ALERT SHEET

UR 112233
Grigg
Georgie
F
05/05/1941
English
22 Nice St
St Albans 3021
Phone: 92999167
DVA:
M/C:
today:

1) ADVERSE DRUG REACTION

(This section may be completed by medical staff, nursing staff or pharmacists)

LIFE THREATENING REACTIONS

Date of reaction State if unknown	Suspected Drug /Substance (generic name)	Description of adverse drug reaction (If unable, state that "details not known")	Today's Date	Name	Designation
Unknown	Trimethoprim	Rash → Anaphylaxis	Today	Jane Booker	RN

OTHER ADVERSE DRUG REACTIONS

Date of reaction State if unknown	Suspected Drug /Substance (generic name)	Description of adverse drug reaction (If unable, state that "details not known")	Today's Date	Name	Designation

2) MAJOR CLINICAL ALERTS (eg. Isolation requirements, Anaesthetic problem) –

SHEET ☐ OF ☐

ALERT SHEET

ALERT SHEET

PATIENT IDENTIFICATION LABEL

Interpreter required (specify language)

3) OTHER ALERTS (eg. Release of information, Jehovah's Witness, deaf, blind etc.)

Power of Attorney/Guardianship/Administration Orders
(Copies of Orders are to be filed in the Correspondence Section)

Type of Order (eg Medical/Financial)			
Name: (eg Name of Power of Attorney)			
Phone (BH):			
Phone (AH):			
Mobile:			
Fax:			
Staff Member's Name:			
Designation:			
Signature:			
Ward/Dept:			
Date:			
Date Order Revoked:			

Health Information Department use only

Cancer Registration Number

Mental Health Registration Number

Baby UR Numbers

Mother UR Number

Microfilm Numbers

Previous records destroyed as per government disposal schedule (Date or Computer Number)

INPATIENT PROGRESS NOTES

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DATE & TIME	NOTES, SIGNATURE AND DESIGNATION
Yesterday 2230	Ortho Amission - (Houston) (Patient transfered from Goldfields regional hospital) 71 y o F Day 0 post - T/F to ward from OR. → ORIF → DHS (Dr Parker) R/V on ward post-op Medical hx 1) Right THR - 2006 (Dr Shepard - Altona) 2) Paroxysmal AF 3) osteoarthritis. 4) CCF 5) T2DM on OHG. 6) Recurrent UTI's - not on ABs @ present. Medications As charted - regular analgesia Allergies - ? sulphonamides Social history lives alone in St Albans (Husband died 5 yrs ago) Double storey home mob (I) with SPS (I) ADL's Non-Smoker, occ Ethol History of presenting complaint. Fall at hotel whilst visiting sovereign hill yesterday Fell on 2nd last step whilst going downstairs → landed on L side & L hip Ambulance called by hotel owner → taken to Goldfields hospital → T/F to theatre Sunshine for DHS Pelvis +ve → Intertrochanteric Left NOF # No Pelvic # PTO

INPATIENT PROGRESS NOTES

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DATE & TIME	NOTES, SIGNATURE AND DESIGNATION

Yesterday Ortho admission (cont)

Chest TR – Left sided rbs # x 2.

Uneventful ORIF; Post op day 0. - Hb 110

Urinary retention overnight - IDC insitu
- CSU phase
- UO satisfactory
- burning + pain

O/E - febrile 38° HR 95 BP 142/98, SaO_2 94% RA

Left surgical wound - moderate oedema
- minimal erythema
- no discharge
- mild tenderness around wound
- pedal pulses intact bilaterally.

ROM (L) hip - 0 - 30° flexion
extension not tested
15 - 20° Abduction and Adduction.

Nail - Immobile.

Investigations (precop from Goldfields)

FBE 112 | 10.1 | 343

UEC 143 | 4.6 | 9.3 | 100

INR 1.7

Left hip TR post ORIF - DHS - good position
- Encircled.

CXR (yesterday) - left basal atelectasis
2° x rbs # (L)

PTO

INPATIENT PROGRESS NOTES

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DATE & TIME	NOTES, SIGNATURE AND DESIGNATION
Yesterday	Ortho Admission (Housen) (cont)
	Issues 1) Left hip DHS post # NOF → pain → rehab goals.
	2) # ribs → pain
	3) Urinary Sx ? UTI low grade fever
	Plan 1) Admit ortho under Dr Parker 2) PT/SW/OT referral please 3) Analgesia as charted 4) ra/rho dbs 5) QID ESL please 6) Increase warfarin to therapeutic INR 7) Soho workup if fever persists 8) CSU - ? ABs.
Yesterday	Nursing Notes - ND shift
0500	71 year old lady admitted directly from theatre following L) ORIF & DHS. Patient had fall yesterday in Sovereign Hill + sustained a/# R) NOF and L) ribs +2. PMH Paroxysmal AF, NIDDM on OHGIs, & KNR recurrent UTI's ABS Alert + orientated, GCS 15, c/o L) hip & rib pain, analgesia as charted. Pain 6-7/10 - morphine s/c 2-5mg as charted with good effect. Oxynorm 5mg is also given for breakthrough pain CVS Skin dry + warm, T-37°, HR 89 reg, BP 140/90, IVC site intact + patent. Resp SV on room air, RR 20 SaO2 95% RA chest clear, c/o pain on inspiration. Physio referral completed.

INPATIENT PROGRESS NOTES

INPATIENT PROGRESS NOTES

PATIENT IDENTIFICATION LABEL

DATE & TIME	NOTES, SIGNATURE AND DESIGNATION
Yesterday 0500	Nursing notes (continued) GIT Nil nausea or vomiting, Sips of fluids Taken overnight. Bowel sounds present. IVT in progress 8/24 = 125 mls N/Saline. Renal - IDC in situ on RTW. UO 30-60 mls/hr. C/O some burning + pain @ times D/W ortho reg - CSU taken. To start ? ABIS this am for ? UTI Metabolic - BSL stable 5.8 mmol/L - QID BSL Mobility - RIB post-op - 2 hourly pressure care - skin intact - nil issues. Braden score recorded Social - NOK to be contacted in am - sister TVJ aware of transfer. - Social work referral made Appears comfortable at time of report Post-op care - Post-op obs stable, wound slight blood stained ooze (McKenzie RN)

BOWEL FUNCTION CHART

Previous Bowel History: normal

Risk Factors on oxycontin regularly, ↓ mobility

REPORT any problems or change in bowel habits eg. Constipation/Diarrhoea, to the nurse In charge / doctor for advice and assessment.

