QuES for excellence	Simulation Scenario		Frimley Health NHS Foundation Trust
Title	Acute myocardial infarction	Version	2.4
Target Audience	FY doctors & student nurses	Run time	10 -15 mins
Authors	Udesh Naidoo, James Foxlee, Karen Britton, Paul Wilder, Mark Loughrey	Last review	4/7/18
Faculty comments	Normal faculty requirements	Necessity	n/a

Brief Summary

This scenario demonstrates management of uncomplicated acute anterior myocardial infarction in a previously well patient. There are no planned physiological deteriorations from the baseline during the scenario.

Educational Rationale

Initial assessment and management of chest pain is an essential skill for all FY doctors and allied health professionals. This scenario looks for systematic assessment and concurrent treatment of this common medical emergency, along with exclusion of differential diagnoses with a similar presentation.

Learning Objectives: Nurse

- ABCDE assessment and NEWS scoring of a deteriorating patient
- · Initial appropriate management
- Suitable escalation and SBAR handover
- · Communication with the patient and inter-professional team working

Learning Objectives: Doctor

- Receiving an SBAR handover and responding appropriately
- ABCDE assessment and initial management of a deteriorating patient
- Consider differential diagnosis for chest pain
- Early recognition of myocardial infarction
- Appropriate investigations and treatments in line with Trust guidelines
- Suitable escalation and SBAR handover



No	CURRICULUM MAPPING	This scenario
1	Acts professionally	✓
2	Delivers patient-centred care and maintains trust	✓
3	Behaves in accordance with ethical and legal requirements	✓
4	Keeps practice up to date through learning and teaching	✓
5	Demonstrates engagement in career planning	
6	Communicates clearly in a variety of settings	✓
7	Works effectively as a team member	✓
8	Demonstrates leadership skills	✓
9	Recognises, assesses and initiates management of the acutely ill patient	✓
10	Recognises, assesses and manages patients with long term conditions	✓
11	Obtains history, performs clinical examination, formulates differential diagnosis and management plan	✓
12	Request relevant investigations and acts upon results	✓
13	Prescribes safely	✓
14	Performs procedures safely	✓
15	Is trained and manages cardiac and respiratory arrest	
16	Demonstrates understanding of the principles of health promotion and illness prevention	✓
17	Manages palliative and end of life care	
18	Recognises and works within limits of personal competence	✓
19	Makes patient safety a priority in clinical practice	✓
20	Contributes to quality improvement	

Candidate Briefing: Nurse

Setting: Resus Bay

You are working in Resus in A&E. A patient is brought in by ambulance with chest pain, having been sent in by their GP. Please perform an initial assessment and escalate as appropriate.

Candidate Briefing: Doctor

Setting: Resus Bay

You are part of the team on the acute medical take.

Your registrar has been referred a 51 year old patient with chest pain by their GP; the patient has arrived by ambulance.

Your registrar is currently busy with a high dependency patient elsewhere in the hospital and they have asked you to perform an initial assessment, management and escalate as appropriate.

How to run with candidates from only one discipline

An additional member of faculty can play the role of the nurse in this scenario if needed.

Sim Nurse briefing:

You are a junior nurse working in A&E. You are expected to perform basic observations and escalate as appropriate. You cannot interpret ECGs but are concerned by the nature of this patient's pain. The patient has taken some GTN spray without effect.

Chest X ray and ECG have already been performed and results are available. You have taken bloods but not sent them off; you will not do so until the candidate specifies the tests required.

CONDUCT

Throughout the scenario you should act as a "competent robot" i.e. you should perform all tasks requested to the best of your ability, but should not initiate any treatment on your own. If you are not being effectively instructed by the candidate, you may be prompted via your ear piece by the lead facilitator as to what your next action should be.

If you strongly disagree with management then you are free to question them, stating your reasons.

If asked to give drugs, you should request that they are prescribed on the drug chart. If they are unsure of the dosage please refer them to the BNF or Hospital Guidelines App or via Intranet.

	Technical set-	up	
Setting	Resus bay		
Simulator	High fidelity manikin / actor		
Gender	Female	Age	51

	Initial	monitor	paramete	ers
RR	O2 sats	Pulse (HR)	ВР	ECG rhythm
20	94% on air	104	140/95	Sinus rhythm, ST elevation
Cap Refill Time	Blood glucose	Temp.		
3 s	5.9	36.9		

	Initial patient se	et-up
a improve	Obstruction	Airway adjunct
Airway	No	No

Broothing	Chest sounds	O2 supply
Breathing	Clear	Air

Circulation	Heart sounds	Cannula	BP cuff	Peripheral pulses
Circulation	Normal	No	Attached	Weak

