NHS Lothian

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

Cardiology

Dr Stephen
Carmondean Medical Group
Carmondean Centre
Livingston
West Lothian
EH54 8PY

Date: 16/11/2021

Inpatient Discharge Summary

Patient	Alan Soave 12 Morrison Way Livingston EH54 8LJ	**CHI** **Date of Birth / Age** **UHPI**	**2911571495** 29/11/1957 (63 years) 800183063V
Ward	Ward 103 RIE	**Admission Date**	08/10/2021
Consultant	Dr Patrick Hugh Gibson	**Discharge Date**	10/10/2021

Dear Dr Stephen

Discharge Drugs:

Aspirin Dispersible Tablets			
Dose	Route	Frequency	To Continue
75 MG	-	ONCE DAILY	Yes
Notes:			
Atorvastatin Tablets			
Dose	Route	Frequency	To Continue
80 MG	-	ONCE DAILY	Yes
Notes:			
Bisoprolol Tablets			
Dose	Route	Frequency	To Continue
1.25 MG	-	ONCE DAILY	Yes
Notes:			
Glyceryl Trinitrate SL Spray			
Dose	Route	Frequency	To Continue
1 SPRAY(S)	-	As Required	Yes
Notes: Use in event of chest pain Wait 5 minutes after use, if pain persisting, take additional spray and call for medical help			
Lansoprazole Capsules			
Dose	Route	Frequency	To Continue
15 MG	-	ONCE DAILY	Not Recorded
Notes: Whilst on DAPT. Stop thereafter			
Levothyroxine Sodium Tablets			

Dose	Route	Frequency	To Continue
75 MCG	-	ONCE DAILY	Yes
Notes: Reheck TFTs in 6 weeks			
Nicotine Patches 21mg/24hrs			
Dose	Route	Frequency	To Continue
1 PATCH	-	ONCE DAILY	Not Recorded
Notes:			
Prasugrel Tablets			
Dose	Route	Frequency	To Continue
10 MG	-	ONCE DAILY	Not Recorded
Notes:			
Ramipril Capsules			
Dose	Route	Frequency	To Continue
2.5 MG	-	ONCE DAILY	Yes
Notes:			

DISCHARGE LETTER CARDIOLOGY

REFERRING HOSPITAL/CONSULTANT: Admitted under Dr Gibson, Department of Cardiology, Royal Infirmary of Edinburgh

PRINCIPAL DIAGNOSIS
Inferior Posterior STEMI
DESx1 to LCx
Hypothyroidism
Commenced on replacement, autoantibodies awaited
Summary of Admission:
Mr Soave was admitted following an episode of typical cardiac sounding chest pain with an initial ECG inkeeping with a inferior-posterior MI. He underwent emergency angiogram (full report below) during which his LCx was stented with only mild residual disease.

He remained clinically well post procedure without any immediate complications.
He is a current smoker and of note his cholesterol and LDL levels were raised. The importance of diet change and statin therapy has been stressed and this will need to be monitored in the community.
He was also found to be biochemically hypothyroid with a TSH of 45 and a T4 of 9 (lower limit of normal) and on questioning did have some symptoms of hypothyroidism. After discussion with the endocrine team he has been commenced on 75mcg of levothyroxine and we would appreciate it if the GP could continue to titrate this as necessary.

Angiogram 08/10:
LMCA normal
LAD mild plaque
LCx mild prox plaque then ectasia with possible thrombus, then occluded.
RCA dominant but no PLV; mild plaque.

Echo:
ECHO 10/10/21

The LV size is normal by basal dimension.
Mild concentric left ventricular hypertrophy.
Inferolateral wall is hypokinetic.
Overall LV systolic function is impaired (mild).
RV is normal is size and function.
Mildly dilated LA. Mild MR.

RISK FACTORS
Current smoker: 10/day
Blood pressure prior to discharge: sBP 100-120
Plasma glucose: < 7
Total cholesterol: 6.1 LDL: 4.8

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
For follow up locally at SJH

ANTIPLATELET THERAPY AND DURATION: Aspirin and Prasugrel 6 months, Aspirin alone thereafter, lifelong

CHANGES TO DRUGS SINCE ADMISSION
Commenced on:
- Aspirin 75mg
- Atorvastatin 80mg
- Ramipril 2.5mg
- Prasugrel 10mg
- Bisoprolol 1.25mg
- Levothyroxine 75mcg
- NRT Patch 21mg/24hr
- GTN Spray
-Lansoprazole 15mg OD whilst on DAPT. To stop after DAPT.

ALLERGIES / ADVERSE DRUG REACTIONS: NKDA

DRVING ADVICE
Refrain from driving for: 1 week

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN
Nil

GP to please consider the following:
Ongoing assessment and management of CAD risk factors, in particular
Hyperlipidaemia: to please repeat lipid profile and LFTs in 3 months time to assess response and tolerance of high dose statin (long term aiming TC<4.0 / LDL < 1.4). Consider early addition of ezetimibe
Smoking cessation: continue to offer NRT, referral also made to community smoking cessation team
Re Thyroid Function
To repeat TFTs in approximately 6 weeks from discharge with a view to increase levothyroxine to 100mcg in the first instance.

Should you need further information please contact the Edinburgh Heart Centre: Wards 103/114, Royal Infirmary of Edinburgh.

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

Yours sincerely,

DR OLIVER BOND FY1 and DR NIALL BURKE IMT

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

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

Patient/Carer Signature.....

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

CONSULTANT COMMENT

The information in the immediate discharge letter is largely complete and accurate. This 63-year-old man was treated in The Royal Infirmary after presenting with an inferoposterior ST elevation MI. He was treated with primary angioplasty to his circumflex artery by Dr Bing, with no residual obstructive coronary disease. His echocardiogram is reported to show wall motion in keeping with the affected territory, and overall mild LV systolic impairment. Troponin was greater than 50,000. The main modifiable risk factors are his smoking habit, and adverse lipid profile with LDL 4.8 mmol/L.

He was found to be hypothyroid with an elevated TSH at 46, borderline low free T4 of 9, and T3 was within normal range at 1.5. His case was discussed with the on-call endocrinology registrar who suggested treating with Thyroxine 75 g and rechecking TSH at 6 weeks in case titration to 100 g as required. I would be grateful if this could be undertaken in the GP surgery. His anti thyroid peroxidase level was significantly elevated at 805 IU/ml (range 0 to 100) and I will copy this letter to my colleagues in endocrinology at St. John's hospital in case further investigation or review is required.

Mr Soave has commenced anti platelet therapy with Aspirin and Prasugrel which should be continued for a minimum of 6 months. By copy of this letter, I will and also ask if he can have follow-up arranged in the post infarct clinic in St. John's Hospital.

Yours sincerely,

Dr Patrick Gibson
Consultant Cardiologist

PG/LP
Secretary: 0131 242 1846

CC:

Consultant Endocrinologist
St. John's Hospital
Howden W Rd, Howden
Livingston, EH54 6PP

Consultant Cardiologist
St. John's Hospital
Howden W Rd, Howden
Livingston, EH54 6PP

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

Intensive Therapy

Dr Stephen
Carmondean Medical Group
Carmondean Centre
Livingston
West Lothian
EH54 8PY

Date: 07/12/2023

Inpatient Discharge Summary

Patient	Alan Soave 34 Southpark Place Livingston EH54 6FG	**CHI** **Date of Birth / Age** **UHPI**	**2911571495** 29/11/1957 (66 years) 800183063V
Ward	SJH Red ITU - Red Intensive Therapy Unit	**Admission Date**	28/11/2023
Consultant	Dr Murray C Geddes	**Discharge Date**	

Dear Dr Stephen

Please note this letter was revised and updated on 7/12/23 at 10am following Mr Soave's discharge overnight
CRITICAL CARE IMMEDIATE DISCHARGE LETTER (CCIDL)
THIS IS A CORE CRITICAL CARE DISCHARGE DOCUMENT INTENDED FOR THE RECEIVING WARD AREA

DISCHARGE WARD: 21
DATE OF DISCHARGE: 7/12/23 07:00
DATE OF ICU ADMISSION: 2/12/23 23:00

ADMISSION:
REFERRING SOURCE: General Medicine, Dr Rimer
PRESENTATIONS AND SYMPTOMS: Lack of improvment on HFNO2

PRIMARY DIAGNOSIS:
1. Community Acquired Pneumonia
---> please note it has been documented Mr Soave had covid pneumonitis however on review of scans it is felt to be CAP with COVID-19 but nil evidence of pneumonitis
2. Covid-19

CRITICAL CARE COMPLICATIONS: Nil

SIGNIFICANT PAST MEDICAL HISTORY:
- STEMI 2021 1x DES to LCx; no residual obstructive disease

- Mild LVSD and LVH
- Hypothyroidism
- High cholesterol
- COPD (active smoker)

INTERVENTIONS IN CRITICAL CARE:
1. Arterial line insertion (removed 6/12/23)
2 Continuation of HFNO and able to wean down
3. BD dosing of LMWH due to covid as per ITU protocol (stepped back down to OD when stepped down)

CLINICAL PROGRESS / TIMELINE OF EVENTS:
- Presented on 28/11 with increasing SOB. Background of COPD but good exercise tolerance and no particular functional limitations at baseline.
- Admitted under Medics. (CTPA - no PE but extensive consolidation; mainly right-sided) and started on Coamox + Clari from 28/11 until 2/12. Also found to be covid Positive on admission
- In MHDU wa son HFNC however after a few days concerns for worsening Type 1 Resp failure and admitted to ITU on 2/12. Abx also switched to Tazocin on micro advice
- HFNC able to be weaned down over the next few days afte rmonitoring sats and gases
- able to wean down to venturi mask on 5/12 and then NC and deemed fit for ward step down on 6/12
- Admitted to ITU 2/12. Managing on HFNO since then. Changed antibiotics to Tazocin 02/12 on Micro advice.

PHYSIOTHERAPY STATUS : SEE TRAK ENTRY

NUTRITIONAL TEAM STATUS: SEE TRAK ENTRY

ALLERGY:NKDA
MEDICATIONS:
CONTINUED
- Levothyroxine 100micrograms)D
- Aspirin 75mg OD
- Atorvastain 80mg OD
- GTN spray PRN

WITHHELD: Nil
STOPPED: Melatonin 2mg OD
NEW
- Piperacillin/Tazobactam TDS started 2/12/23 - for review 7/12/23
- Lansoprazol - increased from 15mg OD to 30mg OD due to increased GI bleed risk on steroids
- Dexamethasone 6mg OD (to finish a 10 day course 7/12/23)
- Dalteparin 5000U
- TED stockings
- Salbutamol PRN
- Paracetamol 1g PRN max QDS
- Nicotine patch 21mg

KEY POINTS FOR REVIEW:
CONTINUED ISSUES
- ongoing recovery from CAP and covid

MEDICATIONS
Antibiotic duration. After day 5 (7/12/23) please consider IVOST to complete 7 day course or to stop course on day

5.
Review lansoprazole dose once steroid course complete

INVESTIGATIONS / SPECIALTY REVIEWS
- please consider referral to smoking cessation services when nearing discharge as Mr Soave keen to quit

TEP COMPLETED: Y - For active treatment and escalation as needed

DELIRIUM STATUS:
IN ICU: N
AT DISCHARGE: N

DISCHARGE NEWS: 2 (ongoing oxygen requirement of 2L)

NAME: Gillespie
POSITION: CT2
CONTACT: 54063
PAGE: 3561

Updated by Dr K Howie (CF) on 7/12 at 10:00

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Stephen
Carmondean Medical Group
Carmondean Centre
Livingston
West Lothian
EH54 8PY

Date: 08/12/2023

Inpatient Discharge Summary

Patient	Alan Soave 34 Southpark Place Livingston EH54 6FG	**CHI** **Date of Birth / Age** **UHPI**	**2911571495** 29/11/1957 (66 years) 800183063V
Ward **Consultant**	Ward 21 SJH Dr Fiona I O'Brien	**Admission Date** **Discharge Date**	28/11/2023

Dear Dr Stephen

Allergen (Group to which Allergen belongs)	Reaction
***No Known Drug Allergies	

Discharge Drugs:

Aspirin 75mg dispersible tablets			
Dose	Route	Frequency	To Continue
75 mg	Oral	Once daily at 0700	Yes
Notes:			
Atorvastatin 80mg tablets			
Dose	Route	Frequency	To Continue
80 mg	Oral	Once daily at 2200	Yes
Notes:			
Glyceryl trinitrate 400micrograms/dose pump sublingual spray			
Dose	Route	Frequency	To Continue
1 Spray(s)	Sublingual	PRN chest pain	Yes
Notes:			
Lansoprazole 15mg gastro-resistant capsules			
Dose	Route	Frequency	To Continue
15 mg	Oral	Once daily at 0700	Yes
Notes:			
Levothyroxine sodium 100microgram tablets			
Dose	Route	Frequency	To Continue

100 microgram	Oral	Once daily at 0700	Yes
Notes:			
Paracetamol 500mg caplets			
Dose	Route	Frequency	To Continue
1000 mg	Oral	PRN 4 hourly for pain or feve MAX 4g in 24 hours	No
Notes:			
Ramipril 5mg capsules			
Dose	Route	Frequency	To Continue
5 mg	Oral	Once daily at 0700	Yes
Notes:			

PRINCIPAL DIAGNOSIS/PROCEDURE 1.Community Acquired Pneumonia
2. Covid-19
3. Type 1 Respiratory failure secondary to above.

TREATMENT
Mr. Soave presented on 28/11/2023 with fever, fatigue, worsening shortness of breath and cough. He was started with HFNO2 and admitted under MHDU. He was started on antibiotics, steroids and LMWH. He was escalated to Critical Care with concerns of worsening type 1 respiratory failure. His HFNC was weaned down over the next few days in ITU after rmonitoring sats and gases. He was further weaned down to venturi mask and then NC. He was stepped down to ward. His symptoms have improved now with no cough and is maintaing his saturation on room air.

Investigations:
CXR - Significant consolidation at RLZ and to a lesser extent at LLZ. No PTX.
CTAP - No PE. Extensive consolidation and inflammatory changes.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
OP CXR in 3 weeks time

CHANGES TO DRUGS SINCE ADMISSION
Lansoprazole dose increased from 15mg to 30mg while on steroids as in-patient.
Stopped melatonin
Withheld ramipril, restarted on discharge

ALLERGIES / ADVERSE DRUG REACTIONS NKDA

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN nil

GP to please consider the following
OP CXR in 3 weeks time
Restart melatonin as appropriate and needed.

Should you need further information please contact ward 21

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

Yours sincerely,
SMirza FY2

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

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Stephen
Carmondean Medical Group
Carmondean Centre
Livingston
West Lothian
EH54 8PY

Date: 15/12/2023

Inpatient Discharge Summary

Patient	Alan Soave 34 Southpark Place Livingston EH54 6FG	**CHI** **Date of Birth / Age** **UHPI**	**2911571495** 29/11/1957 (66 years) 800183063V
Ward	Ward 21 SJH	**Admission Date**	28/11/2023
Consultant	Dr Fiona I O'Brien	**Discharge Date**	08/12/2023

Dear Dr Stephen

FINAL DISCHARGE SUMMARY

Dear Doctor,

I have nothing further to add to the immediate discharge summary below, which you should already have received.

Yours sincerely,

e-checked

Dr Fiona OBrien
Consultant Respiratory Physician

FB/JC
Date Checked : 13/12/23
Date Typed: 15/12/23

PRINCIPAL DIAGNOSIS/PROCEDURE
1.Community Acquired Pneumonia
2. Covid-19
3. Type 1 Respiratory failure secondary to above.

TREATMENT
Mr. Soave presented on 28/11/2023 with fever, fatigue, worsening shortness of breath and cough. He was started with HFNO2 and admitted under MHDU. He was started on antibiotics, steroids and LMWH. He was escalated to Critical Care with concerns of worsening type 1 respiratory failure. His HFNC was weaned down over the next few days in ITU after rmonitoring sats and gases. He was further weaned down to venturi mask and then NC. He was stepped down to ward. His symptoms have improved now with no cough and is maintaing his saturation on room air.

Investigations:
CXR - Significant consolidation at RLZ and to a lesser extent at LLZ. No PTX.
CTAP - No PE. Extensive consolidation and inflammatory changes.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
OP CXR in 3 weeks time

CHANGES TO DRUGS SINCE ADMISSION
Lansoprazole dose increased from 15mg to 30mg while on steroids as in-patient.
Stopped melatonin
Withheld ramipril, restarted on discharge

ALLERGIES / ADVERSE DRUG REACTIONS NKDA

SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil

CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN nil

GP to please consider the following
OP CXR in 3 weeks time
Restart melatonin as appropriate and needed.

