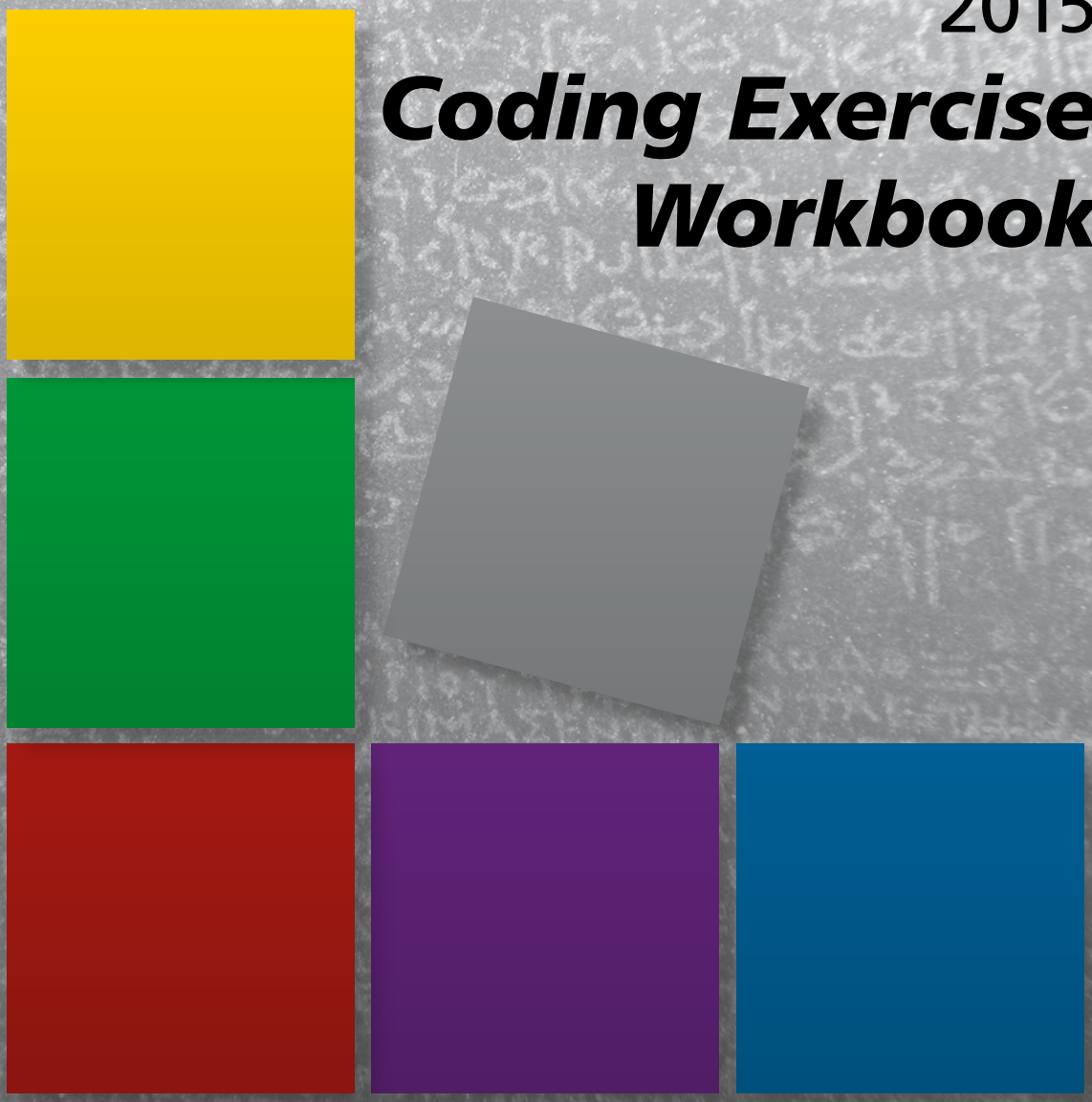
ICD-10-AM/ACHI/ACS

Ninth Edition

2015

Coding Exercise Workbook



Australian Consortium for Classification Development

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ICD-10-AM/ACHI/ACS Ninth Edition

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Australian Consortium for Classification Development

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THE UNIVERSITY OF SYDNEY
NATIONAL CENTRE FOR CLASSIFICATION IN HEALTH

University of Western Sydney

KPMG

ICD-10-AM/ACHI/ACS Ninth Edition Coding Exercise Workbook

Address all correspondence to:

Independent Hospital Pricing Authority
PO Box 483
Darlinghurst, NSW, 1300
Australia

OVERVIEW

The material contained in the *ICD-10-AM/ACHI/ACS Ninth Edition Coding Exercise Workbook* should be reviewed in conjunction with ICD-10-AM/ACHI/ACS Ninth Edition and the *Reference to Changes for ICD-10-AM/ACHI/ACS Ninth Edition*.

This Workbook includes questions designed to provide clinical coders with an overview of areas of major change. Some questions require review of clinical records. Only assign ICD-10-AM, ACHI codes and the condition onset flag as instructed in individual questions. Answers are provided in Chapter 17 of the Workbook.

Clinical coders should also familiarise themselves with the full range of updates by reviewing the *Reference to Changes for ICD-10-AM/ACHI/ACS Ninth Edition*.

VERSION CONTROL

Since original release, the following three updates have been made:

- Clinical record 3 - scenario should be:
  '…admitted to NCCH Hospital on the 5/12/14 for an arthroscopic repair of his right **diabetic** rotator cuff tear**/syndrome** under Dr Kong.'
- Case scenario 4.8 – answer should be:
  L89.15 (2) Pressure injury, stage II, ischium
  L89.19 (2) Pressure injury, stage II, other site of lower extremity (excluding heel and toe)
  L89.09 (1) Pressure injury, stage I, other site of lower extremity (excluding heel and toe)
- Case scenario 9.6 – answer should be:
  Z41.82 Food challenge
  ~~T78.1 Other adverse food reactions, not elsewhere classified~~
  L50.0 Allergic urticaria
  Y57.9 Drug or medicament, unspecified
  Y92.22 Place of occurrence, Health service area

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GLOSSARY OF ABBREVIATIONS

ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
COF	condition onset flag
CVS	continuous ventilatory support
ICD-10	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
IHPA	Independent Hospital Pricing Authority
ITG	ICD Technical Group
MBS	Medicare Benefits Schedule
URC	Update and Revision Committee
WHO	World Health Organization
WHO-FIC	WHO Family of International Classifications
WHO-URC	WHO ICD-10 Update and Revision Committee

1. Supplementary codes for chronic conditions

1.1 Which standard contains instructions for assignment of supplementary U codes?

a) ACS 0001

b) ACS 0002

c) ACS 0003

d) ACS 0004

1.2 What is the Alphabetic Index pathway to look up the new supplementary codes?

1.3 Which three criteria in ACS 0003 render a condition ineligible for assignment of a supplementary U code?

a) in addition to another chapter code for the same condition

b) where a condition persists less than one year after diagnosis

c) for a past history of a condition

d) for an acute condition

e) when ongoing drug therapy is provided

1.4 Supplementary codes will impact the DRG allocation. True or False?

1.5 Complete this sentence from the ACS 0003 Classification instruction:

Where the decision is unclear whether a code from U78.- to U88.- should be assigned,

_____

_____

_____

1.6 Which of the following conditions would ***not*** be eligible for assignment of U codes?

a) obesity
b) intellectual impairment
c) acute renal failure
d) breast cancer
e) hypertension
f) Parkinson's disease
g) osteoarthritis
h) psychosis
i) hemiparesis
j) multiple sclerosis

1.7 Assign U codes to the following conditions:

a) Alzheimer's dementia
b) intellectual impairment
c) epilepsy
d) coronary atherosclerosis
e) hypertension
f) multiple sclerosis
g) depression

1.8 Case scenario

Read the following operation report and identify which condition(s) should be assigned a U code?

_____

_____

_____

Operation Report

Attending M.O.: G, INTESTINE
Admission Date: 24/10/20xx Medical Service: GENERAL SURGERY
Discharge Date: 24/10/20xx

Date of Operation: 24/10/20xx

Background
Hypertension
Down's syndrome

Indications
Acute appendicitis

Primary Operation Performed
Appendicectomy

Other Operations performed
General anaesthesia, ASA 1

Specimens sent to pathology
appendix

Post Operative Orders
PANADOL: PAIN RELIEF
TO BE DISCHARGED BY CLINICIAN WHEN DEEMED FIT
Post Operative follow up
AT GP IN 1 WEEK

1.9 Clinical record 1

From the clinical record below, which conditions should be assigned a U code?

Clinical record 1 – Supplementary codes for chronic conditions

DISCHARGE SUMMARY

Admission Date:	24-FEB-2014	**Discharge Date:**	28-FEB-2014

Background History:
Thank you for the ongoing care of Mrs XXXX, a 68 year old woman who was admitted for pacemaker insertion for AF.

