National Mortality Case Record Review Programme

using the Structured Judgement Review Method

Case Note 1

Contents

Foreword:

These notes have been produced as training material for the National Mortality Case Record Review Programme. They have been developed and extrapolated from clinician's knowledge and experience to resemble actual case notes. They are not actual patient cases and do not contain any confidential patient information.

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Royal College of Physicians

Do Not Attempt Cardio Pulmonary Resuscitation

To be filed in the front of the clinical record
For the authorizing doctor to complete

Name: **Martin Smith**
DOB: **1/1/1940**
NHS No: **111 111 1111**

Ward: **40**
Consultant: **Dr Green**

Record the clinical indication for the Not for attempted CPR decision.

(1) The patient is irreversibly close to death and attempted CPR will be of no benefit

(2) The patient's clinical condition indicates that in the event of cardiopulmonary arrest CPR would be very unlikely to restart the heart and breathing

3. The patient's clinical condition indicates that in the event of cardiopulmonary arrest and CPR being successful, it is very likely that death would only be temporarily averted or the patient would suffer severe and unacceptable complications of the resuscitation attempt.

4. The patient has made a fully informed decision not to have resuscitation attempted in the event of cardiopulmonary resuscitation (record discussion with patient in clinical notes)

Relatives consulted? (Yes) / No / NA
Patient consulted? Yes / No / NA

Authorising doctor's signature: *John Carter*
Print name: **Dr Carter**
Date and time: **29/10/2015**

Consultant's signature:
Print name:
Date and time:

Date of review	Consultant's initials	Date of review	Consultant's initials	Cancellation of Not for CPR decision: Consultant's signature: Date:

NHS COUNTY TOWN HOSPITAL
RESPIRATORY DEPARTMENT

22 Outer Lane,
Leeds

12 Jan 2016

Dr Jones
Short Street GP Surgery
Short Street
Leeds

Dear Dr Jones,

Martin Smith, D.O.B. 01/01/1940, NHS: 111 111 1111

Date admitted: 25/10/2015
Date deceased: 29/10/2015

I regret to inform you of the death of Mr Smith on the 29th of October 2015.

The cause of death was bronchopneumonia with COPD.

Kind regards.

Sincerely,

John Carter

Dr John Carter
Specialist Registrar to Dr Mark Green

NHS County Town NHS Foundation Trust

Martin Smith
01/01/1940
111 111 1111

Medical Admissions Unit Clerking

Doctor's Name: Dr A Keaton

Date and time of admission: 25/10/2015 1700pm

Presenting complaint(s)

Haemoptysis, dorsal chest pain

History of presenting complaint

2/52 hx of upper back pain on L side – more or less on collar bone –pain radiated further down back & into side
Last few days, lost appetite
1/52 hx of haemoptysis
SOB on exertion
No chest pain
Headaches with no blurred vision or change
Felt nauseous, no vomiting
Tiredness and weakness
Arms swollen up last 2 days
Retired miner (worked down pit for 40 years)
Never happened before.

Previous medical Hx

Prev MI – 2 ½ years ago
VD – 2 toes amputated L foot
AF
No TB/asthma/bronchitis/diabetes

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Regular medication

NKA
Warfarin
Amiodarone 200mg od
Digoxin 200mcg od

Family/social Hx

Lives alone in a bungalow
Home help
Walks independently
Sister and brother live very close
Non smoker, stopped alcohol since taking warfarin

Review of systems

CVS - No chest pain/ankle swelling
Resp – no wheeze/productive cough
GI – no abdo pain, hasn't noticed weight change. Not opened bowels last 2 days
GU – no frequency/dysuria/nocturia

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Examination

Looks pale

General
Peripheral oedema at upper limbs
No ankle swelling

BP 150/66
Pulse 68bpm regular – faint and weak
RR 22
Sats 91% on 8L
Temp 36.8

JVP →
HS I + II + 0

Extensive right sided crackles with reduced AE and rhonchi
?effusion

Abdo not distended
No masses
?hepatomegaly
BS present
PR not done

Neuro grossly intact

Seen initially sats 77% on 2L

ABG performed on 2L

pH	7.51
pCO2	4.5
PO2	6.2
Bicarb	27
BE	4

Left arm painful on movement, limited ROM
Tender on palpation

Rt arm FROM

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Differential diagnosis

Chest infection ?effusion

Management plan:

Bloods – FBC, U+Es, LFTs, CRP, gluc, INR and group and save
ABG done
CXR and L arm Xray
ECG
IV ABx/fluids

Tests and results:

Hb	8.6
WCC	20.40
Platelets	511
MCV	
INR/PT	
APTT	
Fib	
d-dimers	
Na	141
K	4.0
U	9.0
Cr	70
Bicarb	28
Glucose	5.6
CRP	257
Calcium	2.87
ALP	142
ALT	89
Bili	12