Disability	Eyelids	Pupils	AVPU/GCS
Disability	Open	Reactive	15

Evenosuro	Posture	Moulage	Bowel sounds
Exposure	45 degrees	None	Normal

Specific equipment / prop requirements

- Crash trolley by bed: including defibrillator (not attached)
- Monitoring: ECG, non-invasive BP (cuff), pulse oximeter (SpO2)
- Cannula in situ
- ABG results (x2)
- Blood bottles with request form
- ECG demonstrating ST elevation in the anterior leads (V2 4) with reciprocal ST depression in II, III, aVF
- CXR (chest radiograph): normal
- Ambulance Handover sheet & A&E front sheet
- Blank drug chart
- NEWS chart (obs chart)
- Mobile phone with guidelines app
- BNF

Facilitator Briefing

Telephone Advice

- You will be sitting in the control room for the duration
- <u>Answer all calls as "switchboard" in the first instance</u> to allow for realistic delay. Call back after 1 2 minutes
- The Medical Registrar should sound busy and state they are tied up with another patient
- They should be helpful but press the candidate hard about what assessment has been performed e.g. nature of pain, findings of physical examination
- If the candidate is not armed with the information, tell them to get the required info and call you back
- Enquire about ECG findings it should show sinus rhythm with anterior (V2-4) ST elevation with reciprocal ST depression (II, III, aVF)
- Enquire about the chest X-ray what did it show?
- End by saying that it sounds like the patient is having an MI and they should be transferred to the cath lab, following cardiology consultation
- The cath Lab Cardiology Consultant should be helpful but want to know the exact ECG findings, duration of pain (2 hours approx) and management instituted
- When this information has been imparted, state that the patient needs a primary PCI and they should be immediately transferred to the cath lab

• If not given, give aspirin and clopidogrel (300mg of each), and fondaparinux

	Patient Briefing
Setting	A&E resus bay
Name	Samantha Tully
Age	51
Gender	Female

What has happened to you?

- Sent in by GP after a telephone conversation; they told you to call an ambulance
- Gradual onset of dull pain in centre of the chest while moving boxes in garage > 2 hours ago
- No arm or jaw pain
- Not relieved by rest or paracetamol. Got better in ambulance (following GTN) but now recurred
- No exacerbating factors
- Never had before

OTHER SYMPTOMS

- Feels nauseous but no vomiting
- Feels hot and sweaty.
- Has had headache (since GTN spray)

How you should role-play

You can talk normally but are in pain and feeling nauseous.

Request analgesia - "something stronger than paracetamol and something to take the sickness away"

Your background

PAST MEDICAL HISTORY

- Varicose veins
- No regular medication
- No known drug allergies

SOCIAL HISTORY

- IT firm employee
- Smoked 20+ cigarettes a day for 20 years
- Binge drinks on weekends

FAMILY HISTORY

Both parents and sibling alive and well

Father on treatment for hypertension and peripheral vascular disease, mother has thyroid trouble and diabetes.

Scenario flowchart

EXPECTED ACTIONS

- Recognise unwell patient
- ABCDE assessment
- O2 facemask
- ECG + BP monitoring
- Consider DDx inc COPD, LVF, ACS etc
- Ix: ABG, bloods inc Trop I, ECG, CXR
- Review medical notes and drug chart
- Escalate as appropriate

EXPECTED ACTIONS

- No improvement with initial treatment
- Consider (and treat) other diagnoses inc ACS as soon as ECG returned
- Escalate to Cardiology

INITIAL SETTINGS

- A: Clear
- B: RR20, SpO2 94% on air, chest clear
- C: HR 104, BP 140/95, CRT 3sec, warm peripheries
- D: E4V5M6, PEARL 3mm BM 5.9, on-going chest pain
- E: No rash, temp 36.9C

DETERIORATION

- A: Clear, speaking in near full sentences with worsening chest pain
- B: RR 28, SpO2 92% on O2, wheeze
- C: HR 140, BP 90/50, CRT 4 sec
- D: E4V5M6, PEARL 3mm
- E: No rash, temp 36.9C (unchanged)

FURTHER DETERIORATION

- A: Clear, speaking in single words
- B: RR 48, SpO2 88% on O2, widespread wheeze & fine crackles
- C: HR 140, BP 90/50, CRT 4 sec
- D: E4, agitated and distressed
- E: No rash, temp 36.9C (unchanged)

RESULTS

INITIAL ABG (on room air)

pH 7.35 pO2 9.7 pCO2 5.8 BE -3 Lact 1.4

CXR: Normal

ECG: Anterolateral

STEMI

ABG (after further deterioration)

pH 7.31 pO2 7.4 pCO2 6.6 BE -4 Lact 1.7

BLOODS: Normal

EXPECTED OUTCOME

- Treat Acute MI including referral for PCI if available locally, or thrombolysis
- Supportive management

LOW DIFFICULTY

- Medical Registrar arrives early, ensures ACS drugs given and arrangements made for PCI
- Patient stabilises