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* Place ✓ in box as appropriate

BOWEL ACTIONS				CONSISTENCY						COLOUR							AMOUNT					OCCULT BLOOD	
Date	Time	Controlled	Incontinence	Hard	Formed	Paste	Soft	Watery	Mucous	Brown	Black	Dark Red	Bright Red	Yellow	Green	Altered	Very Small	Small	Medium	Large	Approx mls	Positive	Negative
yesterday	2330	✓		✓						✓							✓				100ml hard to estimate		✓

BOWEL ACTIONS				CONSISTENCY						COLOUR							AMOUNT					OCCUL BLOOD	
Date	Time	Controlled	Incontinence	Hard	Formed	Paste	Soft	Watery	Mucous	Brown	Black	Dark Red	Bright Red	Yellow	Green	Altered	Very Small	Small	Medium	Large	Approx mls	Positive	Negative

DIABETES RECORD

☐ Western Hospita
☑ Sunshine Hospit

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DATE	TIME	KETONES	BLOOD GLUCOSE	Comments e.g. sliding scale insulin dose, hypo, etc.
Yesterday	1900	N/A	8.2	On admission (had Lantus 23 international units @ 1730 hrs today)
Yesterday	2250		6.8	RTW post-op?
Today	0200		5.8	
"	0730		5.4	
"	1130		7.6	

DIABETES RECORD

28096 04/11

DIABETES RECORD

PATIENT IDENTIFICATION LABEL

DATE	TIME	KETONES	BLOOD GLUCOSE	Comments e.g. sliding scale insulin dose, hypo, etc.

Date: Yesterday

DAILY FLUID BALANCE CHART

Only these following abbreviations should be used on this chart:
IDC - In Dwelling Catheter, **PUIT** - Pass Urine In Toilet , **Incont** - Incontinence, **HNPU** - Has Not passed Urine
NBM - Nil By Mouth, **NGT** - Naso Gastric Tube, **DT** - Drain Tube, **C** - When any bottle/catheter/drain is emptied
SPC - Supra Pubic Catheter, **FR** - Fluid Restriction, **JP** - Jackson Pratt, **RTW** - Return to Ward,
PEG - Percutaneous Endoscopic Gastrostomy, **BF** Breast Fed, **EBM** Expressed Breast Milk
TOV - Trial of Void
PVR - Post Void Residual
All other drain tubes to be written in full (Redivac)

PATIENT IDENTIFICATION LABEL

I.V.

BROUGHT FORWARD FROM PREVIOUS 24 HOURS

Fluid Hartmans Soln	Fluid
Vol. 1 L .	Vol.

ORAL + N/G

Time	Type	Vol.	Total
1200			
22^{30}	RTW from OR Nil orally		
2300			
23^{30}	Sips H2O	50	
2400			
Totals			50

LINE A

Fluid	Vol.	Prog. Total
Hartmans soln 1000mls .	75	75
	125	200
	125	325
		325
TOTAL INPUT		375 .

LINE B

Fluid	Vol.	Prog. Total

OUTPUT

Urine	N/G ASP	N/G F/D	Vomit / Faeces	Drains 1	Drains 2	Drains 3	Drains 4	Prog. Total
IDC in situ (Bag emptied 400mls)								
80								
125								
TOTAL OUTPUT								605 .

Incomplete

DAILY FLUID BALANCE CHART

Date: Today

DAILY FLUID BALANCE CHART

- ☐ Western Hospital
- ☐ Sunshine Hospital
- ☐ Williamstown Hospital
- ☐ Sunbury Day Hospital

Only these following abbreviations should be used on this chart:
IDC - In Dwelling Catheter, **PUIT** - Pass Urine In Toilet , **Incont** - Incontinence, **HNPU** - Has Not passed Urine
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PATIENT IDENTIFICATION LABEL

I.V.

BROUGHT FORWARD FROM PREVIOUS 24 HOURS

Fluid	Hartmans soln.	Fluid	
Vol.	1000 mls	Vol.	

ORAL + N/G

Time	Type	Vol.	Total
0100			
0200			
0300			
0400			
0500	water	50	50
0600	Tea	150	200
0700			
0800	Tea	150	350
0900	milk/OJ	250	600
1000			
1100			
1200	Tea	140	740
1300			
1400			
2400			
Totals			

TOTAL INPUT

LINE A

Fluid	Vol.	Prog. Total
B/F Hartmans Soln	125	125
1000mls @ 125 mls/hr	125	250
	125	375
	125	500
	125	625
	125	750
	125	875
	125	1000
IV fluids ceased	125	1125

LINE B

Fluid	Vol.	Prog. Total

OUTPUT

Time	Urine	N/G ASP	N/G F/D	Vomit / Faeces	Drains 1	Drains 2	Drains 3	Drains 4	Prog. Total
0100	80								80
0200	75								155
0300	50								205
0400	25								230
0500	80								310
0600	120								430
0700	110								540
0800	75								615
0900	80								695
1000	95								790
1100	125								915
1200	130								1045
1300	30								1075
1400	50								1125

TOTAL OUTPUT

INTRAVENOUS AND SUBCUTANEOUS FLUID ORDER FORM

Facility/Service: _____

Ward/Unit: .....

FRONT

Adverse Drug Reaction Sticker

(See Medication Chart for details)

AFFIX PATIENT IDENTIFICATION LABEL

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

UR No:

Family Name:

Given Names:

DOB: Sex ☐ M ☐ F

1st Prescriber to Print Patient's Name and Check Label Correct

DRIP RATE CALCULATOR = Drops per Minute (DPM) Microdrip sets (60 drops = 1mL/hr) mL/hr = Drops/min

Time (hrs)	2	4	6	8	10	12	16	18	24
mL/hr **(1L bag)**	500	250	166	125	100	83	62	55	42
20 drop/mL set	167 DPM	83 DPM	55 DPM	42 DPM	33 DPM	28 DPM	21 DPM	18 DPM	14 DPM

Weight _____ kg

Fluids Must be Prescribed Daily - Only One Bag Will Be Administered Against Each Order

Year 20..			Medical Officer Prescription			Nursing Administration Record				
Date/Time ordered	Line/ Route	Volume	Fluid Type and Additive (amount per bag or syringe)	Rate mL/hr	Dr Signature / Print Name	Date/Time Start	Rate mL/hr	Nurse 1 / Nurse 2	Time Stop	Volume Infused
Today	IV	1000 mls	Normal Saline 0.9%	4hrly	Dr. Brown	Current.				

