BUNDABERG HOSPITAL EMERGENCY RECORD

Surname	Given Name	Date of Birth	Sex
P126		12 Jan 55	M

Patient No:	Emerg. I	Arrival Date and Time
	03011532	29 May 03 22:30

Triage Cat	Area	Complaint
3	A1	ABDOMINAL WOUND DEHIS [redacted]

Allergies:- NKA

Immunisation Status:-

Triage Notes pt states bowel surgery 10/7 ago, discharged from hospital 6/7 ago. staples removed yesterday in S.C. tonight wound has opened up. pt states draining fluid + blowing bubbles [illegible] Morris RN.

TRIAGE RN Printed Name/Stamp: MORRIS RN Signature

TIME	T	P	R	BP	O2	SAO²	GCS	PAIN SCALE (1-10)	NURSING NOTES
2240	37.4 tymp	82	18	122/83	RA	97%			

WARD TEST URINE:-

WEIGHT:-

MEDICATION ORDERS

DATE	TIME	DRUG	DOSE	ROUTE	M.O.	GIVEN BY	TIME GIVEN
29/5		Morphine	5mg	IV	[signature]	[signature]	2323
29/5		Maxalon	10mg	IV	[signature]	[signature]	2323

MEDICAL HISTORY, EXAMINATION, TREATMENT AND FOLLOW-UP

DATE/TIME	
29/5/03	48yr ♂
23:00	PC: pus/blood coming from abdo wound.
EARBY	HPC:
	10/7 ago had sigmoid colectomy for sigmoid diverticulitis
	- no immediate complications, D/C Day 4.
	seen in clinic yesterday + staples removed.
	since then small area of upper ⅓ wound been
	open = ~~1~~ 1-2 cm length section. Bubbling when sits forward/BO
	says having to wear sanitary pad over this area
	as lots discharge today - mixture of blood + pus.
	currently discharging only small amt.
	says tender around wound + Pt also c/o gen'l
	abdo pain.
	BO today - ⓝ stool. Neg BO since Sx
	not eating usual diet - V off food.
	PMH:
	- Diverticular disease + sigmoid colectomy May 19th 03
	+
	Dx:
	Abx: ? ~~Flag~~ metronidazole + Fluclox
	NKDA Zyprexa
	Brufen
	O/E
	Temp 37.4
	P 82 BP 122/83 HS I + II + Nil

ADMISSION CHECKLIST	PROCEDURES	PATIENT DISCHARGE INFORMATION
Medical Order Sheets: ☐ Medication ☐ Fluids ☐ Fluid Balance Chart ☐ XRay ☐ Property List ☐ Relatives Notified Armband ☐ Protocols ☐	IV Cannula ___ gsite ___ IV Fluids in Progress ☐ Bloods ☐ MSU ☐ ABG's ☐ NGT ☐ ___ g IDC ___ g ___ ml O^2 Therapy ___ Lpm via ___ Dressing/Suture Site: ___	Ward ~~D5~~ Speciality Surg Discharge Date ~~2/6/03~~ Time ___ APPT ☐ Department ___ Date ___
IN CARE OF ☐ RELATIVE ☐ FRIEND ☐ SELF		RN Signature:

.....Hospital

CONTINUATION SHEET

Surname P126 U.R. No. _____

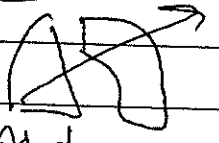
Given Names _____

Sex M D.O.B. 12/1/55

(Affix Patient Identification Label Here)

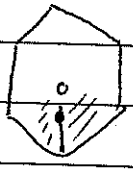
DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT

Resp



clear °creps °wheeze
RR 18 Sats 97% R/A

Abdo



infra umbilical midline laparotomy + open section ~ 1.5cm long oozing pus/ bld mucous bubbles produced on pressing adjacent to wound. °guarding
BS - active, not tinkling
PR - v painful
°mass °bld °stool in rectum.

CNS
NAD.

Imp: ? wound dehiscence

Plan
IV access
Blds - FBC, ELFT, CRP
CXR + AXR
wound c/s sent
analgesia - morphine + maxolon
dipstick urine
ref surgeons

ACCIDENT & EMERGENCY / OUTPATIENT CONTINUATION SHEET

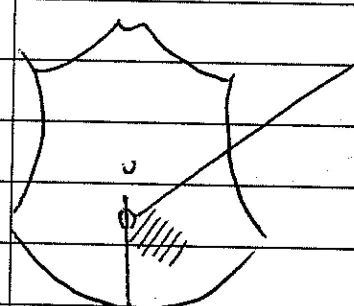
DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
	Hb 134 Na 134 CRP
	WCC 10·8 K 3·4
	Plt 354 urea 3·7
	creat 0·09
	ref'd surgeons
	Thanks Emma.

