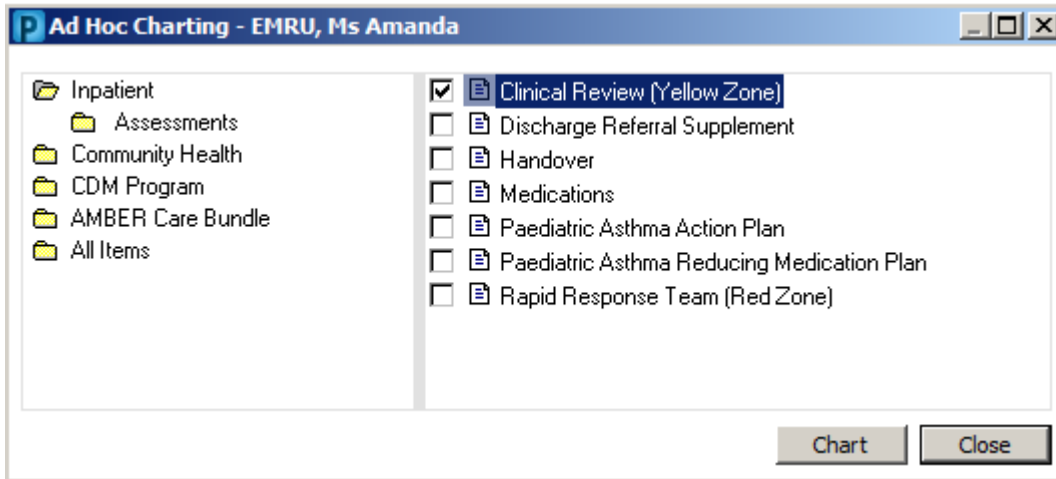


AD HOC CHARTING



SECTION 1

Clinical Review (Yellow Zone) - EMRU, Ms Amanda

*Performed on: 13/05/2014 10:58 AEST

Clinical Review

* CR Assess, Interv

CR All Responder

Clinical Review (Yellow Zone)

Last Reviewed:
July 2012

Emru, Amanda
Shop 6 3 Barncleuth Sq POTTS POINT NSW 2011

MRN: 550
SEX: F

DOB: 04/05/1966
AGE: 48 Years
LOC: 3W; 101; 1

MC: 99999999999

INTRODUCTION

Date / Time Patient in Yellow Zone

Date / Time Call Received

Date / Time Patient First Seen

Is the Patient on Std. Maternity Obs. Chart? Yes No

Senior Responder / Team Leader

Additional Responders? Yes No

Nurse In Charge Consulted? Yes No

SITUATION

Primary Reason for Clinical Review Activation

Other reasons for Clinical Review Activation - Yellow Zone Criteria (Tick all that apply)

| | | |
|--|--|---|
| <input type="checkbox"/> Respiratory Rate high | <input type="checkbox"/> Altered Mental State | <input type="checkbox"/> Concerns by family / patient |
| <input type="checkbox"/> Respiratory Rate low | <input type="checkbox"/> New, increasing or uncontrolled pain | <input type="checkbox"/> Other: |
| <input type="checkbox"/> SpO2 low | <input type="checkbox"/> Decreasing or absent deep tendon reflexes | |
| <input type="checkbox"/> Increasing O2 requirements | <input type="checkbox"/> Temperature high | |
| <input type="checkbox"/> Systolic Blood Pressure high | <input type="checkbox"/> Temperature low | |
| <input type="checkbox"/> Systolic Blood Pressure low | <input type="checkbox"/> Urine output low | |
| <input type="checkbox"/> Diastolic Blood Pressure high | <input type="checkbox"/> Urine output high | |
| <input type="checkbox"/> Diastolic Blood Pressure low | <input type="checkbox"/> Greater than expected fluid loss | |
| <input type="checkbox"/> Heart Rate high | <input type="checkbox"/> Cumulative blood loss | |
| <input type="checkbox"/> Heart Rate low | <input type="checkbox"/> Blood Glucose Level low | |
| <input type="checkbox"/> Poor peripheral circulation | <input type="checkbox"/> Proteinuria | |
| <input type="checkbox"/> AVPU Score = V (rousable only to voice) | <input type="checkbox"/> Concerns by staff | |

BACKGROUND

Previous Clinical Review / Rapid Response (Last 24 hrs)

Yellow Zone trigger without Clinical Review call

Yellow Zone trigger with Clinical Review

Red Zone trigger without Rapid Response call

Red Zone trigger with Rapid Response

Not Applicable

Current Medical Orders

Altered Calling Criteria Other:

Not for Rapid Response

Not for CPR

Natural Death / Palliative Care Pathway

Not Applicable

Background / History

SECTION 2

Clinical Review (Yellow Zone) - EMRU, Ms Amanda



*Performed on: 13/05/2014 1058 AEST

- * Clinical Review
- * CR Assess, Interv
- CR All Responder

Assessment, Interventions and Management Plan

Emru, Amanda **MRN: 550** **DOB: 04/05/1966** **AGE: 48 Years** **MC: 9999999999**
 Shop 6 3 Barncleuth Sq POTTS POINT NSW 2011 **SEX: F** **LOC: 3W; 101; 1**

ASSESSMENT

Airway

Tracheostomy? Yes No

Breathing

Circulation

Disability

Exposure, Fluids, Glucose

Impression / Provisional Diagnosis

Clinical Pathway Chest Pain Pathway Sepsis Pathway Stroke Pathway Other:

- Interventions** (Tick all that apply)
- | | | |
|---|--|--|
| <input type="checkbox"/> No specific intervention | <input type="checkbox"/> Nebulised Medications | <input type="checkbox"/> IV Medications |
| <input type="checkbox"/> CPR | <input type="checkbox"/> Cardiac Monitoring | <input type="checkbox"/> NGT/OGT |
| <input type="checkbox"/> Defibrillation | <input type="checkbox"/> ECG | <input type="checkbox"/> Oral/Enteral Medications |
| <input type="checkbox"/> Airway Management | <input type="checkbox"/> Intravenous Cannula | <input type="checkbox"/> X-Ray |
| <input type="checkbox"/> Intubation/Ventilation | <input type="checkbox"/> Central Venous Catheter | <input type="checkbox"/> CAT Scan |
| <input type="checkbox"/> Bag/Mask Ventilation | <input type="checkbox"/> ABG/VBG | <input type="checkbox"/> Attending Medical Officer contacted |
| <input type="checkbox"/> Oxygen therapy | <input type="checkbox"/> Blood Tests | <input type="checkbox"/> Family contacted |
| <input type="checkbox"/> CPAP/BIPAP | <input type="checkbox"/> IV Fluids | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Tracheostomy Care | <input type="checkbox"/> IV Antibiotics | |

RECOMMENDATIONS

Response to Interventions

Management Plan

Frequency of Observations

- Outcomes**
- | | |
|---|---|
| <input type="checkbox"/> Admitting team notified | <input type="checkbox"/> Transfer to Theatre |
| <input type="checkbox"/> Remains on ward | <input type="checkbox"/> Transfer to another hospital |
| <input type="checkbox"/> Altered Calling Criteria | <input type="checkbox"/> Died |
| <input type="checkbox"/> Rapid Response call | <input type="checkbox"/> Staff education |
| <input type="checkbox"/> Referred to palliative care | |
| <input type="checkbox"/> Transfer to higher level of care | |

Higher Level of Care

Date / Time CR Activity Completed **Total time spent attending to CR**

SECTION 3