THE CANNULA MUST BE CHANGED EVERY 96 HOURS UNLESS INDICATED BY PHLEBITIS SCORE ON THE PERIPHERAL INTRAVENOUS CANNULA FORM

INTRAVENOUS AND SUBCUTANEOUS FLUID ORDER FORM

INTRAVENOUS AND SUBCUTANEOUS FLUID ORDER FORM

Facility/Service: _____

Ward/Unit: .....

BACK

Adverse Drug Reaction Sticker

(See Medication Chart for details)

AFFIX PATIENT IDENTIFICATION LABEL

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

UR No:

Family Name:

Given Names:

DOB: Sex ☐ M ☐ F

1st Prescriber to Print Patient's Name and Check Label Correct

.....

DRIP RATE CALCULATOR = Drops per Minute (DPM) Microdrip sets (60 drops = 1mL/hr) mL/hr = Drops/min

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Weight _____ **kg**

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Date/Time ordered	Line/ Route	Volume	Fluid Type and Additive (amount per bag or syringe)	Rate mL/hr	Dr Signature / Print Name	Date/Time Start	Rate mL/hr	Nurse 1 / Nurse 2	Time Stop	Volume Infused

THE CANNULA MUST BE CHANGED EVERY 96 HOURS UNLESS INDICATED BY PHLEBITIS SCORE ON THE PERIPHERAL INTRAVENOUS CANNULA FORM

PERIPHERAL INTRAVENOUS CANNULA RECORD

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Ward/Department:

The peripheral cannula must be removed no later than 96 hours (4 days) after insertion, or resited (if the patient required continued IV access), irrespective of the phlebitis score.

V.I.P Score (Visual Infusion Phlebitis Score)

Cannula Site	Assessment	Score	Action
I.V. site appears healthy	▶ No signs of Phlebitis	0 ▶	● **OBSERVE CANNULA**
One of the following is evident: ☑ Slight pain or redness near I.V. site	▶ Possible first signs of phlebitis	1 ▶	● **OBSERVE CANNULA**
Two of the following is evident: ☑ Pain near site ☑ Erythema ☑ Swelling	▶ Early stage of phlebitis	2 ▶	● **RESITE CANNULA**
All of the following is evident: ☑ Pain along path of cannula ☑ Swelling ☑ Erythema	▶ Medium stage of phlebitis	3 ▶	● **RESITE CANNULA** ● **Inform Medical Team**
All of the following is evident & extensive: ☑ Pain along path of cannula ☑ Erythema ☑ Swelling ☑ Palpable venous cord	▶ Advanced stage of phlebitis or start of thrombophlebitis	4 ▶	● **RESITE CANNULA** ● **Inform Medical Team**
All of the following is evident & extensive: ☑ Pain along path of cannula ☑ Erythema ☑ Swelling ☑ Palpable venous cord ☑ Pyrexia	▶ Advanced stage of thrombophlebitis	5 ▶	● **Refer to IV policy for treatment** ● **RESITE CANNULA**

Source: Andrew Jackson, Consultant Nurse Intravenous Therapy and Care, Rotherham General Hospital, NHS Trust.

CANNULA NO 1
Date Inserted: Yesterday **Insertion Site:** L) arm **Inserted By:**

DAY 1	Date: Yesterday	
	Shift:	
AM	**PM**	**N**
In use: (Y) / N	In use: (Y) / N	In use: (Y) / N
Phlebitis Score: 0	Phlebitis Score: 0	Phlebitis Score: 0
Flush / Infusion (Y) / N	Flush / Infusion (Y) / N	Flush / Infusion (Y) / N
Cannula removed Y / (N)	Cannula removed Y / (N)	Cannula removed Y / (N)
Initials:	Initials:	Initials:

DAY 2	Date: Today	
	Shift:	
AM	**PM**	**N**
In use: (Y) / N	In use: (Y) / N	In use: Y / N
Phlebitis Score: 0	Phlebitis Score: 0	Phlebitis Score:
Flush / Infusion (Y) / N	Flush / Infusion (Y) / N	Flush / Infusion Y / N
Cannula removed Y / (N)	Cannula removed Y / (N)	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 3	Date:	
	Shift:	
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 4	Date:	
	Cannula must be removed today	
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

PERIPHERAL INTRAVENOUS RECORD

CANNULA NO 2 Date Inserted: / / Insertion Site: Inserted By:

DAY 1	Date:	
Shift:		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 2	Date:	
Shift:		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 3	Date:	
Shift:		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 4	Date:	
Cannula must be removed today		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

CANNULA NO 3 Date Inserted: / / Insertion Site: Inserted By:

DAY 1	Date:	
Shift:		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 2	Date:	
Shift:		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 3	Date:	
Shift:		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

DAY 4	Date:	
Cannula must be removed today		
AM	**PM**	**N**
In use: Y / N	In use: Y / N	In use: Y / N
Phlebitis Score:	Phlebitis Score:	Phlebitis Score:
Flush / Infusion Y / N	Flush / Infusion Y / N	Flush / Infusion Y / N
Cannula removed Y / N	Cannula removed Y / N	Cannula removed Y / N
Initials:	Initials:	Initials:

CONSENT FORM

PATIENT IDENTIFICATION LABEL

Consent For Surgery/ Procedure

I, GEORGIE GRIGG hereby consent to the following operation(s) / procedures(s)
given name surname

DYNAMIC HIP SCREW REPAIR ☒ Left ☐ Right ☐ Not Applicable
specify operation(s) / procedure(s) & side / site in writing
Side must be indicated both in writing and via tick box

being performed on GEORGIE GRIGG
myself or name and relationship to patient if completed by person other than patient

I also consent to such further operative procedures as may be found necessary to be performed during the course of the operation(s) / procedure(s) stated above. In conjunction with the above stated operation(s), I consent to the administration of such anaesthetics as may be considered by the anaesthetist to be necessary or advisable. I understand that Western Health is a teaching hospital and consent to medical students participating in or being present during the operation or procedure. I understand that my tissue(s) will be used for diagnostic and treatment purposes. I understand that it will be kept and may be used for ethically approved research, education and laboratory quality procedures.

