None	1																									
	Best Verbal Response	Orientated	5																									Endotracheal tube or tracheostomy = T
		Confused	4																									
		Inappropriate words	3																									
		Incomprehensible sounds	2																									
		None	1																									
	Best Motor Response	Obeys commands	6																									Always record the best arm response
		Localises to pain	5																									
		Flexion to pain	4																									
		Abnormal flexion	3																									
		Extension to pain	2																									
		None	1																									
Total GCS Score																												
Right Pupil	Size																									+ reacts - no reaction c. eye closed		
	Reaction																											
Left Pupil	Size																											
	Reaction																											
LIMB MOVEMENT	ARMS	Normal power																									Record right (R) and left (L) separately if there is a difference between the two sides	
		Mild weakness																										
		Severe weakness																										
		Extension																										
		No response																										
LEGS	Normal power																											
	Mild weakness																											
	Severe weakness																											
	Extension																											
	No response																											
Initials																												



- REMEMBER
- Record all observations on NEWS2 chart
 - Document concerns/decisions in clinical notes
 - Escalate your frequency of observations
 - If at any point during your assessment you are concerned about your patient - CALL FOR HELP

	Assess	Possible Actions
AIRWAY	Is the airway - - patent - at risk - obstructed	- suction if indicated - head tilt, chin lift / jaw thrust - airway adjuncts - administer oxygen - call 2222 if at risk
BREATHING	- respiratory rate - SpO₂ - accessory muscle use - noises +/- percussion, palpation & auscultation - position / posture	- administer prescribed oxygen to maintain saturations 94-98% (NB COPD 88-92%) - monitor SpO₂ / ABGs - consider chest x-ray - treat underlying cause - call 2222 if not breathing
CIRCULATION	- pulse - blood pressure - capillary refill time - core temperature / colour - urine output - consider 4 body cavities for fluid & blood loss (4 + on the floor) - monitor drain losses	- obtain IV access - obtain blood samples - prepare fluid challenge - initiate fluid balance chart - call 2222 if no circulation - consider initiating major haemorrhage protocol - monitor response to actions
DISABILITY	- AVPU for initial assessment - GCS, on-going neuro assessment - ABC's & treat hypoxia or hypovolaemia - blood glucose - drugs A = Alert V = Voice / Verbal P = Pain U = Unresponsive	- re-assess GCS - check blood glucose if less than 4mmols/litre - activate hypoglycaemia protocol - check drug chart - remember accurate documentation
EXPOSURE	- top to toe examination - look for evidence of blood loss / rashes / drains / wounds etc	- control bleeding - treat any underlying conditions identified - reassess - maintain patient's dignity - evaluate actions

Pain and Symptom Assessment and Management



Pain Score	Nausea Score	Epidural Motor Block Score please do not (✓) motor block column
0 - None Continue to assess pain at least daily	0 - No Nausea	0 - Full Power
1 - 3 Mild Continue to assess pain with routine observations, must be at least daily	1 - Nausea Consider anti-emetic	1 - Weak but able to raise legs
4 - 5 Moderate Assess, administer and review analgesia as appropriate for patient	2 - Nausea / Vomiting Administer anti-emetic	2 - Able to bend knees
6 - 10 Severe Assess, administer and review analgesia as appropriate for patient	3 - Persistent Nausea &/or Vomiting Contact Doctor	3 - Minimal movement
Using appropriate Lothian Guidelines	Using guidelines prescribe / give anti-emetics and review	4 - Paralysis
If score 2 or above please immediately contact the Acute Pain Team or on-call Anaesthetist if out of hours		

24 hour Observation Chart - Level 1 / Level 2 Beds

National Early Warning Score 2 (NEWS2) Chart



Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen

Ward: mhdu

Date: 16/12/23

Consultant: RXJW

Day No: (2)

Special Instructions:

Only to be completed under the direction of a senior member of the medical team

A total NEWS of _____ or individual parameter of _____ is acceptable for this patient because _____

Please escalate if _____

Print _____ Sign _____ Designation _____
Date _____ Time _____ (only valid if signed and dated)