CK series

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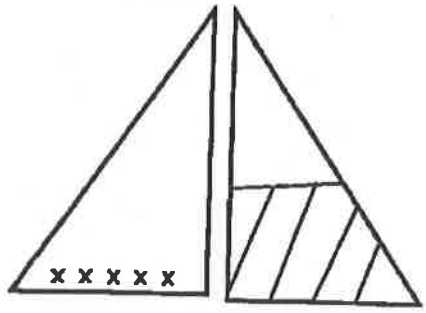
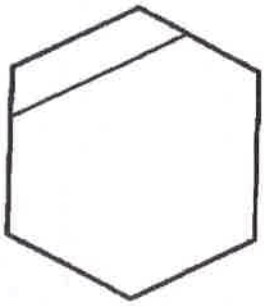
Medical Continuation Notes

25/10/15
Benson Med Reg
75 year old man
General deterioration
2/3 wk hx inc SOB and reduced ex tol
L sided back/chest pain
1/52 haemoptysis /c clots
Poor apetite
Denies wt loss

o/e:
dyspnoeic @ rest
P 70 reg
BP 150/70
JVP →
HS 1+2+0 quiet



R basal crackles
Dull PN left, reduced AE



Difficult exam
Fullness in RUQ ?hepatomegaly
Soft
BS present

L arm bruised and swollen – recent fall

ECG: junctional rhythm/regular/prolonged QTc

CXR: L pleural effusion
R basal midzone consolidation

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Medical Continuation Notes

Humerus X-ray 1x lytic lesion ?significance. No #

Hb	8.6	U+E	normal
WBC	20.4	Adj Ca	2.87
Plts	511	Alb	22
		Bili/ALP/ALT	normal

Imp: possible neoplastic lesion
Plan:

- High flow O2
- Stop digoxin/amiodarone/warfarin
- Rpt ECG later
- IV antibiotics amox/clarithro
- IV fluids
- Abdo USS later
- Transfuse 3 units

Peter Benton
Medical SpR on call

26/10/15
WR Benton
-still having haemoptysis
-in view of pleural effusion, neoplastic lesion is likely
-INR yesterday 26 – repeat INR and for vitamin K
-continue abx therapy
-when INR normal for pleural aspiration and cytology
-added tramadol 50mg and paracetamol 1g qds

M Doyle
PRHO
141

26/10/15
History of haemoptysis (severe) – Hb 8.5
INR 27. Warfarin stopped (for AF)
Suggest:
FFP 4 units + vit K 5mg IV after INR from today checked

G Lawrence
Haematology SpR

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Medical Continuation Notes

26/10/15
INR today 13
P) for vit K 5mg IV

27/10/15
WR SHO
-severe pneumonia (CURB 2) + increased WCC
-L pleural effusion
-haemoptysis
-high INR

-BP/pulse OK
-SaO2 75% on 35% O2 (PaO2 = 5.2)

-increase O2 to 15L via hi-flow mask
-INR – for pleural tap if OK
-change Abx to cefuroxime and clarithromycin

A Lee
SHO (101)

27/10/15
US abdomen – extremely difficult scan as immobile patient
Liver seen well – NAD
GB, bile ducts, kidnes NAD
Panc poorly seen but NAD
Spleen N
Rt pleural effusion minimal
Lt pleural effusion moderately large with areas of soft tissue pleural thickening ?other on pleura

S Wexler
Radiographer

27/10/15
Note bloods

ABG on 15L O2

pH	**7.45**	**Na**	**141**	**CRP**	**257**
pCO2	**5.2**	**K**	**3.4**	**INR**	**1.4**
PO2	**11.3**	**HCO3**	**30**		
		Ur	**9.2**		
		Cr	**77**		

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Medical Continuation Notes

Seen by consultant Dr Green

Plan
Hold off pleural asp/drainage for now
Hold off ITU opinion
Monitor

A Lee
SHO (101)

27/10/15
On-call PRHO – J Coburn 107
Fatigue breathing
USS today – bilateral pleural effusions worse on L side
Sats 76% on 8L O22 today @ 06.50
Now sats 92-94% on 15L rebreathe mask
Obs @1915 BP 190/90 Pulse 70 Apyrexial
O/E
Patient very breathless
RR 40
Laboured breathing, use of accessory muscles and abdo and intercostal breaths
Patient v. fatigued

Loud bilateral creps
Harsh breath sounds

Sputum pot – still some haemoptysis

Plan
For senior review ?ICU or HDU
Continue as currently, monitor sats
?saline nebs
ABG
Saline and salbutamol nebs

Bloods 27/10/15
INR 1.4 PT 14.5 APTT
Hb 10.8 WBC 15.8 Plt 270 Bicarb 30
Na 141 K 3.4 Urea 9.2 Creat 77
CRP 253

ABG 27/10/15 on 15L O2
pH 7.36 PCO2 5.4 PO2 9.8
Bicarb 22 Base excess -2

J Coburn
PRHO 123

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Medical Continuation Notes

27/10/15 9pm
ATSP – SOB
75 year old man
Haemoptysis 3/52, settled since admission as per SN
SOB 3/52
High INR on admission, had vit K IV
INR today 1.4

SpO2 94% rebreathe mask 15L O2
ABG on 15L O2 – pH 7.36 pCO2 5.4 pO2 9.8 HCO3 22
BP 184/82 Pulse 76 JVP raised
Chest -B/L scattered wheeze +
-reduced air entry, VF, VR
-dull on percussion

raised WCC
PT 14.5
U+E N
CRP 257

Imp: R pleural effusion

No CXR available in ward, USG abdo report noted

P)
-Continue high flow O2
-Nebulise salbutamol, IV furosemide 20mg
-Rpt CXR – mobile requested
-Monitor SpO2
-Consider chest drain after CXR