Background
atrial fibrillation
hypertension
hypercholesterolaemia
shingles
dilated ascending aorta
obesity

Problems/Alerts and Diagnoses:
Diagnoses (being addressed in this visit)

Principal Diagnosis	**Dx Type**	**Date**	**Confirmation**
Persistent atrial fibrillation	Discharge	28-FEB-2014	Confirmed

Alerts: Nil

Allergies: Nil

Medications on Discharge/Current:

Medication	**Modified Release**	**Dose**	**Unit**	**Freq**	**Route**	**Duration**	**Dispensed**	**Reason for Change/ Indication**	**Item Status**
Allopurinol		300	mg	nocte	po		No		Pre-existing
Perindopril		10	mg	nocte	po		No		Pre-existing
rosuvastatin		20	mg	nocte	po		No		Pre-existing
Thyroxine		50	mg	daily	po		No		Pre-existing
Fish oil		1tablet		daily	po		No		Pre-existing
Senokot		2 tablets		daily	po		No		Pre-existing
glucosamine sulfate		1 tablet		nocte	po		No		Pre-existing

Clinical Summary:
Issues
1. Pacemaker insertion
- patient's warfarin was ceased for procedure with commencement of bridging clexane
- DDDR pacemaker with permanent transvenous leads were inserted without issues by cardiothoracic surgeon Dr xxxx
- Pacemaker was confirmed to be working normally by biotronic technician prior to discharge

- Discussed with GP, Patient to visit GP daily for recommencement and monitoring of warfarin with bridging clexane.

2. AF
- increased monitoring whilst on bridging clexane

3. ARF
- patient noted to have renal impairment on 25/2 which resolved with IV fluids

Pathology Results:
On admission:

Group	Detail	Date	Value w/Units	Flags	Normal Range	Comment Ind
Blood Chemistries	Sodium	25/02/2014 07:11	140 mmol/L	N	135-145	
Blood Chemistries	Potassium	25/02/2014 07:11	4.3 mmol/L	N	3.2-5.0	
Blood Chemistries	Chloride	25/02/2014 07:11	107 mmol/L	N	95-110	
Blood Chemistries	Bicarbonate	25/02/2014 07:11	28 mmol/L	N	22-32	
Blood Chemistries	Anion Gap	25/02/2014 07:11	9 mmol/L	LOW	12-20	
Blood Chemistries	Urea	25/02/2014 07:11	7.6 mmol/L	HI	3.0-7.5	
Blood Chemistries	Creatinine	25/02/2014 07:11	118 umol/L	HI	60-110	
Blood Chemistries	eGFR	25/02/2014 07:11	52 mL/min /1.73m2	LOW		
Blood Chemistries	Bilirubin Total	25/02/2014 07:11	20 umol/L	N		
Blood Chemistries	Protein	25/02/2014 07:11	60 g/L	N	60-80	
Blood Chemistries	Albumin	25/02/2014 07:11	30 g/L	LOW	35-50	
Blood Chemistries	Total Globulin	25/02/2014 07:11	30 g/L	N	22-39	
Blood Chemistries	ALT	25/02/2014 07:11	80 U/L	HI		
Blood Chemistries	AST	25/02/2014 07:11	61 U/L	HI		
Blood Chemistries	GGT	25/02/2014 07:11	68 U/L	HI		
Blood Chemistries	ALP	25/02/2014 07:11	47 U/L	N	30-110	
Blood Chemistries	Calcium Level	25/02/2014 07:11	2.16 mmol/L	N	2.15-2.55	
Blood Chemistries	Corrected Ca	25/02/2014 07:11	2.36 mmol/L	N	2.15-2.55	
Blood Chemistries	Mg	25/02/2014 07:11	0.93 mmol/L	N	0.70-1.10	
Blood Chemistries	PO4	25/02/2014 07:11	0.94 mmol/L	N	0.75-1.50	
Haematology FBC	Haemoglobin	25/02/2014 07:11	129 g/L	LOW	130-180	
Haematology FBC	WCC	25/02/2014 07:11	6.3 x10^9/L	N	3.7-9.5	
Haematology FBC	Platelets	25/02/2014 07:11	152 x10^9/L	N	150-400	
Haematology FBC	RCC	25/02/2014 07:11	4.2 x10^12/L	LOW	4.3-5.7	
Haematology FBC	Hct	25/02/2014 07:11	0.40	N	0.40-0.54	
Haematology FBC	MCV	25/02/2014 07:11	96 fL	N	82-98	
Haematology FBC	MCH	25/02/2014 07:11	31 pg	N	27-32	
Haematology FBC	MCHC	25/02/2014 07:11	319 g/L	N	300-350	
Haematology FBC	RDW	25/02/2014 07:11	14.9 %	N	11.0-15.0	
Haematology FBC	Abs Neutrophils	25/02/2014 07:11	3.1 x10^9/L	N	2.0-8.0	
Haematology FBC	Abs Lymphocytes	25/02/2014 07:11	2.5 x10^9/L	N	1.0-4.0	
Haematology FBC	Abs Monocytes	25/02/2014 07:11	0.6 x10^9/L	N	0.2-1.0	
Haematology FBC	Abs Eosinophils	25/02/2014 07:11	0.2 x10^9/L	N	0.0-0.5	
Haematology FBC	Abs Basophils	25/02/2014 07:11	0.0 x10^9/L	N	0.0-0.1	
Coagulation Studies	PT	25/02/2014 07:11	20 s	HI	11-18	
Coagulation Studies	APTT	25/02/2014 07:11	36 s	N	24-38	Y
Coagulation Studies	INR	25/02/2014 07:11	1.6	NA		Y

Pathology Results:
On discharge:

Group	Detail	Date	Value w/Units	Flags	Normal Range	Comment Ind
Blood Chemistries	Sodium	28/02/2014 07:23	142 mmol/L	N	135-145	
Blood Chemistries	Potassium	28/02/2014 07:23	4.1 mmol/L	N	3.2-5.0	
Blood Chemistries	Chloride	28/02/2014 07:23	104 mmol/L	N	95-110	
Blood Chemistries	Bicarbonate	28/02/2014 07:23	27 mmol/L	N	22-32	
Blood Chemistries	Anion Gap	28/02/2014 07:23	15 mmol/L	N	12-20	
Blood Chemistries	Urea	28/02/2014 07:23	5.8 mmol/L	N	3.0-7.5	
Blood Chemistries	Creatinine	28/02/2014 07:23	111 umol/L	HI	60-110	
Blood Chemistries	eGFR	28/02/2014 07:23	64 mL/min /1.73m2	LOW		
Blood Chemistries	Albumin	28/02/2014 07:23	35 g/L	N	35-50	
Blood Chemistries	Calcium Level	28/02/2014 07:23	2.28 mmol/L	N	2.15-2.55	
Blood Chemistries	Corrected Ca	28/02/2014 07:23	2.38 mmol/L	N	2.15-2.55	
Blood Chemistries	Mg	28/02/2014 07:23	0.93 mmol/L	N	0.70-1.10	
Blood Chemistries	PO4	28/02/2014 07:23	0.99 mmol/L	N	0.75-1.50	
Haematology FBC	Haemoglobin	28/02/2014 07:23	160 g/L	N	130-180	
Haematology FBC	WCC	28/02/2014 07:23	7.5 x10^9/L	N	3.7-9.5	
Haematology FBC	Platelets	28/02/2014 07:23	183 x10^9/L	N	150-400	
Haematology FBC	RCC	28/02/2014 07:23	5.1 x10^12/L	N	4.3-5.7	
Haematology FBC	Hct	28/02/2014 07:23	0.49	N	0.40-0.54	
Haematology FBC	MCV	28/02/2014 07:23	95 fL	N	82-98	
Haematology FBC	MCH	28/02/2014 07:23	31 pg	N	27-32	
Haematology FBC	MCHC	28/02/2014 07:23	329 g/L	N	300-350	
Haematology FBC	RDW	28/02/2014 07:23	14.9 %	N	11.0-15.0	
Haematology FBC	Abs Neutrophils	28/02/2014 07:23	4.1 x10^9/L	N	2.0-8.0	
Haematology FBC	Abs Lymphocyte	28/02/2014 07:23	2.8 x10^9/L	N	1.0-4.0	
Haematology FBC	Abs Monocytes	28/02/2014 07:23	0.6 x10^9/L	N	0.2-1.0	
Haematology FBC	Abs Eosinophils	28/02/2014 07:23	0.1 x10^9/L	N	0.0-0.5	
Haematology FBC	Abs Basophils	28/02/2014 07:23	0.0 x10^9/L	N	0.0-0.1	
Coagulation Studies	PT	28/02/2014 07:23	14 s	N	11-18	
Coagulation Studies	APTT	28/02/2014 07:23	29 s	N	24-38	Y
Coagulation Studies	INR	28/02/2014 07:23	1.0	NA		Y

Clinical Intervention:

Follow - Up Plan and Appointments:
Plan
1. Patient to go to Dr xxx today for general review and recommencement of warfarin with clexane cover as discussed. (Note: patient has had 5mg warfarin today.)
2. To visit GP daily for warfarin, blood test (INR) and clexane injections
2. Patient to follow up with Dr xxx (cardiothoracic surgeon) next week re: progress post pacemaker insertion.
3. Patient to follow up with Prof xxx (cardiologist) re: progress post pacemaker insertion in 2 months.
4. Patient to continue all other regular medication on discharge as per Dr xxx.

Discharge To:
Home

Discharge Summary Completed By: Medical Officer – Junior

1.10 Clinical record 2

From the clinical record below, assign and sequence the appropriate ICD-10-AM codes.

