Ref: FOI/GS/ID 4747

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

27 June 2018

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Open fractures.

You asked:
1. Does the Trust perform surgery for open fractures?
2. Does the Trust have a specific guideline/policy regarding antibiotic prophylaxis for patients with open fractures?
o If yes, please could this be emailed to me
o If no, what is the commonest form of antibiotic propylaxis (and duration) that these patients are given?

Trust response:
1. We do perform surgery for open fractures
2. Please see the following document. The relevant details can be found on pages 13 and 14 and have been marked.

This image cannot currently be displayed.

Name____________________ Date of birth___/____/____ Number__________________

A&E FAST TRACK PROTOCOL

Age 60 or above ☐

Clinical examination ☐ Neurovascular status Intact ☐

ANALGESIA PRESCRIBED AND GIVEN ☐

AP Pelvic X-Ray		☐	Lateral Hip X-Ray	☐
Catheter		☐	IV Fluids	☐
Chest X-ray		☐	12 lead ECG	☐
Blood tests:	FBC	☐	U&E	☐
	G&S	☐	Calcium	☐
	Clotting	☐	Urinalysis	☐

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

REVIEWED BY ORTHOPAEDICS ☐

On call agreed to admit by (name)__________________ Time__________________

Person Fast tracking __________________ Signature__________________

Time moved to ward __________________

Patient is NOT appropriate for Fast Tracking if

- Any evidence of acute cardiovascular or respiratory compromise
- Urgent medical or other specialty review required on admission
- Diagnosis of fractured neck of femur is in doubt

Name____________________ Date of birth___/____/____ Number________________

DEMENTIA CQUIN

Date completed		Time completed	
Form Completed By		Initials	
Exclusion Applicable?	☐ No. Complete Step 1	☐ Yes. Circle relevant exclusion	
Exclusions	Coma, Critical Illness, Severe speech and/or Language Impairment, Elective Admission, Day Case, Terminally Ill / Palliative Care		

STEP 1

Question	Source	Response	Action
Q1 Does the patient have a known diagnosis of dementia?	☐ GP ☐ Notes ☐ Other (specify):	Yes	Request Antipsychotic drug review (if required).
		No	Proceed to Q2
		Not known	Proceed to Q2 & make further enquiries within 72 hours
Q2 Has the person been more forgetful in the last 12 months to the extent that it has significantly affected their daily life?	☐ Patient ☐ GP ☐ Carer / Relative ☐ Other (specify)	Yes	Step 2 to be filled & inform Orthogeriatrician
		No	Normal Care
		Not known	Make further enquiries within 72 hours
Q3 Does the patient have a delirium?	☐ Clinical ☐ Short CAM ☐ Other (Specify)	Yes	Proceed to Step 2 & inform Orthogeriatrician.
		No	Normal Care

THIS FORM IS COMPLETE IF ANSWERS TO ALL 3 QUESTIONS ABOVE ARE 'NO'

STEP 2 ASSESS & INVESTIGATE

Investigations	Outcome		Action
Urinanalysis Dipstick & MSU ☐	Dementia likely ☐	AMTs < 8 (without delirium)	Perform formal memory assessment and inform Orthogeriatrician
CXR if clinically indicated and not done recently ☐	Inconclusive ☐	In the presence of delirium	Inform Orthogeriatrician
CT/MRI brain if clinically indicated ☐	Dementia unlikely ☐	AMTs > 8	Normal care

Medication Review Done by Orthogeriatrician	Yes	Proceed to next step
	No	Inform Orthogeriatrician & proceed to next step
Subsequent Review within 3 months has been recommended to GP	Yes	Proceed to next step
	No	EDN to be updated

STEP 3 REFERRALS

GP must be informed of the results of Step 1 & 2 in the Electronic Discharge Summary.			Check & initial here
GP information updated? (details filled in discharge summary including AMTS result)	Yes	No	
If required, has referral to Old Age Psychiatry Team been made?	Yes	No	
Has referral to Orthogeriatrician been made?	Yes	No	

Name______________________ Date of birth___/_____/____ Number____________________

ORTHOPAEDIC CLERKING

EPISODE DETAILS

Date patient seen		Time seen	
Patient's location		Referrer	GP / A&E / Ward
Clerking Doctor		Grade of Doctor	
Usual Bleep number		Responsible Consultant	

PRESENTING COMPLAINT(s)

Source of history (patient, relative, carers, SECAMB form etc)