J Dorian
SHO

27/10/15 10.15pm
On call PRHO
Patient discussed with oncall reg
Advised to contact next on call SHO (>10 pm) after mobile CXR
Mobile CXR on ward now. Complete L sided pleural effusion
Next oncall SHO contacted

J Coburn
PRHO 123

27/10/15 2230
ATSP
Admitted with inc SOB → L pleural effusion
Likely neoplasm underlying it
S/B Dr Green today – not for chest drain
Deteriorated since
Now:

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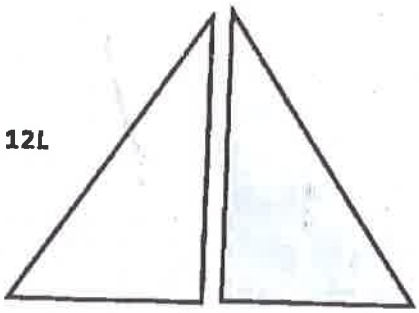
Medical Continuation Notes



Tachypnoeic
Sats 83% on rebreath mask 12L
Struggling

Reduced AE L side
PN dull L
Upper transmitted sounds

CXR – mobile done now
- White out L side lung field
- R side – patchy shadowing – fibrotic.
- No evidence of LVF

Plan
-for aspiration + fluid for cytology and MCS

2250 → attempted aspiration. 5mls 2% lignocaine but not able to aspiration
Small amount blood stained fluid but unable to aspirate further
8th intercostal space posteriorly
D/W reg will r/v

J Cuddy
SHO 106

27/10/15 11pm
ATS – Reg
Agreed ↑SOB
Needs chest drain
L mid axillary line
10ml 2% lignocaine
Blunt dissection. Uncomplicated
20G chest drain – stitched + stuck in place
Straw coloured fluid drained
Rpt CXR

A Patel

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Medical Continuation Notes

28/10/15 00:20
CXR → tube in position
No pneumothorax
Patient catheterized for comfort
Aseptic technique → size 14 PTFE coated catheter
Passed easily → clear urine passed
10mls H20 to inflate balloon
Foreskin replaced
200mls residual

J Cuddy
SHO 106

28/10 WR SHO

HB 12.5
WCC 21.00
Plt 235

note events overnight
-- ↑ing SOB despite high flow O2
chest drain insertion

Na 144
K 3.5
Bic 28
Ur 10.3
Cr 79
CRP 420
INR 1.8

Samples sent for - MC&S / AAFB
- pH, LDH, pro, RF, amy
- cytology

Earlier desaturated 81% on NEB
Now = 91% (15L O2)
Rpt ABG✓
UO poor – restart I.V.I.
+ Ur ↑

A Lee
SHO (101)

29/10 Williams SHO
10.30
ATSP acute SOB
-worse today a.m. but acute deterioration 10 min ago.
°Chest pain
UO – poor
O/E HS I + II + nil
JVP ↑ 6cm

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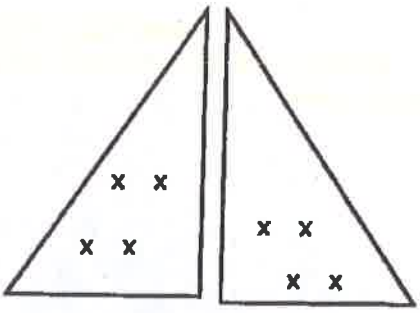
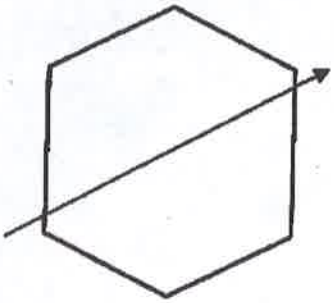
Medical Continuation Notes



Crackles → upper zone bilat.
Drain swinging, °further drainage = 130ml since y'day



Soft/NT

CXR white out L lung but L hemidiaphragm visualized
R lung consolidation

Imp bilateral pneumonia
+/- LVF

Plan IV furosemide 80mg
IV diamorphine
--- L groin femoral V cannulae inserted
aseptic technique /c 1% lignocaine
1st pass ✓
ΔAbx to I.v. cefotaxime
-bloods ✓ , ABG ✓ , ECG–nil acute

ABG on 15L O2

pH	7.28
pCO2	8.2
pO2	7.6
$aHCO_3$	28
$sHCO_3$	24
BE	0

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Medical Continuation Notes

D/W family (brother/sister)
-up to 3/52 ago pt fully independent. Gradual deterioration /c haemoptysis since then
-pt has always been 'a fighter' but he would never have 'wanted to end up in a nursing home/being cared for.'