Bundaberg ......HOSPITAL BUNDABERG HOSPITAL SEX UR NO

P126

INPATIENT PROGRESS NOTES

Ph(B)
OthC

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
29.05.03	PHO IGNTS SURG (Notes @ DEM sited Ø)
	48 year ♂ D10 post elective sigmoid colectomy for diverticular disease
	no immediate complications.
	staples out yesterday and small separate wound edges
	pain/pulls ++
	serosanguinous d/c and bubbles from wound
	exacerbated by ↑ abdo P.
	on PO flagyl and flucloxacillin.
	BO 1700hrs Ø blood Ø mucus
	Ø nausea / vomit / fevers / rigors
	O/E
	 ✓ 1cm wound separate
	serosanguinous d/c and bubbles +++
	generally tender but soft abdomen
	Ø rebound / rigidity
	Ø fluctuant mass palpable
	bs Ø
	PR as per MBM
Assessment not acute surgical abdomen @ this point	
(?) dehiscence of cutaneous layers pending +/- fascia.	
d/w Dr Patel.	
Plan	1. admit Patel 7. Swabs MC&S
	2. triple ABx IV
	3. MBM manage
	4. TEDs please
	5. analgesia as charted
	6. [illegible]

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
30.5.03 NOCTE RN 0205h	ADMISSION Known pt admitted as per previous notes. Obs stable IUT 8/24. IV Abs given. Stated he was feeling the most peaceful he has for days though stated he still had pain. narcotic analgesia given as charted. Orientated to ward. Wound red and oozing purulent discharge dressing applied.
0622h	Resting quietly overnight. Dressing dry/intact. States abdo discomfort improved – refused further analgesia. HWPU — [signature] (MASSETT)
30/5/3 RODEN	WR PATEL → Wound infection → Top part layed open Packed with Saline Swabbed (P) Cont IV Abs D, et [signature] 0075
30/05/03 1430	NURSING - Cares as per care path. Dressing changed, dry + intact Analgesia given with good effect. Seen by surgical team. See report above. [signature]

Bundaberg HOSPITAL

BUNDABERG HOSPITAL P126

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Ph(B)

OthC

(Affix Patient Identification Label Here)

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
30/5/03	Nursing: Pt wound has produced ooze+. Outer
2245	dressing changed twice this shift. Pt complains
	of 'discomfort'. Analgesia given with effect.
	Cares as per care path — M. Hanson RN (Han
31.5.03	Resting quietly overnight.
nate RN 0430h	uncomplaining. IVT contd. IV ABS
	given. Mood much improved.
0645hr	c/o feeling generally uncomfortable
31.5.03	Afebrile — [signature]
6 40Am	Feeling Better
	Appetite improved
	wound. continue to have
	purulent drainage
	Plan: showers
	Continue wound packing
	continue IV antibiotics
	D/C IV Fluids
	Patel
31.5.03	Care given as per care path.
1440HRS.	Dressing attended to +
	occluded due to amount of
	ooze. IVT TKVO. Obs
	D. Evans RN
Add H	? for Vac dressing tomorrow
	Dr Patel to see concerned.

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
25.5.03 2238	Wound remains covered - nil ooze noted. Patient suddenly unwell after tea. Vomited a small amount in toilet. Given IVI Maxalon c̄ good effect. Temp 37^6 - given panadol ii for pyrexia IVT - TKVO. IV A/B' as per MR 85. — Sleane (PEARSE) RN
01.06.03 nocte 0405hr	Resting quietly overnight. No complaints voiced. IV Abs given IVT 24/24 Cares as per carepath. [signature] (CROSSETT)
0710hr	Pt. becoming agitated due to other patients annoying idiosyncrasies pt moved to another room with desired effect - ~~pt now~~ much happier Small serous ooze on dressing — [signature] (CROSSETT)
1/6/3	Ang Pto wound infection confluent sigmoid colectomy for diverticular A. feels well remains afebrile wound dressed ~~this~~ a eating ✓ P/ continue current mx [signature]
1.6.03 1400HR	Wound re dressed. Ooze appears less than yesterday. IVT TKVO. Refused pain relief. Very upset + angry today re problems with wife. Care given

.....HOSPITAL

BUNDABERG HOSPITAL _____ U.R. NO _____
P126 SEX UR NO

INPATIENT PROGRESS NOTES Ph (B)
OthC

DATE AND STAFF CATEGORY	ALL NOTES MUST BE CONCISE AND ...
01-06-03.	Verbalising loudly and aggressively over phone re home situation. Distressed and agitated manner all evening. IV + a/l 6's ✓ Dkm
2.6.03 –	Rested well o/night, IVA/B ✓
2.6.03 8Am	Continues to have purulent - drainage from undrained pocket
	Plan. Reopen - wound completely
	Dressing change 3 times a day
	[redacted]
2/6/03 1532hrs	NURSING – Cares as per care path. Dr attended @ 1000hrs. Dr Patel wants sorbasan dressing TDS – discussed same ✓ A/NPC TILSED – request BD dressings only. ✓ talk to Dr in am. IVAb's continued. Self caring. _____ Kleene (RN)
02-06-03.	Current dressing unsuitable due to excessive drainage. Dr Agris contacted for discussion. I suggested cavity suction dressing but Dr Patel does not want

[redacted]