NORMAL DIFFICULTY

- Seniors not present initially
- Reassess, give ACS drugs
- · Plan PCI with cardiologist

HIGH DIFFICULTY

- Deterioration even though treated appropriately: patient goes into cardiac arrest (VF)
- 3 cycles of CPR results in ROSC with:
- A: Clear
- B: RR 0, Silent chest, SpO2
- 93%
- C: HR 140, BP 90/50, CRT 4sec
- D: Unresponsive
- ITU team arrive and coordinate ongoing care

RESOLUTION

Appropriate treatment prescribed, investigations ordered, events discussed with patient, contemporaneous notes, decisions re: ongoing care

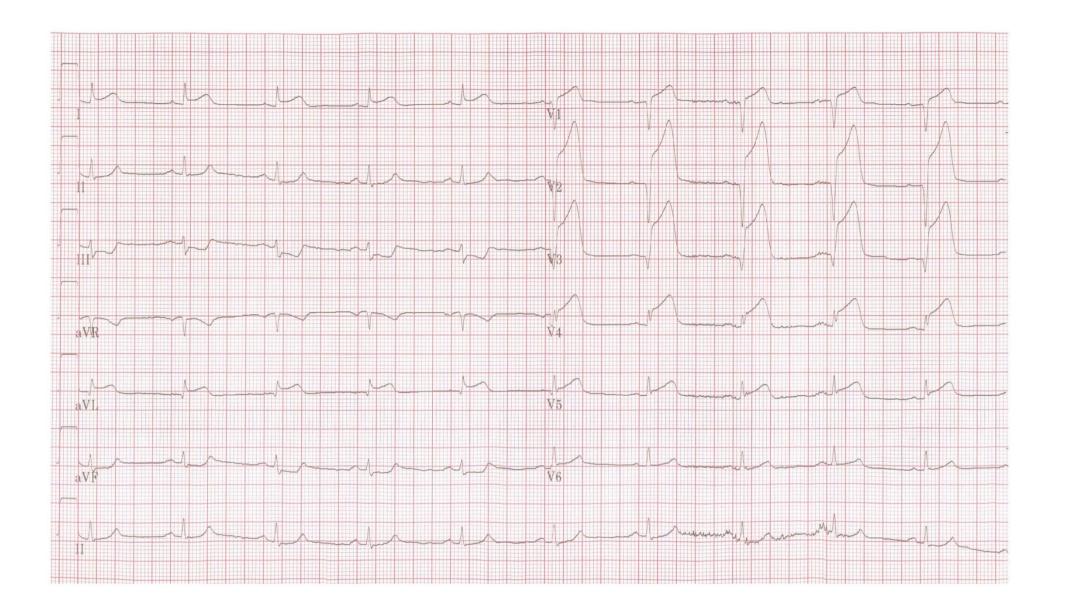
References

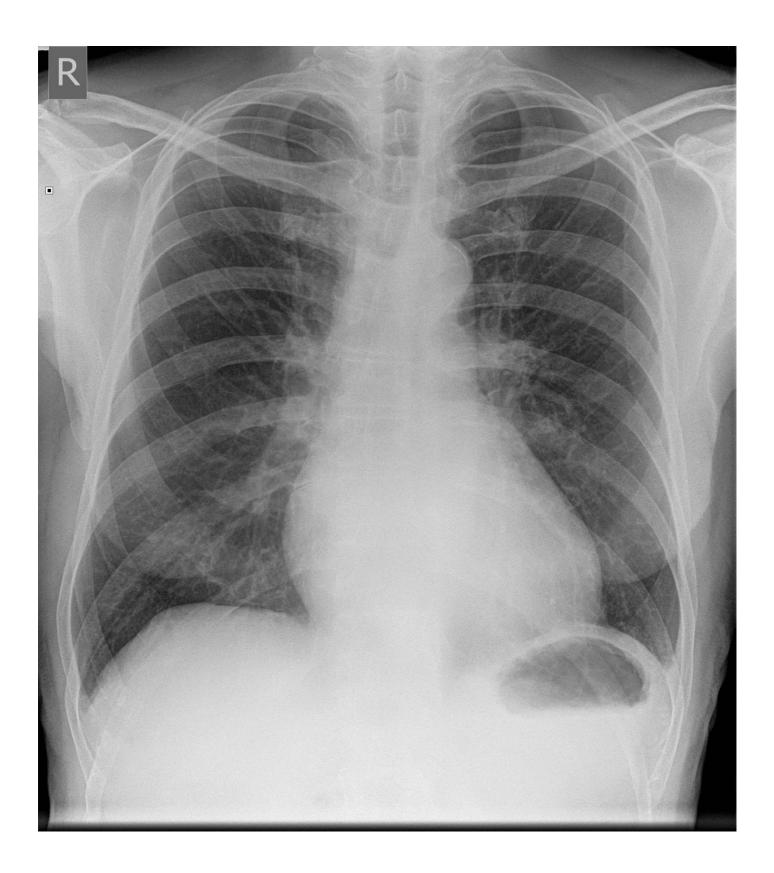
- Local ACS guidelines & hospital guidelines app
- NICE Clinical Guideline 95: Chest pain of recent onset: assessment and diagnosis. Available at: https://www.nice.org.uk/guidance/cg95
- NICE Clinical Guideline 167: Myocardial infarction with ST-segment elevation: acute management. Available at: https://www.nice.org.uk/guidance/cg167
- NICE Clinical Guideline 94: Unstable angina and NSTEMI: early management. Available at: https://www.nice.org.uk/guidance/cg94