Should you need further information please contact ward 21

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

Yours sincerely,
SMirza FY2

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

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Stephen
Carmondean Medical Group
Carmondean Centre
Livingston
West Lothian
EH54 8PY

Date: 21/12/2023

Inpatient Discharge Summary

Patient	Alan Soave 34 Southpark Place Livingston EH54 6FG	**CHI** **Date of Birth / Age** **UHPI**	**2911571495** 29/11/1957 (66 years) 800183063V
Ward **Consultant**	Ward 21 SJH Dr Robert J Grecian	**Admission Date** **Discharge Date**	16/12/2023

Dear Dr Stephen

Allergen (Group to which Allergen belongs)	Reaction
***No Known Drug Allergies	

Discharge Drugs:

Amoxicillin 500mg capsules			
Dose	Route	Frequency	To Continue
1000 mg	Oral	Three times daily at 0700, 1200 & 1800 for 5 day(s)	No
Notes:			
Aspirin 75mg dispersible tablets			
Dose	Route	Frequency	To Continue
75 mg	Oral	Once daily at 0700	Yes
Notes:			
Atorvastatin 80mg tablets			
Dose	Route	Frequency	To Continue
80 mg	Oral	Once daily at 0700	Yes
Notes:			
Glyceryl trinitrate 400micrograms/dose pump sublingual spray			
Dose	Route	Frequency	To Continue
1 Spray(s)	Sublingual	PRN chest pain	Yes
Notes:			
Levothyroxine sodium 100microgram tablets			
Dose	Route	Frequency	To Continue

100 microgram	Oral	Once daily at 0700	Yes
Notes:			
Metronidazole 400mg tablets			
Dose	Route	Frequency	To Continue
400 mg	Oral	Three times daily at 0600, 1400 & 2200	No
Notes:			
Paracetamol 500mg caplets			
Dose	Route	Frequency	To Continue
1000 mg	Oral	PRN for pain and pyrexia max qds	No
Notes:			

PRINCIPAL DIAGNOSIS/PROCEDURE
Right lower lobe pneumonia
Possible underlying COPD - for outpatient investigation

BG Recent HDU admission with COVID pneumonitis - HFNO

TREATMENT
Presented with worsening pleuritic chest pain following a recent admission with COVID pneumonia. He had a CTPA which did not show any evidence of PE but confirmed right basal consolidation. He was treated for pneumonia with Amoxicillin and Metronidazole. He had a slight oxygen requirement of 1-2 litres, which has now been weaned off. He is a current smoker and has been given smoking cessation advice, is also agreeable to community referral.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Ouptatient smoking cessation
For repeat CXR in 6 weeks time - for consideration of CT if not improving.
Outpatient pulmonary function tests in 6 weeks time.

CHANGES TO DRUGS SINCE ADMISSION
Ramipril has been discontinued as Hypotensive during admission - can be re-started at a later date if required.

Yours sincerely...
Alison Perry
Physician associate

NHS Lothian

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

General Medicine

Dr Stephen
Carmondean Medical Group
Carmondean Centre
Livingston
West Lothian
EH54 8PY

Date: 22/01/2024

Inpatient Discharge Summary

Patient	Alan Soave 34 Southpark Place Livingston EH54 6FG	**CHI** **Date of Birth / Age** **UHPI**	**2911571495** 29/11/1957 (66 years) 800183063V
Ward	Ward 21 SJH	**Admission Date**	16/12/2023
Consultant	Dr Robert J Grecian	**Discharge Date**	21/12/2023

Dear Dr Stephen

FINAL DISCHARGE SUMMARY

Dear Doctor,
I have nothing further to add to the immediate discharge letter which you should already have received.

Yours sincerely,

e-checked

Dr Robert Grecian
Consultant Respiratory Physician

RG/KM
17/01/24
22/01/24

PRINCIPAL DIAGNOSIS/PROCEDURE
Right lower lobe pneumonia
Possible underlying COPD - for outpatient investigation

BG Recent HDU admission with COVID pneumonitis - HFNO

TREATMENT
Presented with worsening pleuritic chest pain following a recent admission with COVID pneumonia. He had a CTPA which did not show any evidence of PE but confirmed right basal consolidation. He was treated for pneumonia with Amoxicillin and Metronidazole. He had a slight oxygen requirement of 1-2 litres, which has now been weaned off. He is a current smoker and has been given smoking cessation advice, is also agreeable to community referral.

FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL
Ouptatient smoking cessation
For repeat CXR in 6 weeks time - for consideration of CT if not improving.
Outpatient pulmonary function tests in 6 weeks time.

CHANGES TO DRUGS SINCE ADMISSION
Ramipril has been discontinued as Hypotensive during admission - can be re-started at a later date if required.

Yours sincerely...
Alison Perry
Physician associate

Patient & GP Information

UHPI Number	800183063V
CHI Number	2911571495
Episode Number	I0005303450
Surname/Forename	Soave, Alan
Date of Birth	11/29/57
Sex	Male
Patient Address.	34 Southpark Place Livingston EH54 6FG
Registered GP	AF Stephen
GP Address.	Carmondean Medical Group,Carmondean Centre,Livingston,West Lothian EH54 8PY

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 13:28 Jane Blair	DUAL ACS Trial I returned to discuss study information with Mr Soave,he has not yet read the information provided. We will review him again on Monday should he remain an inpatient, otherwise he has our contact details should he choose to prticipate. Jane Blair Cardiology Research Nurse

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Ward Round Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 17:35 Dr Karen Borges	CCU WR Dr Gibson HR54 BP124/78 Repeat ECG showing sinus brady, no BB Bloods: hypothyroid Plan: 1. Send out autoantibody screen and discuss with endocrine tomorrow morning (was unable to reach today) 2. Aim SJH tomorrow or home Sunday if no new issues 3. Bedside ECHO to assess LV ?driving KBorges

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 08:08 Penny Saliba	Person-Centred Care Alan remained in SR/SB overnight. Cardiac reab. book given. Pain Management No complaints of pain to nursing staff. Altered Stage of Cognition Remains alert and orientated.

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 08:10 Penny Saliba	Deterioration and Escalation troponin repeated last night - >50000. 50000. </body></html>

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 08:13 Dr Niall Burke	CCU AM WR - Bing / Burke Issues: 1. Inferoposterior STEMI - 08/10 primary PCI LCx 2. New Dx Hypothyroid - TSH 45 // T4 9 TC 6.1 // LDL 4.8 Currently: Feeling well in himself No further chest pain Note Telemetry trend - Sinus brady to mid 50s overnight / morning Plan: 1. Trial Bisoprolol 1.25mg 2. Can move to 103 today or SJH 3. TTE tomorrow 4. Endocrine advice re TFTs

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Operation Note Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 07:42 Rong Bing (old code)	Primary PCI for inferoposterior STEMI RB/Varun RRA 6F LMCA normal LAD mild plaque LCx mild prox plaque then ectasia with possible thrombus, then occluded. RCA dominant but no PLV; mild plaque. PCI to LCx EBU 3.5, Sion Blue, Pilot 50 Aspiration thrombectomy -> white thrombus retrieved Long segment of severe disease Pre-dil 3.0 x 20 Stented 3.0 x 32 Resolute Onyx DES Post-dil 3.0 x 20 NC, 3.5 x 8 NC prox TR band IV tirofiban DAPT 6/12 or DUAL-ACS - sugggest prasugrel after tirofiban complete.

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 10:27 Dr Niall Burke	Cardio SHO - N.Burke Re Likely Hypothyroidism Discussed symptoms with patient: - weight gain past 6-12 months though on questioning states diet has changed / worsened with lock down - frequently feels cold, having to turn the heating on / wearing layers out of season - Nil bowel changes or other symptoms Discussed with Endocrine SpR, relayed the above and TFT results, advised: - Add on T3 - Commence Levothyroxine 75mcg OD - GP to check TSH in 6 weeks with aim to titrate to 100mcg if needed - Await thyroid antibodies, though with such high TSH happy to commence therapy before

Surname/Forename	Soave, Alan
UHPI Number	800183063V

Episode Number	I0005303450

Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 11:04 Dr Niall Burke	DISCHARGE LETTER CARDIOLOGY REFERRING HOSPITAL/CONSULTANT: Admitted under Dr Gibson, Department of Cardiology, Royal Infirmary of Edinburgh PRINCIPAL DIAGNOSIS Inferior Posterior STEMI DESx1 to LCx Hypothyroidism Commenced on replacement, autoantibodies awaited Summary of Admission: Mr Soave was admitted following an episode of typical cardiac sounding chest pain with an initial ECG inkeeping with a inferior-posterior MI. He underwent emergency angiogram (full report below) during which his LCx was stented with only mild residual disease. He remained clinically well post procedure without any immediate complications. He is a current smoker and of note his cholesterol and LDL levels were raised. The importance of diet change and statin therapy has been stressed and this will need to be monitored in the community. He was also found to be biochemically hypothyroid with a TSH of 45 and a T4 of 9 (lower limit of normal) and on questioning did have some symptoms of hypothyroidism. After discussion with the endocrine team he has been commenced on 75mcg of levothyroxine and we would appreciate it if the GP could continue to titrate this as necessary. Angiogram 08/10: LMCA normal LAD mild plaque LCx mild prox plaque then ectasia with possible thrombus, then occluded. RCA dominant but no PLV; mild plaque. Echo: ECHO 10/10/21 The LV size is normal by basal dimension. Mild concentric left ventricular hypertrophy. Inferolateral wall is hypokinetic. Overall LV systolic function is impaired (mild). RV is normal is size and function. Mildly dilated LA. Mild MR. RISK FACTORS Current smoker: 10/day Blood pressure prior to discharge: sBP 100-120 Plasma glucose: < 7 Total cholesterol: 6.1 LDL: 4.8 FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL For follow up locally at SJH ANTIPLATELET THERAPY AND DURATION: Aspirin and Prasugrel 6 months, Aspirin alone thereafter, lifelong CHANGES TO DRUGS SINCE ADMISSION Commenced on: - Aspirin 75mg - Atorvastatin 80mg - Ramipril 2.5mg - Prasugrel 10mg - Bisoprolol 1.25mg - Levothyroxine 75mcg - NRT Patch 21mg/24hr - GTN Spray -Lansoprazole 15mg OD whilst on DAPT. To stop after DAPT. ALLERGIES / ADVERSE DRUG REACTIONS: NKDA DRVING ADVICE Refrain from driving for: 1 week

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CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN
Nil

GP to please consider the following:
Ongoing assessment and management of CAD risk factors, in particular
Hyperlipidaemia: to please repeat lipid profile and LFTs in 3 months time to assess response and tolerance of high dose statin (long term aiming TC<4.0 / LDL < 1.4). Consider early addition of ezetimibe
Smoking cessation: continue to offer NRT, referral also made to community smoking cessation team
Re Thyroid Function
To repeat TFTs in approximately 6 weeks from discharge with a view to increase levothyroxine to 100mcg in the first instance.

Should you need further information please contact the Edinburgh Heart Centre: Wards 103/114, Royal Infirmary of Edinburgh.

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

Yours sincerely,

DR OLIVER BOND FY1 and DR NIALL BURKE IMT

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

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

Patient/Carer Signature.....

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

CONSULTANT COMMENT

The information in the immediate discharge letter is largely complete and accurate. This 63-year-old man was treated in The Royal Infirmary after presenting with an inferoposterior ST elevation MI. He was treated with primary angioplasty to his circumflex artery by Dr Bing, with no residual obstructive coronary disease. His echocardiogram is reported to show wall motion in keeping with the affected territory, and overall mild LV systolic impairment. Troponin was greater than 50,000. The main modifiable risk factors are his smoking habit, and adverse lipid profile with LDL 4.8 mmol/L.

He was found to be hypothyroid with an elevated TSH at 46, borderline low free T4 of 9, and T3 was within normal range at 1.5. His case was discussed with the on-call endocrinology registrar who suggested treating with Thyroxine 75 µg and rechecking TSH at 6 weeks in case titration to 100 µg as required. I would be grateful if this could be undertaken in the GP surgery. His anti thyroid peroxidase level was significantly elevated at 805 IU/ml (range 0 to 100) and I will copy this letter to my colleagues in endocrinology at St. John's hospital in case further investigation or review is required.

Mr Soave has commenced anti platelet therapy with Aspirin and Prasugrel which should be continued for a minimum of 6 months. By copy of this letter, I will and also ask if he can have follow-up arranged in the post infarct clinic in St. John's Hospital.

Yours sincerely,

Dr Patrick Gibson
Consultant Cardiologist

PG/LP
Secretary: 0131 242 1846

CC:

Consultant Endocrinologist
St. John's Hospital
Howden W Rd, Howden

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Note Details	Clinical Notes
	Howden W Rd, Howden Livingston, EH54 6PP Consultant Cardiologist St. John's Hospital Howden W Rd, Howden Livingston, EH54 6PP

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 14:39 Hannah Cowie	Person-Centred Care Alan has been feeling great so far today. He has been for a shower and is now mobilisin to the bathroom with no reports of pain or discomfort. Pressure Area Care No issues with pressure areas. Skin healthy. Falls Independently mobile. Removing monitor as and when needed to mobilise to bathroom. Bladder and Bowel Function Independent no complaints. Deterioration and Escalation For full escalation. Observations stable, feels well. Medicine Management As charted. Levothyroxine commenced this morning. NRT patch this afternoon. Pain Management No reports of pain or discomfort. No PRN medication required. Food Fluid and Nutrition Managing free food and fluid. Discharge Planning Alan was awaiting a bed and transport to SJH, but now has a bed in ward 103 where he will hopefully be discharged from tomorrow

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/9/21 16:16 Dr Niall Burke	CCU PM WR - Burke Moved to 103 Issues: 1. Inferoposterior STEMI - 08/10 primary PCI LCx 2. New Dx Hypothyroid - TSH 45 // T4 9 - Commenced Replacement 09/10 Currently: Nil changes Remains well Unlikely to move to SJH tonight Aim home tomorrow

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/10/21 05:23 Sarah N Clarke	Person-Centred Care Settled overnight Deterioration and Escalation Remains on telemetry monitoring - no issues overnight

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/10/21 11:34 Dr Andrew Chapman	Weekend review Inferoposterior STEMI New hypothyroidism Looks well Plan Home today Endocrine plan as documented Review echo report prior to discharge No residual coronary disease - can drive at one week if normal LV function A Chapman ST6

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/10/21 12:58 Dr Karen Borges	ECHO 10/10/21 The LV size is normal by basal dimension. Mild concentric left ventricular hypertrophy. Inferolateral wall is hypokinetic. Overall LV systolic function is impaired (mild). RV is normal is size and function. Mildly dilated LA. Mild MR.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 08:25 Dr Andrew David Stewart Duncan	IMT A Duncan CCU Clerking Admitted this morning via paramedic with chest pain 1. Inferoposterior STEMI - primary PCI LCx Last couple of days aware of niggle in chest like indigestion- took rennies. At 2am last night experienced tight pain across chest radiating up to neck. Called NHS 24 Background - no PMH (just takes cod liver oil, vitamin supplements and antihistamine PRN) - overweight FH Mum angina SH - current smoker - retired electrical engineer O/E SaO2 97% on air Chest clear Warm well perfused HR 53 BP 101/58 ECG- infero posterior STEMI Plan 1. DAPT per op note 2. Risk factor modification 3. Advise stop smoking

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 09:43 Dr Karen Borges	WR Gibson 1. Inferoposterior STEMI - primary PCI LCx 8/10 BG: smoker x7cigarettes/day HR60, BP116/78 Currently: Chest pain completely resided Angiogram results explained Talked about importance of secondary prevention, smoking cessation and need for DAPT to prevent stent occlusion OE: quiet HS1+2+0, chest some wheeze, no crackles Plan: 1. Bloods incl lipids 2. Repeat ECG later this morning 3. Transfer to SJH tomorrow or home Sunday if no new issues 4. Load prasugrel post tirofiban infusion 5. To start ramipril tomorrow KBorges F2

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 09:51 Karen Paterson	Cardiology Research - DUAL-ACS CI/PI: Prof D.E. Newby Patient has been spoken to regarding the DUAL-ACS trial: a comparison of 3 month vs. 12 month dual anti-platelet therapy duration for patients with myocardial infarction. I have given a patient information sheet v 4.0 (22 March 2021) along with the GDPR patient information v3.0 (24th July 2020). A member of the research team will aim to speak to them later today to find out whether they would like to take part or not. Karen Paterson Research Nurse, Cardiology 21884

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005303450 Dr Patrick Hugh Gibson 10/8/21 11:34 Louise McBride	Person-Centred Care Alan has spoken to [redacted] to advise has been brought to CCU. CCU phone number given to Alan and advised of visiting policy. Pressure Area Care No issues with skin or weight loss. Falls Alan is independent. Advised to stay in bed until Tirofiban is completed Bladder and Bowel Function Alan reports no issues with bladder and bowels. Using bottles at bedside until Tirofiban completed Deterioration and Escalation Alan is painfree since PCI this morning, feeling well. Observations stable. Tirofiban running at 14.4mls/hr. TR band insitu, looks fine. Pain Management Alan advised to let staff know of any pain. Infection Prevention and Control Lumeria negative. PCR covid test sent. MRSA swabs sent. Food Fluid and Nutrition Given coffee on arrival, Alan declined breakfast. Altered Stage of Cognition Alert and orientated, no concerns.