_____

_____

_____

DISCHARGE SUMMARY

HOSPITAL XX

Admission: 15/1 **Discharge: 16/1**

HISTORY OF PRESENT ILLNESS: The patient is an (XX)-year-old female who states at approximately 8 a.m. she was putting her pants on, in her bedroom at home when she lost her balance, fell forward and struck her forehead on the handle of a chest of drawers, causing a small laceration. She denies any dizziness or lightheadedness, chest pain, or shortness of breath prior to the fall. She denies loss of consciousness or vomiting. Presents here at the concern of her daughter. She denies any pain. She denies headache, neck pain or back pain. Denies any other injury.

IMMUNIZATIONS: Her tetanus is up-to-date.

ALLERGIES: PENICILLIN AND IODINE.

CURRENT MEDICATIONS: Aggrenox, Avandia, Zocor, Altace, Lasix, Zoloft, Glucotrol, clonidine, allopurinol, clonazepam, oxybutynin, tramadol, levothyroxine, Centrum, and iron.

PAST MEDICAL HISTORY: Neuropathy, Type 2 diabetes, hypertension, IHD, OA, depression, history of skin cancer, history of a CVA with rightsided deficits, primarily weakness.

PAST SURGICAL HISTORY: Right knee replacement recently.

SOCIAL HISTORY: She lives with her daughter.

REVIEW OF SYSTEMS: See HPI, otherwise negative.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure is 180/64, temperature 97.5, pulse 57, respirations 18, pulse oximetry 98%.

GENERAL: The patient is an (XX)-year-old female in no acute distress. She is alert, oriented, pleasant and cooperative throughout the exam.

Her head is normocephalic. She has a small laceration noted to the right frontal aspect of the forehead. There was no evidence of a hematoma. She also appears to have a cystic-type structure, probably a sebaceous cyst, along the mid aspect of the forehead. Otherwise, the remainder of the head was atraumatic. Her pupils are round, equal, reactive to light. Her

extraocular movements are intact. Bilateral TMs are clear. Nares are patent. Mouth: She has a clear oropharynx.

NECK: She was nontender to palpation on the cervical spine.

BACK: There is no obvious malalignment or trauma, no step-offs or instability on palpating the spine. She denies any pain to palpation along the spine.

HEART: Regular rate and rhythm.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Soft and nontender.

EXTREMITIES: She has normal range of motion in all four extremities. She denies any pain to palpation in these areas. Distal pulses were intact. She denied any pain with palpation of the pelvis, was able to flex, extend, internally and externally rotate both hips without difficulty.

EMERGENCY DEPARTMENT COURSE: The patient was discussed with Dr. Smith. The patient was also evaluated by Dr. Smith.

DIAGNOSTIC AND LABORATORY TESTS: A C-spine x-ray was obtained, no acute findings but did show diffuse degenerative changes. A CT of the head without contrast was obtained, read as negative by the radiologist. EKG was obtained, read as within normal limits by Dr. Jones. No acute findings. Cardiac panel was obtained as well as a PT/INR. Her INR was 1.1, PT was 13.6, PTT 33.6. CBC showed a red blood cell count of 3.26, hemoglobin 11.2, hematocrit

32.8. Her glucose was 77. Her troponin was less than 0.1.

PROCEDURE: The forehead was prepped with PCMX, irrigated with normal saline, re-evaluated. The laceration measures approximately 4 mm. Closure performed with Dermabond Skin Adhesive.

PRINCIPAL DIAGNOSIS: Closed head injury.

PLAN:

1. Wound care sheet was given. Head injury precautions were discussed.

2. Tylenol p.r.n.

3. Follow up with her doctor Tuesday for recheck.

4. Return if worse, i.e. weakness, chest pain, headache, vomiting, lethargy.

DISPOSITION: The patient was treated and released in stable condition.

1.11 Clinical record 3

From the clinical record below, assign and sequence the appropriate ICD-10-AM codes.

_____

_____

_____

NCCH Hospital

Location: Adult ward **Attending M.O.: L DELL**
Admission Date: 5/12/2014 **Medical Service: ORTHOPAEDICS**
Discharge Date: 6/12/2014

DISCHARGE SUMMARY

Presenting Problems
R ARTH CUFF REPR/ASPRN/DIABTC

PRINCIPAL DIAGNOSIS
Right rotator cuff tear

Summary of Progress
Thank you for your ongoing care of George Hilltop, a 78 year old gentleman, who was admitted to NCCH Hospital on the 5/12/14 for an arthroscopic repair of his right diabetic rotator cuff tear/syndrome under Dr Kong. The procedure was completed without complication and he was discharged the following day following education of the patient and family regarding appropriate exercises by the ward physiotherapist.

Background:
1) Hypertension
2) hypercholesterolaemia
3) DM Type 2 on oral hypoglycaemics
4) Hep B positive
5) Rheumatoid arthritis
6) Asthma – controlled
7) ex-smoker – ceased 10 years ago

Clinical record 3 – Supplementary codes for chronic conditions (continued)

Medications:
ometec plus 10/6.25 daily
diaformin 1000 BD
gliclazide MR 60 evening
rosuvastatin 5mg nocte
aspirin 100mg second daily
natrilix SR 1.5mg daily
lercandidpine 20mg daily
physiotens 400mg daily

Allergies:
nil

Social History:
- live at home with wife
- wife does all the cooking and cleaning
- retired
- independent with ADLs
- independent with mobility with nil aids

Issues this admission:
Right rotator cuff repair
- operation performed under GA without complication on the 5/12/14, full report below
- patient placed in sling post operatively
- received post operative prophylactic IV cephazolin
- reviewed by ward physio on day 1 post op and educated as to appropriate exercises as per Dr Kong's post op protocol
- pressure dressing removed prior to discharge

PLAN:
1) discharge home in care of family
2) follow up with Dr Kong in rooms in 2/52
3) scripts provided for endone and oxycontin, advised to take regular paracetamol
4) patient counselled to take apperients while taking regular oxycontin

MEDICATIONS
NEW MEDICATIONS
oxycontin: 10, Oral, Twice daily, External Prescription.
oxycodone: 5 mg, Oral, PRN: q4h max 30mg/24hr, External Prescription.
paracetamol: 1 Grams, Oral, Four times daily, Own Supply.

Clinical record 3 – Supplementary codes for chronic conditions (continued)

INTERVENTION & RESULTS

Procedures this Admission

Theatre Procedures
Date of Operation: 05/12/2014
Surgeons
Surgeon Incharge: L KONG
Indications/Background
Right Rotator cuff repair
Primary Operation Performed
Right arthroscopic Rotator cuff repair
Acromioplasty

Operation description
GA Lateral position arm in traction
Std Portals
Glenoid cartilage intact
Biceps tendon rupture
Full thickness supraspinatus tear/ subscap, infraspinatus intact
Portals for subacromial space
Bursectomy and acromioplasty - Tear confirmed
Cuff repair
Crossed **Double** layer cuff repair with 2 x 2 x Swivelock 5.5 Corkscrew anchors
Medial row repair
Repair confirmed
Interrupted Nylon to portals op sites compression dressing
Sling

No specimens sent to pathology

Post Operative Orders
Remain in sling
Analgesia
24/24 IV Abs
Can do wrist ROM exercises
Assisted elbow ROM, Pendular, Closed chain shoulder only
Remain in sling
DC tomorrow if comfortable
F/U Dr Kong Rooms ~2/52

CONTINUED CARE RECOMMENDATIONS

Discharge to:
Home.

Follow up Requirements for:
Outpatient Clinic Appointments

Person to contact regarding this Discharge:
O. Edwards:Intern, Pager number: 82,419.

2. Sepsis

2.1 Which code should be assigned for documentation of severe sepsis?
R65.3 or R65.1

2.2 Which codes should be assigned for sepsis secondary to cholangitis?

a) A41.8 *Other specified sepsis*
and K83.0 *Cholangitis*

b) A41.9 *Sepsis, unspecified*
and K81.9 *Cholecystitis, unspecified*

c) A41.9 *Sepsis, unspecified*
and K83.0 *Cholangitis*

2.3 The codes R65.1 *Severe sepsis* and R57.2 *Septic shock* can be assigned together.
True or False?

2.4 Clinical record 4

From the clinical record below, assign and sequence the appropriate ICD-10-AM codes.

_____

_____

_____

Clinical record 4 – Sepsis

Result Type: Discharge Referral Note

Result Date:	04 October 20 13:58
Result Status:	Auth (Verified)
Result Title:	Discharge Referral Baseline
Performed By:	on 04 October 20 14:04
Verified By:	on 04 October 20 14:11
Encounter info:	Inpatient, 20/09/2 - 04/10/

Discharge Referral Baseline

Patient:
Age: **51 years** Sex: **Male** DOB:
Associated Diagnoses: **Sepsis; Acute urinary tract infection; Malignant melanoma - category**
Author:

Visit Information
Visit Summary

Admission Date:	20/09/20	To be discharged: 04/10/2C
Medical Service:	Medical Oncology	Consulting Clinician:
Attending Medical Officer:		
Interpreter Required:	NO	Language spoken at home: English

Dear Dr xxxx,
Thank you for reviewing xxx a 51 Years old Male to be discharged on 04/10/2 from 12B at Hospital. XXXX presented to this facility with SEPSIS.

Summary of Care
Background:

Metastatic melanoma (low volume lung disease)
Mutliple sclerosis - stable.

This admission:
Patient presented with drowsiness and fever.
Haemodynamically unstable at presentation to ED.
Recent discharge from hospital with pseudomonas UTI.