The nature and effect of the above operation(s) / procedure(s) have been explained to me by Dr Bones

Risks and Complications discussed include:

infection post op; Pain; Bleeding requiring transfusion; failure of procedure and revision

Other options for treatment have been discussed with me? ☐ No ☒ Yes

I have been given the consent information sheet for the surgery / procedure above. ☐ No ☒ Yes

Signed Georgie Grigg Self or relationship to patient Self Date Yesterday

Reason if consent given other than patient

Name of Interpreter	Reason for the person other than qualified interpreter

Confirmation by Medical Officer

I, Dr. T. Bones have explained to the *patient / ~~person responsible for the patient~~, the nature of the above operation(s) / procedure(s). ~~In my opinion,~~ ~~she~~ / she understood the explanation.
**Stike out not applicable

Signature of Medical Officer Bones Date / / YESTERDAY

681570 05/11

CONSENT FORM

Guidelines for commonly asked questions regarding consent to treatment

Answers to commonly asked questions about consent appear below. They should be used as a guide. **Please refer to 'Consent' policy (OP CC3.1.1)** for full details. A person giving consent should show the purpose and the nature of the intervention, the intended effects and the potentially significant side effects, hoped for benefits and reasonable alternatives.

Consent to treatment

- Professional interpreters are used, except in situations of unavoidable urgency. Non-clinical staff should not be used as interpreters.
- If a person other than the patient provides consent, the explanation for this must be documented on the consent form.
- Invalid consent and no consent at the time the proposed treatment is to be administered or on arrival in the procedural area will be documented as an adverse event.

Consent in an emergency

- In an emergency where immediate treatment is necessary to save a person's life or to prevent serious injury to a patient's health, treatment may be given without consent. These matters must be documented in the medical record.

Patients with temporary inability to consent to treatment – non emergency situation

Consent in these situations must be sought from the Office of the Public Advocate (Telephone: 9603 9500).

Patients with long term disability and incapable of consenting to treatment – non emergency situations

Where an adult patient (18 years and over) has a permanent or long term disability and is incapable of giving informed consent due to a lack of understanding of the nature and effect of the proposed treatment, consent is governed by the Guardianship and Administration Act.

The following guidelines apply to persons with long term disability and who are unable to give consent.

- In an emergency situation, there is no need to obtain consent to proceed with the treatment.
- In the case of 'special procedures' only VCAT (Victorian Civil & Administrative Tribunal) may consent to the treatment.
- In all other procedures, consent may be obtained by the 'person responsible'.

'Persons responsible' to provide consent

- The Guardianship & Administration Act permits '**persons responsible**' to provide consent for medical and dental treatment on behalf of a patient with long term disability and who is incapable of giving consent, if the treatment is in the best interests of the patient.
- A person responsible is:

  the first person in a list of persons (refer Guardianship & Administration Act) who is responsible for the patient, reasonably available and willing and able to make a decision in relation to the carrying out of medical or dental treatment on the patient and includes:

  - An agent appointed by the patient (before the patient became incapable of giving consent) to make health care decisions under an Enduring Power of Attorney (Medical Treatment Act 1988).
  - A person appointed by the Victorian Civil and Administrative Tribunal (VCAT) to make decisions about the proposed treatment.
  - A person appointed by VCAT as a guardian under a current Guardianship Order with the authority to make health care decisions.
  - A person appointed by the patient (before the patient became incapable of giving consent) as an enduring guardian with power to make decisions about the proposed treatment.
  - A person appointed in writing by the patient to make decisions about medical or dental treatment which includes the proposed treatment.
  - The patient's spouse, or domestic partner, with whom the patient is in a close and continuing relationship.
  - The patient's primary carer, in receipt of a Centrelink Carer payment but excluding paid carer's or service providers.
  - The patient's "nearest relative' over the age of 18, which means, in order of priority:

    son or daughter, father or mother, brother or sister, grandfather or grandmother, grandson or granddaughter, uncle or aunt, nephew or niece.

- Persons responsible are those appointed:
  - As an agent under the Medical Treatment Act.
  - By the Victorian Civil & Administrative Tribunal in relation to the proposed treatment.
  - Under guardianship order with power to make decisions in relation to the proposed treatment.
  - As an enduring guardian with power to make decisions in relation to the proposed treatment.
  - By the patient in writing (when competent) to make the relevant decision.

Situations where 'person responsible' cannot be found to consent to treatment

- Where no 'person responsible' can be located, the Medical Officer must fax an Intention to Treat form (located on ward) to the Office of the Public Advocate (Facsimile: 9603 9501), It must include clear contact details to facilitate the Office of the Public Advocate notifying the Medical Officer via telephone as soon as possible after receiving the intention to treat form. Treatment can proceed before receiving acknowledgment from the Office of the Public Advocate. It must be clearly documented in the patient's record.

Situations where 'person responsible' refuses to consent to treatment

- Where the person responsible can be located and refuses to consent to the proposed treatment, the doctor must contact the Office of the Public Advocate (Telephone: 9603 9500) prior to carrying out the procedure.

Georgie Grigg

Ramipril 10mg morning - one tablet
Frusemide 40mg morning - one tablet (Fluid)
Aspirin 100mg morning - one
Metformin 1000mg twice a day (Sugar / diabetes)
Lantus (insulin injection) - 23 units after dinner
Atorvastatin 40mg night-time
Warfarin 3mg alternating 2mg

Received	Patient	Patient Name	Referred by	Comments	Referred to
Today	112233	Grigg, Georgie	S Ortho Ward	71yo lady needs mobility review post #NOF Please Review!!(lives alone)	Physio
Today	112233	Grigg, Georgie	S Ortho Ward	Diabetic, new patient transferred from rural	Nutrition
Today	112233	Grigg, Georgie	S Ortho Ward	New patient transferred from private hospital – lives alone other social circumstances unknown, please review	SW
Today	112233	Grigg, Georgie	S Ortho Ward	Post op DHS please review for discharge planning	OT

HOURLY PATIENT ROUNDING – DOCUMENTATION LOG

Bed:	UR:

Date:						
Time period	Staff initials	Pain	Position	Pan	Pt enviro	Plan
TWO HOURLY ROUNDS 2200 – 0600 hrs						
0001						
0200						
0400						
HOURLY ROUNDS 0600 – 2200 hrs						
0600						
0700						
0800						
0900						
1000						
1100						
1200						
1300						
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						

Date:						
Time period	Staff initials	Pain	Position	Pan	Pt enviro	Plan
TWO HOURLY ROUNDS 2200 – 0600 hrs						
0001						
0200						
0400						
HOURLY ROUNDS 0600 – 2200 hrs						
0600						
0700						
0800						
0900						
1000						
1100						
1200						
1300						
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						

This is not a legal document and does not require filling in the patients history.