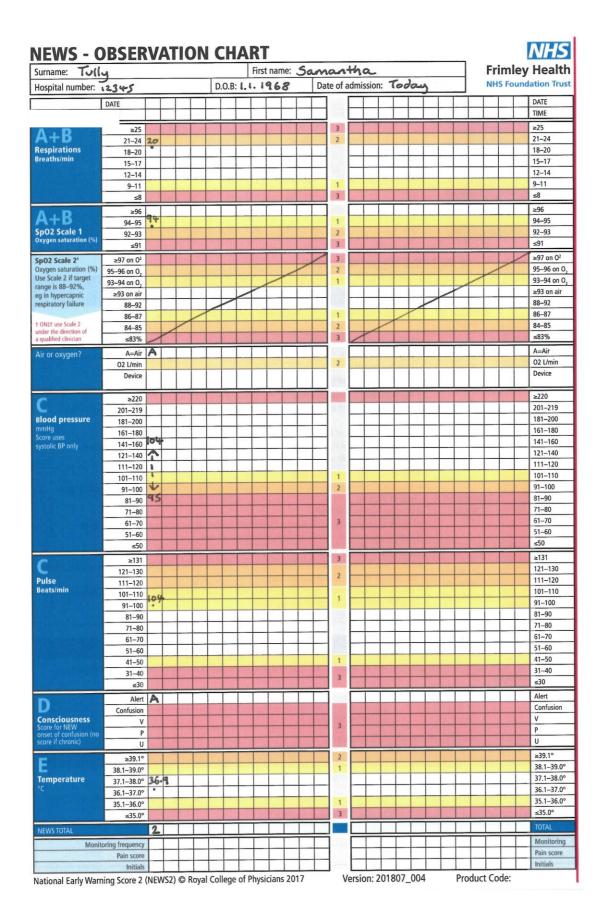
Clinical props

dentifications Patient ID	789987						
Patient Last Name Patient First Name Sex	TULLY Sam Female						
Date of birth FO _* (I) T Sample type Operator		K J PH 1					
Blood Gas Values				_	-		-
pH	7,350		1	7.350) - ;	7.450	1
pCO;	5.80	kPa		4.70			1
1 pO,	9.7	kPa	i	11.1		14.4	1
Hctc	50.0	%					
Oximetry Values							
ctHb	128	g/L					
↓ FO₂Hb	93.8	%	[94.0		9.89	1
sO,	94.0	%					
FCOHb	0.8	%	1	0.5	-	1.5	1
FHHo	3.5	%	1	0.0	-	5.0	1
FMetHb	1.1	%	1	0.0	-	1.5	1
Calculated Values							
cBase(Ecf)c	-3.0	mmol/L					
cHOD, (P)c	21.7	mmol/L					
Electrolyte Values							
cNa*	138	mmol/L	1	136	-	146	1
↑ cK*	4.6	mmol/L	1	3.4		4.5	1
cCl*	102	mmol/L	1	98		106	1
↑ cCe ^s *	2.40	mmoVL	1	22		2.45	1
Anion Gapo		mmol/L					
Metabolite Values							
† cGlu	5.9	mmol/L	1	3.9		5.8	1
cLec	1.4	mmol/L	1	0.5		1.6	1
cCrea	90	hwoN/	į	44		197	1
1222							
Value(s)	shove refere	ence range					
TOPOGRADINE MOMENT	elow refere						
Calculate							