INPATIENT PROGRESS N

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
	bag system to try & keep the wound edges from becoming macerated. Same applied 2000 hrs — effective so far. ——
	Pt agitated, anxious & uptight regarding marital problems – requested Valium. Same given. Pt downstairs often. Pt states that he feels as if the Doctors dont treat him adequately & that his wound infection is not getting better & will not. I have suggested to him that he should have a good talk his Doctor in the morning regarding his present care & what he expects in the future. —— [illegible] RN
05.05.05. 0700HRS.	CARED AS PER CARE PATH —— NO PROBLEMS NOTED TO T.O.R. —— [redacted] RN (MEERMAN).
3/5/3 [illegible]	WR PATEL - Wound dressing ++ overnight - Now very [illegible] - (P) & Repack - Sorbsan + Wound not painful - Emotionally disturbed Re social [illegible] (P) & Psych r/w [illegible]
	[illegible]
3/6/03 SW 1045	I/V c̄ (pt) by CMH intake. (pt) reports current stressors are that of partner having a relationship c̄ (pt)'s friend. (pt) [illegible]

.....HOSPITAL

BUNDABERG HOSPITAL SEX UR NO

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Ph(B)
Othc

INPATIENT PROGRESS NOTES

(Affix Patient Identification Label here)

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT

only recently @ states has been crying + t. Expressing anger towards friend → theme of betrayal etc. @ states is seeking mx to ↓ agitation etc. @ reports hx of PTSD, but feels this is in remission @ this stage, however is aware that this could be a trigger for relapse. MSE: Appearance: male in 40's. Casually dressed, no evident physical disability; Speech: rate, quality, volume + tone appropriate to context; Mood: Rates 5/10 (1= dysthymic 10= euthymic) → states mood dropped since problems + health + relationship became problematic; Affect: flat depressed Thought / perception: Denies presence of suicidal homicidal ideation; denies presence of perceptual disturbances; memory: Reports has been poor for 'years'; Oriented to person, time + place; Sleep: States go prescribed Zyprexa 5mg nocte to augment sleep @

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
3/6/03 cont	mx unwell in hospital. Slept 2 hours last night. Appetite "lousy for a long time" re. medical condition affecting bowels – eats 2 light meals/day. Has gained 10-12 kg's in last few years however. Impression: ⓒ experiencing grief reaction in relation to hers of affair involving partner & friends to a lesser extent issues & pain/mouth problems also a stressor. Plan – ⓒ to organise contact & relationship counsellor @ Cataract (may contact details). Not for CMH f/u @ this time however given contact # if required for future. C. Wright. RN.
1330 NURSING	All care as per care paths. Dressings renewed as per ward round discussion. All obs stable. No complaints of pain offered. Mood appeared low at start of shift – uncommunicative, no eye-contact, etc. This has changed since visit by social worker, and mood now back to patients normal. [signature] MITCHELL RN
03.06.03.	2300hrs. Cares attended. 'O' sedation given as pts request. Visited by wife & children – stressful situation but resolved when pt was again alone. [signature] Cross RN
04.06.03. 0558hrs.	CARES PD PER CARE PATH — REMAINS ASLEEP TO T.O.R. [signature] RN (MEE LWA)

..... HOSPITAL BUNDABERG HOSPITAL SEX UR NO P126 [redacted]

INPATIENT PROGRESS NOTES

Ph(B)
OthC

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
04/06/03	WR w/ Dr. Patel
F. Britten	D16 post sigmoid colectomy for diverticulosis
(Med III student)	D 5 post wound breakdown + ~~disturbance~~ infection FB
8:25	Wound inspected - clean, no erythema around edges, discharge decreased
	Packed with alginate and opsite dressing.
	Psych. consult arranged for pt next.
	Wound care discussed - dressing should be changed twice daily and washed in shower.
	Patient ambulant and afebrile.
	Patient to be discharged and to have weekly reviews at OPD
	Discharge medications organised
	Plan/
	① Psych. review
	② Discharge
	③ Weekly review at OPD
	~~Fiona Britten~~
	(Med III student)
	8:45
04.06.03	NURSING DISCHARGE @ 1100hrs: Pt discharged home @ 1030hrs. Dx attended to. IVC removed & discharge medications

INPATIENT PROGRESS NOTES

DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
	explained & returned to pt. Nil problems
	voiced by pt. ——— [illegible]

Bundaberg Health Service District

MEDICATION CHART

BUNDABERG HOSPITAL SEX UR NO

p126

ALLERGIES/ALERTS

Ph(B) SUK6
OthC

Admission Weight: .... kg

ONCE ONLY (AND PREMEDICATION) DRUGS

DATE	TIME	DRUG	DOSE	ROUTE	DOCTOR	GIVEN BY	TIME GIVEN

VERBAL ORDER MEDICATIONS – Excluding IV Infusions (Must be signed by Medical Officer within 24 hours)

DATE	TIME	Date Given	Time Given	Dose	Sign.
30/5/03	1835				
Medication: Ibuprofen		30/5	1835	400mg	MH
Route: O	Dose: 400mg / Freq.: TDS				
Received by: MHanson	Checked by: [signature]				
Dr ordering: Dr Clemen	Dr's Sign.				

DATE	TIME	Date Given	Time Given	Dose	Sign.
Medication					
Route	Dose / Freq.				
Received by	Checked by				
Dr ordering	Dr's Sign.				

DATE	TIME	Date Given	Time Given	Dose	Sign.
Medication					
Route	Dose / Freq.				
Received by	Checked by				
Dr ordering	Dr's Sign.				

DATE	TIME	Date Given	Time Given	Dose	Sign.
Medication					
Route	Dose / Freq.				
Received by	Checked by				
Dr ordering	Dr's Sign.				