Presenting complaint (s) & mechanism of fall

History of Presenting Complaint(s)

Events leading to any fall

- ☐ Clear story of trip, slip or accident,
- ☐ Palpitations, chest pain, SOB
- ☐ Aura, fit, tongue biting
- ☐ Dizzy, light headed, pale sweaty
- ☐ Other associated medical symptoms
- ☐ Unexplained loss of consciousness

Number of falls in the last 6 months = ____________________

Name Date of birth / / Number

History of Presenting Complaint(s) continued

No Pain · Mild Pain · Moderate Pain · Severe Pain · Very Severe Pain · Worst Possible Pain

PAST MEDICAL HISTORY

☐ Hypertension	7.
☐ Ischaemic heart disease	8.
☐ Heart failure	9.
☐ Hypothyroidism	10
☐ Osteoporosis	
☐ Diabetes mellitus	
1.	
2.	
3.	
4.	
5.	
6.	

Name________________ Date of birth___/____/____ Number________________

Current Medication including self-medication IN CAPITALS

Approved name	Dose	Frequency	Indication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14			
15.			
16.			
17.			

Allergies & Adverse Reactions (include details of reaction)

Name________________________ Date of birth___/____/____ Number____________________

Abbreviated Mental Test Score

(Score Zero if unable to answer questions)

On admission ___/___/______		**Post Operatively on date** ___/___/______	
Age	☐	Age	☐
Time (to nearest hour)	☐	Time (to nearest hour)	☐
Give address to recall		Give address to recall	
(check for correct recall at end of test)		(check for correct recall at end of test)	
Year	☐	Year	☐
Name of this place	☐	Name of this place	☐
Identify two people	☐	Identify two people	☐
Date of birth	☐	Date of birth	☐
Year World War began	☐	Year World War began	☐
Current Monarch	☐	Current Monarch	☐
Count backwards from 20	☐	Count backwards from 20	☐
Address recall	☐	Address recall	☐
Score out of 10	☐	**Score out of 10**	☐

Social & Mobility History

Lives alone? ☐ Yes ☐ No and lives with ....

Admitted from:

☐ Own home / sheltered housing ☐ Residential home ☐ Nursing home ☐ EMI home

☐ Rehabilitation Unit ☐ Already in hospital

☐ Stairs Yes / No (internal / external)

☐ Lift Yes / No

☐ Toilet downstairs Yes / No Everything on one level? Yes / No

Carers ☐ once daily ☐ twice daily ☐ thrice daily ☐ four times daily

Mobility ☐ Unaided ☐ Walking stick ☐ Zimmer frame ☐ Tripod

☐ Wheelchair ☐ Bedbound ☐ other ....

Is the patient accompanied to walk indoors? Yes / No Outdoors? Yes / No

☐ Current smoker per day for year

☐ Former smoker per day for year

☐ Never smoked

☐ Alcohol units per week

Name Date of birth / / Number

Observations and Findings

General appearance	Nutritional status (good / *moderate / poor) MUST score*		
Vital signs	Date & time		
BP		RR	HR
Temp		O2 Saturation	NEW Score
Weight	Height		BMI

Hearing Good Impaired Deaf right / left / bilateral

Eyesight Good Impaired Blind right / left / bilateral Neglect

Glasgow Coma Scale E(4); V(5); M(6) ______ / 15 (AMTS above –if confused GCS will be ≤14)

Cardio Vascular System	
Respiratory System	
Abdomen	PR examination: Catheter: This admission / Long term
Hip Examination	Circulation normal ☐ Skin intact ☐ Sciatic nerve normal ☐ Sensation ☐ Shortened ☐ Abnormalities noted: Externally rotated ☐
Cranial Nerves	II Visual fields III / IV / VI IX VII X VIII XI XII

Name________________ Date of birth___/____/____ Number________________

Peripheral Neurology	RUL	LUL	RLL	LLL
Tone				
Power				
Sensation				
Reflexes				

Pulses

Pressure Areas

Grading of any existing wounds

RELEVANT LEGAL INFORMATION

Mental Capacity Act (MCA)

Does the patient have an abnormality of brain or mind that could affect their ability to make decisions about medical treatment for themselves? YES / NO

Are you concerned the patient does not have the mental capacity to make the decision that needs to be made? YES / NO

If the answer is yes to the above questions, then you must complete the Trust MCA assessment form and then follow the best interest processes in line with the MCA and a Consent Form 4 should be completed.