Patient & GP Information

UHPI Number	800183063V
CHI Number	2911571495
Episode Number	I0005809554
Surname/Forename	Soave, Alan
Date of Birth	11/29/57
Sex	Male
Patient Address.	34 Southpark Place Livingston EH54 6FG
Registered GP	AF Stephen
GP Address.	Carmondean Medical Group,Carmondean Centre,Livingston,West Lothian EH54 8PY

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

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Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Nurse 12/7/23 07:03 Marnie Bell	Alan has arrived in ward 21 SR 3A Handed over from ITU Morning medications given so will handover to ward doctors to update hepma record NEWS2 as charted Alan appears comfortable S/N M Bell

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Angelie Caparoso 12/7/23 10:04 Dr Rachael Lamb	WR SHarp IMT3 Issues: 1. Type 1 RF secondary to CAP and covid pneumonitis. - 4 day HDU admission for high flow nasal oxygen HEPMA: On dexamethasone - to complete 10 day course today D5 tazocin, escalated from co-amox + clari (7 days total antibiotics) NEWS: 4 95% on 40% Venturi Bloods 06/12: WCC 14 Platelets of 800 CRP 17 Negative sputum cultures. Imaging: Negative CTPA on 28th Nov. Today: Sitting up in bed. Says he does not feel breathless. Managing without oxygen to get up to go to toilet Denies chest pain/ankle swelling E+D well Denies vomiting/diarrhoea Explained in HDU his breathing had been improving, but we have increased it overnight. OE: Chest bibasal creps L>R Nil peripheral oedema HS dual Plan: 1. wean oxygen (when left ITU was on 2l NC saturating well) - if unable to wean, ABG later today 2. target sats over 92% 3. complete antibiotics today 4. Bloods tomorrow R.Lamb FY1

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Fiona I O'Brien 12/7/23 19:46 Sophie Vincent	Alan has been settled today required minimal assistance today. Is getting moved into bay this evening, due to isolation period finished. Eating and drinking well. Weaning off oxygen as able, 3L of O2 via Nasal Cannula. Observations stable. Medications taken as per HEPMA. StaffNurse/ Sophie Vincent

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Fiona I O'Brien 12/8/23 05:04 Marnie Bell	Person-Centred Care Alan isolation period over Moved from SR to bay NEWS2 remained stable overnight Remains on 1L02 Independent with all care PVC that had been removed yesterday started bleeding. Dressed x2 and could not manage to stop blood flow. PVC site now has gauze with compression round it in place. No further concerns at this time S/N M Bell

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr Fiona I O'Brien 12/8/23 10:10 Dr Rachael Lamb	WR Dr OBrien Issues: 1. Type 1 RF secondary to CAP and covid pneumonitis. - 4 day HDU admission for high flow nasal oxygen - completed 7 days of taz yesterday HEPMA reviewed. Completed antibioitcs Bloods today awaited. Today: Not coughing anything up Breathing well E+D well Keen to get home, lives with daughter Explained when he gets home he may feel weaker and more fatigued. This can take about 6 weeks to recover from. Encouraged to take it very easy and build it up gradually. Plan OPT CXR in 6 weeks Home today R.Lamb FY1

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 11/28/23 19:01 Dr Lei Hua	ICU re-review 1830 History noted. Now ~4.5 hours into treatment. Seen with Alan and [redacted]. Alan feels that his breathing is a lot easier than earlier this afternoon. Chest discomfort on deep inspiration still present but also significantly better. Now speaking in mid-length sentences (2-3 words in ED) [redacted] feels that Alan looks better than in ED. O/E: SpO2 94% on 80% HNFO RR 30 - 35 HR 111 BP 102/60 temp 36.4C - static over past few hours Maintaining own airway, intermittent increased WOB when not talking - Alan says that this is because of the 'pressure' from the HFNO, not because of difficulty in catching his breath. Right basal creps. Appears WWP with CRT 2-3s peripherally. ABG repeated: H+ 43 pO2 10.3 (10.5) pCO2 5.3 (5.3) BE -2.6 (-3.9) lactate 2.3 (2.7) Imp: stable currently - symptomatically improving. Seen from end of bed by Dr Cross cons - agrees with plan to stay in mHDU at present Plan: - Continue current treatment on mHDU - Try dropping HFNO flow rate to 50L for patient comfort to see if this improves RR - Repeat ABG and get back in touch if clinically deteriorates or begins tiring overnight - Will handover to night team to be aware Updated Alan and wife with plan L Hua CT2

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005809554 Dr Fiona I O'Brien 12/8/23 11:35 Dr Sheher Bano Mirza	PRINCIPAL DIAGNOSIS/PROCEDURE 1.Community Acquired Pneumonia 2. Covid-19 3. Type 1 Respiratory failure secondary to above. TREATMENT Mr. Soave presented on 28/11/2023 with fever, fatigue, worsening shortness of breath and cough. He was started with HFNO2 and admitted under MHDU. He was started on antibiotics, steroids and LMWH. He was escalated to Critical Care with concerns of worsening type 1 respiratory failure. His HFNC was weaned down over the next few days in ITU after rmonitoring sats and gases. He was further weaned down to venturi mask and then NC. He was stepped down to ward. His symptoms have improved now with no cough and is maintaing his saturation on room air. Investigations: CXR - Significant consolidation at RLZ and to a lesser extent at LLZ. No PTX. CTAP - No PE. Extensive consolidation and inflammatory changes. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL OP CXR in 3 weeks time CHANGES TO DRUGS SINCE ADMISSION Lansoprazole dose increased from 15mg to 30mg while on steroids as in-patient. Stopped melatonin Withheld ramipril, restarted on discharge ALLERGIES / ADVERSE DRUG REACTIONS NKDA SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN nil GP to please consider the following OP CXR in 3 weeks time Restart melatonin as appropriate and needed. Should you need further information please contact ward 21 Information contained in this letter has been discussed with the patient/carer. Yours sincerely, SMirza FY2 This is an immediate discharge letter and a further letter may follow.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Nurse 12/8/23 13:51 Karolynn M Grant	Alan has been DC via the lounge. No medications are required. PVC has been removed from right arm. SN Karolynn Grant

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005809554 Dr Fiona I O'Brien 12/15/23 12:51 Julie Cooke	FINAL DISCHARGE SUMMARY Dear Doctor, I have nothing further to add to the immediate discharge summary below, which you should already have received. Yours sincerely, e-checked Dr Fiona O'Brien Consultant Respiratory Physician FB/JC Date Checked : 13/12/23 Date Typed: 15/12/23 PRINCIPAL DIAGNOSIS/PROCEDURE 1.Community Acquired Pneumonia 2. Covid-19 3. Type 1 Respiratory failure secondary to above. TREATMENT Mr. Soave presented on 28/11/2023 with fever, fatigue, worsening shortness of breath and cough. He was started with HFNO2 and admitted under MHDU. He was started on antibiotics, steroids and LMWH. He was escalated to Critical Care with concerns of worsening type 1 respiratory failure. His HFNC was weaned down over the next few days in ITU after rmonitoring sats and gases. He was further weaned down to venturi mask and then NC. He was stepped down to ward. His symptoms have improved now with no cough and is maintaing his saturation on room air. Investigations: CXR - Significant consolidation at RLZ and to a lesser extent at LLZ. No PTX. CTAP - No PE. Extensive consolidation and inflammatory changes. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL OP CXR in 3 weeks time CHANGES TO DRUGS SINCE ADMISSION Lansoprazole dose increased from 15mg to 30mg while on steroids as in-patient. Stopped melatonin Withheld ramipril, restarted on discharge ALLERGIES / ADVERSE DRUG REACTIONS NKDA SIGNIFICANT CHANGES MADE TO CARE ARRANGEMENTS nil CHANGES TO DNACPR STATUS / DETAILS OF TREATMENT ESCALATION PLAN nil GP to please consider the following OP CXR in 3 weeks time Restart melatonin as appropriate and needed. Should you need further information please contact ward 21 Information contained in this letter has been discussed with the patient/carer. Yours sincerely, SMirza FY2 This is an immediate discharge letter and a further letter may follow.

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Note Details	Clinical Notes

Surname/Forename	Soave, Alan
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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005809554 Nurse 1/17/24 15:20 Sarah Norris	Critical Care Recovery Service – Nurse Specialist Follow Up Call today 16/01/24 at 1350hrs All listed AHP question put to patient during follow up call. SALT Alan was not intubated or ventilated, and has no concerns with regards to eating and drinking. He stated that he has a good appetite and eats most of his meals. He added that he was 13 ½ stone on admission to hospital, weighed himself today and he is now 9 ½ stone. He has no concerns with talking or with how his voice sounds or about your reading and writing. He did add that he feels short of breath but not as bad as he was in hospital. He has not experienced any coughing/choking/food getting stuck/ feeling chesty/wheezy after eating drinking/struggling to chew food/loosing food from his mouth. He denies any problems with language difficulties such as word finding, spelling, written words, or in understanding what has been said to him. OT Alan is independent with all ADL's including shopping and cooking. He is retired. He exercises by walking and picking up his grand child from school. Psychiatry Alan stated that's his mood is ok. He denies any of the following bad dreams/hallucinations/frightening memories about his time in ICU. He stated that he has no issues with sleeping. Physio Alan has been mobilising around the house independently. However, he has reported "feeling really short of breath"(SOB), not progressively getting worse, and not as bad as it was as an inpatient (COVID then Pneumonia T1RF). It gets much worse when climbing stairs, and also has weakness in his legs. He has to stop several times on climbing the stairs to catch his breath. He is concerned about this. I offered to refer to our physio services in the community to help him with the weakness, but he declined this service. He then added that during the night he wakes up with a very high temperature 40 – 41 degrees C, then by the morning his temp is back to normal again. Yesterday he was at the Gp Practice to seen the nurse and his blood pressure was found to be low (low during last admission and anti hypertensives were stopped). He admitted to feeling dizzy when bending over and feeling SOB. Alan was recently 're admitted' on 16/12/23 with worsening pleuritic chest pain following a recent admission 04/12/23 with COVID pneumonia (HDU) and T1RF (ICU admission). He had a CTPA which did not show any evidence of PE but confirmed right basal consolidation. He was later discharged on 21/12/23 and GP advised to arrange CXR and offer smoking sessation service. Alan stated he only smokes 1 cigarette a day now. I advised him to get on the phone to his GP as soon as possible regarding this, and make an appointment to be checked and also to discuss the following changes: High Temp at night with sweaty and shivery Low Bp with dizzy spells Increased short of breath (? COPD Empyema on last CT) Weakness in legs – to request referral to community physiotherapy Recent weight loss from 13 ½ stone to 9 ½ stone in last couple of months without dieting. I offered to call the PT and GP myself but he insisted he would call himself. Worsening advice was given to Alan, and I highlighted recent similar hospital presentations. He is aware to call out of hours, if Gp is not available and/or attend A&E as an emergency if any further deterioration/worsening of his condition. He agreed to do this. Any questions or concerns relating to their critical care admission or our service, please contact the Critical Care Recovery Service on 07811026003 or CriticalCareRecovery.SJH@nhslothian.scot.nhs.uk Sarah Norris Nurse Specialist Critical Care Recovery Service.

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Note Details	Clinical Notes

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 11/28/23 23:22 Dr Mehika Sood	Patient review- chest pain Issues: 1. CAP 2. COVID + NEWS 7 (RR 25, sats 92% on 50L (80% HFNO), BP 132/79, HR 121, alert, T 37.5) 8 hrs into treatment for pneumonia (clari + co-amox), and covid (dex). Had a short episode of chest pain with initially 6/10 pain which gradually decresed to 3/10 and stopped within <5 minutes. Pain was over top of chest when antibiotics were beng put up. Pain was dull in nature, worse on deep inspiration and did not radiate to jaw/ arm. Denies being increasingly SOB/ clammy/ otherwise unwell when pain came on. No alliviating factors- gradually went away on its own. Does not feel the pain was the same as when he had his MI. O/E: Patient looks well form end of bed- some work of breathing present but able to talk in sentences. Feels well within himself, believes he is improving by the hour. HS I + II (although hard to auscultate) Chest reduced AE, cerpitations heard on R lung base CRT 2s, extremities warm and well-perfused Abdo SNT, BS + Calves SNT Passed bowel yesterday, catheter in-situ: urine dark, on IV fluids currently. Not managing much orally. ECG: sinus tachy, no acute ischaemic changes Plan: 1. Dicuss with senior re further ivx Update: Discussion with reg Bain- likely pleurisy pain from pneumonia, not for any investigations at the moment. ECG- no ischaemic changes, tachycardia. Plan: 1. Control with analgesia Sood FY1

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr HR Gillett 11/29/23 05:55 Jemma Macdonald	Person-Centred Care Alan has not managed to get much sleep overnight. Deterioration and Escalation Has had a NEWS of 7, o2 requirement increased overnight. Scoring for RR 39, sats 92% on 85% with 60L flow (airvo) - settings for airvo increased after speaking to medical team re sats dipping to 89%. HR 120 ovenright and temp 37.5-37.9. Had one episode of chest pain at start of night, 3/10- resolved with paracetamol, no changes on ecg. Pressure Area Care Alan states his skin is healthy and intact. Mobility Alan has been bedrest overnight due to SOB. Bladder and Bowel Function BNO overnight. Cath patent and draining fluid balance chart updated. Medicine Management Medications given as per hepma. Pain Management PRN paracetmol given for temp. Infection Prevention and Control Nursed in side room with appropriate ppe as covid +. Food Fluid and Nutrition Alan has not felt up to eating overnight, has been able to tolerate sips of fluids. Altered Stage of Cognition Alan is alert and orietated.

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UHPI Number	800183063V

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Nurse 11/29/23 13:09 Lisa Marie Hunt	*** AUTO GENERATED BY {Frailty Screening} QUESTIONNAIRE *** Does this person have markers of frailty? No Summary of screening: **CLINICAL FRAILTY SCORE 2** - Well: no active disease symptoms and occasionally active. - No obvious frailty input required - Continue care as usual, please refer to frailty team if needed.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 11/29/23 14:23 Dr Merlin Hetherington	28/11/2023 CT Angiogram Pulmonary Reasonable opacification pulmonary arterial tree. No central or lobar PE. Gross consolidation of the right lower lobe with further significant consolidation within the lingula. Further inflammatory nodularity within the left upper lobe. Enlarged, likely reactive mediastinal nodes. No endobronchial lesion evident on CT. Moderate right pleural effusion but no CT features to suggest empyema. Background emphysema. No destructive bone lesion. Comment: No PE. Extensive consolidation and inflammatory changes.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr HR Gillett 11/29/23 19:12 Nicola Colvin	Person-Centred Care Introduced myself to Alan esplaining all care delivered and procedures carried out. Deterioration and Escalation Alan remains in SR due to being covid positive. 1 hourly observations. NEWS 7-9 throughout the day. Continues on AIRVO settings this AM flO 60L, 85% fi02-SP02 92-94%. CBG done this AM-see chart and NEWS-weaned Fi02 to 80%. Further CBG done in afternoon, FLO only weaned to 55L. Currently 55L FLO, Fi02 80%-Sp02-93%. Will continue to wean as able. Pyrexial this afternoon-1 gram of paracetamol given-blood cultures taken, medics advised. RR 27-35, hypotensive at times. Blood taken late AM as per medics instructions, FBC, U&Es and CRP. Continues on IV co-amoxiclav and IV Clarithromycin. Pressure Area Care Alan is able to relieve his own pressure areas in the bed. Skin and pressure areas intact. Alan has had an assisted wash this AM. Mobility Alan has remained in the bed for today. Bladder and Bowel Function Alan has an IDC in situ-good diuresis from this-fluid balance in situ. BNO as yet today-stoo, chart in situ. Medicine Management Medications as per HEPMA. Pain Management Alan denies any pain. Infection Prevention and Control Covid positive, nursed in a sideroom. Green PVC in R ACF dated, dressing changed today. Food Fluid and Nutrition Alan has been eating and drinking today as able-see fluid balance chart. BGL stable-see chart. Altered Stage of Cognition GCS 15

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005809554 Dr Alastair G Matthews 11/28/23 15:14 Sarah Dickson	Checklist completed as per SOP SJH/CT/058 with no contraindicating factors. Patient gave verbal consent for IV bolus injection. No adverse reaction noted prior to leaving radiology department. Omnipaque 350 130ml injected Lot: 16486371 Exp: 06/26

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Lewis Bain 11/29/23 23:34 Dr Lewis Bain	Bain ST5 Question at handover about possible pleural effusion. CTPA shows densely consolidated lung R lung. Bedside USS performed tonight. There is no pleural fluid. On the right side there is heavily consolidated, hepatised lung with several static air bronchograms and shredded pleura in keeping with severe pneumonia. Patient feeling better. SpO2 95% on HFNC. Plan 1. Continue current care Bain 3991

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr HR Gillett 11/30/23 06:24 Linda McKie	Person-Centred Care Alan hasn't slept overnight Feeling too hot despite the window being open and having no bed covers on Deterioration and Escalation Remains on constant monitoring - ST Hourly observations carried out - NEWS 8, tachycardic, tachypnoeic, 02 requirement, pyrexial BM stix 4.1 mmols this morning Continues on HFNO 80% with 60 litres to maintain target sp02 of >92%, CBG carried out this morning Pressure Area Care Alan is independent with his pressure area care He can change position as required Mobility Alan is normally independent however due to the various monitor and Airvo cables he has remained in bed overnight, nurse call bell within easy reach Bladder and Bowel Function Alan has an IDC in situ and has had hourly urine volumes recorded which have been adequate Bowels not opened overnight Medicine Management Medications as per HEPMA Pain Management No c/o pain overnight Infection Prevention and Control Alan is Covid posititve and is being nursed in a single room Appropriate PPE and signage available outside the room He also has a PVC and IDC in situ - care bundles in place and updated Food Fluid and Nutrition Alan can eat and drink as able Fluid balance chart maintained Altered Stage of Cognition Alan is alert and orientated

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005809554 Nurse 11/30/23 10:58 Gemma Newall	Respiratory In reach ward round - Dr Noble Issues: CAP COVID +ve On HFNO 80% o2 with 60L flow NEWS 7 - RR 30, Spo2 93% on 80% HFNO, BP 100/70, temp 37.8 CTPA shows densely consolidated lung R lung. Bedside USS performed overnight. There is no pleural fluid. On the right side there is heavily consolidated, hepatised lung with several static air bronchograms and shredded pleura in keeping with severe pneumonia. CRP 405, urea 11.5, K+4.3 Plan: Continue with IV Coamoxiclav/clarithromycin Continue with HFNO Remain in HDU CBG later today IV fluids as precribed. Gemma Newall RNP 3051

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr HR Gillett 11/30/23 18:29 Emma Dick	Person-Centred Care Alan is feeling a bit better, although stilll very tired and short of breath on minimal movement. He was up to sit in the chair for half an hour. His wife is in to visit. Deterioration and Escalation NEWS between 5 and 7 today, due to high RR, O2 requirement and tachycardia. HFNO weaned to 70% and continues on 60 L flow. CBG improved. Pressure Area Care Alan is moving about the bed by himself. Pressure areas are healthy. Mobility Alan transferred up to the chair with supervision. Bladder and Bowel Function Catheter draining good volumes of urine. No bo. Medicine Management Continues on IV antibiotics. Given prn paracetamol for temp of 37.9. Infection Prevention and Control COVID +VE -DROPLET PRECAUTIONS IN PLACE AND APPROPRIATE PPE Food Fluid and Nutrition Eating and drinking small amounts. IVI running at 100 mls/hour. Altered Stage of Cognition Alan is orientated. Discharge Planning Alan needs to stay in MHDU while on high flow nasal O2.