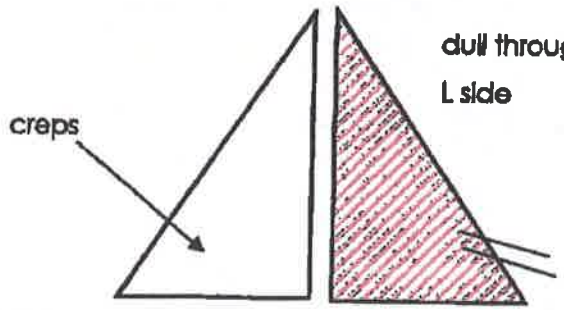
D/W SpR (Carter)
-will contact ICU

A Lee
SHO (101)

29/10/15 12.30pm
Godwin ITU SpR ATSP
75 ♂ PMH IHD - MI 3 years ago
AF – on warfarin
Denies previous resp disease
Ex smoker – 'years ago'. Ex miner
Recent Hx of haemoptysis + clots

Presents with 3/7 Hx of resp failure
On admission: L sided white out and effusion R sided consolidation
Despite drainage of 300-400mls fluid
→worsening gradually during day

Now: GCS 3/15
A: 15L O2 via rebreathe
B:



pH 7.24
pCO_2 8.2
pO2 7.3
on 15L

RR 35/min ↑ing markers of sepsis

Only ventilating R upper zone

C: P=90/min. Cold peripheries. BP 90/50
Minimal urine output 20ml in 4hrs

Imp: Concern is that despite drainage of effusion
L sided white out persists
i.e. ?obstructing lesion

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Medical Continuation Notes

Pleural aspirate results not yet back
But other markers of Ca - ↑Ca^{2+}
?liv edge etc.
However no definite diagnosis

Plan: D/W Dr Conn Cons ITU – he will review

Brief D/W family (sister)
Explained ICU only appropriate if obvious reversibility. This needs to be established.

Godwin
T Godwin
456 SpR

29/10/15
1330

Mr Smith seems to be very close to death. In my opinion which I have expressed to his close family, putting him through invasive ventilation would be fruitless and an indignity even if it was proven he was not suffering from a cancer. I believe it is in his and his family's best interests to keep him comfortable – oxygenated via a mask + hydrated. At present he is deeply unconscious and not reacting to painful stimuli so further sedation is obviously not appropriate

The result of the cytology is hopefully imminent and would be a comfort to his family to know the result but I believe he is too ill to benefit from any ICU intervention.

R Conn
Conn
Cons ICU

29/10/15
S/N asked me to verify Mr Martin Smith's death.
No cardiac output
No respiratory output
Death verified 22.30

C Jackson
PRHO 101

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Nursing Continuation Notes

Date/time		Signature
25/10/2015 1635	Pt admitted via GP after 2 week history of generalised deterioration, cough – haemoptysis, increasing shortness of breath, anaemia. Over last few days pt has developed peripheral oedema. O/A to MAU, pt alert and orientated. Pulse, BP and temperature stable, respirations 22. SaO_2 63% on air, Pts capillary refil slow, lips pink. Dr informed and O_2 adminstered. 2L via mask. SaO_2 increased to 73% then 81%. Dr performed ABG and assessed pt	
1648	Pt alkalotic O_2 increased to 38% 8L	E O'Connor
1752	S/B SHO: 1) Chest infection 2) ?Pleural effusion Plan:- 1) Bloods and group and save 2) CXR 3) ECG @10.00pm 4) Antibiotics IV 5) ABG ✓	E O'Connor E O'Connor
	Pt given antibiotics S/B RMO Impression see notes: 1) Stop medications 2) Start IVI 3) Abdo ultrasound 4) Transfuse 3 units 5) Bloods 6) High flow O_2	E O'Connor
25/10/15 23.45	Observations recorded and satisfactory, antibiotics given as per script, pt comfortable. 1st unit blood commenced.	H Bradley J Cordon
26/10/15 00:00	Observations remain stable, 15 mins post transfusion	J Cordon
04:25	1st unit transfused with no problems. Observations remain satisfactory. 2nd unit blood commenced, 20mg furosemide cover given orally following conversation with SHO on call.	J Cordon
08:30	Less breathless, sats 92% on 8L oxygen. Blood infusing slowly (cannula positional). Refused breakfast, tolerating oral fluids. Washed and shaved by nursing staff	
09:40	S/B Dr Benton INR ↑ (not reviewed earlier) Needs vitamin K. Regular analgesia for back pain. Needs diagnostic pleural tap when INR normal. Continue IV antibiotics	
1045	2nd unit of blood infused. IV clarith infusing then for 3rd unit of blood. 3rd unit blood commencing. Bruising ++ observed to left arm. Arms remain oedematous.	A Nurse
1245	Discussed with haematology reg Dr Lawrence for FFP and vitamin K Message from lab INR 13. Dr to be informed. No lunch taken. Not hungry	A Nurse
26/10/15 1524	Pt sleeping. Easily rousable, stable observations. Blood infused. Then flushed cannula with 0.9% normal saline. Vitamin K bolus	