Has the patient made an advance decisions to refuse specific medical treatment? If so detail the evidence provided and check it is valid and covers relevant care refusals.
Is there a Lasting Power of Attorney for health and welfare decisions? If so detail the evidence provided and check that it is registered and valid and that it covers the decision(s) to be made.
If the patient lacks the mental capacity to make their own decisions and are un-befriended with no family or friends you have a duty to refer the patient to the IMCA service for an advocate to be allocated to work with that patient.

Does the patient make persistent attempts to leave the hospital and does not have the mental capacity to understand why then need care or treatment in hospital? If so consider an urgent Deprivation of Liberty Safeguards application – seek advice from the Matron for Safeguarding Adults or the site practitioner.

Name________________________ Date of birth___/____/____ Number_______________________

INVESTIGATIONS

Hip / Pelvis X-Ray

Intracapsular	Displaced	☐	Undisplaced	☐	
Extracapsular	Basicervical	☐	Intertrochanteric	☐	Subtrochanteric
Side of fracture	Left	☐	Right	☐	
Any sign of pathological fracture?			**YES**	☐	**NO**

If **YES** then request **AP & Lateral Whole Femur**

NOTTINGHAM HIP FRACTURE SCORE

30 day mortality = %

DIAGNOSIS

1.
2.
3.
4.
5.
6
7
8
9
10

NOTE

OMIT the following medicines pre-operatively, where applicable

- Warfarin until Orthogeriatrician review. Reverse INR according to earlier algorithm.
- Other oral anticoagulants (Rivaroxaban, Dagibatran, Apixaban etc)
- Antiplatelets (clopidrogrel, dipyridamole, aspirin)
- Angiotension converting enzyme (ACE) inhibitors e.g. ramipril
- Angiotension II receptor antagonists (ARBs) e.g. candersartan
- Oral hypoglycaemics e.g. metformin, sulphonylureas, then according to local Trust guidelines guidance of Peri-operative Management of Diabetes Mellitus,
- prescribe sliding scale insulin with appropriate IV fluids if needed.

CONTINUE all beta blockers e.g. atenolol, bisoprolol pre-operatively

CONTINUE all other medicines pre-operatively unless instructed otherwise.

Seek advice from pharmacist or physicians if in doubt.

Name____________________ Date of birth___/____/____ Number__________________

MANAGEMENT PLAN

- ☐ **Nil by mouth from ____:____ on ___/____/____**

  (Pre surgery : 2hrs clear fluids, 6 hrs food and milk)
- ☐ Consent signed
- ☐ Site Marked
- ☐ VTE form completed
- ☐ AMTS and Dementia CQUIN Completed
- ☐ NUTRICIA PRE-OP DRINKS (2-4 cartons up to 2hrs pre-op)
- ☐ Cardio-respiratory / Neurovascular observations every.................................hours
- ☐ Adequate analgesia (prescribe I.V Paracetamol, PRN Oromorph +/- Morphine)
- ☐ Oxygen if required. (If COPD, maintain saturations between 88 - 92%)
- ☐ IV Fluids (prescribe 1litre Hartmanns 12hrly. Seek advice On Call Medical advice if known CCF)
- ☐ DVT Prophylaxis prescribed – if not, state reason ....

  To be given 18:00 if patient for surgery tomorrow morning
- ☐ If INR raised, use the reversal algorithm.
- ☐ Skin traction 5lbs if indicated
- ☐ Antibiotic prophylaxis for operation

  Teicoplanin 400mg IV (if from care home)

  Cefuroxime 1.5g IV (from own home)
- ☐ Orthopaedic Registrar contacted
- ☐ Patient and / or next of kin are informed as to risks following Fractured NOF

  (including 16% in-patient mortality in the over 85s)
- ☐ (If needed) OnCall Medical review requested at _____:_____ on _____/_____/_____
- ☐ Anaesthetist On-call contacted for review at _____:_____ on _____/_____/_____

MUST HAVE SURGERY WITHIN 36 HOURS OF ADMISSION!