Patient II		789987			1016			
Patient F Sex	ent First Name Sam							
Date of b FO _s (I) T Sample to Operator	уре	457 P.C. T. ST. S.	X Li PH 1					
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1 00	,	7.4	kPa	1	11.1	-	14.4	1
Hot	c	50.0	%					
Oximetr	y Values							
ctH	b	128	g/L					
↓ FO	,Hb	91.9	%	1	94.0	-	98.0	1
sO		92.0	%					
FC	ОНЬ	0.8	%	[0.5	-	1.5	1
FH	Нэ	3.5	%	1	0.0	-	5.0	1
FM	lefHb	1.1	%	1	0.0	-	1.5	1
Calculat	ted Values			ľ				
сВ	ase(Ecf)c	-4.0	mmol/L					
cH	OD, -(P)c	21.7	mmol/L					
	yte Values							
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1 cK		4.6	mmol/L	1	3.4		4.5	1
cC.		102	mmol/L	1	98		106	1
† cC		2.40	mmol/L	i	22		2.45	i
	on Gape		mmol/L					35
	lite Values							
† cG		5.9	mmol/L	1	3.9		5.8	1
1 ch	ac	1.7	mmol/L	i	0.5		1.6	i
-	rea	90	µmal/l	į	44			1
votes	Value(e)	bove refere	ence rance					
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Frimley Park Hospital NHS NHS Foundation Trust

Hospital Number: 78	89987 23456								
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Postcode: Tel (H): Tel (M):	7		NOK: Address:						
Employer / Educ. E: Religion: こんずき Language: こんら			Relationship Tel (H): Tel (M):						
	Self 1325 Cinn		GP: Address:						
No of Attendances i Previous Attendance			Tel No: Fax No:						
To be seen in:	Resus a	10 May 1.4		at the fin	1				
Speciality Expected Specialty:	MEDIO	ime referred to s ime seen:	pecialty:	Duty/On		gency Department ultant:			
Presenting Complain	int:	- K							
Triage Nurse:	Tom (_		Time of Triage	13	30			
Presenting Complaint: «		-	10	Triage (ESI)	3				
History of Presenting Cor	mplaint: ושל שווי	cusco chest f	naum	Pain Score	10	/10			
Previous Medical History:	Charles and the second	aun, tadiaban	s to neck	Allergies	: N	o ಬಳ			
Social History: 110	es alone			Tetanus Status					
				Triage Treatment	EC(5, TO RESUS			
				Triage Notes					
Temperature	26.5	Blood Pressur	re (1,0) 450			Yes			
Temperature Pulse	36. S	Blood Pressur		Nurse Co		Yes = EVM=715			
Pulse	103	SP O² (Air)	98	Nurse Co	oncern	<u>Yes</u> EVM ^{±5} 715			
		and the second s		Nurse Co	oncern	Yes EVM=715			

Hosp No.: 789987

Name	Signature	Initials	Position	Speciality	Date	Time

Have you considered the use of a Chaperone when seeing this patient, Please refer to the Trust and Emergency Department Chaparone Policy.

Chaperone Used?

Name:

Presenting Complaint:

HISTORY: (Please continue on continuation sheets if necessary)

Pelpitchos

Age >65 3 Coronary Artery Disease (CAD) Risk Factors: Family history, raised cholesterol, diabetes mellitus, hypertension, active smoker Known CAD stenosis >50% Aspirin use in past 7 days Recent (<24 hours) severe angina Raised cardiac markers (CK) ST deviation TIMI Risk

Age >60	
BP >140/90	
Clinical features:	
Unilat weak (2 pts)	
Speech only (1 pt)	
Duration:	
>60 mins (2 pt)	
10-59 mins (1 pt)	
<10 mins (0 pt)	
Diabetic	
ABCD2	
Score (max 7)	

Women of Childbearing age? LMP:

Pregnant? Y / N

2

Voricos	veirs			
☐ Diabetes ☐ AF ☐ COPD ☐ Arthritis		☐ Hypertension ☐ Asthma	☐ IHD/Angi	ina cer
(Please tick relevant conditions if p	resent)			
Drugs		,		
Is the patient on anti-cancer medication Please contact Lead Chemo Nurse on		s, what?		
1.0				
N/A.				
		¥		
Allergies				
Drug		Reaction	3678 3	Date
		-		
			1	

	7 Hosp No.: 789987	¥ 5
Systematic Enquiry:		
		*
Family History		
Social History		
Alcohol:units/wee	k Smoking:	
Occupation:	Retired: Yes /N	0
Lives in: House / Flat / Bungal	ow / WCF / Residential Home / Nursing	Home/ Barracks
Surrey / Hampshire / Berkshire	e/ Other/ Not known	
Usually able to go out: Yes / N	lo Lives alone: Yes / No	Stairs: Yes / No
Mobility: Independent	Services: ☐ MOW Carer	r/s: None
☐ Stick	□ Bathing services	☐ Spouse
☐ Frame	☐ District Nurse	□ Other family
□ Wheelchair	☐ Day Centre	☐ Friend/ Neighbour
	□ Day Hospital	□ OD □ BD □ TDS □ QDS
Drives: Yes / No		
Use memory deffett been		
Has memory deficit been prese	ent for 6 months or more? Yes	□No
AMT (N/A)		
-	ion of two persons Time (to neare	
☐ Address for recall	□ WW2 □ Year	☐ Present monarch
☐ Location ☐ Count ba	ckwards 20 - 1	
	Score	/10
f Score 7 or below commence	dementia CQUIN ☐ Yes ☐	No

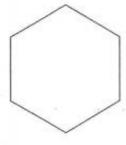
. Hosp No.: 789987 **EXAMINATION** Lymphadenopathy Cyanosed Clubbed Jaundiced Anaemic Cap Blood Glucose..... Temp General Impression: Cardiovascular HR reg / irreg BP sitting BP Standing (Remember >2 mins for Postural BPs) BP lying..... HS..... Murmur? Y N Carotid Bruit? Y N JVP Oedema Respiratory Sats on Air Sats on% 0, RR Best PEFR Predicted PEFR Current PEFR.....