	administration checked with on call pharmacist. 5% glucose bolus given to flush cannula. Vitamin K 5mg given over 3 minutes. Cannula then flushed with further 5ml of 5% glucose	P Smith
1815	IVI started at around 1550. Stopped for fresh frozen plasma. Observations stable.	P Smith
2330	Observations recorded, sats remain 89-90% on 35% O_2. Medications given as per chart, IV fluids continue over 8 hours, taking oral fluids, adequate urine output	L Johns
27/10/15 01.25	Bed booked on ward 4, handover given to staff, relatives unaware of transfer. Ward 4 will ring when bed ready, trying to acquire pressure mattress. Thank you.	L Johns
27/10/15 0335	Martin transferred to ward 4 at 02.40hrs. IVI and O_2 35% in progress. Nimbus II mattress obtained prior to transfer. On warding SaO_2 77-78%. Encouraged to keep mask on – has risen to 89% on O_2 35% with no other intervention. Other observations satisfactory.	J Taunton
0710	Noted that IVI had run through in 5-6 hours, should have gone through in 10 hrs. Observations stable, although O2 saturations have gone down to 76% on O2 35% (however Alfred intermittently removing his mask). On transfer to ward, appears 150-200mls already absorbed. Due to pmh of heart failure SHO on call informed and has come to review patient.	J Taunton
0720	ABG taken by SHO on call	J Taunton
27/10/15 1125	Pyrexial at 37.9 paracetamol given as prescribed pain in situ. IV antibiotics altered to cefuroxime 1.5g tds. Sats 75% on 2L O_2, O_2 therapy changed to 15L via a non-rebreath mask. O2 sats now 93%. To await INR result before pleural tap performed. Bloods obtained for INR.	S Saunders
1140	To fast from now for abdominal ultrasound scan this afternoon.	S Saunders
1145	Abdominal ultrasound performed indicates bilateral pleural effusions. Reviewed by Dr Green. To withhold pleural drainage. Continue to observe. Requested to change to 60% at 15 Litres O_2	S Saunders
2030	Desaturated to 73%. Reviewed by Dr Coburn. To recommence 15L O2 via rebreath bag. Sats 92%. General condition remains poor. Complaining of laboured breathing. Sats 93% on 15L via rebreath mask. Reviewed by Dr Coburn HO on call. Hypertensive 190/90. ABGs done.	L Jenkins
2100	Seen by Dr Dorian ?for ICU or HDU	L Jenkins
28/10/15 00:40	S/B Dr Coburn and Dr Dorian at 21:00 hrs. For stat dose of IV frusemide 20mg – same given. Commenced on salbutamol nebulisers. IVI discontinued by Dr Dorian. Mobile CXR performed on ward. Reviewed by Dr Cuddy at 22.30 hrs. INR now 1.4. Aspiration attempted but unsuccessful. Reviewed by reg Dr Patel at 22.30 hrs. Chest drain inserted. Mobile CXR done and reviewed by Dr Cuddy – drain in correct position. Catheterised at 00:20 hrs by Dr Dorian with size 14 catheter	K Marsh
00:55	Brother and sister have gone home. To contact them at any sign of	

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	deterioration.	K Marsh
28/10/15 1240	Reviewed by Dr Cuddy, IV fluids not to be recommenced at present time. To encourage oral fluids, monitor chest drain and regular observations. Chest drain swinging.	K Marsh
	Catheter bypassing. Water replaced in balloon. Please observe overnight.	K Marsh
29/10/15 12.40	This mane sats 88% on 15L/min rebreath mask, pt not well and around 10.15 pt seen gasping for breath and unresponsive. Informed and bleep Dr Williams to come ASAP. Observation BP 11/57, pulse 80. On sat 83% on 15L O2 via rebreath mask. Seen and reviewed by Dr Williams (SHO), bloods taken, ECG performed and had mobile chest X-ray done on the ward. Inserted L femoral line done by Dr Williams. Given stat dose of IV diamorphine 2.5mgs and IV frusemide 80mgs. Doctors aware that patient only had 20mls of output from 08.00 until since 12.15 hrs. BP low side 85/39mm Hg, RR 38, O2 sat 81% on 15L and temp 37.1oC. Family informed and Dr Williams discussed patients present medical status. Chest drained swinging 20 ml drained from 0800-1200hrs. Impression – bilateral pneumonia, ECG nil acute. Seen by ICU doctors, awaiting review by ICU consultant. Awaiting pleural aspirate results. Observation monitored every 15 mins. ICU consultant phoned path and pleural aspirate will be back this afternoon. ?pt needs to go to ICU	H Tapp
29/10/15	Pt referral to OT	P Wright
1440	ICU consultant discussed condition with registrar, family wants pt to be comfortable. Not for resuscitation. Form signed this afternoon @13.30hrs.	H Tapp
1930	IV fluids commenced 12 hrly. Urine output remains minimal, only 22ml from 12.15 to 1900. Dr's aware of low urine output. Patient settled and comfortable. Sister in attendance ?staying overnight	? Rowlands
2145	Condition deteriorated, now Cheyne-Stoking. Sister (Martha) present. Contacted brother to come in asap.	K Marsh
2150	Martin passed away peacefully. Awaiting to be certified by Dr.	K Marsh

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Allergy Status
NKDA

Martin Smith
01/01/1940
111 111 1111

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Drug Prescription and Administration Chart

Ward		Name	Martin Smith
MAU		DOB	01/01/1940
Admission Date		NHS Number	111 111 1111
25/10/2015		Consultant	Green

Chart Number		Pharmacy Check	Weight
1 2 3 4			Height

DO NOT ADMINISTER DRUG UNTIL THIS SECTION IS COMPLETED			
Known Allergies			Allergy Status Unconfirmed
NKDA			
Signature	Date	Signature	Date
A Keaton	25/10/15		