Name Date of birth / / Number

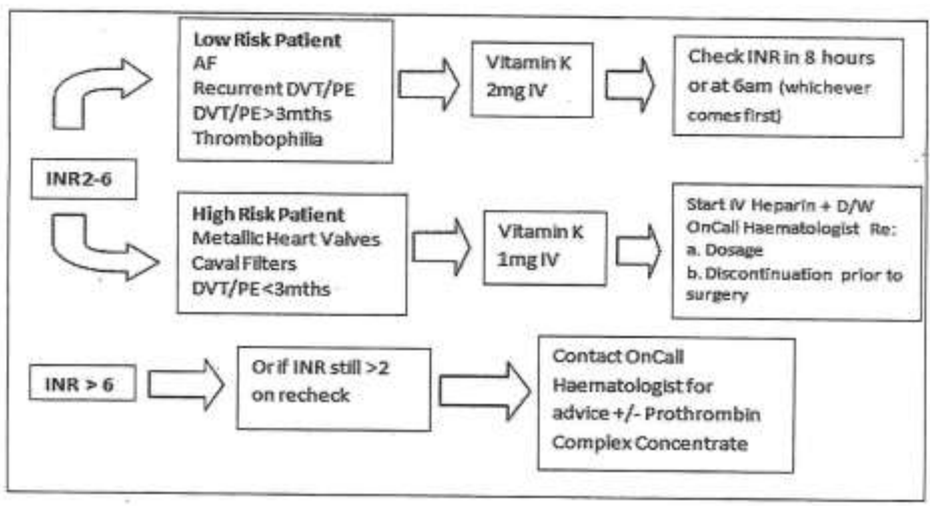
ADMISSION INVESTIGATIONS (& Anaesthetic Checks)

Date:					
Hb			Na		
WCC			K		
Neutrophils			Creatinine		
Plt			Calcium		
MCV					
INR					
ECG					
CXR					
Urine Dip result	Nitrites ☐	Leucocytes ☐	Protein ☐	Blood ☐ Ketones ☐	MSU Sent ☐

Group & Save ☐

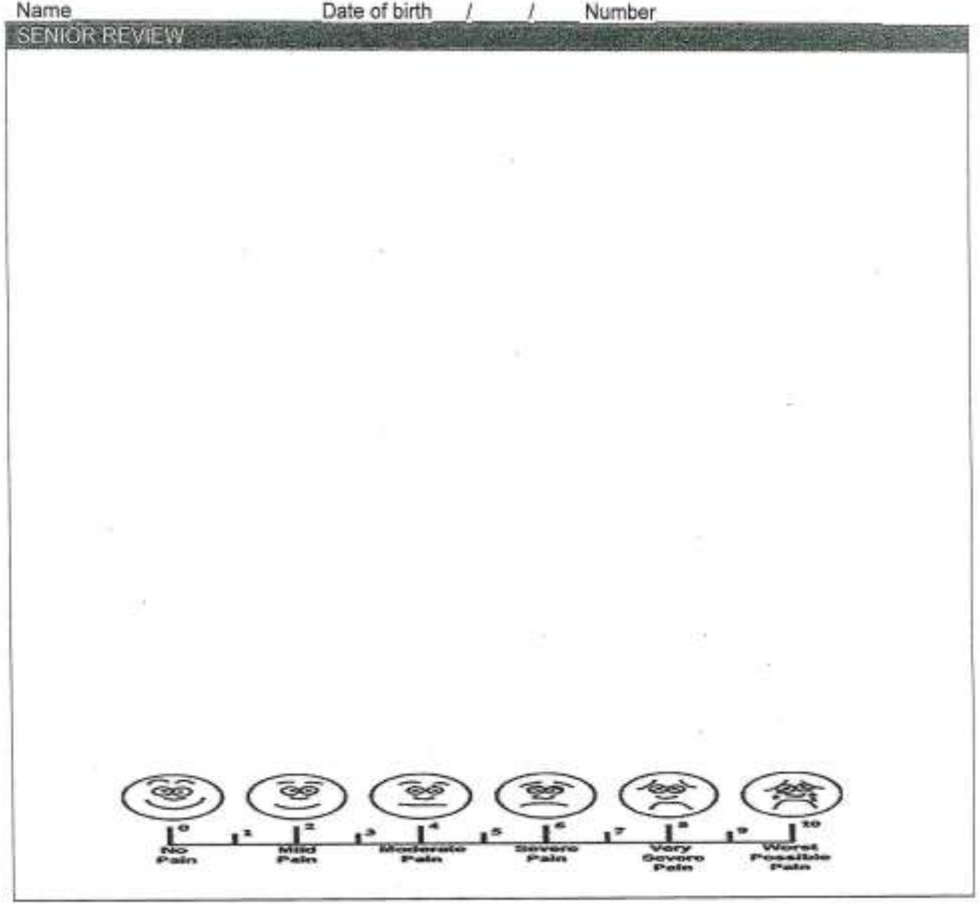
Transfuse if Hb <9 pre-op ☐ **Number of units** ______