HOURLY PATIENT ROUNDING – DOCUME ATION LOG

Bed: L 4 | UR: 112233

Date: Today						
Time period	Staff initials	Pain	Position	Pan	Pt enviro	Plan
TWO HOURLY ROUNDS 2200 – 0600 hrs						
0001		✓	✓	✓	✓	✓
0200		✓	✓	✓	✓	✓
0400		✓	✓	✓	✓	✓
HOURLY ROUNDS 0600 – 2200 hrs						
0600		✓	✓	✓	✓	✓
0700		✓	✓	✓	✓	✓
0800		✓	✓	✓	✓	✓
0900			✓	✓	✓	✓
1000		✓	✓	✓	✓	✓
1100						
1200		✓	✓	✓	✓	✓
1300						
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						

This is not a legal document and does not require filling in the patients history.

Date:						
Time period	Staff initials	Pain	Position	Pan	Pt enviro	Plan
TWO HOURLY ROUNDS 2200 – 0600 hrs						
0001						
0200						
0400						
HOURLY ROUNDS 0600 – 2200 hrs						
0600						
0700						
0800						
0900						
1000						7
1100						
1200						
1300						
1400						
1500						
1600						
1700						
1800						
1900						
2000						
2100						
2200						

ISBAR COMMUNICATION TOOL

ATTACH HOSPITAL LABEL HERE IF AVAILABLE

UR Number: _____

Surname _____

Given name _____

Date of Birth _____ Sex: M / F

Time of call _____ Date of call ____/____/____ Callers name _____

Name of person contacted _____ Pager/mobile number called _____

I — IDENTIFY

Identify yourself Ward _____ Bed number _____

I am calling about _____ Age _____

S — SITUATION

Problem _____

_____

State severity

Severe ☐ Very concerned ☐ Concerned ☐ Controlled ☐

B — BACKGROUND

Admitting diagnosis / operation _____

Date of admission _____

Circle if relevant: AMI, Anxiety, Asthma, CCF, COPD,CRF, Diabetes, IHD, PE, Pneumonia, Smoker, Stroke, UTI, Dementia, Depression, Behaviour issues

A — ASSESSMENT

Most recent vital signs @_____hrs RR_____Sa02_____HR_____

Pain Score_____ BP_____ Temp_____ UO _____

Pt on oxygen? ☐ Yes ☐ No Litres/min_____IV Fluid _____

Test Results _____

Patients mental state _____

Assessment of skin / extremities _____

R — REQUEST

☐ I would like you to see the patient within the next 30 minutes

☐ I would like you to see the patient now

Are any tests/imaging needed:

☐ Do you need any tests? _____

Doctors orders / comments _____

_____

If the patient's condition continues to deteriorate please follow ward escalation response – referral algorithm for clinical markers.

Name Signature Designation

RESPONDER: Please document response on back of page

ISBAR COMMUNICATION TOOL

ISBAR COMMUNICATION TOOL

ATTACH HOSPITAL LABEL HERE IF AVAILABLE

UR Number_____

Surname _____

Given name _____

Date of Birth_____ Sex: M / F

RESPONSE TO ISBAR

DATE:_____ TIME:_____

Summary of Situation

Summary of Your Assessment

Recommendations

Name Signature Designation

FUNCTIONAL MAINTENANCE CARE PLAN AD 82.0

UR 112233
Grigg
Georgie
F
22 Nice St
Nicetown 8909
Phone: 92999167

05/05/1941
English
DVA:
M/C:
today:

Interpreter: N/Y_____ **Date:____/____/____ LOS Day:_____** **Comments / Progress / Plan updated:**

General	*Observations*	Frequency:	
	Additional Monitoring	❑ BSL ❑ Weight ❑ Neuro Vasc_____ ❑ Other _____	❑ Drain tubes/ICC _____
	Oxygen	❑ _____LPM ❑ Face Mask ❑ Nasal Prongs ❑ Humidified	
Pain	*Acute or Chronic*	❑ Type/Location/Mx: _____ ❑ Sedation score _____	
Cognition	*Orientation & Behaviour*	❑ Alert ❑ Drowsy ❑ Oriented ❑ Confused ❑ Other: _____	
	Supportive Comminication	❑ Hearing Aid – Left / Right ❑ Dentures – Top / Bottom ❑ Glasses / Legally Blind	
Nutrition Ensure weekly weigh and rescreen for malnutrition risk weekly	*Assistance Required*	❑ Nil ❑ Set-up ❑ Feeding ❑ Oral Hygiene	MST score: _____ Next MST screen due: _____ Next weight due: _____
	Fluid	❑ Fluid Bal. Chart ❑ ____ L/Day FR ❑ Normal Fluid ❑ IV / NGT / PEG ❑ Modified Fluids ❑ NBM	
	Food	❑ Food Chart ❑ HEHP diet ❑ Full Ward Diet ❑ Supplements ❑ Diabetic Diet ❑ IV / NGT / PEG ❑ Modified Diet ❑ NBM	
Medication (must be supervised)	*Assistance Required*	❑ Nil ❑ Set-up ❑ Crushed medication	
	IV Cannula	Location: Resite Due:	
	Patch	Location: Change Due:	
Continence	*Bladder*	❑ IDC ❑ Continent ❑ Prompting ❑ Incontinent	❑ Stoma _____ ❑ Skin regime if double incontinence
	Bowel	❑ Bowel Chart ❑ Continent ❑ Prompting ❑ Incontinent	
Skin Integrity Braden score ≤ 12 high risk 13-14 medium risk 15-18 low risk	*Pressure injury prevention*	Braden Score:_____ Due on ...../...../..... ❑ Pressure Care as per Braden Ax ❑ Daily full skin check for **ALL** patients	❑ Air Mattress ❑ Turning regime ❑ Elevate heels ❑ ROHO cushion
	Wound Mx	❑ Wound(s) present ❑ Wound chart updated	
Mobility & Self-Care	*Transfers/ Off bed/On bed*	❑ Hoist: _____ ❑ Supervise ❑ Assist ❑ Independent ❑ (1) Slide sheet ❑ (2) Slide sheets	
	Ambulation	WB Status: _____ Gait Aid: _____ ❑ Independent ❑ Supervise ❑ Assist ❑ Unable to assist	
	Toileting **OTF = over toilet frame*	IDC / Pad / Pan / Bottle / Commode / Toilet ❑ OTF* ❑ Supervise ❑ Assist ❑ Independent	
	Hygiene	Sponge / Shower Chair / Standing Shower ❑ Set-up ❑ Supervise ❑ Assist ❑ Independent	
	Dressing	❑ Set-up ❑ Supervise ❑ Assist ❑ Independent	