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005809554 Nurse 12/1/23 09:45 Gemma Newall	Respiratory In reach ward round - Dr Martin CAP COVID +ve Requiring HFNO - oxygen has been weaned to 70% o2 Currently on IV coamoxiclav and clarithromycin Usually fit and well, good ET. Retired 2 months ago, worked as an electrician Smoker, keen to stop now, smoker of 10 cpd. Has declined NRT. No previously pneumonia No recent travel No pets or birds. Oxygen levels slowly improving. NEWS 5 due to oxygen requirement, RR 33. Eating and drinking well now BC negative Sputum commensals only. Plan: Continue with current management Remain in HDU whilst on HFNO Wean oxygen as able. Would be for ICU if deteriorated. Stop IV fluids Gemma Newall RNP 3051

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 03:04 Leanne Foster	Person-Centred Care Alan has had a very settled night. He has slept for long periods. Deterioration and Escalation Alan continues on 1 hourly NEWS monitoring and continuous cardiac monitoring. NEWS 3 - 6 throughout the night, he has not required escalation. Alan also continues on HFNO2 75% / 60L. Pressure Area Care Alan's pressure areas are intact and he is able to relieve them independently. Bladder and Bowel Function Alan has SRC in situ which has been patent and draining well - see FBC. BNO overnight. Medicine Management All medication administered as per HEPMA. Pain Management Nil complaints from Alan overnight. Infection Prevention and Control Covid positive, nursed in a sideroom with appropriate PPE. SRC and PVC bundles updated Food Fluid and Nutrition Alan has has some oral fluids overnight-see fluid balance chart. BGL stable-see chart. Altered Stage of Cognition GCS 15

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 09:32 Dr Stephen Walker	WR w/ Dr O'brien 66 y/o male presenting on the 28/11/23 w/ chest pain and SOB Issues// CAP COVID +ve Requiring HFNO - oxygen has been weaned to 75% o2 Currently on IV coamoxiclav and clarithromycin (since 28/11/23), Dex 6mg Today// NEWS 5 (RR 28, sat 92 on 75% o2) Pt alert in bed states that breathing is feeling better last name pronounced suave - ey feeels well, eating and drinking O/E reduced entry in left base calves SNT Plan// chest physio, if able then please sputum sample id declines then can escalate to ITU cont. abx + dex nicotine patch CXR - ?development of parapneumonic effusion

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 11:49 Dr Stephen Walker	Dr S.Walker FY1 CXR looks worse consolidation, switched to taz as per Dr O'brien advice will update ITU on progression

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 12:25 Dr Marc Deya Jones	D/W ITU on call - presentation and events so far reviewed, will kindly come and see in ward. Marc Deya Jones GPST

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr HR Gillett 11/28/23 15:42 Dr Helen Gillett	PTWR HRG Problems: COVID-19 CAPUsually fit and well Retired auto electrician Recent ex-smoker (10 days) MI 2021 - stopped smoking at that time but restarted when on holiday Presented with a week's history of flu-like symptoms which resolved Then developed cough productive of brown sputum, fever and SOB CXR - right mid and lower zone pneumonia with possible further minor consolidation left lower zone Bloods - WCC 15 (neutrophilia), platelets 451, albumin 22 and CRP 417 O/E reasonably comfortable on high flow nasal oxygen (60/60%) - sats 93% Has had iv coamoxiclav and oral clarithromycin - continue On iv fluid, HFNO and dexamethasone Has had review by ICU in ED and they will come back to review Plan Continue antibiotics, steroids, HFNO and fluids Prophylactic LMWH For full escalation H Gillett

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 13:44 Dr Matthew Dunne	CRITICAL CARE REFERRAL & REVIEW (CCRR) CRITICAL CARE CONSULTANT ON CALL: M Crawford (anaesthetics consultant) ASSESSING CRITICAL CARE TEAM MEMBER inc. GRADE: Matthew Dunne ACCS CT2 Time of Referral: 12:17 Time of Review: 12:45 Time of Recommendation: 13:45 REASON FOR REFERRAL: Lack of improvement on HFNO2 RELEVANT CASE BACKGROUND: Hx of presentation noted 7/7 worsening dyspnoea, fever. Productive cough Hypoxic on RA. Covid Positive, diffuse consolidation/pneumonitis on CTPA. HFNO on mHDU. Max FiO2 0.8, now on FiO2 0.75. He feels better than on admission. Feels he is able to talk in longer sentences. Feels he has expectorant to bring up but sturggling to at present. No chest pain. No fevers. PMHX: STEMI in 2021 - nil angina since stenting. Has used GTN one time in the 2 years since Hypercholesterolaemia Hypothyroid No dx of COPD no emphysema on CT Lifelong smoker - 10/day for 50 years. Alcohol within limits BASELINE FUNCTIONAL STATUS: Lives at home with wife and son Retired - used to be army electrian Still drives Functionally independent all ADLs ASSESSMENT: Maintaining own airway unsupported HFNo2 75% 60l/min (static last 24 hours). Able to talk in prolonged sentences. No audible wheeze from end of bed. RR 22-28. Has been stable throughtou admission. Sats 94% at time of review. Warm periperhally - good volume radial pulse. No JVPNE elevation or peripheral oedema Abdomen SNT Good volume urine in catheter Bloods: Hb 110, WCC 12.8, Plt 404 eGFR >60, creating 61 CXR today; worsening diffuse consolidation/pneumonitiis ABG performed during review H+35, pO2 9.5, pCO2 5.2, lacatete 1.7. IMPRESSION: Currently stable with severe covid pneumonititis + superadded CAP - severe T1RF but acheiving appropriate PaO2 on current treatment RECOMMENDATION: At present appropriate to remain in mHDU. Remains a candidate for ITU for I&V but not currently tiring and no notable derioration in hypoxia in last 24 hours, at risk of deterioration if begins to tire but currently escalation to critical care would be for furter Will review later today but please contact if ongoing deterioration in hypoxia - would be considering I&V if PaO2 falling towards 8.0 Above discussed with Dr Crawford IS THE TREATMENT ESCALATION PLAN (TEP) DOCUMENTED? Unless otherwise stated: 1) The patient remains the responsibility of the referring team until the patient arrives on Critical Care 2) There will be no routine re-review of patients.

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	In the event of deterioration or uncertainty prior to transfer please contact Critical Care. Please contact the Critical Care Registrar if you have any questions or concerns or the Critical Care Coordinator for an update on admission timeframe.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Nurse 12/2/23 15:01 Emma Dick	Alan's O2 saturations have been 92-95% throughout morning,on HFNO2 running at 60L flow/75%. Saturations decreased to 89% at 14.00. Dr informed and O2 increased to 80%. S/N E Dick

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Physiotherapist 12/2/23 17:12 Alexandra J Christie	Physiotherapy review seen 13:40 with Heather Nelson (Band 5 Physiotherapist) S: Action with patient's best interests. TRAK entries reviewed, handover from S/N and discussion with Matthew (ITU CT2) who had just assessed patient in room. Referral for ACT and sputum sample reqested earlier not indicated at present- ongoing high O2 requirement due to Covid pneumonitis and consolidation unable to benefit from Physiotherapy input currently. O: THRAx: 1 considered Obs and NEWS as charted. O/E: mild increaed WOB, opting to keep chatting with visitors. Sitting up in chair position HFNC FiO2: 0.75 talking to family and sipping fluid with straw from beaker. A: Benefit from Physiotherapy input limited at time of assessment as pneumonitis and consolidation will not change with techniques at present. Talking/ engaging with visitors will cause fatigue and at risk of deterioration, resting and supported positions to ease work of breathing encouraged. May benefit from prone lying if tolerated to optimise oxygenation, and possibly ?CPAP. P: Please rerefer to Physiotherapy should patient condition change that will benefit from ACT/ moblising thank you. Discharged from IPPT Sandie Christie (Band 6 Physiotherapist)

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 18:00 Dr David W Roach	Asked about suitability for Tocilizumab whilst unwell with Covid Note guidance : Serious and sometimes fatal infections have been reported in patients receiving immunosuppressive agents including IL-6 inhibitors. While being on antibiotics per se is not a contraindication, IL-6 inhibitor treatment generally must not be initiated in patients with active, severe bacterial (including active tuberculosis), fungal, viral, or other infection (besides COVID19). Healthcare professionals should exercise caution when considering the use of IL-6 inhibitors in patients with a history of recurring or chronic infections. CRP >300 and we're treating for superimposed infection. I think we should hold off on Tocilizumab at the moment given that he has ongoing / worsening consolidation. Note change to Tazocin today, which is appropriate. Need to update CRP and repeat bloods tomorrow. DWR IMT3

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 18:16 Dr Marc Deya Jones	Repeat ABG today shows downtrending p02. Discussed with ITU on call who have kindly reviewed - accepted for transfer to ITU . Marc Deya Jones GPST

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Note Details	Clinical Notes
Significant Information- TEP Episode/Ref: I0005809554 Dr HR Gillett 11/28/23 15:43 Dr Helen Gillett	Treatment Escalation Plan –Summary of Escalation Goals of treatment: Treatment Escalation / Limitation: For active treatment, escalate as needed For Cardio Pulmonary Resuscitation (CPR)?: Yes Discussion has taken place with: Full details can be seen by selecting the Treatment Escalation Plan tab

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 18:39 Dr Matthew Dunne	Matthew Dunne ACCS CT2 Notified of repeat ABG taken on increased HFNO2 Have re-reviewed patient following this. Maintaining saturations at 92-93% on increased HFNO of 80% 60l/min. Patient does not feel changed in himself and does not appear to be tiring from end of bed. Concern is of progressive hypoxia over course of day - PaO2 down from 9.5 to 8.7 despite increased HFNO Have discussed further with Dr Crawford (Cons on-call). In agreement for transfer to HDU for art-line, further HFNO but in case of requirement for intubation. Plan Admit HDU Continue HFNO2 Art-line Continue tazocin DW Micro regarding any adjunctive medications for covid

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 18:44 Emma Dick	Person-Centred Care Alan is feeling a bit better today. He was up to sit in the chair for a while and his wife is in visiting. Deterioration and Escalation NEWS 2-6, due to O2 requirement and high RR. Escalated to mmedics when saturations decreased. High flow nasal O2 running at60L flow/80%. Pressure Area Care Alan's sacrum is slightly red. He relieves his pressure areas by moving about the bed independently. May benefit from a pressure relieving mattress if tiring, as he is only comfortable on his back when in bed just now. Mobility Alan transferred to chair with supervision. Bladder and Bowel Function Alan is passing good volumes of urine via his catheter. No bowel movement. Medicine Management Continues on IV tazocin. Pain Management No complaints of pain. Infection Prevention and Control COVID +VE -DROPLET PRECAUTIONS IN PLACE AND APPROPRIATE PPE PVC in R arm. Bundle updated. Food Fluid and Nutrition Alan is eating and drinking well. Altered Stage of Cognition Alert and orientated. Discharge Planning Alan is for transfer to ITU.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 12/2/23 19:32 Dr Matthew Dunne	\CRITICAL CARE ADMISSION (CCADMIT) TIME OF ADMISSION» 2300 CRITICAL CARE CONSULTANT» M Crawford (On-call anaesthetic consultant) REFERRING CONSULTANT» Dr Rimer - medical consultant DIAGNOSIS» Covid Pneumonitits ACTIVE PROBLEMS» 1» Covid Pneumonitis +/- superadded infection 2» Significant Type 1 Respiratory Failure secondary to above 3» CRITICAL ILLNESS PRESENTING HISTORY» As per CC review above BASELINE FRAILTY / FUNCTIONAL STATUS» Functionally independent with ADLs Retired – electrician Still drives Lives with partner at home Can walk several miles on flat, can climb multiple flights of stairs Smoker – smoked 10/day since aged 14 until admission Alcohol within limits No recreational drug use Has had all covid vaccine and booster except for the latest booster CRITICAL CARE ADMISSION (CCEXAM) RESPIRATORY» RR 20/min. Sats 95% on 80% HFNO2 60l/min. Chest sound clear anteriorly when ausculating. Does not feel that he is short of breath himself and is able to complete sentences with minimal fatigue. CVS» HR 80. BP 130/80. Warm peripherally. JVPNE. MM moist. No pedal oedema. ECG» Sinus rythm on telemetry CNS / PAIN» Alert and orientated. GCS E4V5M6. Denies any pain at present GI / NUTRITION» Eating and drinking at present. RENAL / FLUIDS» Drinking well. Passing good volumes urine at present – catheterised MICROBIOLOGY/ANTI-MICROBIALS» Tazocin commenced today. Covid positive 28/11/23. INVASIVE DEVICES» PVC at present MEDICATION / ECS REVIEW» Tazocin to continue with continuous infusion Dexamethasone 6mg daily PPI cover while on dexa OTHER ISSUES» CRITICAL CARE ADMISSION (CCPLAN) IMPRESSION» Covid Pneumontitis with type 1 respiratory failure PLAN» Admit HDU A-line HFNO2

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Note Details	Clinical Notes
	Tazocin Dexamethasone Will require I&V if further deterioration and hypoxia DW Dr Martin - micro consultant on-call - unable to guide on direct treatment for covid-19 but has guided on additional antimicrobial cover - happy with tazocin monotherapy at present - has had 3 days of clari and has suggested following tests -Extended respiratory viral -Legionalle Antigens urinary RESP (INCL MAX VT) TARGETS» Sats >92%, PaO2 >8.0 CVS TARGETS» MAP >65 FLUID BALANCE TARGET» natural TARGET RASS» 0 THROMBOPROPHYLAXIS» Covid dose dalteparin 5000units 2x daily ULCER PROPHYLAXIS» Lansoprazole NUTRITION PLAN» Fast at present in case of need for intubation INCAPACITY FORM REQUIRED?» not at present SEDATION PLAN (RASS, Hold Y/N) » N/A RECENT RADIOLOGY REVIEWED?: yes. NAME» Matthew Dunne GRADE» ACCS CT2

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/3/23 00:50 Urszula Gebala	Person-Centred Care I have introduced myself to Alan, who has been admitted to the unit tonight at 11pm. He was orientated to staff and ward and explained all care given. Awake and aware. Alan has wife Marueen, who is his next of kin and 5 kids (4 boys and 1 girl). Alan has been made aware that his family may be not able to visit him today due to AGP, which he understands , however will speak to dayshits for the latest update on policy Deterioration and Escalation Alan was admitted fo high flow oxygen Respiratory: Fio2 80% via HFNC, Flow 60L Able to talk in full sentences, not tiring , no use of accessory muscles. ABG 23:30 PO2 13.4 PCO 7. Fio2 weaned to 70% at the time Air enty audible Cardiovasculary: HR 69-80bpm, sinus rhytmn BP - 137/70 (92) Peripheries warm Apyerxial No support 0100hrs Fio2 weaned to 60% as PO2 13.4, and SPO2 98% Extended viral screen sent as per dr request 0300hrs Fio2 weaned to 50% as SPO2 97% , no concerns 0600hrs Fio2 kept at 50% with sPO2 92% flow kept at 60L as when reduced to 50L SPO2 89-90% Pressure Area Care Alan is moving independenly on the bed and able to relief his pessure areas himself. Teds stocking applied Dalteparin 5000 BD Weight 79kg Mobility Bed rest at present Bladder and Bowel Function Alan has IDC in situ. NBO since admission Legionella sample sent as per medical team request Medicine Management All medications givn as prescibed NKDA- allergies 0600hrs Medications given as described. Alan was able to swallow his regular oral medications. IV Tazocin given over 4 hrs this morning Pain Management Alan is not complaining of any pain at present Infection Prevention and Control Covid +ve Nursed in a side room with full RPE and appriopriate door signage