Urine culture: pure growth pseudomonas

Blood cultures on this admission:
Mucoid pseudomonas, multidrug resistant.
Group B streptococococcus sensitive to amoxicillin.

Swab from stage 2 pressure ulcer on lower back: MRSA

Patient was admitted to ICU for 3 days for inotropic support due to septic shock.
Treated with 2 weeks of IV tazocin on the advice of microbiology. Microbiology also advised that they would not recommend any prophlyactic antibotics in the future.

The patient has a known staghorn calculus. Urology reviewed this patient during his admission and advised that he was not a suitable candidate for an operation to remove the calculus and that it was too large to remove with lithotripsy.

Doppler scan of both calves was performed - no DVT seen.

Plan:

Patient discharged home into the care of his brother and with his normal services re-instated.
Follow up appointment with Dr xxxx will be booked via trial co-ordinator nurses.

Health Status

Principal and Other Diagnosis

Provisional Sepsis : SNMCT 151281010, Discharge, Nursing.
Acute urinary tract infection : SNMCT 2768145014, Final, Medical.
Malignant melanoma - category : SNMCT 2672981016, Final, Medical.

Problems, Past History & Alerts

All Problems

Malignant melanoma of unknown primary / 2647863019 / Confirmed
MS - Multiple sclerosis / 1223980016 / Confirmed
Multi- resistant Pseudomonas aeruginosa / Confirmed
IPAC. Blood 21/9/11. Contact Precautions 2.
Multiple resistant staphylococcus aureus (MRSA) / Confirmed
MRSA pressure ulcer back 24/01/2003/ Contact Precautions 1.
Quadriplegia from multiple sclerosis / 19943011 / Confirmed

Medications .

Discharge Medications:

Medication Name	Dose	Freq	Route	Start Date
BISACODYL	**10 mg**	**Night**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
CALTRATE	**600mg**	**Night**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
DOXEPIN	**100 mg**	**Night**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
DIAZEPAM	**5 mg**	**Other: night prn**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
NAUTRAL TEARS	**1drop**	**QID**	**Eye, both**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/20 13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
PARACETAMOL	**1 g**	**Other: qid prn**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
NATURAL VITAMIN E	**250iu**	**Morning**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/20 13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
COD LIVER OIL	**1 cap**	**BD**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/20 13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
FISH OIL	**2 capsule**	**BD**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			
Medication Name	**Dose**	**Freq**	**Route**	**Start Date**
FISH OIL	**1 capsule**	**Midday**	**Oral**	
Status:	Medication continued - dose unchanged			

Last Updated: 04/10/2 13:57

Medication Name	Dose	Freq	Route	Start Date
EVENING PRIMROSE OIL	**1000mg**	**TDS**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
CRANBERRY 10000	**i tab**	**Morning**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
GARLIC 3000	**i tab**	**BD**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
C COMPLEX SR	**1 tab**	**BD**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			

Medication Name	Dose	Freq	Route	Start Date
SUPER ONE-A-DAY	**1 tab**	**Daily**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			

Medication Name	Dose	Freq	Route	Start Date
VITAMIN D3	**1000u**	**Morning**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
SELENIUM	**i tab**	**Morning**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			

Medication Name	Dose	Freq	Route	Start Date
MOVICOL	**1 sachet**	**PRN**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
CHOLECALCIFEROL	**1000 units**	**Morning**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			

Medication Name	Dose	Freq	Route	Start Date
VEMURAFENIR	**960mg**	**BD**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
PANTOPRAZOLE	**40mg**	**Daily**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			

Medication Name	Dose	Freq	Route	Start Date
DOXEPIN	**25mg**	**Night**	**Oral**	
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2(13:57			

Medication Name	Dose	Freq	Route	Start Date
BISACODYL	**10mg**	**every second day**	**Oral**	
Comment Freq:	At midday			
Status:	Medication continued - dose unchanged			
Last Updated:	04/10/2 13:57			

2.5 Clinical record 5

From the clinical record below, assign and sequence the appropriate ICD-10-AM codes.

_____

_____

_____

eDischarge.

Result Date: 28 February 13:18
Result Status: Auth (Verified)
Performed By: ı on 28 February 13:19
Verified By: ı on 28 February 13:25
Encounter info: HOSP, Inpatient, 21-02-20 - 28-02-20

Consultant:		Registrar:		JMO:	
Additional Copies To:					
Admission Date:	21-FEB-20	**Discharge Date:**	28-FEB-20		
Nominated Primary Healthcare Provider:	No GP information on system				

Presenting Complaint:
Mrs is an 85 year old lady admitted from nursing home with urosepsis.

Background History:
- Febrile and tachycardiac on admission
- Urine and blood cultures positive for E. Coli

Problems/Alerts and Diagnoses:
Diagnoses (being addressed in this visit)

Clinical DX	Dx Type	Ranking	Date	Confirmation	Entered By
Urosepsis	Discharge		28-FEB-2	Confirmed	
Hypokalaemia	Discharge		28-FEB-2	Confirmed	
Cachexia	Discharge		28-FEB-2	Confirmed	

Problems

Name of Problem	Onset Date	Confirmation	Classification	Last Updated	Last Updated By	Severity
Dementia		Confirmed	Medical	28-FEB-2(		

Allergies: No known allergies

Medications on Discharge/Current:

Medication	Modified Release	Dose	Unit	Freq	Route	Duration	Dispensed	Reason for Change/ Indication	Item Status
Potassium hydrochloride		1200	mg	BD	PO		Yes		New
Glyceryl trinitrate		5	mg	daily (on 8am; off 8pm)	TOP		Yes		Pre-existing
Digoxin		62.5	mg	mane	PO		Yes		Pre-existing
Coloxyl and senna		2	Other: tabs	BD	PO		Yes		Pre-existing
Systane eye drops		1-2	Other: drops	daily (both eyes)	TOP		Yes		Pre-existing
Verapamil		40	mg	TDS	PO		Yes		Pre-existing

Printed by:
Printed on:

Page 1 of 4
(Continued)

eDischarge.

Pantoprazole		40	mg	noct e	PO		Yes		Pre-existin g
Paracetamol		1	g	TDS	PO		Yes		Pre-existin g
Simvastatin		20	mg	noct e	PO		Yes		Pre-existin g
Fentanyl patch		12	micrograms(s)	ever y 3 days	TOP	(new patch applied today)	No		Pre-existin g
Ferrous sulphate		1	Other: tab	daily	PO		Yes		Pre-existin g
Frusemide		40	mg	man e	PO		Yes		Pre-existin g
Magnesium aspartate		1	g	noct e	PO		Yes		Pre-existin g
Aspirin		100	mg	man e	PO		Yes		Pre-existin g

Clinical Summary:

Urosepsis
- Treated with IV antibiotics
- Afebrile throughout admission
- Reviewed by physiotherapy regarding increased weakness: back to near baseline mobility with 4WW on discharge.

Hypokalaemia
- Potassium 2.9 on admission, replacement given
- Electrolytes monitored throughout admission, potassium 3.9 on discharge (28/2)

Cachexia
- Long standing
- Reviewed by dietician, given supplements

Pathology Results:

Bloods on discharge

Detail	Date	Value w/Units	Flags	Normal Range
Sodium	27/02/ 08:13	136 mmol/L	N	135-145
Potassium	27/02/ 08:13	3.5 mmol/L	N	3.2-5.0
Chloride	27/02/ 08:13	100 mmol/L	N	95-110
Bicarbonate	27/02/ 08:13	29 mmol/L	N	22-32
Anion Gap	27/02/ 08:13	10 mmol/L	LOW	12-20
Urea	27/02/ 08:13	4.6 mmol/L	N	2.5-6.5
Creatinine	27/02/ 08:13	55 umol/L	N	45-90
eGFR	27/02/ 08:13	>=90 mL/min/1.73m 2	NA	
Albumin	27/02/ 08:13	27 g/L	LOW	35-50
Calcium Level	27/02/ 08:13	2.48 mmol/L	N	2.15-2.5 5
Corrected Ca	27/02/ 08:13	2.74 mmol/L	HI	2.15-2.5 5
Mg	27/02/ 08:13	0.84 mmol/L	N	0.70-1.1 0
PO4	27/02/ 08:13	0.97 mmol/L	N	0.75-1.5 0
C Reactive Protein	27/02/ 08:13	25 mg/L	HI	
Haemoglobin	27/02/ 08:13	124 g/L	N	115-165

Printed by:
Printed on:

Page 2 of 4
(Continued)

eDischarge.