DATE	TIME	Date Given	Time Given	Dose	Sign.
Medication					
Route	Dose / Freq.				
Received by	Checked by				
Dr ordering	Dr's Sign.				

DATE	TIME	Date Given	Time Given	Dose	Sign.
Medication					
Route	Dose / Freq.				
Received by	Checked by				
Dr ordering	Dr's Sign.				

BUNDABERG HOSPITAL SEX UR NO

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16

FOR DRUGS NOT GIVEN INSERT
(according to Hospital Policy)

R REFUSED — A ABSENT
S STARVING — W WITHHELD

Ph (B)
OthC

2003. June

Record of Administration	Date → / ↓ Time	30/5/03	31	1/6	2	3	4	5	Discharge Supply
Drug: olanzapine	2100	?	SP	[illegible]	[illegible]	[illegible]			5 days
Route: PO; Dose: 5mg; Freq: daily; Start: 29.5.3									Dr's Signature; Pharmacist
Doctor: [signature]; Time check									
Drug: ampicillin	0600	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			days
Route: IV; Dose: 1gm; Freq: QID; Start: 29.5.3	1200	[illegible]	[illegible]	[illegible]	[illegible]				Dr's Signature
	1800	MH	SP	[illegible]	[illegible]				Pharmacist
Doctor: [signature]; Time check	2400	[illegible]	[illegible]	[illegible]	[illegible]				
Drug: metronidazole	0200	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			days
Route: IV; Dose: 500mg; Freq: tds; Start: 29.5.3.	1000	[illegible]	[illegible]	[illegible]	[illegible]				Dr's Signature
	1800	MH	SP	[illegible]	[illegible]				Pharmacist
Doctor: [signature]; Time check									
Drug: paracetamol	0600	R	[illegible]	R					5 days
Route: PO; Dose: 1gm; Freq: QID; Start: 29.5.3	1200	[illegible]		R	R	R			Dr's Signature
	1800	R	R	R	R				Pharmacist
Doctor: [signature]; Time check	2400	Asleep		R	[illegible]	[illegible]			
Drug: TEDS									days
Route; Dose; Freq; Start									Dr's Signature; Pharmacist
Doctor: [signature]; Time check									

Ampicillin: ceased [signature] 3-6-3
Metronidazole: ceased [signature] 3-6-3

NOT DISP

Drug	Date	Time	Sig.
Temazepam	02-06-03	2210	[illegible]
Route: PO; Dose: 20mg; Freq: Nocte; Start: 2/6	03-06-03	2150	[illegible]
Doctor: [signature]; Time check			

Discharge Supply 5 days; Dr's Signature; Pharmacist

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BUNDABERG

Bundaberg Health Service District

REGULAR MEDICATION CHART

BUNDABERG HOSPITAL SEX UR NO

P126

Ph(B)
OthC

2003

Record of Administration	Date → ↓ Time	3/6	4	5	6	7	8	9	Discharge Supply
Drug: Somac	0800	—	04						5 days
Route: PO / Dose: 40mg / Freq: ws / Start: 3/6/03	1800	10	—						Dr's Signature
Doctor / Time check									Pharmacist
Drug / Route / Dose / Freq / Start / Doctor / Time check									Discharge Supply ☐ days Dr's Signature Pharmacist
Drug / Route / Dose / Freq / Start / Doctor / Time check									Discharge Supply ☐ days Dr's Signature Pharmacist
Drug / Route / Dose / Freq / Start / Doctor / Time check									Discharge Supply ☐ days Dr's Signature Pharmacist
Drug / Route / Dose / Freq / Start / Doctor / Time check									Discharge Supply ☐ days Dr's Signature Pharmacist
Drug / Route / Dose / Freq / Start / Doctor / Time check									Discharge Supply ☐ days Dr's Signature Pharmacist

NST 21

PITAL

Bundaberg Health Service District

PRN MEDICATION CHART

BUNDABERG HOSPITAL SEX UR NO 18

p126

Ph(B)
OthC

(Patient Identification Label Here)

PRN ADMINISTRATION

DRUG: morphine

ROUTE	DOSE	FREQ.	START
S/C I/V	5mg	q2hr	29.5.3.

DOCTOR: LMAS — Time check

Date	Time	Dose	Sig
30/5/03	0140	5mg	[illegible]
30/5	0905	5mg	NE

Discharge Supply: ☐ days Dr's Signature: _____ Pharmacist: _____

PRN ADMINISTRATION

DRUG: metoclopramide

ROUTE	DOSE	FREQ.	START
IV	10mg	8hr	29.5.3

DOCTOR: LMAS — Time check

Date	Time	Dose	Sig
31/5/03	2015	10mg	SP

Discharge Supply: ☐ days Dr's Signature: _____ Pharmacist: _____

PRN ADMINISTRATION

DRUG: Ibuprofen

ROUTE	DOSE	FREQ.	START
PO	400mg	6hr	29.5.3

DOCTOR: LMAS — Time check

Date	Time	Dose	Sig
30/5	0900	400	MEQ
30/5	2830	See nebulizer	
31/5	0730	400mg	MEQ
31/5	1340	400mg	MEQ
31/5	1830	400mg	SP