Once Only Prescription

Date	Drug	Dose	Route	Time	Signature	Given by	Time	Pharm.
26/10	Vitamin K	5mg	IV		Jackson	Hyde	1510	
26/10	Frusemide	20mg	IV		Jackson	Hyde	1710	
~~26/10~~	~~Frusemide~~	~~40mg~~	~~IV~~		~~Jackson~~			
27/10	Frusemide	20mg	IV	stat	Lee	Marks	2140	
29/10	Frusemide	80mg	i.v.		Williams	Nicks	1055	
29/10	Diamorphine	2.5mg	i.v.		Williams	Nicks	1045	

Allergy Status
NKDA

Martin Smith
01/01/1940
111 111 1111

Regular Prescription

Drug		
Warfarin		08.00
Route	Dose	12.00
PO	APC	18.00 X
Signature & bleep		22.00
A Keaton 123		

25	26	27	28	29										
X	X	X	X	X										

Drug		
Amiodarone		08.00 X
Route	Dose	12.00
PO	200mg	18.00
Signature & bleep		22.00
A Keaton 123		

25	26	27	28	29										
X	X	X	X	X										

Drug		
Digoxin		08.00 X
Route	Dose	12.00
PO	250mcg	18.00
Signature & bleep		22.00

25	26	27	28	29										
X	X	X	X	X										

Drug		
Amoxycillin		08.00 X
Route	Dose	12.00
IV	500mg	~~18.00 X~~
Signature & bleep		22.00 X
A Keaton 123		

25	26	27	28	29										
	RE	RT												
FG	RE													
FG	RT													

Drug		
Clarithromycin		08.00 X
Route	Dose	12.00
IV	500mg	18.00 X
Signature & bleep		22.00
A Keaton 123		

25	26	27	28	29										
	RE	RT	FG	FG										
FG	RE	RT	FG	FG										

Allergy Status
NKDA

Martin Smith
01/01/1940
111 111 1111

Drug		
Tramadol		08.00 X
Route	Dose	12.00 X
Oral	50mg	18.00 X
Signature & bleep		22.00 X
A Keaton 123		

25	26	27	28	29									
		RT	FG	FG									
	RE	RT	FG	2									
	RE	RT		2									
	RE	2	FG	2									

Drug		
Paracetamol		08.00 X
Route	Dose	12.00 X
Oral	1g	18.00 X
Signature & bleep		22.00 X
A Keaton 123		

25	26	27	28	29									
	RE	RT	FG	FG									
	2	RT	FG	2									
	RE	RT	FG	2									
	RE	2	FG	2									

Drug		
Cefuroxime		08.00 X
Route	Dose	12.00 X
i.v.	1.5g	~~18.00~~
Signature & bleep		22.00 X
A Keaton 123		

25	26	27	28	29									
			FG	FG									
		RT	FG										
		RT	FG										

Drug		
Salbutamol		08.00 X
Route	Dose	12.00 X
neb	2.5mg	18.00 X
Signature & bleep		22.00 X
N Pike 101		