WCC	27/02/2	08:13	6.8 x10^9/L	N	3.9-11.1
Platelets	27/02/	08:13	229 x10^9/L	N	150-400
RCC	27/02/	08:13	3.4 x10^12/L	LOW	3.9-5.0
Hct	27/02/	08:13	0.39	N	0.36-0.44
MCV	27/02/2	08:13	115 fL	HI	82-98
MCH	27/02/2	08:13	37 pg	HI	27-32
MCHC	27/02/2	08:13	320 g/L	N	300-350
RDW	27/02/2	08:13	12.8 %	N	11.0-15.0
Abs Neutrophils	27/02/2	08:13	5.1 x10^9/L	N	2.0-8.0
Abs Lymphocytes	27/02/2	08:13	0.9 x10^9/L	LOW	1.0-4.0
Abs Monocytes	27/02/2	08:13	0.5 x10^9/L	N	0.2-1.0
Abs Eosinophils	27/02/2	08:13	0.3 x10^9/L	N	0.0-0.5
Abs Basophils	27/02/2	08:13	0.0 x10^9/L	N	0.0-0.1

Blood culture

FINAL REPORT - 24 February 20 12:26 -
Result of Culture
Escherichia coli was isolated from the aerobic and anaerobic bottles
Please contact the Clinical Microbiologist for further information, if required

Urine culture

FINAL REPORT - 23 February 2(07:07 -

Colony Count : 10E7 to 10E8 organisms/L of Escherichia coli
Possible UTI

Medical Imaging Results:

CR Chest
Xray Chest performed on 21-FEB-20 06:55 PM REPORTED BY

AP view only.
There has been improved aeration of the lungs compared to the previous CXR on 22.7.2
The diaphragm contours are now clearly defined and there is no evidence of basal pleural fluid.
The lungs appear clear and hyper-inflated. There is slight cardiomegaly. There is age related arteriosclerotic degeneration of the thoracic aorta, together with prominence of the upper lobe veins, consistent with pulmonary venous hypertension.
The right breast shadow is not clearly visible and may have been removed: correlation with clinical evidence is needed.
There are no surgical clips in the right axilla.

Follow - Up Plan and Appointments:

Please follow-up with GP in 3 days.

Please consider ongoing physiotherapy at the nursing home.

Advice To Patient:

If symptoms recur or if concerned please seek medical advice.

Please see follow-up plan as detailed above.

Discharge To:

Other (home/discharge to usual residence/own accommodation/welfare institutions including prisons, hostels and group

Printed by:
Printed on:

Page 3 of 4
(Continued)

Clinical record 5 – Sepsis (continued)

eDischarge.

homes)

Location of Discharge:

Discharge Summary Completed By:

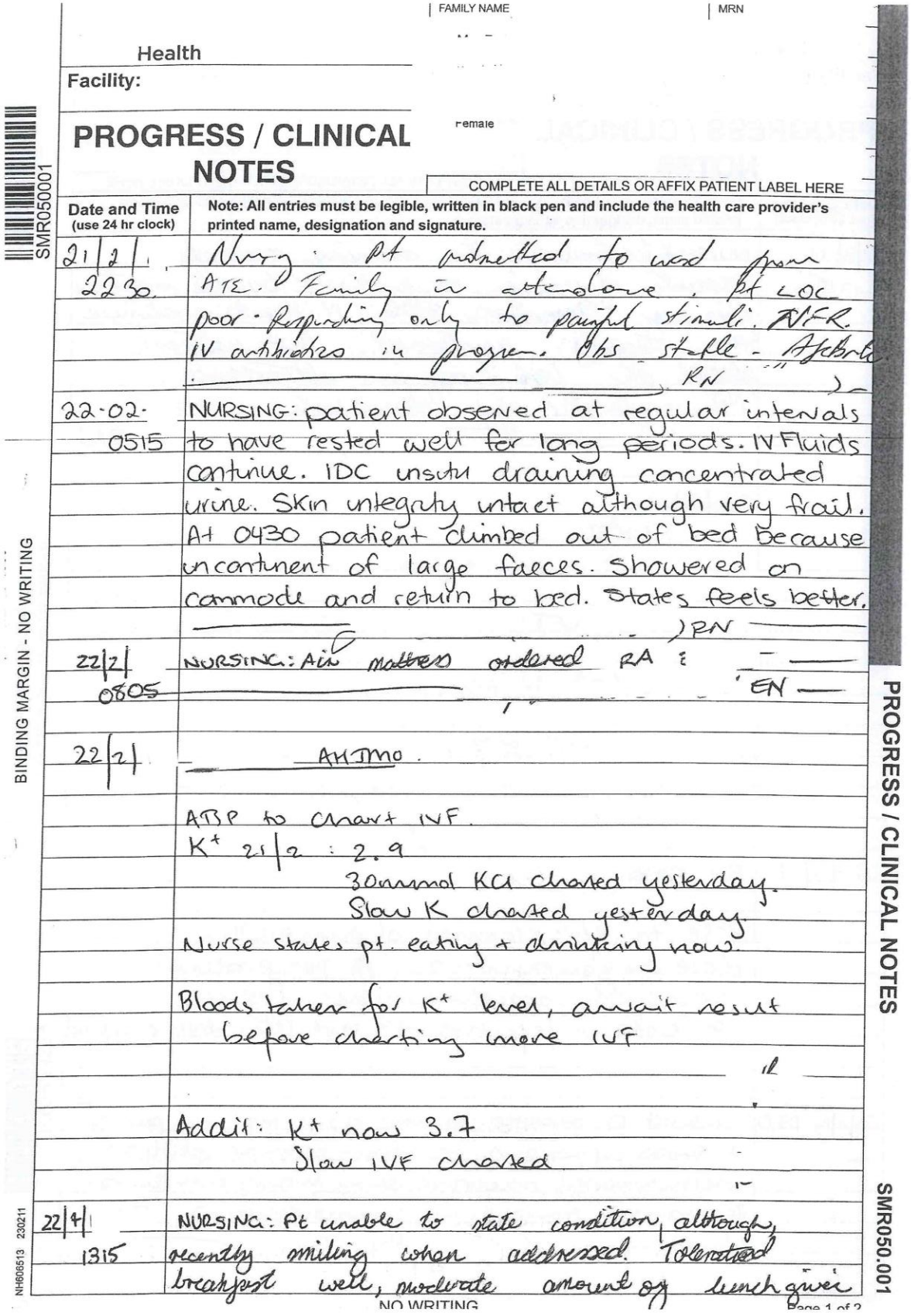
Completed Action List:

```
* Perform b                          on 28 February .     13:19
* Modify by                         on 28 February     . 13:19
* Sign by                           n 28 February      13:25  Requested by
Rb                                  13:25
* Modify by                             February       13:25
* VERIFY by                             February       13:25
```

Printed by:
Printed on:

Page 4 of 4
(End of Report)

Clinical record 5 – Sepsis (continued)



Health Facility:

FAMILY NAME | MRN

female

PROGRESS / CLINICAL NOTES

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR050001

BINDING MARGIN - NO WRITING

PROGRESS / CLINICAL NOTES

SMR050.001

NH6006513 230211

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
21/2/ 2230	Nursing: Pt admitted to ward from ATE. Family in attendance. Pt LOC poor. Responding only to painful stimuli. NFR. IV antibiotics in progress. Obs stable - Afebrile. RN
22-02- 0515	NURSING: patient observed at regular intervals to have rested well for long periods. IV Fluids continue. IDC insitu draining concentrated urine. Skin integrity intact although very frail. At 0430 patient climbed out of bed because incontinent of large faeces. Showered on commode and return to bed. States feels better. RN
22/2/ 0805	NURSING: Air mattress ordered RA EN
22/2/	AHJMO.
	ATBP to chart IVF.
	K+ 21/2 : 2.9
	30mmol KCl charted yesterday.
	Slow K charted yesterday.
	Nurse states pt. eating + drinking now.
	Bloods taken for K+ level, await result before charting more IVF
	Addit: K+ now 3.7
	Slow IVF charted
22/2/ 1315	NURSING: Pt unable to state condition, although recently smiling when addressed. Tolerated breakfast well, moderate amount of lunch given