Percussion / Auscultation



4/5

<u>Abdominal</u>



Ascites? Y / N		
PR		
PV		

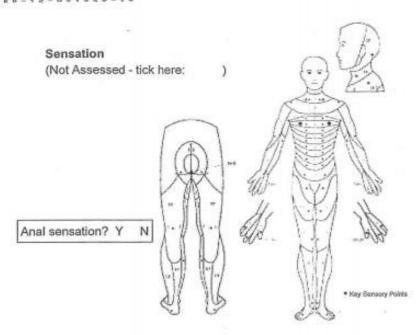
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bnormali	ties:							
	I No.							
eriphera	Nerves: (Not	Assessed	- tick here	e:)				
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Shoulders	abd (c5,6)			12	KIT.			
	add (c5,6,7)				100			
Elbaw	flex (c5,6)			Biceps (c5,6)				
	ext (c7,8)			Triceps (c7,8)				
Wrists	flex (c6,7,8)			Supinator (c6)				
	ext (c7,8)							
Hips	flex (11,2,3)		7				1	
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Hips	100000000000000000000000000000000000000			128 6 14		7/-		
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Hips Knees	ext (I5,s1,2) abd (I4,5,s1)			Knee (I2-4)				
	ext (I5,s1,2) abd (I4,5,s1) add (I2,3,4)			Knee (12-4)				
	ext (15,s1,2) abd (14,5,s1) add (12,3,4) flex (14,5,s1,2)			Knee (i2-4) Ankle (s1,2)			,	
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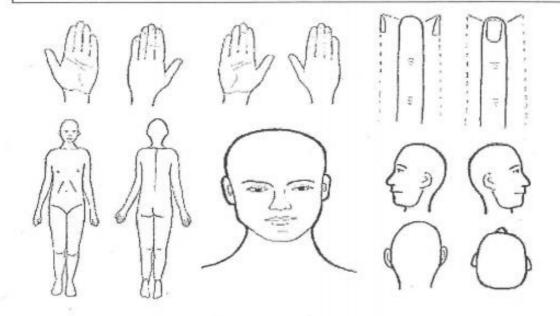
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Hosp No.: 789987





Other examination findings / comments:



				9						
vestigatio	ons:									
adiology:	□CXF	2	□ AXF	3	□СТНе	ead	□ Othe	эг	 	
esults:									 	
	(F)									
	□FВС									
	□U&Es		FTs		□Bone	9	□ CRP			
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	□U&Es		FTs		□Bone	9				
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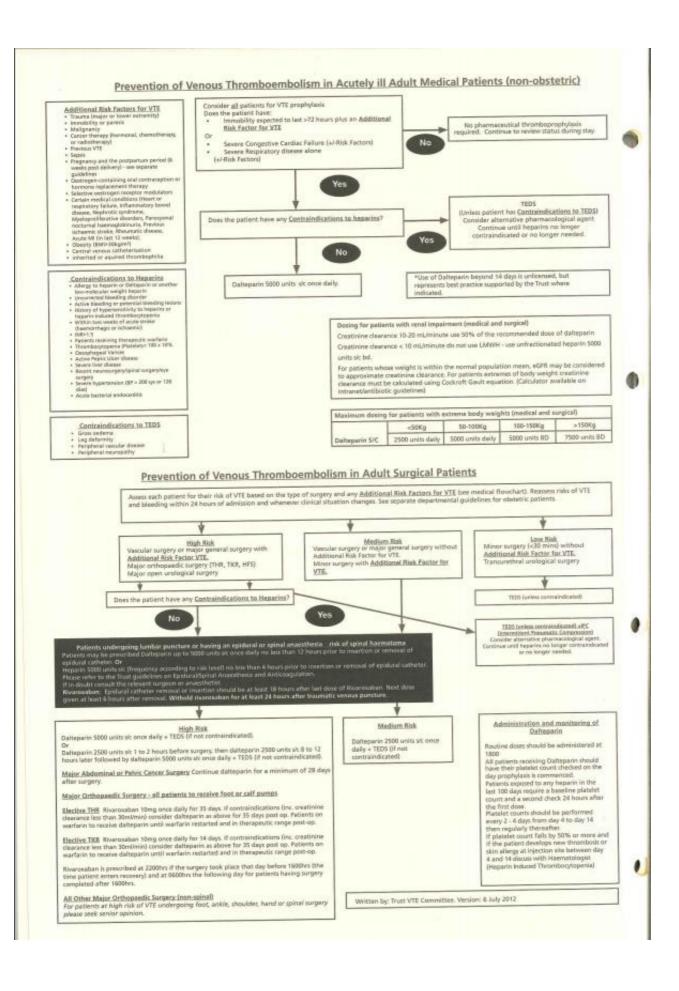
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TE Risk?				risk assessment sl				
		t - reasons	ted VTE propt s:	nylaxis?	Υ	N		
IRSA Statu				0.577				
IKSA Stati	ıs.			C. Diff status:				
	Y	N		For CPR? Orange sticker?	Y	N N		
let Calls	Υ			For CPR?		N		
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let Calls	Y iew: N	ame:		For CPR? Orange sticker?	ation:	N		
let Calls	Y iew: N	ame:		For CPR? Orange sticker? Design	ation:	N		