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Note Details	Clinical Notes
	Food Fluid and Nutrition Eating and drinking independly at the moment- likes coffee with milk and one sugar BM stable Altered Stage of Cognition Alan is orienated in time and place . GCS 15 RASS 0 0700hrs Alan has managed to sleep few hours overnight. No complains of any pain or discomfort. Had a good settle night.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Murray C Geddes 12/3/23 10:11 Dr Matthew Dunne	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 1 REVIEWER: M Dunne CONSULTANT: M Crawford ADMITTING DIAGNOSIS: Covid19 Pneumonititis EVENT LIST: ACTIVE PROBLEMS: 1 Covid19 Pneumonititis 2 Type1 Resp Failure on HFNO2 RESPIRATORY: Sitting and talking in full sentences. Appears comfortable. Some crackles right base. RR 26. Sats 94% on 50% 60l HFNO2 PaO2 9.5 ABG CVS: BP 135/68. HR 72. Warm well perfused CNS: GCS 15. moving all four limbs. PAIN: denies DELIRIUM: n RASS -0 CAM-ICU status +ve/-ve : -ve If +ve Delirium Tool complete Y/N GI / NUTRITION: Eating and drinking as able RENAL / FLUIDS: 100mls/hour last 5 hours eGFR >60. Creat 61. U9.3 MICROBIOLOGY: Extended VTS sent Still require urinary legionalla MAX TEMP IN PAST 24HRS: 36.8 WCC: 10.1 ANTIBIOTIC REVIEW: Tazocin INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): CVC AGE: CVC SITE APPEARANCE: A LINE AGE: 1 A LINE SITE APPEARANCE: clean LINES STILL REQUIRED?: yes - for sampling RADIOLOGY REVIEW: CXR reviewed MEDICATION REVIEW: reviewed THROMBOPROPHYLAXIS: Y ULCER PROPHYLAXIS: Y OVERALL IMPRESSION: Improved hypoxia from yesterday - remains on significantly high flows but encouraging signs PROVISIONAL PLAN: Cotninue HFNO - wean as able

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Note Details	Clinical Notes
	Continue tazocin Continue dexa and PPI cover

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr Murray C Geddes 12/3/23 12:52 Dr Matthew Dunne	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: M Crawford IMPRESSION: Slight improvement in oxygenation Remains on high flow - desaturated on lower flows PLAN: Continue on hfno2 wean as able target 8 and 8 Continue tazocin No need to discuss ajunctive therapy at present due to likely superadded pneumonia Ideally keep in HDU for further 24 hours but if significant pressures for beds could be stepped down to mHDU on HFNO2 MOBILISATION GOAL: sit out if willing SEDATION GOAL: unsedated FLUID BALANCE GOAL: neutral INVASIVE LINES REVIEWED?: a-line continue RADIOLOGY REVIEWED?: y AWI/CAPACITY ASSESSED?: y ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?: y ANY ISSUES TO RAISE WITH MICRO: n

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Murray C Geddes 12/3/23 16:30 Dr Matthew Dunne	CRITICAL CARE MICROBIOLOGY ROUND (CCMR) MICROBIOLOGY CONSULTANT PRESENT: Dr Martin SENIOR ICU STAFF PRESENT: Matthew Dunne GRADE: ACCS CT2 PROVISIONAL NEW RESULTS: Negative legionalla CHANGE REQUIRED: YES = AGREED PLAN (All changes on Micro WR should be agreed by both ICU and Micro consultants): extended viral swab not sent yesterday - need to send Send MSU - ok to come off catheter Keep on tazocin as improving clinically ANTIMICROBIAL DE-ESCALATION PLAN: ANTIMICROBIAL ESCALATION PLAN:

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/3/23 18:52 Linsay MacAndrew	Person-Centred Care Introduced myself to Alan, who is managing to speak in sentances. Alan is tolerating the HFNO well, and states that he is comfortable. All aspects of Alan's care was explained to him prior to commencing and caried out with dignity and care. Alan is able to make informed decisions about his care. Alan was asking if his wife would be able to visit, printed out the COVID-19 IPC Guidance, which states that their are no routine restrictions for visiting patients with confirmed. Explained the risks to Alan, and that we would recommend that Wife wears a mask when in room. Will speak to Alan's wife when she visits later this afternoon. Alan has his mobile phone to hand, and is able to communicate to family via this. Deterioration and Escalation RESP Alan has HFNO in place, Fio2 50% Flow 60L RR 20-26 Spo2 92% Air entry is audible throughout Alan is managing to converse in full sentences, not tiring. Nil cough ABG taken at 10.00hrs Pco2 4.68 Po2 9.21 K+ 3.7 Lac 1.7 - Aiming for a Po2 >8 Pco2<8 Update at 15.00hrs ABG taken Po211.4, Pco2 4.36 Lac 1.5 Fio2 reduced to 45% Update 18.30hrs ABG taken Po2 9.90 Pco2 4.36 Lac 1.3 K+ 3.8 Fio2 reduced to 40% Extended viral swabs sent along with MSU as per Dr's request CARDI Aline inserted into L radial ABP 137/72 (92) - unsupported NIBP 140/69 (82) HR 71-75 SR Temp 36.0 Warm and well perfused. Pressure Area Care Alan is normally independent with his ADLS Able to reposition himself in bed to relieve own pressure areas Declined asst with personal care this morning, and states he will 'sort himself' later this afternoon Alan normally wears dentures which are out at present. TEDS in place Commenced on dalteparin BD Mobility Alan is currently nursed in bed, 1:1 offered to Asst Alan to chair this afternoon but declined. Bladder and Bowel Function Alan has a catherter placed, draining approx 120-180mls/hr BNO since admission to ITU Legionella sample sent this morning with morning bloods Medicine Management Medications given to Alan as charted on kardex. Continues with IV Taz

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Note Details	Clinical Notes
	Pain Management When asked Alan states that he is comfortable, and not in any pain. Infection Prevention and Control Alan is COVID 19 +ve Nursed within the sideroom of ITU Full RPE worn due to continual AGP Door sinage in use Aline in L radial, day 2, clean and dressed Green PVC inserted into R upper arm, day 2 , clean and dressed Food Fluid and Nutrition Alan is managing a good intake of food and fluids No IVI running Bm stable, 6.8 at last check Currently sitting at -296ml Altered Stage of Cognition GCS 15/15 CAMS -VE RASS 0 Orientated to time, place and reason for admission

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/4/23 05:09 Hayley Watson	Person-Centred Care I introduced myself to Alan at the beginning of the evening and have explained all aspects of care prior to carrying this out. Alan is alert and oriented and is able to express his care goals/preferences. Alan has been on the phone to his family overnight and has updated them regarding his care. I have ensured to maintain his respect and dignity at all times. Pressure Area Care Alan is able to independently relieve his pressure areas and states that his skin is healthy. Asked Alan if he would like assisted with pressure area care or position change which he declined. Alan has been frequently repositioning himself in the bed. Alan is being nursed on a nimbus mattress and hs ted stockings insitu. Alan is on dalteparin for DVT prophylaxis. Mobility Alan is currently being nursed in bed and has bedrails insitu as per ITU policy. Alan is usually fully mobile and denies any recent falls. Bladder and Bowel Function Alan has an IDC insitu and has been on hourly urne output monitoring overnight. Passing around 120-180mls of urine per hour. currently in a negative fluid balance of 1585 as charted. bowels have not opened overnight. Pain Management Alan has denies any pain overnight, offered prn paracetamol before bed which he declined. Infection Prevention and Control Alan is being nursed in sideroom in ITU due to being COVID +ve. full PPE worn due to ongoing HFNO. All infection control measures in place. left radial A-line insitu (now day 3) and PVC in right upper arm (dated 1/12/23) Altered Stage of Cognition Alan is alert and oriented on assessment and able to make informed decisions regarding his care. Alan is GCS 15 - E4, V5, M6. puils both size 3 and reactive to light. RASS score 0.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/4/23 05:09 Hayley Watson	Deterioration and Escalation Alan remains on HFNO with FIO2 40% and flow 50 and is maintaining SPO2 90-93% on this and acheiving PO2 of 8.4 and PCO2 4.7. Respiratory rate beteen 20-27 overnight. Alan is tolerating HFNO well and states that he is comfortable on this. On chest auscultation at beginning of the evening he had an audible inspiratory wheeze at both right and left upper lung zone and to the left lung base - this has since eased and has good air entry throughout. PRN salbutamol nebs prescribed. update- SPO2 dropped to 87% flow titrated back up to 60L with little effect so FIO2 increased to 50. repeat blood gas PO2 10.2 and PCO2 4.66. FIO2 weaned back down to 40%. Alan has remained cardiovascularly unsupported overnight, ABP 116/57 (MAP 76). HR between 67-75 SR overnight. Apyrexial overnight - current temp 36.1 and is warm and well perfused peripherally. Current BM 7.3. K+ 3.8, Ca 1.17 and lactate 1.5 on blood gas.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Craig A Walker 12/4/23 08:59 Dr Craig A Walker	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 2 REVIEWER: C Walker CONSULTANT: C Walker ADMITTING DIAGNOSIS: COVID-19 Pneumonitis + likely superimposed infection. EVENT LIST: Presented on 28/11 with increasing SOB. Background of COPD but good exercise tolerance and no particular functional limitations at baseline. Admitted under Medics. CTPA - no PE but extensive consolidation; mainly right-sided. Coamox + Clari from 28/11 until 2/12. Had worsening Type 1 Resp failure. Admitted to ITU 2/12. Managing on HFNO since then. Changed antibiotics to Tazocin 02/12 on Micro advice. ACTIVE PROBLEMS: 1) COVID-pneumonitis + likely superimposed infection and ongoing Type 1 Resp Failure. RESPIRATORY: HFNO 50% at 50L/min. Reduced to 40% yesterday but PaO2 8.0 so increased back to 50%. RR16. Speaking in sentences. Sats 95% at present. Reasonable BS bilaterally - reduced on right MZ +LZ. CVS: Warm peripheries. No per oedema. HR 70, ABP 144/84 (MAP ~100). CNS: GCS 15. Alert. Not distressed. PAIN: Nil DELIRIUM: RASS CAM-ICU status Negative If +ve Delirium Tool complete Y/N GI / NUTRITION: Eating breakfast at present. Drinking well. BMs fine. On Dex for COVID-pneumonitis. RENAL / FLUIDS: UO ~100ml/hr. Neg ~2.3L/24hrs yesterday. Urea 8.2, Cr 58. MICROBIOLOGY: As above. MAX TEMP IN PAST 24HRS: WCC: 11.5 ANTIBIOTIC REVIEW: Coamox + Clari from 28/11-02/12 then changed onto Tazocin 2/12 until now. INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): CVC AGE: CVC SITE APPEARANCE: A LINE AGE: 2 A LINE SITE APPEARANCE: Clean LINES STILL REQUIRED?: Y RADIOLOGY REVIEW: Y MEDICATION REVIEW: Y THROMBOPROPHYLAXIS: Y ULCER PROPHYLAXIS: Y OVERALL IMPRESSION: Stable. No worsening since ITU admission. Holding steady on 50% 50L at present. PROVISIONAL PLAN: - Does not require intubation at present; managing on HFNO. - Allow negative fluid balance/ don't chase it. - Continue on Dex + Tazocin. - Same targets: happy with PaO2 8.0-12; PaCO2 <6.

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005809554 Infection Prevention and Control Team 12/4/23 09:22 Strathie E Adams	Infection prevention and control Result not called out as already known by clinical staff COVID-19 TEST POSITIVE- 28/11/23 (further positive 03/12/23) TRANSMISSION BASED PRECAUTIONS: Droplet for all patient contact. Airborne precautions for aerosol generating procedures (AGPs). See below on where to access a full and current list of AGP's. PPE: Droplet precautions require you wear a fluid repellent surgical face mask (FRSM) Type IIR + apron + gloves + eye protection. If AGP taking place Airborne precautions require you wear a filtering face piece respirator (FFP3), long sleeved gown/apron +gloves+ eye protection PATIENT PLACEMENT: Single room or cohort with patients with same confirmed organism HAND HYGIENE: Soap and water and/or alcohol based hand gel ENVIRONMENTAL CLEANING: Enhanced cleaning for both nursing and domestic to be completed with Chlor Clean twice daily including the toilet facilities EQUIPMENT: Use dedicated patient care equipment. Shared equipment MUST be cleaned using Chlor Clean before use by another patient LINEN: Treat as infected in to alginate bag then red linen bag IPCN notes: At discharge/ time of transfer a Terminal Clean to be completed including the toilet facilities Please access NHSL Covid19 IPC guidance on the intranet for further support. A full list of current AGPs and additional advice for PPE can be found in HPS National Infection Prevention and Control Manual. Step down can occur on day 6 (from first positive result/symptom onset) as long as there is an improvement in respiratory symptoms and the patient is apyrexial for 48 hours without the use of antipyretics. IPCN Adams

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Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0005809554 12/4/23 10:36 Anne Neally	Phar:D EB 8/12/23 All regular medications at home Ramipril restarted on the discharge Paperwork only. Phar:1 an 6/12/23 Taz day 4 r/v on day 5 dalteparin to decr to od Phar:1 an 5/12/23 CAP with covid Tazocin continues LMWH assay 0.23 in range: no change to dosing dexamethasone day 8 of 10 Med Rec: meds contiue as per ECS (old date on ECS for aspirin but pt confirms that it is current) new Nicotine patch Phar:1 an 4/12/23 Covid /cap on HFNO PMHx COPD Med Rec completed: N Sources used (min.of 2):ECS only Side room not entered (need full RPE) Outstanding Med Rec issues: Outstanding/ ongoing care issues: Kx not seen d/w ward round co amox and clari started in MAU (day 9 of covid symptoms)then switched to Tazocin on 2/12/23 as per micro Dexamethasone for 10/7 Dalteparin (no weight recorded) BD dosing : covid Rx anti Xa level to be done 3-4 hrs post LMWH dose: requested Changes to medication: Discharge/Compliance information:

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr Craig A Walker 12/4/23 12:15 Dr Craig A Walker	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: C Walker IMPRESSION: As per my daily review. PLAN: As per daily review. Target PaO2 8-12; PaCO2 <6. If reducing HFNO, I'd reduce the FiO2 first (down to ~30%) prior to dropping the flow rate from the current 50L/min. Fluid balance neutral to 2L negative but would allow up to 3L negative before consideration intervention (UE currently fine). MOBILISATION GOAL: Y. Physio + up to chair. SEDATION GOAL: N/A. Nil sedation. FLUID BALANCE GOAL: As above. INVASIVE LINES REVIEWED?: A-line RADIOLOGY REVIEWED?: Y AWI/CAPACITY ASSESSED?: Y - has capacity. ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?: Y ANY ISSUES TO RAISE WITH MICRO: Nil new.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Murray C Geddes 12/4/23 14:52 Dr Katherine Howie	CRITICAL CARE MICROBIOLOGY ROUND (CCMR) MICROBIOLOGY CONSULTANT PRESENT: Kalima SENIOR ICU STAFF PRESENT: Walker GRADE: Consultant PROVISIONAL NEW RESULTS: Nil - ?does not appear sputum sample has been sent yet CHANGE REQUIRED: NO AGREED PLAN (All changes on Micro WR should be agreed by both ICU and Micro consultants): - continue with taz - ensure sputum sample sent if able to obtain Dr K Howie CF ICU

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/4/23 16:19 Lauren Hunter	Person-Centred Care I introduced myself to Alan this morning. All care discussed and agreed to. Alan is very independent and washed himself prior to moving into an armchair this morning. He is looking forward to his wife and daugher visiting this afternoon. Deterioration and Escalation Alan continues on HFNC. Currently 45%Fio2 with the aim of reducing to 40% before reducing the flow rate. Flow rate 60L. Cadiovascularly unsupported BP: 121/64 (98) HR: 70 RR:16 SpO2: 96% Temp: 35.6 Alan remains on 1 hourly observations. Air entry audible but quieter in the lower sectors. Remains covid positive. No wheezing noticible today so far. Factor 10 due at 10pm Asked Alan to provide a sputum sample if he managed to cough anything up. Pressure Area Care Alan is very independent and has been able to relieve pressure on key areas himself. I had a look at his skin while Alan was having a wash and it appears healthy. Daltaparin prescribed. Ted stocking in situ. Continues to be nursed on a nimbus mattress. Mobility Alan is quite steady on his feet. Independently moved from the bed to the chair. Bladder and Bowel Function Alan has a urinary catheter in place which is patent and draining good volumes of urine. Alan opened his bowels this morning just prior to shift change, reported as being a small amount and a mucus consistancy. Medicine Management All medications given as per patient Kardex. Pain Management Alan has not reported having any pain today. Infection Prevention and Control Alan continues to be nursed in a side room with full PPE. Appropriate sinage in place. COVID +ve A-line: Left radial Pink PVC left forearm, Dated 4/12 Food Fluid and Nutrition

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Note Details	Clinical Notes
	Alan is able to eat and drink freely. Altered Stage of Cognition Alan remains CAM ICU Negative GCS 15. RASS: 0

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/4/23 18:47 Lauren Hunter	

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/5/23 07:22 Laura Clark	Person-Centred Care Introduced myself to Alan at the start of the shift and gained consent prior to any nursing interventions. Alan understands his reason for his admission and is able to communicate his needs and wishes. Deterioration and Escalation Alan continues on HFNC to remain weaning as able FI02 weaned from 40% to 30% then increased back up to 40% as per ABG . ABG this am on 40% with flow of 60 lt PO2 9.56 Pc02 4.54 H+ 35.4 A/E in all fields slighlty quieter at L base, nil sputum produced overnight RR 20-24 Sp02 89-96 % Targets remains as per dayshift CVS PWWP HR SR 67-76 ABP 102/65- 136/82 MAP 86 Apyrexial 36.3-36.5 Pressure Area Care Alan remains nursed on a nimbus mattress with teds on. He is Independant with ADL and shall ask when he needs assistance. Alan declined mouthcare before going to sleep this evening and does not require eyecare and is able to change his position in bed should he require it. Mobility Alan has been nursed on bedrest overnight and does not require any assistance with PAC overnight. He is not a falls risk due to this and has x 1 cot side up as he is using a bedside table. Bladder and Bowel Function Catheter insitu, patent and draining clear volumes of urine. Currently negative 2.9 litres. Aiming for neutral to negative 2-3 litres. BNO overnight but passing flatus. Medicine Management Alan has been given all medications as per kardex and does not require any PRN medication Pain Management Alan denies any pain at present and knows that he can ask nursing staff for analgesia should he require any. Infection Prevention and Control Alan remains Covid +ve, all infection control precautions remain inplace as above. Alan is aware of his infection status and his need for isolation. L radial a line remains insitu. Pink PVC insitu L foream Food Fluid and Nutrition Alan remains on oral diet and fluids and needs encouraged. He has tolerated oral fluids overnight. BM 3.9 this morning yoghurt given and coffee and blood sugar increased to 6.2. Breakfast ordered Altered Stage of Cognition GCS 15 alert and orientated.