Discharge Supply: 5 ☐ days Dr's Signature: WS Pharmacist: _____

PRN ADMINISTRATION

DRUG: Diazepam 2003

ROUTE	DOSE	FREQ.	START
PO	5mg	2°	2/6/3

DOCTOR: [illegible] — Time check

Date	Time	Dose	Sig
2/6	1815	5mg	[illegible]
2/6	2210	5mg	[illegible]
3/6	0310	5mg	[illegible]

Discharge Supply: 5 ☐ days Dr's Signature: WS Pharmacist: _____

DRUGS WITH VARIABLE DOSE

DRUG	ROUTE	Discharge supply ..... days. Dr's signature:

DATE	TIME	DOSE	DOCTOR	NURSE

DRUG	ROUTE	Discharge supply ..... days. Dr's signature:

DATE	TIME	DOSE	DOCTOR	NURSE

BUNDABERG HOSPITAL SEX UR NO: 1

A126

Queensland Government
Queensland Health

BUNDABERG HEALTH SERVICE DISTRICT

PATIENT PROFILE

Ph (H)
Ph (B)
OthC

UNEMPLOYED

Date: 30.5.03 Time Admitted to Ward: 0125 h

Information given by: Patient ☑ Relative ☐ Other:

Presenting Problem/Illness/Reason for Admission: Wound infection.

Preferred name: Jan

Correct name band in place: Yes ☑ No ☐

Relatives aware of admission: Yes ☑ No ☐

(include accident/injury details)

Allergies or Reactions: No.

Is patient on any medication: Yes ☑ No ☐

Medication brought in: Yes ☑ No ☐ N/A ☐

Polypharmacy > 5 drugs: Yes ☐ No ☐ N/A ☐

Communication:

Coherent: Yes ☑ No ☐
Incoherent: Yes ☐ No ☑
English spoken: Yes ☑ No ☐
English understood: Yes ☑ No ☐
Interpreter needed: Yes ☐ No ☐
Other language preferred:

Impairment:
Speech: Yes ☐ No ☑ Speech pathology notified Yes ☐ No ☐
Hearing: Yes ☐ No ☑ Hearing aid Yes ☐ No ☐
Retained by patient Yes ☐ No ☐
Sight: Yes ☐ No ☑ Glasses/contact lenses Yes ☐ No ☐
Retained by patient Yes ☐ No ☐

Social History:

Notes:

Does patient smoke: Yes ☐ No ☑
Did patient smoke: Yes ☑ No ☐ 10 days ~30 days.
Does patient drink alcohol: Yes ☐ No ☑
Does patient have problems sleeping: Yes ☐ No ☑ ··· Sleep pattern No.

Does patient live alone: Yes ☐ No ☑
Family support: Yes ☑ No ☐
Whom and what support: 3 children

Prior to admission was patient receiving:

			Notified: (if applicable)		
Meals on Wheels	Yes ☐	No ☑		Yes ☐	No ☐
Home Help	Yes ☐	No ☑		Yes ☐	No ☐
Domiciliary Nursing	Yes ☐	No ☑		Yes ☐	No ☐
St Vincent	Yes ☐	No ☑		Yes ☐	No ☐
Blue Care	Yes ☐	No ☑		Yes ☐	No ☐
Community Health	Yes ☐	No ☑		Yes ☐	No ☐
Oxygen therapy	Yes ☐	No ☑		Yes ☐	No ☐

Does the patient have any concerns regarding hospitalization:

Spouse Yes ☐ No ☑
Children Yes ☐ No ☑
Transport Yes ☐ No ☑

Accomodation:

Lives in own home Yes ☑ No ☐
Lives in nursing home Yes ☐ No ☐
Lives in hostel Yes ☐ No ☐
Other:

Someone to care for them Yes ☑ No ☐
Special needs:

Personal care status:

	Independent	Assist	Dependant
Hygiene/shower/bath	☑	☐	☐
Mobility/transfer	☑	☐	☐
Meals/feeding	☑	☐	☐
Dressing	☑	☐	☐
Toileting	☑	☐	☐

Medical History

Chest infection Yes ☐ No ☑
Asthma Yes ☐ No ☑
Pneumonia Yes ☐ No ☑
Cardiac problems Yes ☐ No ☑

Diabetes Yes ☐ No ☑ Which type (1 or 2)
Epilepsy or fits Yes ☑ No ☐
Previous operations/illness:

General appearance: good.

Skin: General condition:

Pressure areas: Yes ☐ No ☐ Sacrum:
Heels: Other:

Wounds
Site(s): midline. abdo.
Current dressing: telfa.
Frequency:
Slow wound healing Yes ☐ No ☑ · Bleeding tendency Yes ☐ No ☑

Nutrition
How does patient describe their appetite: Poor ☑ Fair ☐ Good ☐ *Dietition needed* Yes ☐ No ☐
Special diet Yes ☐ No ☐ Details:
Diet and food preference: As Desired.

Spiritual needs
Religious needs: NO
Pastoral care required Yes ☐ No ☐ Contact:
Cultural needs:
Emotional state: Withdrawn.