Discharge Destination: **EDD:**

Nurse Initials (Each Shift)	**A.M.**	**P.M.**	**Night**

FUNCTIONAL MAINTENANCE CARE PLAN

FUNCTIONAL MAINTENANCE CARE PLAN AD 82.0

PATIENT IDENTIFICATION LABEL

Interpreter: N/Y_____		Date:____/____/____ LOS Day:_____	Comments / Progress / Plan updated:
General	*Observations*	Frequency:	
	Additional Monitoring	❑ BSL ❑ Weight ❑ Neuro Vasc_____ ❑ Other _____	❑ Drain tubes/ICC _____
	Oxygen	❑_____LPM ❑ Face Mask ❑ Nasal Prongs ❑ Humidified	
Pain	*Acute or Chronic*	❑ Type/Location/Mx: _____ ❑ Sedation score _____	
Cognition	*Orientation & Behaviour*	❑ Alert ❑ Drowsy ❑ Oriented ❑ Confused ❑ Other: _____	
	Supportive Comminication	❑ Hearing Aid – Left / Right ❑ Dentures – Top / Bottom ❑ Glasses / Legally Blind	
Nutrition Ensure weekly weigh and rescreen for malnutrition risk weekly	*Assistance Required*	❑ Nil ❑ Set-up ❑ Feeding ❑ Oral Hygiene	MST score: _____ Next MST screen due: _____ Next weight due: _____
	Fluid	❑ Fluid Bal. Chart ❑ ____ L/Day FR ❑ Normal Fluid ❑ IV / NGT / PEG ❑ Modified Fluids ❑ NBM	
	Food	❑ Food Chart ❑ HEHP diet ❑ Full Ward Diet ❑ Supplements ❑ Diabetic Diet ❑ IV / NGT / PEG ❑ Modified Diet ❑ NBM	
Medication (**must** be supervised)	*Assistance Required*	❑ Nil ❑ Set-up ❑ Crushed medication	
	IV Cannula	Location: Resite Due:	
	Patch	Location: Change Due:	
Continence	*Bladder*	❑ IDC ❑ Continent ❑ Prompting ❑ Incontinent	❑ Stoma _____ ❑ Skin regime if double incontinence
	Bowel	❑ Bowel Chart ❑ Continent ❑ Prompting ❑ Incontinent	
Skin Integrity Braden score ≤ 12 high risk 13-14 medium risk 15-18 low risk	*Pressure injury prevention*	Braden Score:_____ Due on ...../...../..... ❑ Pressure Care as per Braden Ax ❑ Daily full skin check for **ALL** patients	❑ Air Mattress ❑ Turning regime ❑ Elevate heels ❑ ROHO cushion
	Wound Mx	❑ Wound(s) present ❑ Wound chart updated	
Mobility & Self-Care	*Transfers/ Off bed/On bed*	❑ Hoist: _____ ❑ Supervise ❑ Assist ❑ Independent ❑ (1) Slide sheet ❑ (2) Slide sheets	
	Ambulation	WB Status: _____ Gait Aid: _____ ❑ Independent ❑ Supervise ❑ Assist ❑ Unable to assist	
	Toileting **OTF = over toilet frame*	IDC / Pad / Pan / Bottle / Commode / Toilet ❑ OTF* ❑ Supervise ❑ Assist ❑ Independent	
	Hygiene	Sponge / Shower Chair / Standing Shower ❑ Set-up ❑ Supervise ❑ Assist ❑ Independent	
	Dressing	❑ Set-up ❑ Supervise ❑ Assist ❑ Independent	
Discharge Destination:			**EDD:**
Nurse Initials (Each Shift)	**A.M.**	**P.M.**	**Night**

FUNCTIONAL MAINTENANCE SCREENING TOOL

- To be completed within 8 hours of admission.
- At least 1 action must be taken for each domain

UR 112233
Grigg
Georgie
F
22 Nice St
Nicetown 8909
Phone: 92999167

05/05/1941
English
DVA:
M/C:
today:

Date of Admission: ____ / ____ / ____ **Reason for Admission:** _____

Patient Goal/s (in their own words): _____

	Usual Status at Home	Status on Admission	Action/s Taken	Date	Initials
Cognition **Delirium** **Dementia** **Depression**	❑ Previous episode of delirium or post-operative confusion ❑ Diagnosed cognitive impairment: ❑ Dementia ❑ Depression ❑ Other: _____ ❑ Concerns regarding behaviour, memory or emotional health	❑ Confused / disorientated ❑ Poor short term memory ❑ Wandering / exit seeking ❑ Agitated / aggressive / restless ❑ Hallucinating / delusional / paranoid ❑ Fluctuating level of consciousness ❑ Withdrawn / apathetic / lethargic ❑ Disturbed mood / sleep / appetite ❑ Lack of interest in usual activities	Nil issues identified / nil action required Discuss with Medical Team Collect information about usual routine Commence Behaviour Management Plan / Chart Commence Patient Special Needs Assessment and Management Chart Refer to Psychologist / C-L Psychiatric Nurse Other:		
Nutrition & Swallowing Height: ____ cm Weight: ____ kg	❑ Chewing / swallowing difficulties ❑ Specified diet: _____ ❑ Specified fluids: _____ ❑ Fluid restriction: _____ L/day ❑ Diagnosed diabetes with unstable blood sugar levels ❑ Concerns regarding poor appetite / nutritional status	❑ Gurgling breathing / wet voice / choking / coughing with eating and / or drinking ❑ Recent pneumonia (in past 1/12) ❑ Feeding assistance / Set up Only 1. Have you lost weight recently without trying? (in last 6 months) No (0) Unsure (2) If Yes, amount: 1-5kg (1) 6-10kg (2) 11-15kg (3) 15kg+ (4) Unsure (2) 2. Have you been eating poorly because of a decreased appetite? No (0) Yes (1) Total malnutrtion risk score (1+2); ☐	***All patients:*** Weekly weigh & re-screen for malnutrition If malnutrition risk score: • = 2 commence High Energy High Protein Diet (HEHP) • > 2 refer to dietician Discuss with Medical Team Commence nil by mouth / specified diet / specified fluids _____ Commence Daily Fluid Balance / Food Chart Refer to Speech Pathologist / Diabetes Educator Refer to Feeding Assistance Program Other:		
Medication	❑ Difficulty swallowing medication ❑ Difficulty opening medication packets ❑ Difficulty remembering to take medications ❑ Medication management: _____ ❑ Concerns regarding medication use	❑ Change in ability to take medications ❑ Requiring additional assistance to take medications ❑ Taking 4 or more medications ❑ On warfarin / insulin / other "high risk" medications	Nil issues identified / nil action required Discuss with Medical Team Refer to Pharmaceutical Care Plan Refer to Pharmacist Other:		