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Note Details	Clinical Notes
	CAM ICU -ve PEARL 4+ve slept well overnight

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005809554 Dr HR Gillett 11/28/23 16:52 Dr Murray C Geddes	CRITICAL CARE REFERRAL & REVIEW (CCRR) CRITICAL CARE CONSULTANT ON CALL: Geddes ASSESSING CRITICAL CARE TEAM MEMBER inc. GRADE: Geddes Time of Referral: 13:30 Time of Review: 14:00 Time of Recommendation: 14:00 REASON FOR REFERRAL: Escalation, Covid (+), pneumonitis + consolidation (R) RELEVANT CASE BACKGROUND: 1 week SOB, cough, URTI symptoms PMHX: IHD, STEMI 2021 (stent), good function since, no angina, stopped smoking, hypercholesterol and hypothyroid, no COPD diagnosis BASELINE FUNCTIONAL STATUS:Good ASSESSMENT: reservoir mask, SpO2 95%, RR 35, cardiovasc. OK, lactate 4-ish IMPRESSION: Covid and pneumonia RECOMMENDATION: As per discussion with medical team. Currently on appropriate treatment for Covid and pneumonia. Will review in 4-6 hours, if no improvement on current therapy then will admit for invasive ventilation. I have discussed this with him and his wife. IS THE TREATMENT ESCALATION PLAN (TEP) DOCUMENTED? Yes Unless otherwise stated: 1) The patient remains the responsibility of the referring team until the patient arrives on Critical Care 2) There will be no routine re-review of patients. In the event of deterioration or uncertainty prior to transfer please contact Critical Care. Please contact the Critical Care Registrar if you have any questions or concerns or the Critical Care Coordinator for an update on admission timeframe.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Murray C Geddes 12/5/23 09:50 Dr Katherine Howie	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 3 REVIEWER: Howie (CF) CONSULTANT: Service ADMITTING DIAGNOSIS: Community acquired pneumonia with Covid-19 EVENT LIST: Presented on 28/11 with increasing SOB. Background of COPD but good exercise tolerance and no particular functional limitations at baseline. Admitted under Medics. CTPA - no PE but extensive consolidation; mainly right-sided. Coamox + Clari from 28/11 until 2/12. Had worsening Type 1 Resp failure. Admitted to ITU 2/12. Managing on HFNO since then. Changed antibiotics to Tazocin 02/12 on Micro advice. ACTIVE PROBLEMS: 1) COVID-19 with community acquired pneumonia and ongoing Type 1 Resp Failure. - on Abx as well as Dex - remains on HFNO RESPIRATORY: HFNO 35% at 60L/min currently. Managed to reduce to 30% for period of time yesterday then back up to 40% overnight (?if flow was reduced to 50% though appears ti maybe have stayed on 60L/min the entire time) --> noted when flow weaned down sats begin to drop more --> does not report blocked or dry nose THis morning speaking in full sentences, reports feels better than when admitted RR 20 Sats 93%, appears comfortable Good AE though reduce with mild crackles in right bases CVS: Warm peripheries. not oedematous. HS 1+2+0, radial pulse present and reg - HR 75 (SR) ART BP 124/64 (84) CNS: GCS 15. Alert. nil neurological concerns PAIN: Nil DELIRIUM: Nil RASS: 0 CAM-ICU status Negative If +ve Delirium Tool complete Y/N GI / NUTRITION: Eating as able, abdo soft, bowels opened yesterday,. BMs fine. On Dex (D8 of 10) for COVID-pneumonitis. RENAL / FLUIDS: UO ~150ml/hr. Neg ~2.8L/24hrs yesterday (-2.3L day before). Urea 7.5 (8.2), Cr 68 (58). Does not appear dehydrated MICROBIOLOGY: Swabs from 3/12 reamins covid positive ,sputum samples negative MAX TEMP IN PAST 24HRS: 36.8 WCC: 15.6 (11.5) ANTIBIOTIC REVIEW: Coamox + Clari from 28/11-02/12 then changed onto Tazocin 2/12 until now. INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): A LINE AGE: 3 A LINE SITE APPEARANCE: Clean LINES STILL REQUIRED?: Y RADIOLOGY REVIEW: Y MEDICATION REVIEW: Y THROMBOPROPHYLAXIS: Y (Covid dosing and FXa taken last night) ULCER PROPHYLAXIS: Y OVERALL IMPRESSION: Improving oxygenation though continues to require high flow rate PROVISIONAL PLAN: - Aim to wean HFNO down --> ?may be requires slight increase in oxygen to try and get flow down --> continue as same targets as yesterday (PaO2 8-12 PaCO2 <6) - IDC to come out

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Note Details	Clinical Notes
	Dr K Howie CF ICU

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr Murray C Geddes 12/5/23 11:39 Dr Avril Bonnaud	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: Dr Service IMPRESSION: - Right CAP - Covid positive - Currently seems flow dependant rather than oxygen dependant. Would likely benefit from CPAP rather than HFNO considering CAP/Covid. Significant mouth breathing. PLAN: - Trial of CPAP - To keep in side room currently - Aim sat > 92 - RR <30 MOBILISATION GOAL: currently out in chair SEDATION GOAL: Nil FLUID BALANCE GOAL: Negative VENTILATION GOAL: Aim sat > 92 - RR <30 INVASIVE LINES REVIEWED?: Y - A.line RADIOLOGY REVIEWED?: nil new AWI/CAPACITY ASSESSED?: has capacity ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?: Y ISSUES TO RAISE ON MICRO. ROUND: N

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/5/23 18:19 Lauren Hunter	Person-Centred Care I re-introduced myself to Alan again this morning. He reported having had an ok night and thinks he managed to get a couple of hours sleep. Alan continues to be very independent. He has had a wash this morning, got ichanged and has been sitting in the arm chair.. He is expecting visitors in this afternoon. All care ogiven to Alan was done so with his permission. Deterioration and Escalation at the start of today, Alan was on Hopgh Flow Vendtilation, 60% Fio2 with Flow remaining at 60L. This was changed to ventilating via a venturi mask, 60% FiO2. Remains cardiovascularly unsupported. HR: 72 BP: 133/63 MAP: 92 SpO2: 95+ Air entry audible but quieter in bases. Alan has been managing well with the venmturi mask. Sats have remained elevated and steady. His A-line remains in place and is clean/patent. Catheter removed and has been passing good volumes into bottles. Continuing with antibiotics. Pressure Area Care Alan remains independent and has been able to wash and dress himself today. He has declined any oral care - From what I understand he normally wears dentures and they are at home... Continues to wear his TED stockings. Daltaparin presctibed. Mobility Alan is independent and has been able to mobilise from the bed to chair on his own. He feels more steady on his feet today. Bladder and Bowel Function Alan has had his catheter removed this morning and is continuing to pass good volumes of urine into bottles. He has not opened his bowels today. Medicine Management All medications given as per patient kardex. Cntinuing with IV Tazocin. Pain Management Alan has denied having any pain and has not required any pain relief. Infection Prevention and Control Alan continues to be nursed in the side room for poCOVID precautions. A-line remains in place - clean and patent. Pink PVC in left forearm.

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Note Details	Clinical Notes
	Food Fluid and Nutrition Alan is able to eat and drink freely. Altered Stage of Cognition Alan is CAM ICU Negative GCS: 15 He is alert and orientated.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/6/23 07:57 Laura Clark	Person-Centred Care Introduce myslef to Alan at the star of the shift and explained all nursing procedure gaining consent prior to all procedures. Alan understands reason for admission and is able to make decisions based on his care needs and has full capacity at present. Deterioration and Escalation Alan on FM 02 initially on 40% via VT mask and weaned down to 28% and tolertaed well overnight however increased back up to 31% this monring as desaturated to 90 when drinking his morning coffee. aiming for sats >93% A/E in all fields RR 22-24 Sp02 92-96% ABG as charted. Morning bloods sent CVS PWWP Apyrexial Temp 36.1 -36.5 HR SR 69-74 ABP 124/74 (79) Pressure Area Care Alan is independent with PAC and does not require assiatnce, Teds insitu. On BD dalteparin due to covid staus Mobility Alan is nursed on bedrest overnight with x 1 bedrail up. He is not a falls risk at present. Bladder and Bowel Function Catheter removed by dayshift on 5/12/23 as mobility improving. Alan passing good volume of urine into bottles. Negatove balance -1327mls Medicine Management All medications given as per kardex. Continues on Iv Tazoin and Dexomathasone Pain Management Alan denies any pain and is aware he can have PRN analgesia as required. Infection Prevention and Control Alan continues to be nursed in isolations due to covid status as before. L radial aline insitu ? if this can be removed. PVC remains insity L forearm. Food Fluid and Nutrition Alan can have normal oral diet and fluids. He had some coffee before he went to sleep and has been drinking water overnight. Blood sugar stable before bed. Altered Stage of Cognition Alan was alert and orientated at the start of the shift and able to communicate his needs and wishes. He has slept well overnight and hopes to be discharged to ward level care later today GCS 15 CAM ICU -ve PEARL 3+ RASS -ve

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/6/23 10:55 Lauren Hunter	Person-Centred Care I re-introduced myself to Alan again this morning. He reported having had a good night. Remains independent. Plan is to move to the ward today when a bed becomes available. Deterioration and Escalation Alan is currently on 31% FiO2. His sats are sitting steady at 93% . FiO2 reduced to 28%, Sats remain at 92% A-line removed. Ward fit. ;BP: 99/65 map: 76 hr: 87 temp: 36.3 SpO2: 92 There has been no further changes to Alan's care in the past 24 hours. Pressure Area Care Alan is independent and has been able to move about his bed, relieving pressure on key PA's himself. He has a some tender areas on the top of his ears where his glasses have been sitting. Skin not broken and he has been applying some vasaline Up to chair today. Mobility Alan is able to move from the bed to the chair on his own. He is keen to get moving. Bladder and Bowel Function Alan has had no bowel movement since 4/12. there are bowel sounds. Alan continues to pass urine into bottles. Passing good volumes. Medicine Management All medications given as per patient Kardex. Pain Management Alan denies having any pain and has not required any PRN pain relief. Food Fluid and Nutrition Alan has been eating and drinking freely. He does normally wear dentures and has asked for his wife to bring them in so he can have a more varied diet.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Murray C Geddes 12/6/23 10:57 Dr Katherine Howie	CRITICAL CARE DAILY REVIEW (CCDR) DAY OF CC STAY: 4 REVIEWER: Howie (CF) CONSULTANT: Howie ADMITTING DIAGNOSIS: Community acquired pneumonia with Covid-19 ACTIVE PROBLEMS: 1) CAP with covid-19 - continues to improve, now no longer on HFNO for >24 and oxygenating well without tiring RESPIRATORY: Crackles in Right mid and lower zone and left lower zone, good AE throughout - appears comfortable, not obviously breathless and can complete sentences RR 26 talking and 18 at rest, sats 95% on 31% Venturi CVS: Warm peripheries. not oedematous. HS 1+2+0, radial pulse present and reg - HR 76 (SR) ART BP 123/67 (86) CNS: GCS 15. Alert. nil neurological concerns PAIN: Nil DELIRIUM: Nil RASS: 0 CAM-ICU status Negative If +ve Delirium Tool complete Y/N GI / NUTRITION: Eating as able, abdo soft, bowels opened yesterday,. BMs fine. On Dex (D9 of 10) for COVID RENAL / FLUIDS:Good UO, -1.3L yesterday, eating and drinking to thrist and not clinically dry MICROBIOLOGY: Nil new MAX TEMP IN PAST 24HRS: 36.4 WCC: 14.1 (15.6) ANTIBIOTIC REVIEW: Coamox + Clari from 28/11-02/12 then changed onto Tazocin 2/12 until now. INVASIVE DEVICES (Consider changing CVC after 7 days or suspicion of infection): A LINE AGE: 4 left wrist A LINE SITE APPEARANCE: Clean LINES STILL REQUIRED?: N RADIOLOGY REVIEW: Nil MEDICATION REVIEW: Y THROMBOPROPHYLAXIS: Y (continues with BD dosing of LMWH) ULCER PROPHYLAXIS: Y OVERALL IMPRESSION: Continues to improve and reayd for step down to ward e PROVISIONAL PLAN: - A line out - clarify length of double dosing LMWH due to covid - Continue Taz for 5 day course and then review (?IVOS to complete 7days or to finish after 5 days) - Step down to medicla ward --> disucssed with Med Reg Lindsay and kindly accepted for a medical bed Dr K Howie CF ICU

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr HR Gillett 11/28/23 16:52 Dr Marc Deya Jones	Arrived in MHDU - Prescriptions actioned on HEPMA - double up PPI while on steroids for COVID - withhold statin while on clarithromycin - Prophylactic LMWH Since arrival oxygen requirement increased - now needing 80% to maintain p02 10.5, pC02 and pH normal. ITU colleagues will kinldy review. Updated patient and wife on CT findings - no clot, severe pneumonia, COVID positive Marc Deya Jones GPST

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005809554 Dr Murray C Geddes 12/6/23 11:41 Dr Murray C Geddes	CRITICAL CARE CONSULTANT WARDROUND (CCCW) REVIEWING CONSULTANT: Geddes IMPRESSION: Pneumonia CoViD-19 (+) Much improved - 2l O2, SpO2 94%, RR late teens PLAN: Discharge medicine (accepted, thanks) MOBILISATION GOAL: Out of bed SEDATION GOAL: N/A FLUID BALANCE GOAL: Natural INVASIVE LINES REVIEWED?: Y RADIOLOGY REVIEWED?: Y AWI/CAPACITY ASSESSED?: N/A ANTIBIOTIC INDICATION & REVIEW DATE ON KARDEX?:Y ANY ISSUES TO RAISE WITH MICRO:N

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/6/23 13:56 Dr Alexandra Vine	Please note this letter was revised and updated on 7/12/23 at 10am following Mr Soave's discharge overnight CRITICAL CARE IMMEDIATE DISCHARGE LETTER (CCIDL) ***THIS IS A CORE CRITICAL CARE DISCHARGE DOCUMENT INTENDED FOR THE RECEIVING WARD AREA*** DISCHARGE WARD: 21 DATE OF DISCHARGE: 7/12/23 07:00 DATE OF ICU ADMISSION: 2/12/23 23:00 ADMISSION: • REFERRING SOURCE: General Medicine, Dr Rimer • PRESENTATIONS AND SYMPTOMS: Lack of improvment on HFNO2 PRIMARY DIAGNOSIS: 1. Community Acquired Pneumonia ---> please note it has been documented Mr Soave had covid pneumonitis however on review of scans it is felt to be CAP with COVID-19 but nil evidence of pneumonitis 2. Covid-19 CRITICAL CARE COMPLICATIONS: Nil SIGNIFICANT PAST MEDICAL HISTORY: - STEMI 2021 1x DES to LCx; no residual obstructive disease - Mild LVSD and LVH - Hypothyroidism - High cholesterol - COPD (active smoker) INTERVENTIONS IN CRITICAL CARE: 1. Arterial line insertion (removed 6/12/23) 2 Continuation of HFNO and able to wean down 3. BD dosing of LMWH due to covid as per ITU protocol (stepped back down to OD when stepped down) CLINICAL PROGRESS / TIMELINE OF EVENTS: - Presented on 28/11 with increasing SOB. Background of COPD but good exercise tolerance and no particular functional limitations at baseline. - Admitted under Medics. (CTPA - no PE but extensive consolidation; mainly right-sided) and started on Coamox + Clari from 28/11 until 2/12. Also found to be covid Positive on admission - In MHDU wa son HFNC however after a few days concerns for worsening Type 1 Resp failure and admitted to ITU on 2/12. Abx also switched to Tazocin on micro advice - HFNC able to be weaned down over the next few days afte rmonitoring sats and gases - able to wean down to venturi mask on 5/12 and then NC and deemed fit for ward step down on 6/12 - Admitted to ITU 2/12. Managing on HFNO since then. Changed antibiotics to Tazocin 02/12 on Micro advice. PHYSIOTHERAPY STATUS : SEE TRAK ENTRY NUTRITIONAL TEAM STATUS: SEE TRAK ENTRY ALLERGY:NKDA MEDICATIONS: • CONTINUED - Levothyroxine 100micrograms)D - Aspirin 75mg OD - Atorvastain 80mg OD - GTN spray PRN • WITHHELD: Nil • STOPPED: Melatonin 2mg OD • NEW - Piperacillin/Tazobactam TDS started 2/12/23 - for review 7/12/23 - Lansoprazol - increased from 15mg OD to 30mg OD due to increased GI bleed risk on steroids - Dexamethasone 6mg OD (to finish a 10 day course 7/12/23) - Dalteparin 5000U - TED stockings - Salbutamol PRN - Paracetamol 1g PRN max QDS