Dentition
Full denture Yes ☐ No ☐ Partial denture Yes ☐ No ☐ Prosthesis:
Upper denture Yes ☑ No ☐ Lower denture Yes ☐ No ☐ With patient Yes ☐ No ☐

Mobility aids (Wheelchair, walking stick, etc)
Specify: NIL
With patient: Yes ☐ No ☐ Allied health notified: Yes ☐ No ☐ N/A ☐

PAC nurse signature | Printed name/designation | Date

To be completed on admission:
Condition of patient on arrival:

Level of Consciousness:
Fully conscious: Yes ☑ No ☐ Drowsy: Yes ☐ No ☐
Unresponsive: Yes ☐ No ☑
If unresponsive, response to stimuli: Verbal: Yes ☐ No ☐
Pain: Yes ☐ No ☐
Have base line observations been done? Yes ☑ No ☐
Emotional state: Reserved.

Thought Process:
No problems noted: Yes ☐ No ☑
Confused/vague: Yes ☐ No ☑
Comments:
Is the patient cyanosed: Yes ☐ No ☑

MRSA
Transfer from another facility Yes ☐ No ☐ Transfer notes in file Yes ☐ No ☐ N/A ☐
Swabs required Yes ☐ No ☑ Swabs taken Yes ☐ No ☐ Date

Risk Assessment *(write score next to assessment)*
Pressure areas Waterlow's scale documented Yes ☐ No ☑ Score Notes:
Falls Risk Yes ☐ No ☑ Score
Heart start risk Yes ☐ No ☑ Score
Diabetes risk Yes ☑ No ☐ N/A Score

Valuables
With patient Yes ☐ No ☑ Articles kept with patient:
Taken home Yes ☐ No ☐ X-rays with patient Yes ☐ No ☐
Trust facilities offered Yes ☐ No ☐ N/A ☐ Placed in trust Yes ☐ No ☐ N/A ☐

Unit orientation
Call bell ☐ Visiting hours ☐ Smoking rules ☐ NOK/contact details checked ☐
Lights ☐ Menu/meals ☐ Television ☐ Family notified (DEM admission) ☐
Bathroom/toilet ☐ Telephones ☐ Qld Health Public Patient Charter explained/given ☐
Fire exits and evacuation procedures ☐ Specific instructions:

Notes:

BUNDABERG DISTRICT HEALTH SERVICE
SURGICAL DISCHARGE SUMMARY

BUNDABERG HOSPITAL SEX UR NO
P126

Local Doctor Dr. G. Patel
Address Barolin Family Med Practice
66A Barolin St. Bundaberg
4670

Ph(B)
OthC

Admission Date: 30/05/03
Consultant: Dr. Patel

Discharge Date: 04/06/03
Follow-up Clinic:

PRINCIPAL DIAGNOSIS*

Wound infection post sigmoid colectomy for diverticular disease

SECONDARY DIAGNOSES

☐ IHD ☐ Peptic Ulcer ☐ Anaemia ☐ Asthma ☐ Obesity
☐ CCF ☐ Dementia ☐ Hypertension ☐ COAD ☐ Diabetes
☐ Chronic Renal Failure
☐ Other (Specify)

SYMPTOMS/SIGNS ON PRESENTATION

serosanguinous d/c and bubbles from wound exacerbated by ↑ in abdo. pressure

PRINCIPAL PROCEDURE

Wound opened and allowed to drain

SECONDARY PROCEDURE/S

☒ Upper Endoscopy ☐ Rigid Sigmoidoscopy ☐ Colonoscopy

INVESTIGATIONS:

WRITE ABNORMAL RESULTS

	Y	N	NAD
F.B.C.	☐	☐	☐
Biochem	☐	☐	☐
L.F.T.'s	☐	☐	☐
Microbiology	☑	☐	☐
Histology	☐	☐	☐
Xray	☐	☐	☐

WRITE ABNORMAL RESULTS

	Y	N	NAD
Ultrasound	☐	☐	☐
CT Scan	☐	☐	☐
ECG	☐	☐	☐
Angiogram	☐	☐	☐
Other	☐	☐	☐

COMPLICATIONS

☐ Haematoma ☐ Atelectasis ☐ DVT ☐ IV Site Phlebitis
☐ Pneumonia ☐ Haemorrhage ☑ Wound Infection/Breakdown ☐ Prolonged ileus
☐ Pulmonary Embolism ☐ CCF/LVF ☐ Myocardial Infarction ☐ Urinary Retention
☐ Acute Renal Failure ☐ CVA ☐ UTI ☐ Adverse Drug Reaction
☐ Other (Specify) ☐ Decubitus Ulcer ☐ Unplanned Return to Theatre

CLINICAL COURSE

Wound d/c decreased – review weekly in OPD

☐ GP Wound Follow-up ☐ Remove Sutures Date...../...../.....

Cause of injury/poisoning (if applicable) Place of occurrence

DISCHARGE MEDICATIONS	
As per admission	

Signature Fiona Butler

SURGICAL DISCHARGE SUMMARY

BUNDABERG BASE HOSPITAL

UR 22[illegible]