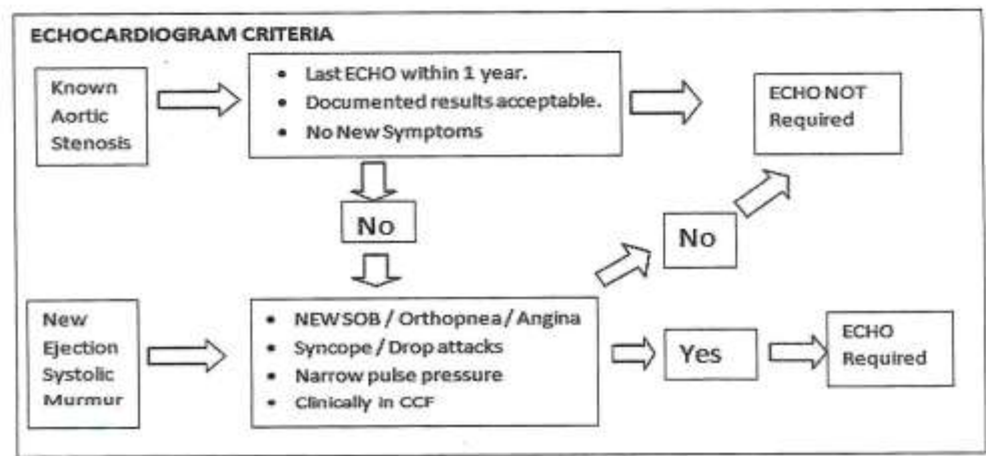
INR Management (Stop WARFARIN on admission)



Name Date of birth / / Number

SENIOR REVIEW





Name________________ Date of birth___/____/____ Number________________

POST TAKE WARD ROUND

Consultant | Date | Time

Investigations reviewed

Bloods ☐ Hip X-ray ☐ Chest X-Ray ☐ ECG ☐ Urine ☐

Working / differential diagnosis

1.

2.

3.

4.

Management plan

1.

2

3.

4.

5.

IF NOT FOR SURGERY WITHIN 36 HOURS OF FRACTURE DIAGNOSIS STATE WHY

Name .... Designation ....

Signature....................................... Date .... Bleep..................................

Name________________ Date of birth___/____/___ Number________________

GERIATRICIAN REVIEW (must occur within 72 hours of fracture diagnosis)

Doctor.. Grade..........................

Date .... Time............................

Likely Cause of Falls

- Postural Instability ☐
- Postural hypotension ☐
- Syncope ☐
- Unexplained fall ☐
- Accidental ☐
- Poor safety awareness ☐
- Others (please specify) ☐

Investigations For Falls

- Physio balance assessment ☐
- Lying and standing BP ☐
- 24 / 48 hr tape ☐
- Echo ☐
- Tilt test ☐
- Fill Falls Proforma ☐
- No intervention required ☐

Bone protection

Patient <75yrs: DEXA scan ☐

Patient >75yrs :

- Already on treatment ☐
- Check Vitamin D & Calcium ☐
- Oral Calcium + Vitamin D3 supplements ☐
- Alendronate once weekly (if renal function,Vit D levels normal able to comply and safely swallow) ☐
- Unable to take bisphosphonate ☐
- GP to refer for Denosumab ☐
- FRAX / QFracture Score ☐

Name Date of birth / / Number

PRE SURGERY REVIEWS

Date..Time.......................

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Name________________ Date of birth___/___/___ Number________________

OPERATION NOTES

Surname Forename Date of birth NHS number Hospital number		Date Of Surgery Time Of Surgery Responsible Consultant
Operation Code	Surgeon	Assistant
Anaesthetist	Type of Anaesthetic	Scrub Nurse
OPERATION PERFORMED		

Name________________ Signature________________________

Name________________________Date of birth___/_____/____ Number____________________

IMPLANT STICKERS

Post-operative instructions

WEIGHTBEARING STATUS

Name__________________________Signature_________________________________

Name________________________Date of birth___/_____/____ Number______________________

ORTHOPAEDIC POST OPERATION REVIEW

Date...   Time..

Reviewed By..

Neuro-vascular status of operated leg:

Hb........................(Transfuse if Hb <8)

Check x-ray...