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Note Details	Clinical Notes
	- Nicotine patch 21mg KEY POINTS FOR REVIEW: • CONTINUED ISSUES - ongoing recovery from CAP and covid • MEDICATIONS Antibiotic duration. After day 5 (7/12/23) please consider IVOST to complete 7 day course or to stop course on day 5. Review lansoprazole dose once steroid course complete • INVESTIGATIONS / SPECIALTY REVIEWS - please consider referral to smoking cessation services when nearing discharge as Mr Soave keen to quit TEP COMPLETED: Y - For active treatment and escalation as needed DELIRIUM STATUS: • IN ICU: N • AT DISCHARGE: N DISCHARGE NEWS: 2 (ongoing oxygen requirement of 2L) NAME: Gillespie POSITION: CT2 CONTACT: 54063 PAGE: 3561 Updated by Dr K Howie (CF) on 7/12 at 10:00

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005809554 Dr Murray C Geddes 12/6/23 21:04 Dr Ross Gillespie	Gillespie CT2 - Nights Pneumonia/COVID-19 SpO2 90-94% on nasal oxygen Plan 1. For medical step-down when bed available

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005809554 Dr Murray C Geddes 12/7/23 01:00 Hayley Watson	Person-Centred Care I introduced myself to Alan at the beginning of my shift and have explained all areas of care prior to carrying them out. Alan is alert and oriented and has been able to communicate his care preferences/ goals. Alan has slept so far overnight. Deterioration and Escalation Alan continues to self ventilate on 28% venturi mask and is acheiving targe SPO2 >90% - current SPO2 92%. Alan's respiratory rate has been between 19-23 overnight. slight crackles heard at right lung base on ausculation - but goot air entry heard at all lung zones. UPDATE- dropped SPO2 to 87% on 28% venturi, little improvement on 31% so titrated up to 40% and is now maintaining SPO2 92-94%. current NEWS score 7 due to O2 requirement, raised RR, SPO2 92% and BP 100 systollic. Alan is cardiovascularly unsupported - most recent blood pressure 116/79 and HR 69, Alan has been apyrexial overnight and blood glucose 5.1 before bed. Alan continues to be monitored on 4hourly observations whilst awaiting medical bed. Pressure Area Care Alan has been independently relieving her pressure areas overnight and has declined assitance with position changes etc. Alan denies any areas of pressure area damage. Alan is being nursed on a NIMBUS mattress and has ted stockings insitu. Alan is on dalteparin as DVT prophylaxis. Mobility Alan has been nursed in bed overnight, was up in chair during the day. Alan has bedrails insitu. nursing call bell within reach at all times. Bladder and Bowel Function Alan has been passing urine into bottles overnight without issues - fluid balance monitoring continues - remains in a positive balance. Nil BO overnight. Medicine Management medication given as per kardex - IV TAZ currently running over 4hs. nil PRN medication required overnight. Pain Management Alan has denies any pain overnight and not requested any analgesia. Infection Prevention and Control Alan continues to be nursed in side room in ITU due to being COVID +ve. All appropriate infection control precautions in place. PVC in left arm - dated 4/12 and nil redness or signs of infection. Food Fluid and Nutrition Alan is eating and drinking independently, had coffee before bed and has been drinking good vols of water - declined any food before bed. Altered Stage of Cognition Alan remains alert and oriented and is able to express his own care wishes - GCS 15/15

Patient & GP Information

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CHI Number	2911571495
Episode Number	I0005821868
Surname/Forename	Soave, Alan
Date of Birth	11/29/57
Sex	Male
Patient Address.	34 Southpark Place Livingston EH54 6FG
Registered GP	AF Stephen
GP Address.	Carmondean Medical Group,Carmondean Centre,Livingston,West Lothian EH54 8PY

Report Contents

The report bundle provides information on the following:

* IP/OP Clinical Notes

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Inpatient/Outpatient Clinical Notes

Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Maria Corretge 12/16/23 02:04 Jemma Macdonald	Person-Centred Care Alan has been admitted to MDHU from ED due to SOB. Alan is settled on arrival to the ward, nursing call bell to hand. Deterioration and Escalation NEWS 2 on arrival to ward. Scoring as sats 94% on air and bp 106 systolic. Pressure Area Care Alan states his skin is healthy and intact. Mobility Alan is ind mobile. Bladder and Bowel Function Alan has not passed urine or moved bowels since arrival to ward. Medicine Management Medications given as per hepma. IVF running. Pain Management Nil complaints of pain on arrival to ward. Infection Prevention and Control Alan had a cephid in ED which was positive for covid, unable to tell if this is from previous admission or new strain, Alan is to be nursed in side room with appropriate ppe. Food Fluid and Nutrition Alan has had a cup of coffee and a sandwhich on arrival to ward. Altered Stage of Cognition Alan is alert and orientated.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Anna Bethany Bryans 12/16/23 08:03 Dr Anna Bryans	Bryans IMT3 Reviewed overnight - transferred to MHDU from ED due to bed space rather than clinical need but deteriorated overnight with new O2 requirement and pyrexia 66M recently discharged after being admitted with covid-19 and superadded bacterial infection - presentation prompted by rash starting on lower limbs and affecting rest of body and trunk - ICU admission, did not require intubation and ventilation A: patent B: RR24-30, sats initially maintained on air - new O2 requirement 2-4L via nasal cannula chest - scattered creps bilaterally C: radial pulse palpable, regular warm peripherally, clammy HS I + II + 0 HR 86, BP 101 systolic calves SNT, no peripheral oedema or evidence of DVT D: fully alert, orientated pupils 3mm bilaterally pyrexic 38 E: has passed urine 1/2 bottle since arriving on MHDU blanching maular rash all over body ECG: sinus rhythm CXR: right-sided ?collection or abscess, no fluid level but appears well circumscribed, possibly loculated Bloods: WCC13, CRP 109, eosinophils not raised, LFTs slightly derranged fibrinogen >9 Micro: nil positive from previous admission, sputum no growth Imp: - likely complicated bacterial infection with possibly empyema infection - rash appears more typical of drug reaction, - at risk of PE, though I suspect chest x ray findings are in keeping with current presentation. Plan: - ABG - Antibiotic choice discussed with Microbiology - as per below plan - Not for steroids at present - I think this picture if more in keeping with complicated bacterial infection rather than covid pneumonitis - Repeat full septic screen - blood cultures sent, requires sputum sample, MSU - CTPA/CT chest to assess lesion and rule out PE - Strict fluid balance - We have made ICU aware of patient as remains for full escalation but does not currently require organ support

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 08:08 Dr John Cafferkey	SJH CRITICAL CARE REFERRAL & REVIEW (CCRR SJH) ASSESSING CRITICAL CARE TEAM MEMBER inc. GRADE: J Cafferkey CT3 REASON FOR REFERRAL: Deteriorating news RELEVANT BACKGROUND inc. PMH: Recent ICU admission COVID + pneumonia Discharged a week ago Represents pyrexial, rash, short of breath, cough ASSESSMENT: T1RF, but on 4L NC. New well demarcated R sided CXR changes Fib > upper limit normal. Medical team are planning to investigate with CT & Holding off Rx dose LMWH - clot seems less likely and would impede ?empyema drainage. IMPRESSION: Superadded/opportunistic chest infection Decreased reserve after recent ICU admission RECOMMENDATION: No current need for organ support in ICU Remains a suitable candidate for consideration of critical care Please re-refer if concerns or deterioration WOULD CRITICAL CARE ADMISSION AT ANY POINT BE APPROPRIATE FOR THIS PATIENT? Yes IF YES, WHAT SHOULD PROMPT RE-REFERRAL? Worsening T1RF Other deterioration IF NO, WHY NOT? MOST SENIOR CRITICAL CARE DOCTOR INVOLVED IN DECISION: Cafferkey CT3 - discussed at anaesthetic handover The Critical Care team will not be able to take over care of the patient until their arrival in ICU. In the event of deterioration or uncertainty prior to transfer please contact Critical Care on #3561

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Nurse 12/16/23 08:20 Rebecca Russell	*** AUTO GENERATED BY {Frailty Screening} QUESTIONNAIRE *** Does this person have markers of frailty? No Summary of screening: **CLINICAL FRAILTY SCORE 2** - Well: no active disease symptoms and occasionally active. - No obvious frailty input required - Continue care as usual, please refer to frailty team if needed.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 08:40 Claire Russell	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: No data entered Time Seen: No data entered Problem/Request: on gentamicin for sepsis - had dose 0700AM, will need level ~2100pm please Outcome: No data entered

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 09:22 Dr Rachel Sheppard	WR Dr Wright Issues: 1) Recent covid - ITU admission 2) Pneumonia - on IV vanc/met/gent NEWS 8 - RR 24, sats 93% on 4L, BP 100/61, HR 88, afebrile Eating and drinking ok Passing urine ok Bowels moved yesterday O/E: - crackles at right base Plan: - continue IV antibiotics - chase CTPA - could step down to ward 21 (side room) - wean oxygen as able - sputum culture as able R Sheppard SHO

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Note Details	Clinical Notes
Significant Information- TEP Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 13:39 Dr Rohana J Wright	Treatment Escalation Plan –Summary of Escalation Goals of treatment: Treatment Escalation / Limitation: For active treatment, escalate as needed For Cardio Pulmonary Resuscitation (CPR)?: Yes Discussion has taken place with: Full details can be seen by selecting the Treatment Escalation Plan tab

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 15:33 Emma Dick	Person-Centred Care Alan is feeling quite well. His wife is in to visit. He is able to communicate his needs and care preferences. Deterioration and Escalation NEWS has been 5-8. Alan continues on 4L O2, his RR has been 22-26 and he has been slightly hypotensive. Pressure Area Care Alan's skin is slightly dry, but intact. His rash remains the same. He is able to relieve his pressure areas independently. Mobility Alan transferred easily fom bed to chair, with supervision. Bladder and Bowel Function Alan is passing good volumes of urine in to urinals. Infection Prevention and Control COVID +VE -DROPLET PRECAUTIONS IN PLACE AND APPROPRIATE PPE PVC sites healthy. Food Fluid and Nutrition Alan is eating and drinking well. IVI discontinued after d/w Dr. He is in a positive balance. Altered Stage of Cognition Alan is alert and orientated. Discharge Planning Alan can step down from MHDU to a medical sideroom.

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005821868 On Call CT Reporting 12/16/23 16:18 Diane R Duncan	Checklist completed as per SOP SJH/CT/058 with no contraindicating factors. Patient gave verbal consent for IV bolus injection. No adverse reaction noted prior to leaving radiology department. Omnipaque 350 200ml bottle 65ml injected Lot: 161615625 Exp: 12-2025

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Nurse 12/16/23 19:17 Emma Dick	Alan has been slightly hypotensive. Bp dropped to 89/59 at 19.00. NEWS 8. Is in a positive balance. asked Dr to review and he has been prescibed IVI at 75 mls/hour. S/N E Dick

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/17/23 02:27 Alex Queen	HOSPITAL at NIGHT / WEEKEND Type of Request: Task Assigned To: Alex Queen Time Seen: No data entered Problem/Request: Blood cultures required Outcome: obtained as requested

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Anna Bethany Bryans 12/17/23 04:42 Dr Anna Bryans	Bryans IMT3 High news score overnight having spiked temperature RR26 sats maintained 4L O2 - unchanged from previous temp 38.9 tachy ~110 BP 106 sysolic -> 83 systolic remains comfortable, not in respiratory distress CT: no PE. slightly improving but extensive infection Micro: blood and sputum cultures in progress Plan: - stat fluid bolus now with continued maintenance fluid prescribed - repeat blood cultures - continue vanc/gent/metro for now (within 48 hours) - chase sputum/blood cultures

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 03:37 Dr Marc Deya Jones	D Dimer not analized - discussed with haem lab, analyzer fault, need another sample. Marc Deya Jones GPST

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Nurse 12/17/23 05:02 Claire Hale	Alan has been in bed overnight. Independent and using bottles. No complaints. Spiked a temp, had paracetamol with good effect and blood cultures. IVfluids continued at 75mls/hr. BP dipped to 80s systolic and escalated to Drs, IVFluid bolus. News as charted. Continues on 02 therapy 4L NC. Fluid balance chart, currently in a positive balance.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005821868 Dr Rohana J Wright 12/17/23 09:17 Dr Rachael Lamb	WR Corregde Issues: 1. Recent covid - ITU admission 2. Recent Pneumonia - initially on co-amox and clari - developed empyemas - now on vanc/gent and metro Today: Had a rash across leg - not itchy improving Explained likely a drug reaction Explained plan to continue with fluids and antibiotics Explained observations OE: Dermographism Warm peripherally Impression: Rash - drug reaction Empyemas Plan: Continue antibiotics - monitor vanc + gent levels Continue IV fluids R.Lamb FY1

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/17/23 11:14 Nicola Colvin	Person-Centred Care Introduced myself to Alan explaining all care delivered and procedures carried out. Deterioration and Escalation Currently Alan is a NEWS of 6. RR 24 4LO2 therapy-SP02 94-97 93 systolic BP. Remains on 4 L02 voa n/c SP02. Continues on 1 hourly observations. UPDATE*HYPOTENSIVE 82 systolic-encourage increased oral intake-will continue to monitor. Vancomycin and Gentamycin levels will be taken at 17.00 hours. Pressure Area Care Alan manages to wash and dress himeslf-states that his skin and pressure areas are intact. Alan is able to relieve his own pressure areas. PVC in his L ACF has been removed due to tissuing-a slight rash to this arm. Rash on bilateral legs fading. Mobility Alan is independant from bed to chair. Less able to move around the room due to the constraints of the monitoring leads and 02 therapy. Bladder and Bowel Function Alan has been passing urine into bottles, BNO as yet. Fluid balance insitu. Medicine Management Medications as per HEPMA. Pain Management Alan denies any pain. Infection Prevention and Control Alan has been nursed in a sideroom due tp having a covid positive result. PVC in R ACF-in date. PVC in R wrist 17/12/23 Food Fluid and Nutrition Alan is eating and drinking as able. Fair nutritional status. Altered Stage of Cognition Alan has a GCS of 15

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rachael Lamb 12/17/23 18:37 Dr Rachael Lamb	Vanc level: 9 Recommended to increase by 2 bands as target 15-20 Have prescribed new dose: 1250mg TDS Gent: continue 24 hrly dosing R.Lamb FY1

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/18/23 02:52 Tracey Lynch	Person-Centred Care Alan has had a settled night, no new nursing issues Deterioration and Escalation Remains on 4l 02 via n/c, 4hrly observations, NEWS 3-8 Pressure Area Care Alan able to reposition himself independently, rash not so evident Mobility Alan is independently mobile Bladder and Bowel Function Alan is fully continent/independent, using bottles overnight, bowels not open Medicine Management medication given as per HEPMA Pain Management Alan has not complained of any pain overnight Infection Prevention and Control Alan is isolated PPE/Handwashing as per hospital policy X2 PVC's insitu, no sign of infection Food Fluid and Nutrition managing good oral diet/fluids, fluid balance recorded

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005821868 Dr Rohana J Wright 12/18/23 09:08 Dr Imran Shah	Ward Round - Dr Dickinson Issues: 1. Pneumonia, - R lower lobe, with additional consolidation throughout - No Empyema 2. Persistently +ve for COVID Bloods: Hb 113, WCC 11.0, Urea 2.9, Creat 65, ALP 140, CRP 118 (107) ECG: SR Progress Last temp spike on 16/12, temp now settled. Patient says he feels great this morning, feels a lot better than he did. Explained results of his scan. Still coughing up sputum. Have explained recovery from COVID and Pneumonia will take around 2 months. Plan 1. Sputum and Blood cultures in progress 2. Further 24hours of IV Abx then IVOS 3. Step down to Ward 21 4. Wean off O2 as able 5. Aim home in the next 2-3 days 6. Follow up CXR in 6 weeks Shah FY1

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005821868 Infection Prevention and Control Team 12/18/23 09:37 Sharon Broadley	COVID-19 TEST POSITIVE- _15_/_12_/_23 and 16/12/23 also previously positive on 28th November and 3rd December but still appears to be symptomatic reading notes._, spoke with _S?N Leanne Foster_____ TRANSMISSION BASED PRECAUTIONS: Droplet for all patient contact. Airborne precautions for aerosol generating procedures (AGPs). See below on where to access a full and current list of AGP's.- Alan is not currently getting any AGP's, he is on oxygen. PPE: Droplet precautions require you wear a fluid repellent surgical face mask (FRSM) Type IIR + apron, eye protection and glovers if dealing with bloos or body fluids. If AGP taking place Airborne precautions require you wear a filtering face piece respirator (FFP3), long sleeved gown/apron +gloves+ eye protection PATIENT PLACEMENT: Currently isolated in MHDU HAND HYGIENE: Soap and water and/or alcohol based hand gel ENVIRONMENTAL CLEANING: Enhanced cleaning for both nursing and domestic to be completed with Chlor Clean twice daily including the toilet facilities EQUIPMENT: Use dedicated patient care equipment. Shared equipment MUST be cleaned using Chlor Clean before use by another patient LINEN: Treat as infected in to alginate bag then red linen bag IPCN notes: At discharge/ time of transfer a Terminal Clean to be completed including the toilet facilities and when staying in the room but has been stepped down from a COVID perspective. Please see the IPC manual on the intranet for more information and stepdown criteria. Many thanks Sharon Broadley GL IPCN

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Clinical Pharmacist 12/18/23 11:05 Joanna de Giacomo Araujo	Please consider stopping lansoprazole. Patient was on this historically while on DAPT (in 2021) with instructions from cardio to stop the PPI when DAPT finished, but this was not actioned. Patient confirms he is not taking a PPI for any alternative reason (no reflux etc). If no clear indication for PPI, better not to be taking one while on broad spec abx.