Time Date Signature

	51.4							
First Name(s):			Wa		100000000000000000000000000000000000000	e chart rted	Chart n	umber
Surname:	er:			ED .			of	1
NHS Number:	1734		Co	sultant		ctor bleep nber	Date of admissi	ion
Date weighed	Weight (kg)	Height (M)	Surface are	Ideal B Weight	ody t (IBW)	Body Mass Index (BMI)	Diet	6
Drug/substance			(nown)	ils of reactio	n		180	
Drug/substance				ls of reactio	n	6		
	so has the follow	ving additional c	Deta	11	elevant t	pox (es))		
This patient als	so has the follow	ving additional c Chemothe Epidural	Deta	11	elevant t			
This patient als	chart	Chemothe	Deta	11	elevant t		Sign and Bleep No.	Actions sign ar date
This patient all IV heparin infusion PCA	chart	Chemothe	Deta	11	elevant t		Bleep	sign ar
This patient all IV heparin infusion PCA	chart	Chemothe	Deta	11	elevant t		Bleep	sign ar
This patient all IV heparin infusion PCA	chart	Chemothe	Deta	11	elevant t		Bleep	sign ar

Date of referral to smoking cessation nurse:

FPH40 CSP 03/11



RISK ASSESSMENT RECORD SHEET FOR VENOUS THROMBOEMBOLISM (VTE)

- Please use in conjunction with Trust guidelines overleaf
 Please see separate Trust guidelines for obstetric patients

Thrombosis Risk	Patient Related	Procedure Related	Assessment	Assessment at 24 hours	Assessment	Assessmen
High	Previous VTE					
	Immobility expected to test >72 hours					
	Malignancy					
	Acute or chronic lung disease	1				
	Acute or chronic inflammatory disease					
	Chronic heart failure					
	Lower limb paralysis (excluding acute					
	stroke) Acute infectious disease, e.g. pneumonia					
	BMI >30kg/m2					
	Inharited or acquired thrombophilia					
	Pregnancy or less than 6 weeks post parturn					
	20000	Hip or Knee replacement				
		Hip fracture				
		Other major orthopaedic surgery				
		Surgical procedure tasting >30mins				
Medium	Oestrogen containing one! contraception or HRT	with additional VTE risk factor(s)				
	Selective sestrogen receptor modulators					
	Age > 60					
	Dehydration					
	Varicose vains with phiebitis	1				
		Minor surgical procedure with addisonal VTE risk factor(s)				
		Surgical procedure tasting >30mins with no additional VTE risk factors Plaster cast immobilisation of lower				
Low		limb				
Blooding State	None of above	None of above				
Bleeding Risk/ Contraindications	Patient Related	Procedure Related				
Se Skehelingeringer	Haemophilia or other known bleeding disorder					
	Thrombocytopenia (Platelets < 100 x		7			
	10 ⁵ fL) Within two weeks of acute stroke				_	
	(haemorrhagic or ischaemic) Severe hypertension (BP > 200 systolic or 120 diestolic)					
	Severe liver disease					
	Oesophageal Varices					
	Active Peolic Ulcer disease					
	Active bleeding or potential bleeding					
	lesions Major bleeding risk, existing anticoagulant therapy					
	Severe renal disease					
		Neurosurgery, spinal surgery or eye surgery Other procedure with high bleeding				
		risk Lumber puncture/spinatispidural in previous 4 hours or anticipated in				
čisk assessment per	rformed by	next 12 hours				
lignature						
The second secon	mation Leaflet given to patient		Yes No			