25	26	27	28	29									
			FG	FG									
			FG	2									
			?	2									
		FG	FG	2									

	08.00
	12.00
	18.00
	22.00

24

Allergy Status
NKDA

Martin Smith
01/01/1940
111 111 1111

As required medication

Drug		
Route	Dose	Frequency
Signature & bleep		

Date									
Time									
Dose									
Given									

Drug		
Route	Dose	Frequency
Signature & bleep		

Date									
Time									
Dose									
Given									

Drug		
Route	Dose	Frequency
Signature & bleep		

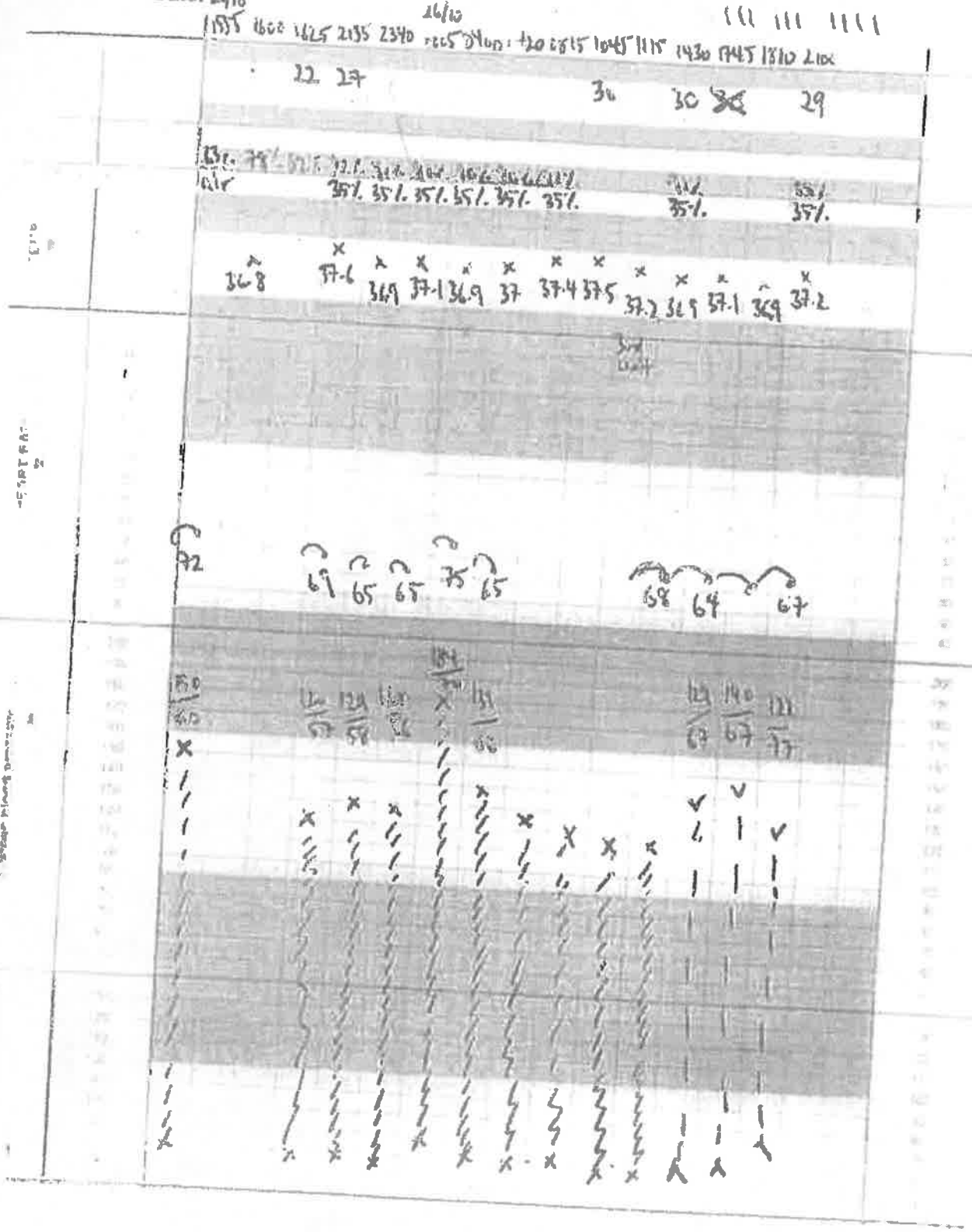
Date									
Time									
Dose									
Given									