NEWS TOTAL	Monitoring Frequency	Clinical Response Document concerns/decisions in patients clinical notes
0	Minimum 12 hourly/ 4 hourly in admission areas	• continue routine NEWS monitoring
Total 1 - 4	Minimum 4-6 hourly	• inform registered nurse • registered nurse assessment • review frequency of observations • if ongoing concern, escalate to medical team • consider fluid balance chart
3 in single parameter	Minimum 1 hourly	• registered nurse assessment • medical assessment • management plan to be discussed with senior trainee or above • consider fluid balance chart
Total 5 - 6 Urgent response threshold	Minimum 1 hourly	• registered nurse assessment • urgent medical assessment • management plan to be discussed with senior trainee or above • consider senior trainee review if NEWS does not improve following initial medical assessment • consider level of monitoring required • consider anticipatory care planning (ACP) • start fluid balance chart
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• registered nurse to assess immediately • immediate assessment by senior trainee or above • discuss with supervising consultant • if appropriate contact Critical Care for review • consider anticipatory care planning (ACP) • start fluid balance chart

REMEMBER

- Record all observations on NEWS2 chart
- Document concerns/decisions in clinical notes
- Escalate your frequency of observations
- If at any point during your assessment you are concerned about your patient - **CALL FOR HELP**

Pain and Symptom Assessment and Management

Supportive care - pain: Always score worst pain in the last 24 hours or since last assessment. If the patient has deteriorating health with limited reversibility, refer to **Scottish Palliative Care Guidelines**

Acute Pain: Score current pain on movement, e.g. deep breathing. Refer to **Acute Pain Guidelines**

Persistent pain - 6 or above which distresses the patient and is unresponsive to guidelines

Call Medical Staff / Senior Nurse / Nurse Practitioner

For further advice contact:

ACUTE

Mon-Fri: bleep Acute Pain Team
Out of Hours: on-call Anaesthetist

SPECIALIST PALLIATIVE CARE

Mon-Fri: bleep Palliative Care Team
Out of Hours: via Switchboard

Pain Score

0 None

Continue to assess pain at least daily

1-3 Mild

Continue to assess pain with routine observations, must be at least daily

4-5 Moderate

Assess, administer and review analgesia as appropriate for patient

6-10 Severe

Assess, administer and review analgesia as appropriate for patient

Use appropriate Lothian Guidelines

Nausea Score

0 - No Nausea

Consider anti-emetic

2 - Nausea / Vomiting

Administer anti-emetic

3 - Persistent Nausea &/or Vomiting

Contact Doctor

Using guidelines prescribe / give anti-emetics and review

AVPU

A - The patient is awake

V - The patient responds to verbal stimulation

P - The patient responds to painful stimulation

U - The patient is completely unresponsive



NEWS of 5 or more? Think Sepsis!

In a patient with a **NEWS of 5 or more** and a known infection, signs and symptoms of infection, or at risk of infection, think 'Could this be sepsis?' and **escalate care immediately**.

NEWS ≥ 3 AND SIRS 2

(see observation chart for details)

Time: _____

With clinical signs of infection:

THINK SEPSIS

Sepsis 6 within 1 hour	Time
Consider high flow oxygen	
Measure lactate	
Blood cultures	
IV fluids	
IV antibiotics	
Measure urine output	

	Assess	Possible Actions
AIRWAY	Is the airway - • patent • at risk • obstructed	→ suction if indicated → head tilt, chin lift / jaw thrust → airway adjuncts → administer oxygen → call 2222 if at risk
BREATHING	• respiratory rate • SpO ₂ • accessory muscle use • noises +/- percussion, palpation & auscultation • position / posture	→ administer prescribed oxygen to maintain saturations 94%-98% (NB COPD 88%-92%) → monitor SpO ₂ / ABGs → consider chest x-ray → treat underlying cause → call 2222 if not breathing
CIRCULATION	• pulse • blood pressure • capillary refill time • core temperature / colour • urine output • consider 4 body cavities for fluid & blood loss (4 + on the floor) • monitor drain losses	→ obtain IV access → obtain blood samples → prepare fluid challenge → initiate fluid balance chart → Call 2222 if no circulation → consider initiating major haemorrhage protocol → monitor response to actions
DISABILITY A = Alert V = Verbal P = Pain U = Unresponsive	• AVPU for initial assessment • GCS, on-going neuro assessment • ABC's & treat hypoxia or hypovolaemia • blood glucose • drugs	→ re-assess GCS → check blood glucose if less than 4mmols/litre → activate hypoglycaemia protocol → check drug chart → remember accurate documentation
EXPOSURE	• top to toe examination • look for evidence of blood loss / rashes / drains / wounds etc	→ control bleeding → treat any underlying conditions identified → reassess → maintain patient's dignity → evaluate actions