Full weight bearing / Partial weight bearing / NON weight bearing

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Name ....   Designation ....

Signature.......................................   Date ....   Bleep................

Name____________________ Date of birth___/____/____ Number__________________

4AT

To Be Done Within 24-36 Hours After Surgery

The 4 'A's Test: screening

		CIRCLE
[1] ALERTNESS *This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.*		
	Normal (fully alert, but not agitated, throughout assessment)	0
	Mild sleepiness for <10 seconds after waking, then normal	0
	Clearly abnormal	4
[2] AMT4 *Age, date of birth, place (name of the hospital or building), current year.*		
	No mistakes	0
	1 mistake	1
	2 or more mistakes/untestable	2
[3] ATTENTION *Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.*		
Months of the year backwards	Achieves 7 months or more correctly	0
	Starts but scores <7 months / refuses to start	1
	Untestable (cannot start because unwell, drowsy, inattentive)	2
[4] ACUTE CHANGE OR FLUCTUATING COURSE *Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs*		
	No	0
	Yes	4

4 or above: possible delirium +/- cognitive impairment
1-3: possible cognitive impairment
0: delirium or severe cognitive impairment unlikely
(but delirium still possible if [4] information incomplete)

4 AT SCORE : ______

GUIDANCE NOTES

Version 1.1. Information and download: www.the4AT.com

The 4AT is a screening instrument designed for rapid initial assessment of delirium and cognitive impairment. A score of 4 or more *suggests* delirium but is not diagnostic: more detailed assessment of mental status may be required to reach a diagnosis. A score of 1-3 suggests cognitive impairment and more detailed cognitive testing and informant history-taking are required. A score of 0 does not definitively exclude delirium or cognitive impairment: more detailed testing may be required depending on the clinical context. Items 1-3 are rated *solely on observation of the patient at the time of assessment*. Item 4 requires information from one or more source(s), eg. your own knowledge of the patient, other staff who know the patient (eg. ward nurses), GP letter, case notes, carers. The tester should take account of communication difficulties (hearing impairment, dysphasia, lack of common language) when carrying out the test and interpreting the score.

Alertness: Altered level of alertness is very likely to be delirium in general hospital settings. If the patient shows significant altered alertness during the bedside assessment, score 4 for this item. **AMT4 (Abbreviated Mental Test - 4):** This score can be extracted from items in the AMT10 if the latter is done immediately before. **Acute Change or Fluctuating Course:** Fluctuation can occur without delirium in some cases of dementia, but marked fluctuation usually indicates delirium. To help elicit any hallucinations and/or paranoid thoughts ask the patient questions such as, "Are you concerned about anything going on here?"; "Do you feel frightened by anything or anyone?"; "Have you been seeing or hearing anything unusual?"

Name Date of birth / / Number

FALLS ASSESSMENT

NOT REQUIRED? ☐ **If so, state reason:**

Brief description of fall

Number of previous falls in last year

Brief details

Relevant Medical History (Tick all that apply)

Current delirium	☐	Cognitive impairment/ dementia	☐
Stroke	☐	Other chronic neurological disease	☐
Degenerative joint disease	☐	Visual impairment	☐
Syncope	☐	Epilepsy	☐
Urinary incontinence	☐	Other (please specify)...................................	

Medication Review			Appropriate?		Action Taken
On 4 or more medications?	Yes	No	Yes	No	
On night sedation ?	Yes	No	Yes	No	
On anti-depressant ?	Yes	No	Yes	No	
On anti-hypertensives	Yes	No	Yes	No	
On anti-coagulation	Yes	No	Yes	No	

All psychoactive medications increase the risk of falls – consider discontinuing if appropriate.
Antihypertensives can cause orthostatic hypotension.
Anticoagulants increase bleeding risk and may cause harm. Weigh up risks and benefits. POSTURAL BLOOD PRESSURE

Lying BP	mmHg	mmHg
Standing BP	mmHg	mmHg

*If **symptomatic** significant drop (at least 20mmHg systolic or 10mmHg diastolic), review possible causes and consider treatment options.*

Name________________ Date of birth___/___/___ Number________________

Neurological Examination			Done at admission ☐	
Peripheral	**RUL**	**LUL**	**RLL**	**LLL**
Tone				
Power				
Sensation				
Reflexes				
Vibration				

Visual Acuity			
Left Eye		Right Eye	

If vision impaired, assess likely cause and consider optician/ ophthalmology referral

Record ECG	

If ECG abnormal, with syncope or an unexplained fall, consider 24hour tape

LIKELY CAUSE(S) OF FALL

Interventions	**Tick when done**
Ensure patient has appropriate footwear	
Ensure call bell within reach	☐
Ensure patient has appropriate walking aids (if applicable)	☐
Low-profiling bed needed?	☐
Refer to physiotherapy	☐
Supply Falls Information leaflet	☐

Other Interventions Performed

Assessment completed by.................................Date.....................