FUNCTIONAL MAINTENANCE SCREENING TOOL

	Usual Status at Home	Status on Admission	Action/s Taken	Date	Initials
Continence 	❑ Urinary / faecal incontinence ❑ Constipation / diarrhoea ❑ Continence management:_____ _____ ❑ Concerns / pain / embarrassment regarding bladder or bowels	❑ Urinary / faecal incontinence ❑ Constipation / diarrhoea ❑ Indwelling catheter (IDC) ❑ Abnormal urinalysis result	Nil issues identified / nil action required		
			Discuss with Medical Team		
			Commence Inpatient Continence Assessment and Management Form / Bowel Function Chart		
			Commence Daily Fluid Balance / Food Chart		
			Other:		
Skin Integrity 	❑ History of skin tears / fragile skin ❑ History of leg ulcers ❑ Previous pressure ulcer ❑ Concerns regarding skin integrity ❑ Risks to skin integrity - incontinence or diarrhoea / immobility / malnutrition	❑ Current skin tears ❑ Current pressure injury ❑ Current wound ❑ Any reddened areas (observe <u>all areas</u> including back of head, spine, sacrum, lower legs. heels and toes)	***ALL PATIENTS:*** *Assess risk: Braden Pressure Ulcer Risk Ax Tool* *Skin checks: Daily full skin integrity checks*		
			Commence Wound Management Chart		
			Refer to Wound Care Nurse / Podiatrist		
			Other:		
Mobility / Falls 	❑ Bedbound / assisted / supervised / independent mobility ❑ History of fall/s in last 12 months ❑ Mobility aid/s: _____ _____ ❑ Concerns regarding unsafe mobility / dizziness / frailty / home access ❑ Ability to comprehend mobility tasks	❑ Change in mobility status / weight bearing / balance / cognition ❑ Unable to assist with on/off bed tasks ❑ Unable to assist with transfers ❑ Unsteady / unsafe mobility ❑ Admitted as the result of a fall ❑ Fall since admission	*ALL PATIENTS: Assess falls risk: Falls Risk Assessment, Prevention & Management Plan.*		
			Unable to assist on/off bed - Use slide sheets & bed mechanics		
			Unable to assist with transfers - Use mechanical aid		
			Refer to PT / OT *(all sub-acute patients)*		
			Other:		
Self-Care (activities of daily living) 	❑ Fully dependent / assisted / supervised self-care ❑ Community services: _____ _____ ❑ Concerns regarding self-care	❑ Reduced ability to perform self-care ❑ Unsafe ability to perform self-care	Nil issues identified / nil action required		
			Perform Barthel / FIM *(sub-acute patients only)*		
			Refer to OT *(all sub-acute patients)*		
			Other:		
Pain 	❑ History of chronic pain – specify details:	❑ Current pain – specify details:	Nil issues identified / nil action required		
			Discuss with Medical Team		
			Other:		
Social & Communication 	❑ Social isolation ❑ Legal issues ❑ Concerns regarding social situation ❑ Supportive communication _____ _____	❑ Carer stress ❑ Family conflict ❑ Potential inability to return to previous living arrangements ❑ Communication issues	Nil issues identified / nil action required		
			Refer to Social Worker *(all sub-acute patients)*		
			Refer to Speech Pathologist		
			Other:		

Staff Name (please print) and Signature	A.M. _____	P.M. _____	Night. _____

BRADEN PRESSURE ULCER RISK ASSESSMENT TOOL

UR 112233
Grigg
Georgie
F
22 Nice St
Nicetown 8909
Phone: 92999167

05/05/1941
English
DVA:
M/C:
today:

Assessment to be completed:

- On admission to Western Health
- 2/7 post admission
- Weekly thereafter (acute/subacute) OR if the patient's condition deteriorates.
- Monthly (residential care)

High Risk ≤ 12
Medium Risk = 13-14
Low Risk = 15-18
Nil Risk = 19-23

RISK FACTOR	SCORE/DESCRIPTION				DATES OF ASSESSMENT → Yesterday	Today		
					14			
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort.	**1. COMPLETELY LIMITED** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation OR Limited ability to feel pain over most of body surface	**2. VERY LIMITED** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR Has a sensory impairment that limits the ability to feel pain or discomfort over 1/2 of body.	**3. SLIGHTLY LIMITED** Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR Has some sensory impairment which limits ability to feel pain.	**4. NO IMPAIRMENT** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	4			
MOISTURE Degree to which skin is exposed to moisture	**1. CONSTANTLY MOIST** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. OFTEN MOIST** Skin is often but not always moist. Linen must be changed at least once a shift.	**3. OCCASIONALLY MOIST** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. RARELY MOIST** Skin is usually dry: linen only requires changing at routine intervals	4			
ACTIVITY Degree of physical activity	**1. BEDFAST** Confined to bed.	**2. CHAIRFAST** Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. WALKS OCCASIONALLY** Walks occasionally during day but for very short distances with or without assistance. Spends majority of each shift in bed or chair.	**4. WALKS FREQUENTLY** Walks outside room at least twice a day and inside room every 2 hours during waking hours.	2			
MOBILITY Ability to change and control body position	**1. COMPLETELY IMMOBILE** Does not make even slight changes in body or extremity position without assistance.	**2. VERY LIMITED** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. SLIGHTLY LIMITED** Makes frequent though slight changes in body or extremity position independently.	**4. NO LIMITATIONS** Makes major and frequent changes in position without assistance.	3			
NUTRITION Usual food intake pattern. NPO: Nothing by mouth IV: Intravenously TPN: Total Parenteral Nutrition	**1. VERY POOR** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IV for more than five days	**2. PROBABLY INADEQUATE** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR Receives less than optimum amount of liquid diet or tube feeding	**3. ADEQUATE** Eats over most meals. Eats a servings of protein(meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered, OR Is on a tube feeding or TPN regimen, which probably meets most of nutritional needs.	**4. EXCELLENT** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat or dairy products. Occasionally eats between meals. Does not require supplementation.	3			
FRICTION AND SHEAR	**1. PROBLEM** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down the bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	**2. POTENTIAL PROBLEM** Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. NO APPARENT PROBLEM** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		2			
TOTAL SCORE: Total score of 12 or less represents HIGH RISK								
					INITIAL SIGNATURE HB			
					DESIGNATION RN			

Level of risk MUST BE documented on reverse side of this form and appropriate preventative strategies implemented/documented with each assessment.