16/12/23

NEWS2 Key		Date: 16/12/23	Time: 06:00
0	1	2	3
A+B		Respirations	
Breaths/min		≥25	
21-24		18-20	
15-17		12-14	
9-11		≤8	
A+B		SpO ₂ Scale 1	
Oxygen saturation (%)		Use Scale 1 if target range is 94-98%	
SpO ₂ Scale 2*		Oxygen saturation (%)	
Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure		Use Scale 2 if target range is 88-92% eg. in hypercapnic respiratory failure	
* ONLY use Scale 2 under the direction of a qualified clinician		Tick box if using SpO ₂ Scale 2	
Sign:		Sign:	
Air or Oxygen?		A = Air	
O ₂ L/min or %		O ₂ L/min or %	
Device		Device	
≥220		201-219	
181-200		161-180	
141-160		121-140	
111-120		101-110	
91-100		81-90	
71-80		61-70	
51-60		≤50	
≥131		121-130	
111-120		101-110	
91-100		81-90	
71-80		61-70	
51-60		41-50	
31-40		≤30	
Alert		New Confusion	
V		P	
U		≥39.1°	
38.1-39.0°		37.1-38.0°	
36.1-37.0°		35.1-36.0°	
≤35.0°		NEWS TOTAL	
Monitoring frequency		Escalation of care Y/N	
Initials		Heart rate: Rhythm	
C.V.P.		Suction Y/N	
Secretions (see scale)		Pain score (0-10)	
Nausea score (0-3)		Blood Glucose level or N/A	

GLASGOW COMA SCALE		PUPILS		LIMB MOVEMENT	
E	Spontaneously	4			
Eyes Open	To speech	3			
	To pain	2			
	None	1			
V	Orientated	5			
	Confused	4			
	Inap. words	3			
	Incomp. sounds	2			
M	None	1			
	Obeys	6			
	Localises	5			
	Flexion to pain	4			
	Abnormal flexion	3			
Best Motor Response	Extension to Pain	2			
	None	1			
	GCS TOTAL				
R	Size				
L	Reaction				
	Size				
ARMS	Normal power				
	Mild weakness				
	Severe weakness				
	Extension				
LEGS	No response				
	Normal power				
	Mild weakness				
	Severe weakness				
	Extension				
	No response				

Rm

Pupil Scale (mm)

1 •

2 •

3 •

4 •

5 •

6 •

7 •

8 •

IV fluids for adults: for more details, see pocket guideline or App
Consider volume status: Hypovolaemic / Euvolaemic / Hypervolaemic
Does your patient need IV fluids? If so, are they needed for:
Maintenance, Replacement, or Resuscitation?
Write in Maintenance requirements in next 24 hours:

Weight (kg)

Essential

Address: 29/11/1937
Soave, Alan
34 Southpark Place,
Livingston,
West Lothian, EH54 6FG

CHI 2911571495
78010 AF Stephen
00010206237

Volume 30ml/kg	Sodium 1mmol/kg	Potassium 1mmol/kg (unless K ⁺ > 5.0)
ml	mmol	mmol

Estimate oral intake in the next 24 hours _____ ml. Oral intake will reduce the intravenous volume required

Never give more than 100ml/hr of
0.18% NaCl / 4% Glucose: risk of hyponatraemia

If sodium ≤ 132 mmol/l, then Plasmalyte 148 should be used for maintenance. Plasmalyte 148 not to be used for maintenance in other circumstances.

Weight (kg)	Maintenance Fluid requirements in 24hr	Rate ml/hr	Equivalent to 1000ml over
35-44	1200ml	50	20hr
45-54	1500ml	65	16hr
55-64	1800ml	75	14hr
65-74	2100ml	85	12hr
≥ 75	2400ml	100 max)	10hr

Prescribe maintenance fluids and diabetic fluids here. Max rate is 100ml/hr

Prescribe subcutaneous fluids using SC guidelines

Use separate prescription chart if more bags are required Mark as 'Sheet 2'

Type + Additions	Vol (ml)	IV / SC	Rate (ml/hr)	Start time	Finish time	Prescribed by (sign & print)	Set up by (Sign & print)

Use the box below to prescribe any additional fluids that are required for Replacement or Resuscitation

PLASMA LYTE	500ml	IV	2 HOURS	0620	13:20	HAZARD	MM
PLASMA LYTE	500ml	IV	75ml/hr	19:30	0240	HAZARD	GP
PLASMA LYTE	500	IV	75	0245		HAZARD	CHILL
PLASMA LYTE	250	IV	START	0620		HAZARD	D. Pan