Drug		
Route	Dose	Frequency
Signature & bleep		

Date									
Time									
Dose									
Given									

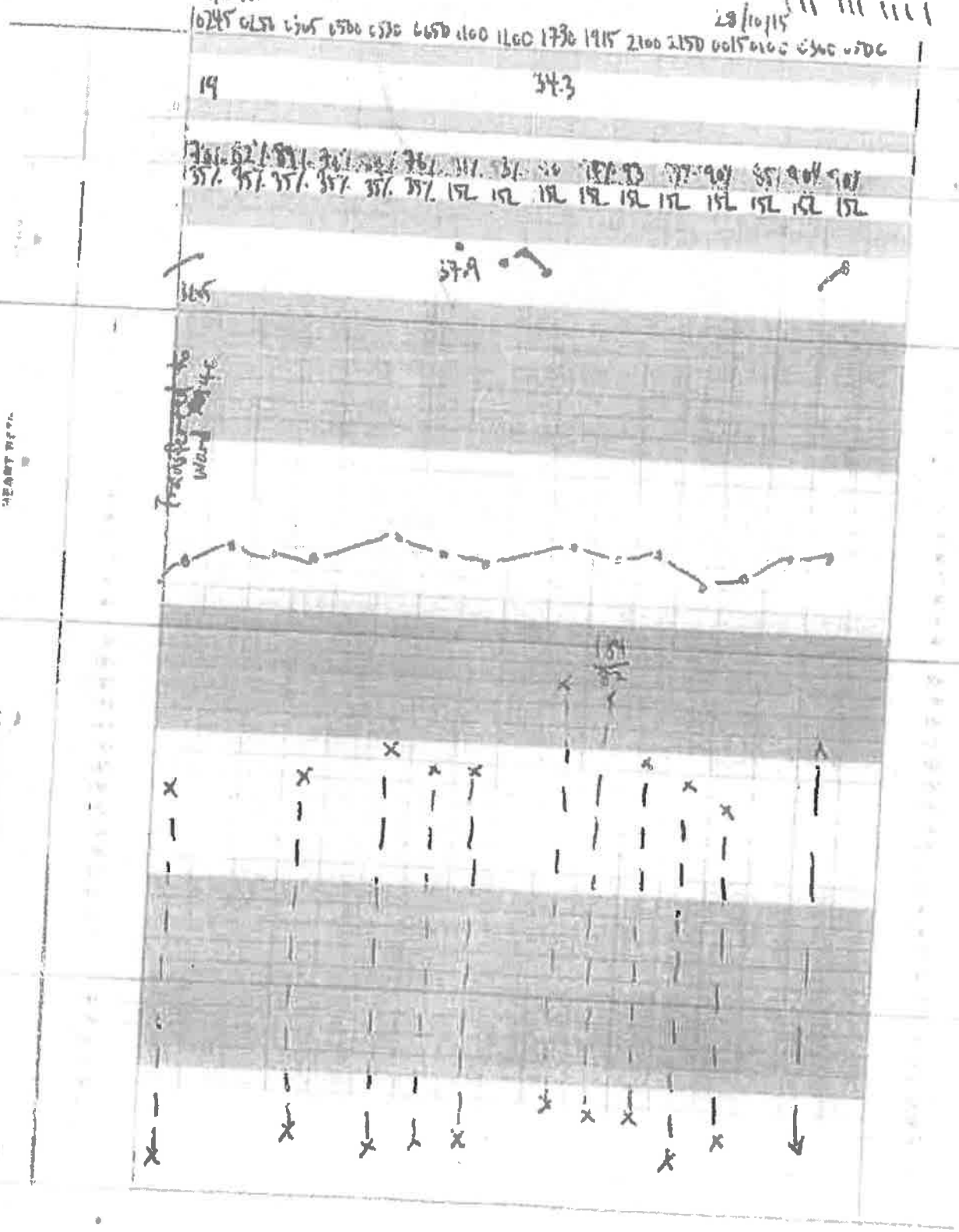
Martin Smith
1/1/1940

Date: 25/10



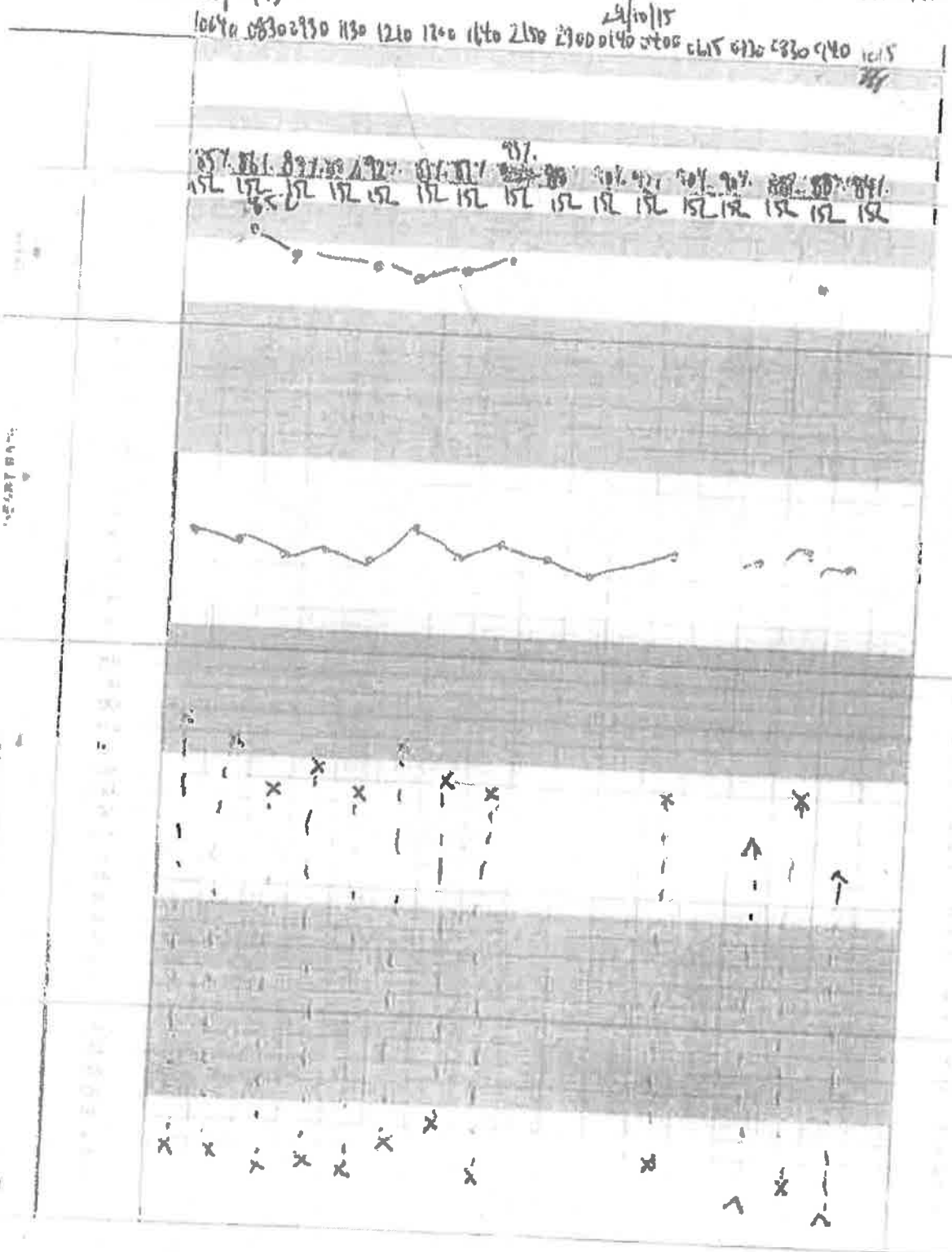
Martin Smith
1/1/40

Date: 29/10/15



Martin Smith
1/1/1990

Date: 28/10/15



Martin Smith
1/11/1940

Date:

11135 1145 1210 1225 1235 1250 1400 1430 1430
34 36 58 38 53