NO WRITING

Page 1 of 2

Health
Facility: MEDICAL A

PROGRESS / CLINICAL NOTES

Female

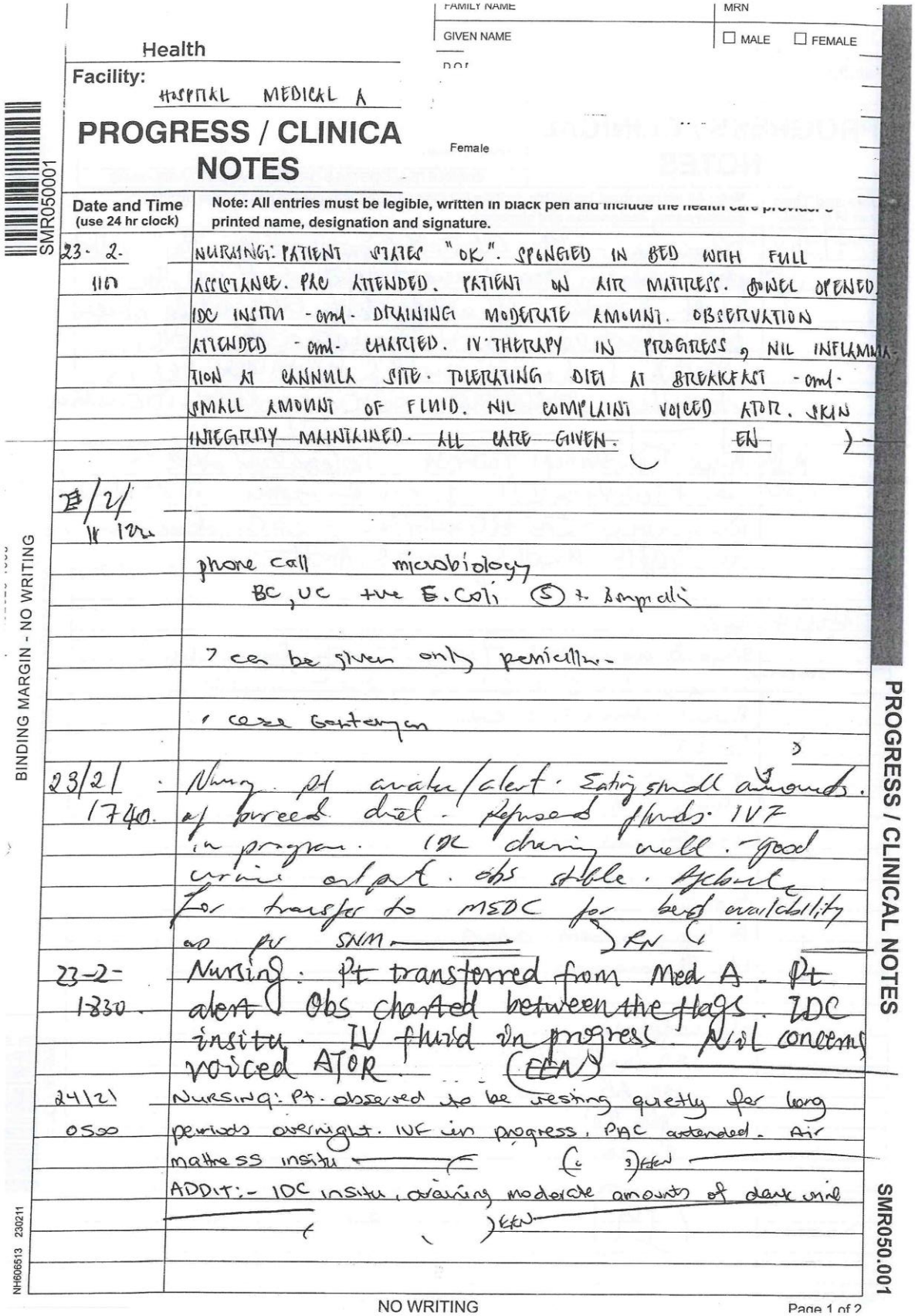
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
22/2 1315	NURSING (continued): IDC draining moderate amount of urine, no further bowels motions this am. Obs stable. IV fluids continue. Skin integrity maintained. Air mattress placed on bed. Family in attendance. Nil complaints of discomfort — EN
	22/2 ... Went ... sepsis ... UTI ... IV ABs ... gentamicin.
22/2	AH JMO ATSP to R/V closeness of ampicillin dose to gentamicin. As per protocol penicillin in-activates gent. if given within a few hrs → WH 1800 dose ampicillin
23/2 0340	NURSING: PT OBSERVED TO HAVE RESTED FOR LONG PERIODS. IV FLUIDS INPROGRESS. IDC INSITU – DRAINING SMALL TO MODERATE AMOUNTS. TOLERATING SMALL AMOUNT ORAL FLUIDS. REPOSITIONING ATTENDED. NIL COMPLAINTS VOICED — RN

Page 2 of 2 NO WRITING

Holes punched as per AS2828-1999 BINDING MARGIN - NO WRITING

SMR050001



FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B
Female

Health
Facility: HOSPITAL MEDICAL A

PROGRESS / CLINICA NOTES

SMR050001

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
23-2-11 0	NURSING: PATIENT STATES "OK". SPONGED IN BED WITH FULL ASSISTANCE. PAC ATTENDED. PATIENT ON AIR MATTRESS. BOWEL OPENED. IDC INSITU - oml - DRAINING MODERATE AMOUNT. OBSERVATION ATTENDED - oml - CHARTED. IV THERAPY IN PROGRESS, NIL INFLAMMATION AT CANNULA SITE. TOLERATING DIET AT BREAKFAST - oml - SMALL AMOUNT OF FLUID. NIL COMPLAINT VOICED ATOR. SKIN INTEGRITY MAINTAINED. ALL CARE GIVEN. EN
23/2/11 12n	phone call microbiology BC, UC true E. Coli (5) + Ampicill ? can be given only penicillin. , case Gentamycin
23/2/11 1740.	Nursing. Pt awake/alert. Eating small amounts of forrect diet. Reposed fluids. IVT in progress. IDC draining well. Good urine output. obs stable. Arranged for transfer to MSDC for bed availability as per SNM. RN
23-2-11 1830.	Nursing: Pt transferred from Med A. Pt alert. Obs charted between the flags. IDC insitu. IV fluid in progress. Nil concerns voiced ATOR. (EEN)
24/2/11 0500	NURSING: Pt. observed to be resting quetly for long periods overnight. IVF in progress. PAC attended. Air mattress insitu (EEN) ADDIT:- IDC insitu, draining moderate amounts of dark urine (EEN)

BINDING MARGIN - NO WRITING

PROGRESS / CLINICAL NOTES

SMR050.001

NH606513 230211

NO WRITING

Page 1 of 2

Health
Facility:

PROGRESS / CLINICAL NOTES

Female

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
24/2	Nursing – Pt. Alert & Cooperative. Responsive
1550	when spoken too. Hearing deficit. Sat up for
	bfast. Feeds self adequately. All meds given
	as charted. Bed Sponge attended.
	BOX 1 large and Visited by
	family. Relative s/w update
Add	After Feeding Patch. Tolerated diet
1400	& Fluids well. 1. PIV & insitu. IV Hartmans
	in progress @ 80 mls/hr. IDC draining
	in good amt of urine.
24/2/1	MR
	85yo ♂ admitted w/ sepsis 2° UTI, from N/H.
Bloods	Urine culture ⊕ E. Coli } sensitive to ampicillin.
	Blood culture ⊕ E. Coli }
	K+ 2.9
	Mg 0.64
	Phosph. 0.39.
	WCC (N) CRP 107 ↑.
	ϕ pain.
	Pt lying in bed, alert.
	B/G dementia.
	O/E: afebrile
	BP 120/70
	HR 69
	SpO2 98%.
	RR 18.
	(signature)

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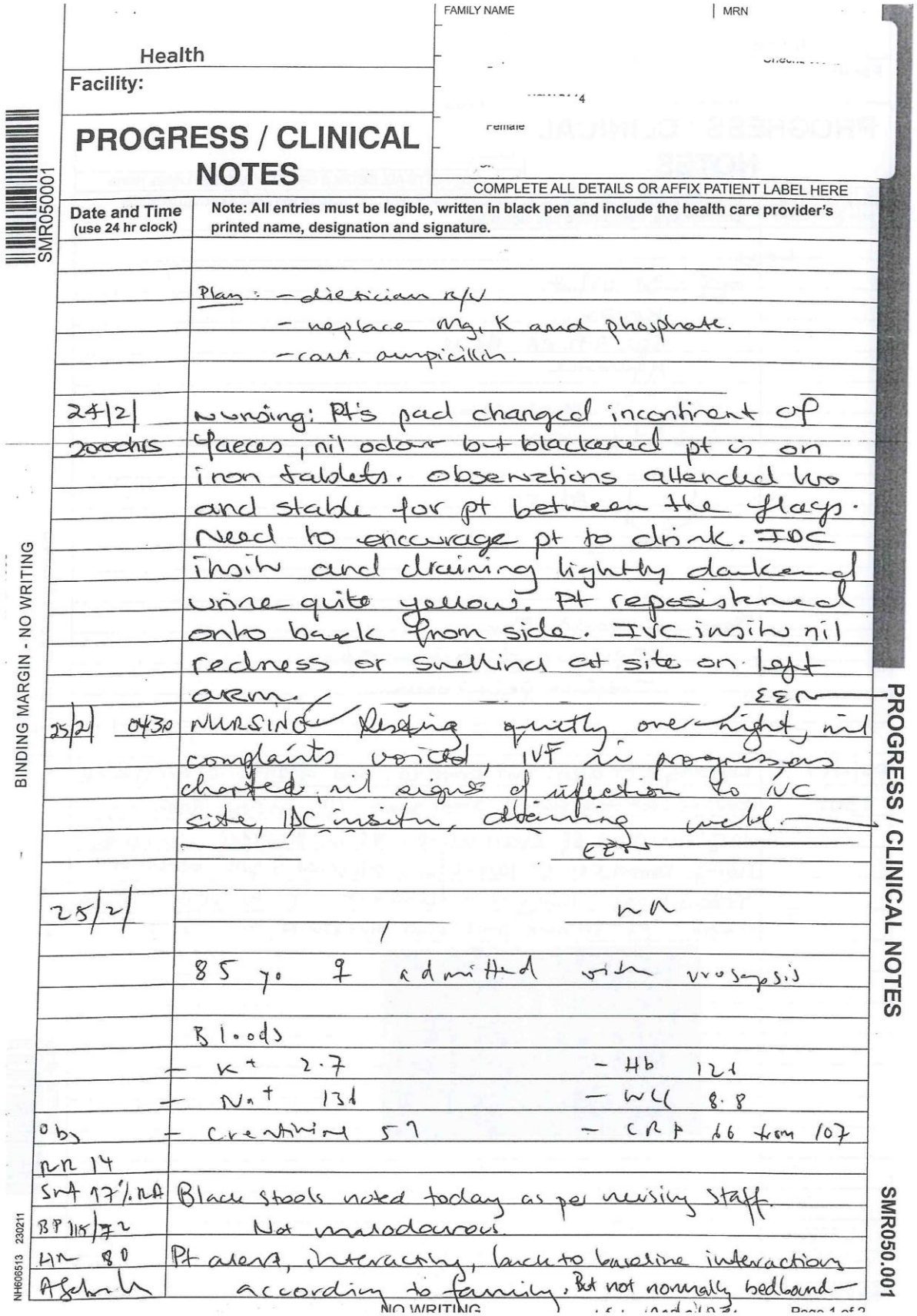
SMR050001