Resuscitation: give Fluid Challenge 250ml to 500ml Plasmalyte 148 over 5 to 15min. Stop and assess before repeat.
Request senior / ICU option if 2000ml insufficient

Fluid Balance	06 ⁰⁰	07 ⁰⁰	08 ⁰⁰	09 ⁰⁰	10 ⁰⁰	11 ⁰⁰	12 ⁰⁰	13 ⁰⁰	14 ⁰⁰	15 ⁰⁰	16 ⁰⁰	17 ⁰⁰	18 ⁰⁰	19 ⁰⁰	20 ⁰⁰	21 ⁰⁰	22 ⁰⁰	23 ⁰⁰	24 ⁰⁰	01 ⁰⁰	02 ⁰⁰	03 ⁰⁰	04 ⁰⁰	05 ⁰⁰
Plasmalyte IVI 1	250					250									35	75	75	75	75	75	75	75	75	
Plasmalyte IVI 2																								
CENTAMICIN Drugs			100																					
VANCOMYCIN Drugs			166	166	166	166							166	166	166	166								
Naso Gastric / PEG																								
Oral	100		200	200		150	200	200	150		200	150	200		100									
Hourly Total																								
Cumulative Input	250		350	550	716	966	1166	1416	1666	1916	2166	2416	2666		3116								4137	
Urine	330		330			375			280	200		410	310	350					305				830	
Gastric																								
Bowels																								
Other																								
Cumulative Output						705			980	1080		1490	1500										3285	
Cumulative Balance						1043									1506							852		

Fluid Balance:

Today:

Previous 24hrs:

BiPAP / CPAP - Non-invasive Ventilation Care Plan

Date and time started:

Date and time discontinued:

Mask size:

Target SpO₂:

Is BiPAP/CPAP ceiling of care? Y / N

DNA CPR in place Y / N

Date/ Time	ABG/ CBG	H+/pH	pO ₂	pCO ₂	pCO ₂	FiO ₂	SpO ₂	RR	IPAP	EPAP	TiMax	Back-up rate	Tidal vol	Leak	CPAP PEEP	Comments

BiPAP - ABG to be obtained prior to commencing NIV. Thereafter CBG can be monitored. Please obtain CBG 1 hour, then 4 hours after after commencing NIV and 1 hour after any changes in settings. CBG should be obtained early morning and mid afternoon for duration of treatment.

Setting Ti max and back up rate with COPD

Patients with COPD typically require a longer expiratory time to avoid or minimise air trapping. Failure to cycle to expiration can occur due to high airway resistance and/or a high leak condition. This could increase inspiratory time and cause further air trapping, interfere with cycling and eventually cause poor patient/ventilatory synchrony. A safe system. Ti max, has been added to the Stella 100 to prevent late cycling.

Setting Ti max

1. Measure the patient's respiratory rate during assisted ventilation
2. Refer to table column entitled COPD Ti max
3. Adjust (if indicated) Ti max to the value that corresponds to the resting respiratory rate
4. The back up rate (which is 10 when the factory defaults are reset), limits the Ti max. Therefore, if the patient's respiratory rate necessitates a Ti max < 1.2 seconds, the back-up rate should be increased
5. If the patient complains the inspiratory time is too short, verify the respiratory rate and Ti max. Ask the patient: "Do you have enough time to breath in or is the machine cutting you short?"

Patients respiratory rate	COPD Ti max	Set back up rate required
30	0.7	17
29	0.7	17
28	0.7	17
27	0.7	17
26	0.8	15
25	0.8	15
24	0.8	14
23	0.9	14
22	0.9	14
21	0.9	14
20	1.0	12
19	1.0	12
18	1.1	11
17	1.2	10
16	1.2	10
15	1.3	10
14	1.4	10
13	1.5	10
12	1.7	10

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NIV	patient on NIV system	0	nil	hCO₃	21 - 29 mmol/L
RM	reservoir mask	1	minimal	Base excess	-2 - +3 mmol/L
TM	tracheostomy mask	2	moderate	Total haemoglobin	115 - 160 g/L
CP	CPAP mask	3	large	Potassium ion	3.6 - 5 mmol/L
H	humidified oxygen and percentage (e.g device = H, L/min or % = 40)			Lactate (POCT)	0.5 - 1.6 mmol/L (arterial)
OTH	Other specify			Blood glucose	4 - 7 mmol/L