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Note Details	Clinical Notes
Pharmaceutical Care Issues Episode/Ref: I0005821868 12/18/23 11:11 Joanna de Giacomo Araujo	Phar:D EB 21/12/23 IDL screened, TTO supply. Phar:1 vanc, gent Med Rec completed: Y - ECS, IDL - not spoken to pt as has covid. But I did put head round door to confirm no reason for PPI. Outstanding Med Rec issues: stop PPI - no indication (was started for DAPT in 2021 but can now stop). Outstanding/ ongoing care issues: - Pneumonia on bg recent admission for pneumonia and covid. Still testing persistently positive for covid. On vanc/gent/met. - Gent - has had 3 doses. All levels ok for 24hrly dosing. Cr low and stable (65). Ideally can stop now. - Vanc - aiming 15-20 as was ?empyema, but patient now confirmed no empyema so can reduce range? - VTEP: dalteparin 5000 od - Wt 70kg, Cr 65. Changes to medication: nil, but pls to stop lansoprazole permanently. Discharge/Compliance information: independent.

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/18/23 14:39 Leanne Foster	Person-Centred Care Alan has had a very settled day. He has refused a wash today. Family currently in attendance and Alan has updated on current condition and plan of care. Deterioration and Escalation Alan was initially on 1 hourly NEWS recording. NEWS 6 at time of doctors ward round. NEWS 3 now and switched to 4 hourly as able to stepdown to ward 21. He continues on 3L O2 via N.C Pressure Area Care Alan states that all his pressure areas are fully intact and he is able to relieve them independently. Mobility He has been independently mobile around sideroom. Bladder and Bowel Function Alan has been passing urine into urinals. BNO as of yet today. Medicine Management All medication administered as per HEPMA. 3rd amaintenance dose of IV Vancomycin due @ 22.00 - will require pre dose Vancomycin level. Pain Management Alan has not c/o any pain. Infection Prevention and Control He has been nursed in sideroom with appropriate PPE and signage - see infection control entry. PVC bundle updated. Food Fluid and Nutrition Alan is eating and drinking well

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/19/23 04:58 Linda McKie	Person-Centred Care Alan appears to have had a settled night Deterioration and Escalation Alan's NEWS has been variable overnight Hourly observations recorded due to same, NEWS 5 at this time He is able to step down to Ward 21 Pressure Area Care Alan is changing position independently to protect his pressure areas Mobility Alan has remained in bed overnight Nurse call bell witiin easy reach Bladder and Bowel Function Alan is using urinals at the bedside to pass urine Bowels not opened overnight Medicine Management Medications given as per HEPMA Pain Management Alan has not c/o pain overnight and has appeared comfortable Infection Prevention and Control Alan is COVID +VE and is being nursed in a single room All appropriate signage and PPE available outside his room He has x 2 PVC's in situ Care bundles in place and updated Food Fluid and Nutrition Alan is eating and drinking well Fluid balance chart maintained Altered Stage of Cognition Alan is alert and orientated and can communicate his needs

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/19/23 08:46 Dr Rebecca S Dickinson	WR Dickinson Issues: 1. Pneumonia, - R lower lobe, with additional consolidation throughout - No Empyema 2. Persistently +ve for COVID Looking much better Apyrexial for >24h Sats 96% on 3LO2 Plan 1) IVOS - amox 1g + metronidazole 2) Stop PPI 3) Wean O2 4) Needs CXR in 6 weeks 5) Step down any ward bed

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 06:57 Dr Marc Deya Jones	ATSP NEWS 9 - up from 7 earlier this evening - pyrexial - new 02 requirement Discussed with microbiology cons on call. - rash may be hypersensitivity or infection related (eg group A strep). Avoid Beta lactams. Start Gent and Vanc and Metro - in that order - actioned - likely still testing posttiive for COVID rather than active infection - suggests keeping off steroids if no concerns of airway disease (I don't have any) - if empyema early intervention and sampling would be key - understands pending further imaging . Marc Deya Jones GPST

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/19/23 11:45 Tracey Lynch	Person-Centred Care Alan has had a settled morning, up in chair, independent basin wash, face time with family Deterioration and Escalation awaiting a bed in ward 21, remains on 3l 02 via n/c, 4hrly observations, NEWS 2 Pressure Area Care Alan is able to reposition himself independently Mobility independent with mobility/ADL's Bladder and Bowel Function passing urine into bottles, fluid balance chart completed, has not opened bowels as yet today Medicine Management medications given as per HEPMA, antibiotics now changed to oral Pain Management Alan has not complained of any pain Infection Prevention and Control Alan remains isolated, signage insitu, PVC in date no signs of infection, PPE/Handwashing as hospital policy Food Fluid and Nutrition Alan managing good oral diet/fluids Discharge Planning no discharge date as yet

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/20/23 06:10 Cema Yohannan	Person-Centred Care Alan appeared settled and appaeared to have slept on and off overnight. Deterioration and Escalation News varies 4-5 as on 3-4 liters of 02 via nasal prongs , sats 95% and was hypotensive as well. Pressure Area Care Alan`s skin is healthy and intact.He is able to cahnge position independently in bed. Mobility Alan mobilizes independently around bed spaces as connected to 02. Bladder and Bowel Function Alan is using bottles to pass urine,bowels not opened so far. Medicine Management Alld ue medications given as per Hepma. Infection Prevention and Control Alan is Covid +E SO ENSURE Barrier nursing sign post on ddor PPE to be worn Good hand washing techniques Follow infection control protocol as per west lothian guidelines Food Fluid and Nutrition Alan is eating and drinking well. Altered Stage of Cognition Alan is fully alert and oriented.GCS is 15.

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Note Details	Clinical Notes
Ward Round Episode/Ref: I0005821868 Dr Rohana J Wright 12/20/23 09:25 Dr Ben Lomako	*** AUTO GENERATED BY {Structured Ward Round} QUESTIONNAIRE *** Ward Round Lead : Dr Andrew J Degnan Ward Round Note : Issues: 1. Pneumonia, - R lower lobe, with additional consolidation throughout - No Empyema -Oral Amox and IV Gent 2. Persistently +ve for COVID 3. Note BPV -ve, blood and sputum culture no growth Today: NEWS 2 3L Sats 97%, BP 107/65, RR 18, Temp 37.0 Bloods 19/12/23 Hb 102, WCC11.7 , Plts 416, Na 132, K 4.3, creatinine 70, eGFR >60 -Reports no pain -Feeling generally better in himself -Not breathless -Smoker 10-12 per day -Explained patient would benefit from remaining in hospital for care right now due to O2 require/ CXR O/E: -Regular HR -Pure HS -Bibasal crepitations worse on R side -No peripheral oedema Cons Impression: -66M with breathlessness secondary to recent SARS-CoV2 infection and pneumonia -improving but remains on O2 - needs to remain IP while on O2, do not want premature discharge given recent readmission Plan: 1- Continue oral antibiotics 2-Withhold ramipril due to hypotension(Has IHD), would benefit restarting in due course 3- Step down to ward 21 or gen med ward 4- CXR 6 weeks as OP 5 -Wean O2 as able - aim home once mobilising and O2 weaned/sats stable 6 check previous sats from last admission - note smoker

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/20/23 13:54 Leanne Foster	Infection Prevention and Control Called infection control nurse re. whether Alan could come out of isolation as apyrexial and last PCR result 17/12 was a weak positive. They advise that medical team should call on call virologist to discuss this matter. Doctors informed.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/20/23 15:50 Dr Nathan Sharp	IMT 3 Sharp D/W on call virologist Happy that comes out of isolation Very weak positive sample so therefore doesn't need to continue in side room

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Note Details	Clinical Notes
Care Plan Summary Episode/Ref: I0005821868 Dr Rohana J Wright 12/20/23 16:42 Juliana Da Silva Tome	Person-Centred Care Alan has had a settled day. He expressed that he wanted to have a shower today, however due to recent covid positive test, confirmation form the infection control team is necessary. Medical team is chasing it with virology as per infection control advice. Alan had a settled day and his wife visited in the afternoon. He remains keen to go home when medically fit. Deterioration and Escalation Alan's observations conducted four hourly. Alan has been scoring a 2 on his NEWS observations due to O2 therapy. Attempted to wean O2 from 3 to 2 litres down, but saturations dropped at every attemp. Alan's BP systolic was also low around 95 mmgH, medical team withheld Ramipril to improve BP. Alan remained apyrexial today. oral antibiotics continued. He is medically fit to step down to a medical/respiratory ward. Pressure Area Care Alan was encouraged to mobilise within his room, due to droplet precautions in situ. He remains independent with majory of his ADL's and reports that his skin remains intact and healty. Mobility Alan is normally independent and has been encouraged to mobilise within his bedroom. He has been alert and orientated and has the appropriate footwear in situ. Bladder and Bowel Function Alan has been continent and independent with elimination needs today. He has been passing urine regularly and bowels opened this afternoon. Medicine Management All medication adminsitred as per HEPMA and following ll relevant guidelines. Alan has continued his oral antibiotis therapy. Pain Management Alan has been comfortable today with no complaints of pain. He has been encouraged to mobilise more within his bedroom. Infection Prevention and Control All contact and droplet precautions ahdred to as patient has recent covid positive test. Infection control team has been contacted as patient remains apyrexial for more than two days. Virology to be contacted by medical for a finald ecision of cessating droplet precautions. No PVC in situ as antibiotics switched to oral. Food Fluid and Nutrition Alan tolerated oral fluids and diet and has kept a good apetite at meal times. Altered Stage of Cognition Alan has been alert and orientated and able to express his wishes and needs. Discharge Planning Alan remains keen to go home when medically fit.

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Robert J Grecian 12/21/23 10:44 Alison Donnelly (PA)	WR Dr Grecian 1) Right lower lobe pneumonia - confirmed on CTPA on 16/12 Day 5 Amoxicillin and metronidazole 2) Recent COVID - remains weak positive Functionally independent. Smoker 10-12 a day - since aged 12 CRP 59 (88) EWS 4 Sats 94% on 2L BP 100/64 HR 94 Sitting out in chair. Feeling well, keen to get home. Sats 94% on air - mobilised with oxygen probe, remained at 94% O/E Right basal crackles A bit dull at right base Smoking cessation advice given. Happy to see smoking cessation team in community. Plan: 1) Repeat CXR in 4-6 weeks to assess resolution 2) Outpatient PFTs in 6 weeks - assess for underlying lung disease ? COPD 3) Smoking cessation referral 4) Home today Alison Perry Physician associate

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005821868 Dr Robert J Grecian 12/21/23 12:09 Alison Donnelly (PA)	PRINCIPAL DIAGNOSIS/PROCEDURE Right lower lobe pneumonia Possible underlying COPD - for outpatient investigation BG Recent HDU admission with COVID pneumonitis - HFNO TREATMENT Presented with worsening pleuritic chest pain following a recent admission with COVID pneumonia. He had a CTPA which did not show any evidence of PE but confirmed right basal consolidation. He was treated for pneumonia with Amoxicillin and Metronidazole. He had a slight oxygen requirement of 1-2 litres, which has now been weaned off. He is a current smoker and has been given smoking cessation advice, is also agreeable to community referral. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL Ouptatient smoking cessation For repeat CXR in 6 weeks time - for consideration of CT if not improving. Outpatient pulmonary function tests in 6 weeks time. CHANGES TO DRUGS SINCE ADMISSION Ramipril has been discontinued as Hypotensive during admission - can be re-started at a later date if required. Yours sincerely... Alison Perry Physician associate

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Note Details	Clinical Notes
Inpatient Discharge Summary Episode/Ref: I0005821868 Dr Robert J Grecian 1/22/24 11:16 Kerry McAllister	FINAL DISCHARGE SUMMARY Dear Doctor, I have nothing further to add to the immediate discharge letter which you should already have received. Yours sincerely, e-checked Dr Robert Grecian Consultant Respiratory Physician RG/KM 17/01/24 22/01/24 PRINCIPAL DIAGNOSIS/PROCEDURE Right lower lobe pneumonia Possible underlying COPD - for outpatient investigation BG Recent HDU admission with COVID pneumonitis - HFNO TREATMENT Presented with worsening pleuritic chest pain following a recent admission with COVID pneumonia. He had a CTPA which did not show any evidence of PE but confirmed right basal consolidation. He was treated for pneumonia with Amoxicillin and Metronidazole. He had a slight oxygen requirement of 1-2 litres, which has now been weaned off. He is a current smoker and has been given smoking cessation advice, is also agreeable to community referral. FUTURE INVESTIGATIONS AND FOLLOW-UP BEING ARRANGED BY HOSPITAL Ouptatient smoking cessation For repeat CXR in 6 weeks time - for consideration of CT if not improving. Outpatient pulmonary function tests in 6 weeks time. CHANGES TO DRUGS SINCE ADMISSION Ramipril has been discontinued as Hypotensive during admission - can be re-started at a later date if required. Yours sincerely... Alison Perry Physician associate

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005821868 Nurse 1/22/24 13:53 Sarah Norris	Critical Care Recovery Service - Nurse Specialist Telephone call to find out if Alan made an appointment on Thursday and if he has attended his Gp Practice regarding our last conversation FU Call on 16/01/24. He stated he was experiencing high Temp at night: feeling sweaty and shivery; Low Bp with dizzy spells; increased short of breath (? COPD / Empyema on last CT); weakness in legs – he stated he would request referral to community physiotherapy when seeing his GP; recent weight loss from 13 ½ stone to 9 ½ stone in last 2/12 without dieting. He stated that he felt concerned and anxious about this. Worsening advice was given at the end of the last call. My details were left on the answer machine message of his mobile number. Sarah Norris Nurse Specialist Critical Care Recovery Service

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 07:19 Dr Marc Deya Jones	ITU review requested Marc DJ GPST

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Note Details	Clinical Notes
Specialty Review Episode/Ref: I0005821868 Nurse 4/12/24 09:44 Sarah Norris	Critical Care Recovery Service 2nd Follow up call to Mr Alan Soave on 03/04/24 High Risk Pathway patient All AHP questions asked when doing the follow call. Written in retrospect due to time constraints SALT Alan stated tat he has no concerns regarding eating and drinking. He stated he feels better now and denies any problems now with talking or with how his voice sounds or about reading and writing. Alan has not reported and problems with coughing/choking/food getting stuck/ feeling chesty/wheezy after eating drinking/struggling to chew food/loosing food from his mouth. He has no difficulties with word finding difficulties, spelling difficulties, difficulties understanding written words, difficulties understanding what is said to him. Physio Alan has stated that he mobilises independently around his house. He said that he manages allright with the stairs in his home. Alan has no concerns at this time with his mobility. OT Alan is able to carry out all personal hygiene, and washing and dressing himself. Alan manages his shopping and cooking independently. He is retired. Alan has his own medicine box and decants all his medication into it himself. He manages his medications without difficulty. Psychiatry Alan has no issues with bad dreams/hallucinations/frightening memories about ICU. His mood is ok Alan has no problems with sleeping either. Alan thanked me for calling him. He has the SJH CCRS new telephone number and is aware he can contact me should he have any questions, or require further support. He knows that he should contact his GP in the first instance if he becomes unwell, 111 if out of hours or A&E in an emergency. Sarah Norris Nurse Specialist Critical Care Recovery Service St John's Hospital 07483321406

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Note Details	Clinical Notes
Progress Notes Episode/Ref: I0005821868 Dr Rohana J Wright 12/16/23 07:37 Dr Marc Deya Jones	Verbal consent obtained for BBV screen - taken MDJ GPST