Page 2 of 2 NO WRITING



Health
Facility:
PROGRESS / CLINICAL NOTES
FAMILY NAME
MRN
Female
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
SMR050001
BINDING MARGIN - NO WRITING
PROGRESS / CLINICAL NOTES
SMR050.001
NH606513 230211
NO WRITING

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
	Plan: - dietician R/V - replace Mg, K and phosphate. - cont. ampicillin.
24/2/ 2000hrs	Nursing: Pt's pad changed incontinent of faeces, nil odour but blackened pt is on iron tablets. observations attended to and stable for pt between the flags. Need to encourage pt to drink. IDC insitu and draining lightly darkened urine quite yellow. Pt repositioned onto back from side. IVC insitu nil redness or swelling at site on left arm. EEN
25/2/ 0430	NURSING Resting quietly overnight, nil complaints voiced, IVF in progress as charted, nil signs of infection to IVC site, IDC insitu, draining well. EEN
25/2/	N/A
	85 yo ♀ admitted with urosepsis
	Bloods - K+ 2.7 - Hb 121 - Na+ 131 - WCC 8.8 - creatinine 57 - CRP 66 from 107
obs	
RR 14	
SAT 97% RA	Black stools noted today as per nursing staff.
BP 115/72	Not melodarous.
HR 80	Pt alert, interacting, back to baseline interactions
Afebrile	according to family. But not normally bedbound—

Clinical record 5 – Sepsis (continued)

Health

Facility:

Female

PROGRESS / CLINICAL NOTES

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
	Cont.
	O/E: BP 115/64 HR 75 SpO2 97% RA, RR 18 Afebrile. Chest clear HSD ASNT.
	Plan: - cont. Abx - physio, dietician R/V. - replace potassium.
25/2/ 1300	Nursing = Pt alert. but confused. bed sponge with assist x2 BWO x2 (see stool chart); stool sent. IDC in situ. draining large amount of clear urine. IVF in progress. currently running 10mmol KCl. at 100mls/hr. all vital signs between yellow flags. family in attendance. Pt tolerating small amount of mixed diet and thin fluid. —

PERIPHERAL INTRAVENOUS CANNULA ALERT

Insertion Date: 25 / 2 /

Insertion Time: 13:15

Insertion Site Limb: L / R

Arrange replacement in 72 hrs

Holes punched as per AS2828-1999

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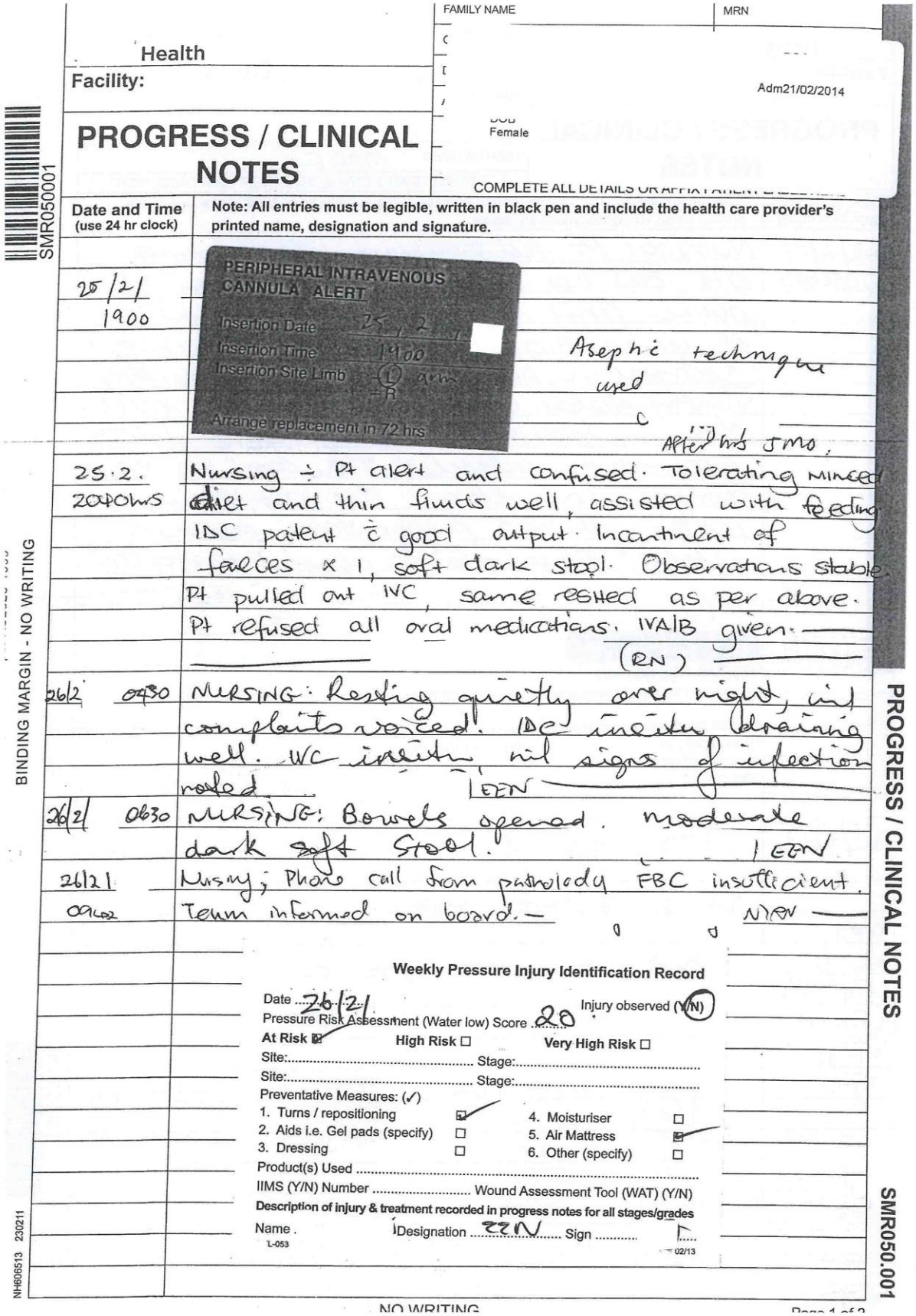
SMR050001

Page 2 of 2

NO WRITING

Clinical record 5 – Sepsis (continued)



Health
Facility:

FAMILY NAME | MRN

Adm21/02/2014

DOB
Female

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL

PROGRESS / CLINICAL NOTES

SMR050001

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
25/2/ 1900	PERIPHERAL INTRAVENOUS CANNULA ALERT Insertion Date 25/2/ Insertion Time 1900 Insertion Site Limb (L) arm R Arrange replacement in 72 hrs Aseptic technique used C Appt hrs JMO.
25.2. 2040hrs	Nursing ÷ Pt alert and confused. Tolerating minced diet and thin fluids well, assisted with feeding IDC patent ĉ good output. Incontinent of faeces x 1, soft dark stool. Observations stable. Pt pulled out IVC, same rested as per above. Pt refused all oral medications. IVAB given. (RN)
26/2 0430	NURSING: Resting quietly over night, nil complaints voiced. IDC in situ, draining well. WC intact, nil signs of infection noted. LEEN
26/2 0630	NURSING: Bowels opened. moderate dark soft Stool. LEEN
26/2/ 0900	Nursing; Phone call from pathology FBC insufficient. Team informed on board. NIEN