BRADEN PRESSURE ULCER RISK ASSESSMENT TOOL

BRADEN PRESSURE ULCER RISK ASSESSMENT TOOL

PATIENT IDENTIFICATION LABEL

h Pressure Ulcer Preventative Strategies

Each risk assessment to be dated, document actual score and tick strategies implemented

	RISK ASSESSMENT DATE: →	yesterday			
Low Risk Braden Score = 15-18	**SCORE**	17			
Skin Integrity	Check daily and document presence of pressure ulcers				
Education	Provide educational pamphlet to patient / carer				
Bed device/s	High density Macmed "Oze Ultimate"				
Seating	Educate patient to shift weight independently 15/60 if able				
	Encourage patient to stand hourly to relieve pressure- if chair-bound requires ROHO cushion				
Turning regime	Able to turn self				
	Two hourly				
	Four hourly				
Heel devices/aids	Elevate heels using pillows **OR** wedges if patient has restricted mobility				
	Loose bed clothes **OR** bed cradle				
	Slide sheets				
Medium Risk Braden Score = 13-14	**SCORE**	14			
Skin Integrity	Check daily and document presence of pressure ulcers				
	Skin care regimen neutral pH soap and protective barrier creams if patient incontinent				
Education	Provide educational pamphlet to patient / carer				
Bed device/s	High density Macmed "Oze Ultimate"				
Seating	Educate patient to shift weight independently 15/60 if able				
	Stand patient hourly to relieve pressure if chair-bound				
	ROHO cushion if unable to reposition self independently				
Turning regime	Able to turn self				
	Two hourly				
	Four hourly				
	Other (specify)				
	Head of bed 30 degrees unless medical condition contraindicates				
Heel devices/aids	**Score 1 or 2 in mobility** Allevyn heels to reduce shear and friction				
	Elevate heels using pillows **OR** wedges				
	Loose bed clothes **OR** bed cradle				
	Slide sheets / lifting devices				
	Activate knee brake on bed				
Allied health	Referral to Dietitian for nutritional assessment				
	Referral to physio to increase mobility to pre-morbid function				
High Risk Braden Score = ≤12	**SCORE**				
Skin Integrity	Check daily and document presence of pressure ulcers				
	Skin care regimen pH neutral soap and protective barrier creams if patient incontinent				
Education	Provide educational pamphlet to patient / carer				
Bed device/s	Macmed "OzeUltimate" + ROHO mattress or alternating air mattress				
Seating	ROHO cushion if sitting out of bed				
	Limit seating to <2 hours at a time				
	DO NOT sit patient out of bed for >one hour if grade 3 or 4 pressure ulcer on sacrum / ischial tuberosity (need medical consent)				
Turning regime	Two hourly				
	Four hourly				
	Head of bed 30 degrees unless medical condition contraindicates				
Heel devices/aids	**Score 1 or 2 in mobility** Allevyn heels to reduce shear and friction				
	Elevate heels using pillows **OR** wedges				
	Loose bed clothes **OR** bed cradle				
	Slide sheets/lifting devices				
	Activate knee brake on bed				
Allied health	Referral to dietitian for nutritional assessment				
	Referral to physio to increase mobility to pre-morbid function				
	RN completing assessment to initial	JB			

Goldfields
private hospital
salutem est opes

Nursing Transfer Letter

To Nursing Staff,

Thanks you for accepting Georgie Grigg into your care. She is a delightful 71-year old lady who sustained # Left NOF and 2 Left # ribs following a fall yesterday. As she is on holiday here, she requires transfer for urgent surgery.

Past history: Paroxysmal AF, NIDDM on insulin, R) TKR, OA, IHD

CNS: alert and orientated, PEARL, regular analgesia for hip and rib pain,

CVS: Vital signs stable, afebrile

Resp: Chest clear, SaO2 95% R/A, pain on coughing due to rib fractures

GIT: Tolerating diabetic diet and fluids, bowels opened this morning

Metabolic: QID BSL stable 5.8 – 9.4mmols/l, Lantus 23 i/u nocte + metformin 1g BD

Skin: Pressure areas intact

Renal: Urine output satisfactory

Mobility: RIB

Social: Widowed, lives alone, but Ivy her younger sister lives nearby. Supportive Sister Ivy, who has been notified about imminent transfer to sunshine hospital. Appears to have some concerns regarding her sisters ability to return home.

Thanks you once again for accepting this lady into your care

Regards

Janet Jones, RN

PHYSIOTHERAPY DISCHARGE SUMMARY

Goldfields private hospital
salutem est opes

Date: Yesterday

Dear Physiotherapist,

Bradma

Therapist: B. Wilson
Phone number/Pager 234

CURRENT FUNCTIONAL LEVEL:

TRANSFERS	Independent	Supervision	Assist x 1	Assist x 2
Bed Mobility	o	o	o	o
Lying to Sitting	o	o	o	o
Sitting to Standing	o	o	o	o

MOBILITY	Independent	Supervision	Assist x 1	Assist x 2
Ambulation	o	o	o	o

Gait Aid Used: RIB Weight bearing status: RIB

Exercise Tolerance: Current: RIB Pre-morbid: 100m (arthritis in knee)

STEPS – not assessed yet

Front:	Rail(s):	Independent	o
Back:	Rail(s):	Supervision	o
Internal:	Rail(s):	Assist x 1	o
Gait Aid Used:		Assist x 2	o

Pre-morbid function: independent, SPS, 100m ltd by arthritis. Falls history – 2 near misses.

Additional comments (eg. precautions, objective measures, falls, cognition, chest, etc.):

L #NOF post fall -transfer to Sunshine for DHS as was on holiday here. Pain issues++, Associated rib #s – no acute chest issues.

Treatment Aims:

Please do not hesitate to contact me if you require further information.

Regards,

Physiotherapist

Goldfields
private hospital
salutem est opes

Dear colleague,

Thanks for accepting care of Georgie as discussed on the phone (Dr Shem to Dr Calzone)

She requires urgent surgery for # NOF. Please note she has also 2 x left rib #.

Past history : T2DM, Right TKR, paroxysmal AF, OA

Yours sincerely

Dr Peter Benton

Orthopaedic resident