NCE O	NLY DRUG	S AND PREMEDICATION.							
ate	Time	Drug	Dose	Route	Prescriber Sig. GMC no.	Batch number (vaccines only)	Time given	Sig.	Pharm.
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REASO Date	NS FOR D	RUGS NOT ADMINISTERE		ONS TAKEN	Reason	(s) for non a	dministratio	n and action	(s) taken
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	STERED ENTER THE APPROPRIATE COD					31	REFUSED MABLE (NI
REGULAR PRE	SCRIPTIONS					() TIMES	S DATE
	Circle target satu	ention		Target oxygen satur	ration	0000	
OXYGEN		maintain specified oxy	gen saturation	88 to 92%	94 to 98%	1200	
PRESCRIBERS SIGNATURE			DATE			1890	y
Home Oxygen Indicated: YES Referral to Respiratory Nurse	/ NO for HDCF Date:			Other:	_	2200	
	confirm oxygen is being administered as virate is to be documented to the left of			2L Sign		Device	
PHARMACOLOGICAL YTE PROPHYLAXIS/TREATMENT IN	CLUDING NOACS		DOSE	ROUT	£		
PRESCRIBERS SIGNATURE	GMC No.		START	REVIEW	STOP		
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New	Previous Admission

C. Diff Status

New	Previous Admission

y Dosing	g Regin	ne 5mg/kg	3	3mg/kg		Other	
Time to be given	Dose (mg)	Prescribers signature GMC No.	Date of sig.	Start time of infusion	Given by: (sign)	Dute and Time blood level taken sign:	Gentamicin Levels mg/l
				н			
	Time to be	Time Dose to be (mg)	Time Dose Prescribers signature (mg) CIAC No.	Time Dose Prescribers Date of to be (mg) GMC No	Time Dose Prescribers Date of Start time to be (mg) GMC No.	Time Dose Prescribers Date of Start time Given to be (mg) Start time sign of by:	Time Dose Prescribers Date of Start time Given Dute and Time to be (mg) GMC No sign of by: blood level

General Guidance

- All antimicrobial prescriptions MUST follow the Trust's Antimicrobial Policies or MUST have been agreed by Microbiology. See full up to date policy on intranet.
- INDICATION, STOP AND REVIEW DATES MUST BE RECORDED ON THE CHART.
- CURB 65 score MUST be recorded for all community acquired pneumonia.
- Check previous relevant microbiology results before prescribing antibiotics and check new microbiology results daily. If a patient is not responding to treatment seek advice from a consultant microbiologist.
- Doses need to be adjusted to suit patient's age, size and renal function. To calculate creatinine clearance use calculator on intranet and see dose adjustments for antibiotics.
- All IV regimes MUST be reviewed at 48 hours and switched to oral if appropriate.

IV SWITCH GUIDELINES

If YES to all, consider change to ORAL	If YES to any, remain on IV
Patient able to swallow and tolerate oral fluids?	Oral route compromised?
Temperature settling and < 38°C for at least 48hrs?	Continuing serious sepsis?
Heart rate <100bpm for last 12hrs? (no unexplained tachycardia)	Febrile with neutropenia?
WCC between 4-12x10 ⁹ /L2	Specific indication / deep seated infection. (Meningitis, endocarditis, encephalitis, osteomylitis,
Oral formulation available?	neutropenia, cystic fibrosis, septicaemia, haematology/ immunocompromised pts, continuing sepsis, other
Others markers: BP stable Respiratory rate <20 breaths/min CRP returning to normal and less than 100 (adult)	severe infections as discussed with microbiology.) Seek microbiology advice if unsure.
Absence of mental confusion (when representing symptoms of infection)	No oral formulation available (seek microbiology advice on alternative)

NOTE: DRUGS MUST NOT BE ADDED TO BLOOD PRODUCTS	DDED 10	0 81.00	D PRODUCTS	2		Name:		-	
Does the patient require CMV negative blood? (Indicate as appropriate) Yes / No? Does the patient need irradiated blood? (Indicate as appropriate) Yes / No?	gative b	lood? (I	ndicate as approprise as appropriate) Ye	riate) Yes /	No?	Hospital Number:			
BLOOD PRODUCTS TO BE ADMINISTERED	INISTER	ED	1		NCLUDING	Date of Birth:	BULINS)		
Blood product	Total	Route	Drugs required to cover infusion (must be prescribed on once only section of chart)	Duration / rate of infusion	Signature GMC No.	Batch number/Unit number (Attach sticker)	Start time / stop time	Given by/ chsckad by	Did patient experience adverse reaction? (Yes/No) ◆
									Yes / No
									Yes / No
									Yes / No
									Yes / No
									Yes / No
									Yes / No
									Yes / No
									Yes / No
									Yes / No
									Yes / No

Drugs to be added		Il Route 0	Rate Of inhuson time				41414114			
	DRUGS TO BE ADMINISTERED BY INTRAVENDUS / SUBCUTANEOUS INFUSION	Infusion solution Drugs to be added								