Name ____________ Date of birth __/__/__ Number ____________

PHYSIOTHERAPIST Post Operative Review

Date.. Time..

Reviewed By..

Full weight bearing / Partial weight bearing / NON weight bearing

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Able to Stand Day 1 Post Op? Yes / No

If No, Reason : Delirium / Hypotension / Hypotension / Anaemia <8 / Anxiety / Refused / Other

Physio Goals:

Name .... Designation ....

Signature.. Date .... Bleep................

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

0 No Pain, 1, 2 Mild Pain, 3, 4 Moderate Pain, 5, 6 Severe Pain, 7, 8 Very Severe Pain, 9, 10 Worst Possible Pain

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed

0 No Pain | 1 | 2 Mild Pain | 3 | 4 Moderate Pain | 5 | 6 Severe Pain | 7 | 8 Very Severe Pain | 9 | 10 Worst Possible Pain

Name________________________Date of birth___/____/____ Number____________________

To Be Done 4 – 7 Days After Surgery

The 4 'A's Test: screening

		CIRCLE
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[4] ACUTE CHANGE OR FLUCTUATING COURSE *Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs*		
	No	0
	Yes	4

4 AT SCORE :______

4 or above: possible delirium +/- cognitive impairment
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0: delirium or severe cognitive impairment unlikely
(but delirium still possible if [4] information incomplete)

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Name____________________ Date of birth___/____/____ Number__________________

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)	
Dated & timed	

0 No Pain | 1 | 2 Mild Pain | 3 | 4 Moderate Pain | 5 | 6 Severe Pain | 7 | 8 Very Severe Pain | 9 | 10 Worst Possible Pain

Name_______________ Date of birth ___/___/___ Number_______________

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

0 1 2 3 4 5 6 7 8 9 10

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Name ______ Date of birth ___ / ___ / ___ Number ______

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

0 No Pain, 1, 2 Mild Pain, 3, 4 Moderate Pain, 5, 6 Severe Pain, 7, 8 Very Severe Pain, 9, 10 Worst Possible Pain

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed

0 No Pain | 1 | 2 Mild Pain | 3 | 4 Moderate Pain | 5 | 6 Severe Pain | 7 | 8 Very Severe Pain | 9 | 10 Worst Possible Pain

Name____________________ Date of birth___/_____/____ Number____________________

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Worst Possible Pain

Name________________ Date of birth___/___/___ Number________________

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)	
Dated & timed	

0 No Pain | 1 | 2 Mild Pain | 3 | 4 Moderate Pain | 5 | 6 Severe Pain | 7 | 8 Very Severe Pain | 9 | 10 Worst Possible Pain

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

No Pain — Mild Pain — Moderate Pain — Severe Pain — Very Severe Pain — Worst Possible Pain

Name________________________ Date of birth___/_____/____ Number____________________

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)	
Dated & timed	

No Pain | Mild Pain | Moderate Pain | Severe Pain | Very Severe Pain | Worst Possible Pain

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

0 1 2 3 4 5 6 7 8 9 10

No Pain · Mild Pain · Moderate Pain · Severe Pain · Very Severe Pain · Worst Possible Pain

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

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Dated & timed	

Name Date of birth / / Number

Multi Disciplinary Notes (Geriatrics, Orthopaedics, Nursing & Therapists)

Dated & timed	

Name________________________ Date of birth___/____/____ Number________________________

DATE									
Hb									
WCC									
Plt									
MCV									
Neut									
INR									
PT									
ESR									
CRP									
Na									
K									
Creat									
Bili									
AlkP									
AST									
Albumin									
Protein									
Ca									
Adj Ca									
Mg									

Date:					
B12		TSH		Plasma protein electrophoresis	
Folate		fT4			
Vitamin D				Urine electrophoresis (where indicated)	

Date	O2 Conc.	pH	pCO2	pO2	BE	HCO3	Lactate