PUBLIC 106934-5

Title	Surname	Given Names	Date of Birth	Age
MR	P126			

Address

4670

Sex	M.S.	Country of Birth	Religion
M	M	AUSTRALIA	OthC

Ethnic Origin: NOT ABORIG. OR ENGLISH ONLY

Telephone - Home

Telephone - Business

Occupation (Current or Last): UNEMPLOYED

First Contact

Alternative Contact

If discharged in last 7 days, from which hospital

Date Admitted: 30 May 2001

Time Admitted: 00:55

Admission Source: A & E

Referring Doctor/Person

DR G PAGEL
BAROLIN FAMILY MED PRACTICE
66A BAROLIN STREET
BUNDABERG 4670

41531155

Unit	Ward	Bed	Treating Doctor
SURG	12		PATEL J

Account Class	Health Fund	Health Schedule
GPE	NIL	

Medicare Number: 3182045705

Pension Number

Date Discharged: 4-6-03

Time Discharged: ~~1100~~ 1045

Discharge Status: Home

ICD9CM CODES

	T51.91		
	753.6		
	792.22		
	263.9		
	272.0		
	95550-01		

ADMISSION FRONT SHEET

Bundaberg HOSPI

BUNDABERG HOSPITAL SEX UR NO
P126 M

GENERAL OBSERVATION SHEET

Ph(H)
Ph(B)
OthC

DATE: 30.5.03 | 31.5.03 | 1.6.03 | 2.6.03 | 3.6.03 | 4.6.03 | 5.6.03

TIME: AM PM | AM PM | AM PM | AM PM | AM PM | AM PM | AM PM

TEMPERATURE ° C

PULSE ° ><

BLOOD PRESSURE

RESPIRATIONS

BOWELS

WEIGHT

FOETAL HEART

URINE PROTEIN ALBUSTIK

GENERAL OBSERVATION SHEET

BUNDABERG DISTRICT HEALTH SERVICE

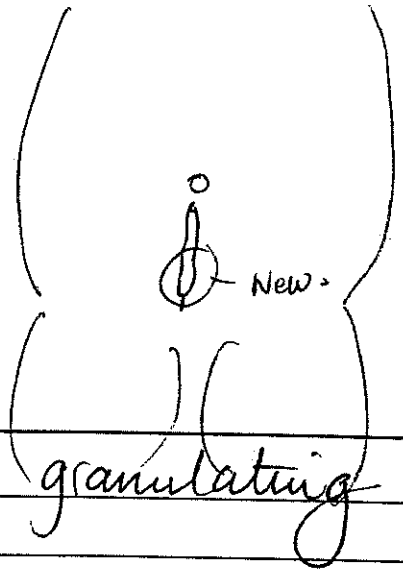
BUNDABERG HOSPITAL SEX 24 UR NO
M
P126

WOUND CARE CHART

Ph(H)
Ph(B)
OthC

INITIAL ASSESSMENT DATE	2/6/03
WARD	Surgical
CAUSE	surgical breakdown.
WOUND SITE	Abdo
SIZE	10cm
DEPTH	3-5cm.
ODOUR	No.
DRAINS	ND.
PAIN	Yes.

ILLUSTRATION



CONDITION OF WOUND EDGES OR SURROUNDING TISSUE red granulating

EXUDATE NO ☐ YES ☑ COMMENT fresh blood.

SWAB TAKEN NO ☑ YES ☐ DATE

REACTION TO LOCALIZED TREATMENT

SIGNATURE Alleene (RN)

DRESSINGS

TIME & DATE COMMENCED	FREQUENCY OF DRESSING	CLEANING AGENT	PRIMARY DRESSING	SECURING OF DRESSING	SIGNATURE
10cms 2/6/03	TDS (Patel Request)	N/Sale Shower	Sofbasan	opsite.	Alleene
3/6/3	ONCE daily	N/Saline	Sorbsan	opsite	

BUNDABERG DISTRICT HEALTH SERVICE

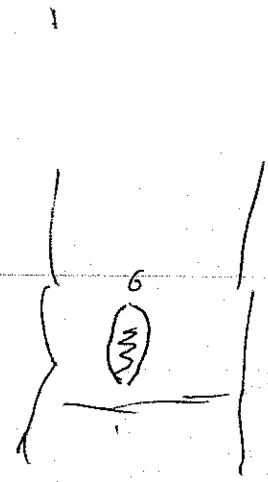
BUNDABERG HOSPITAL SEX UR NO 23

P126

WOUND CARE CHART

Ph (H)
Ph (B)
OthC

INITIAL ASSESSMENT DATE 5/6/03	ILLUSTRATION
WARD DAS	
CAUSE PostOP Wound Infection	
WOUND SITE (L) abdomen.	
SIZE 10 x 5 cm.	
DEPTH 4 cm.	
ODOUR Nil	
DRAINS Nil	
PAIN	



CONDITION OF WOUND EDGES OR SURROUNDING TISSUE ______

EXUDATE NO ☐ YES ☐ COMMENT ______

SWAB TAKEN NO ☐ YES ☐ DATE ______

REACTION TO LOCALIZED TREATMENT ______

SIGNATURE ______

DRESSINGS

TIME & DATE COMMENCED	FREQUENCY OF DRESSING	CLEANING AGENT	PRIMARY DRESSING	SECURING OF DRESSING	SIGNATURE
5/6/03	Daily	N/Saline	aquacel pack.	allevyn combine opsite	[illegible]
14/6/03	daily	Saline	aquacel	alevyn	S McCall
21/6/03	dly	Saline	aquacel. combine.	combine [illegible]	[illegible]

CODE: Y = Yes
N = No
N/A = Not Applicable

DATE DRESSING TAKEN DOWN:		6/6	7/6/03	8/6/03	9/6/03	11/6/03	12/6/03	13/6/03	16/6/03	17/6/03	19/6/03
HEALING WITHOUT INFECTION:		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
IS WOUND DISCHARGING	SEROUS	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
	BLOOD STAINED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	PURULENT	N	N	N	N	N	N	N	N	N	N
WOUND APPEARANCE	CLEAN	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	RED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	SWOLLEN	N	N	N	N	N	N	N	N	N	N
	HAEMATOMA	N	N	N	N	N	N	N	N	N	N
	SLOUGH	Y	N	N	N	N	N	N	N	N	N
STAGE OF HEALING	RED	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	YELLOW	N	N	N	N	N	N	N	N	N	N
	BLACK	N	N	N	N	N	N	N	N	N	N
DRAIN SITE	CLEAN										
	RED										
	SLOUGH										
DRAIN OUT (DATE)											
DISCHARGE FROM DRAIN/SITE											
IF SO	SEROUS										
	BLOOD STAINED										
	PURULENT										
COMMENTS											
SIGNATURE (PERSONNEL ATTENDING DRESSING)											

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BUNDABERG HOSPITAL SEX UR NO
P126.

.....Hospital

Ph(H)
Ph(B)
OthC

CONTINUATION SHEET

(Affix Patient Identification Label Here)

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
- 5 JUN 2003	**DRESSING REVIEW**
	Large Post-op infection to lower abdomen, copious amount of purelent discharge. aquacel pack to cavity Covered /c alleyn combine + op-site —
	27/6/03. Foskett RN,
6-6-2003	**DRESSING REVIEW**
	Wound re dressed as per MR91 - less discharge — 27/6/03 Foskett RN
09 JUN 2003	**DRESSING REVIEW**
7.6.03	Surgical Service
	Wound clean redressed as per MR91. — LMcCall SMCALL
8.6.03.	NURSING: DRESSING ATTENDED TO AS PER CLINICAL CARE PLAN Ken Storey
9/6/03.	Dressing attended to as per MR91. —
	L Kendall EN KENDALL
11/6/03	Dressing attended to as per MR91 — LKendallEN KENDALL
12 JUN 2003	**DRESSING REVIEW**
13 JUN 2003	Dressing attended to as per MR91. LKendallEN KENDALL
	DRESSING REVIEW
	Dressing attended as per MR91. LKendallEN KENDALL
14 Jun 2003	SURGICAL OCCASIONS OF SERVICE
	Wound redressed as per MR91 — LMcCall EN SMCALL
15/6/03	Dressing attended as per MR91 — KBurn (Grad)
16/6/03	Dressing attended as per MR91 — LKendallEN KENDALL
17/6/03	Dressing attended as per MR91 - LKendallEN KENDALL

DRESSING REVIEW

ACCIDENT & EMERGENCY / OUTPATIENT CONTINUATION SHEET

DATE AND TIME	HISTORY, EXAMINATION AND TREATMENT
17 JUN 2003	DRESSING REVIEW
19 JUN 2003	DRESSING REVIEW Redressed as per MR 91 —— L Kendall EN KENDALL
20 JUN 2003	DRESSING REVIEW Redressed as per MR 91 —— Heber (HEBER) EN ——
21 JUN 2003	DRESSING REVIEW Dx attended as per MR 91 Pt states he will attend own dx tomorrow. Extra dx's given. —— (JOHNSTON) RN
23/6/03.	Pt will attends own dressing & attend dressing clinic Monday & Thursday. Wound redressed as per MR 91. L Kendall EN KENDALL
25 JUN 2003	DRESSING REVIEW
26 JUN 2003	DRESSING REVIEW Redressed as per MR 91 L Kendall EN Kendall
30 JUN 2003	DRESSING REVIEW Redressed as per MR 91 —— POSTILL
3 JUL 2003	DRESSING REVIEW Cancelled by pt. —— POSTILL
7 JUL 2003	DRESSING REVIEW Wound clean + dry. Pt. discharged from D/clinic —— POSTILL

BUNDABERG HEALTH SERVICE

WOUND CARE CHART (Continuation)

BUNDABERG HOSPITAL SEX UR NO

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A126 M

CODE: Y = Yes
N = No
N/A = Not Applicable

Ph(H)
Ph(B)
OthC

DATE DRESSING TAKEN DOWN:		21/6	23/6/03.	26/6/03.	30/6/03	7/7/03					
HEALING WITHOUT INFECTION:		Y	Y	Y	Y	Y					
IS WOUND DISCHARGING	SEROUS	Y	N	N	N/A	N					
	BLOOD STAINED	N	N	N	N	N					
	PURULENT	N	N	N	N	N					
WOUND APPEARANCE	CLEAN	Y	Y	Y	Y	Y					
	RED	Y	Y	Y	Y	N					
	SWOLLEN	N	N	N	N	N					
	HAEMATOMA	N	N	N	N	N					
	SLOUGH	N	N	N	N	N					
STAGE OF HEALING	RED	Y	Y	Y	Y	Y					
	YELLOW	N	N	N	N	N					
	BLACK	N	N	N	N	N					
DRAIN SITE	CLEAN										
	RED										
	SLOUGH										
DRAIN OUT (DATE)											
DISCHARGE FROM DRAIN/SITE											
IF SO	SEROUS										
	BLOOD STAINED										
	PURULENT										
COMMENTS											
SIGNATURE											

MH/97A (Continuation)