Weekly Pressure Injury Identification Record

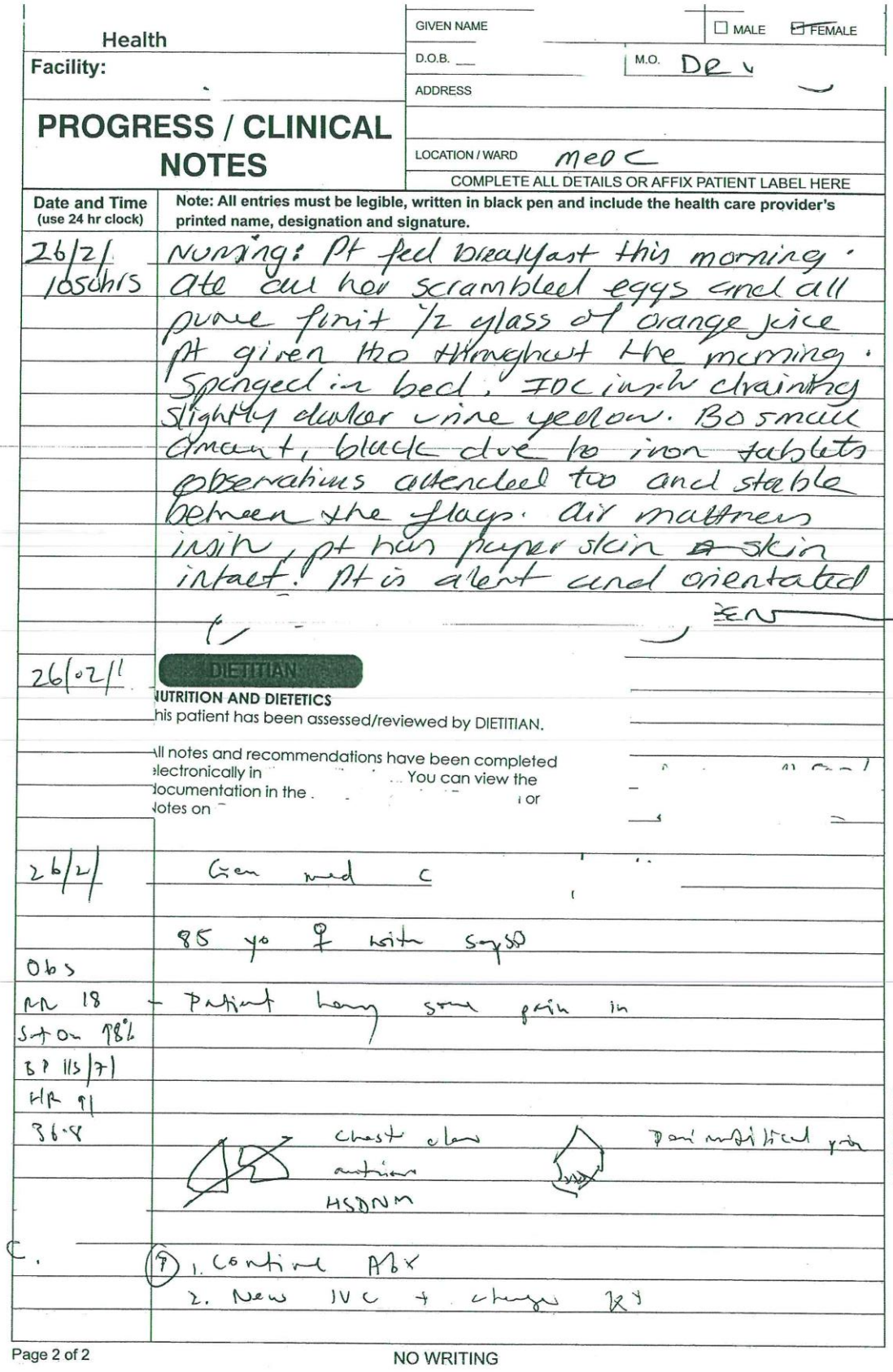
Date 26/2/ Injury observed (Y/N)
Pressure Risk Assessment (Water low) Score 20
At Risk ☑ High Risk ☐ Very High Risk ☐
Site: Stage:
Site: Stage:
Preventative Measures: (✓)

1. Turns / repositioning	☑	4. Moisturiser	☐
2. Aids i.e. Gel pads (specify)	☐	5. Air Mattress	☑
3. Dressing	☐	6. Other (specify)	☐

Product(s) Used
IIMS (Y/N) Number Wound Assessment Tool (WAT) (Y/N)
Description of injury & treatment recorded in progress notes for all stages/grades
Name . Designation RN Sign
L-053 02/13

BINDING MARGIN - NO WRITING
NO WRITING
NH606513 230211
PROGRESS / CLINICAL NOTES
SMR050.001

Clinical record 5 – Sepsis (continued)



Health

Facility:

PROGRESS / CLINICAL NOTES

GIVEN NAME ☐ MALE ☒ FEMALE

D.O.B. M.O. Dr v

ADDRESS

LOCATION / WARD med C

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
26/2/ 1050hrs	Nursing: Pt fed breakfast this morning. ate all her scrambled eggs and all pure finit ½ glass of orange juice pt given H2O throughout the morning. Sponged in bed. IDC in-situ draining slightly darker urine yellow. Bo small amount, black due to iron tablets observations attended too and stable between the flags. air mattress in situ, pt has paper skin ~~a~~ skin intact. Pt is alert and orientated EN
26/02/1	DIETITIAN NUTRITION AND DIETETICS This patient has been assessed/reviewed by DIETITIAN. All notes and recommendations have been completed electronically in ... You can view the documentation in the ... or notes on
26/2/	Gen med C
	85 yo ♀ with sepsis
Obs	
RR 18	Patient having some pain in
Sat on 98%	
BP 115/71	
HR 91	
36.8	chest clear antibiotics HSDNM Pain modified pain
C.	(9) 1. Continue ABX 2. New IVC + change IVF

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NO WRITING

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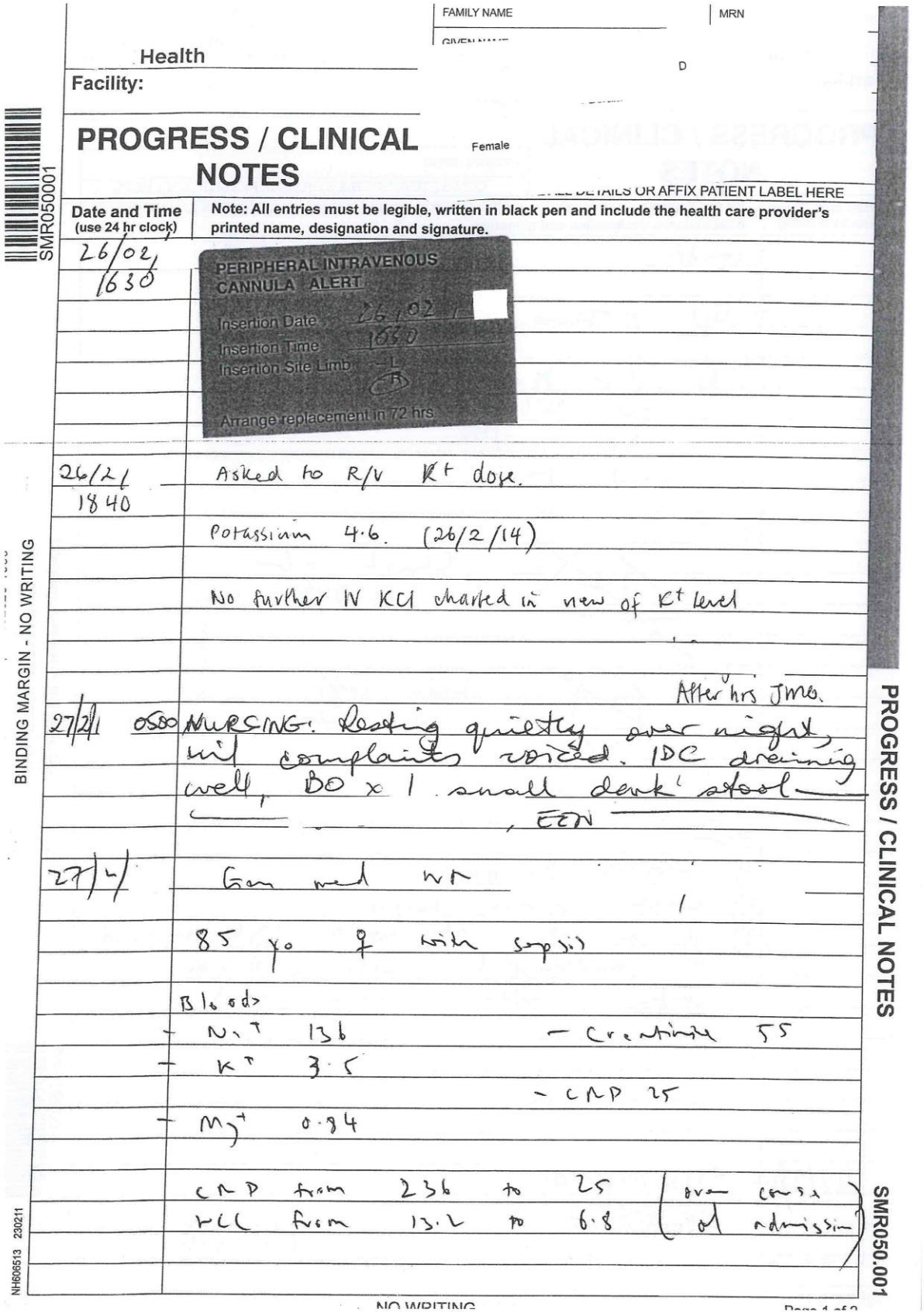


Health
Facility:

FAMILY NAME
MRN
D
Female

PROGRESS / CLINICAL NOTES

SMR050001

...TAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
26/02/1630	PERIPHERAL INTRAVENOUS CANNULA ALERT Insertion Date 26/02/ Insertion Time 1630 Insertion Site Limb L R Arrange replacement in 72 hrs
26/2/1840	Asked to R/V K+ dose. Potassium 4.6. (26/2/14) No further IV KCl charted in view of K+ level After hrs JMO.
27/2/0500	NURSING: Resting quietly over night, nil complaints voiced. IDC draining well, BO x 1 small dark stool , EEN
27/2/	Gen med NF 85 yo ♀ with sepsis Blood: - Na+ 136 - Creatinine 55 - K+ 3.5 - CRP 25 - Mg+ 0.94 CRP from 236 to 25 (over course of admission) WCC from 13.2 to 6.8

BINDING MARGIN - NO WRITING

PROGRESS / CLINICAL NOTES

SMR050.001

NH606513 230211

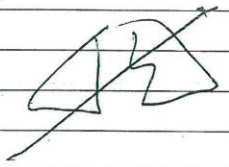
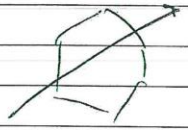
NO WRITING

Clinical record 5 – Sepsis (continued)

Health
Facility:

PROGRESS / CLINICAL NOTES

GIVEN NAME ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ M.O.
ADDRESS
LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

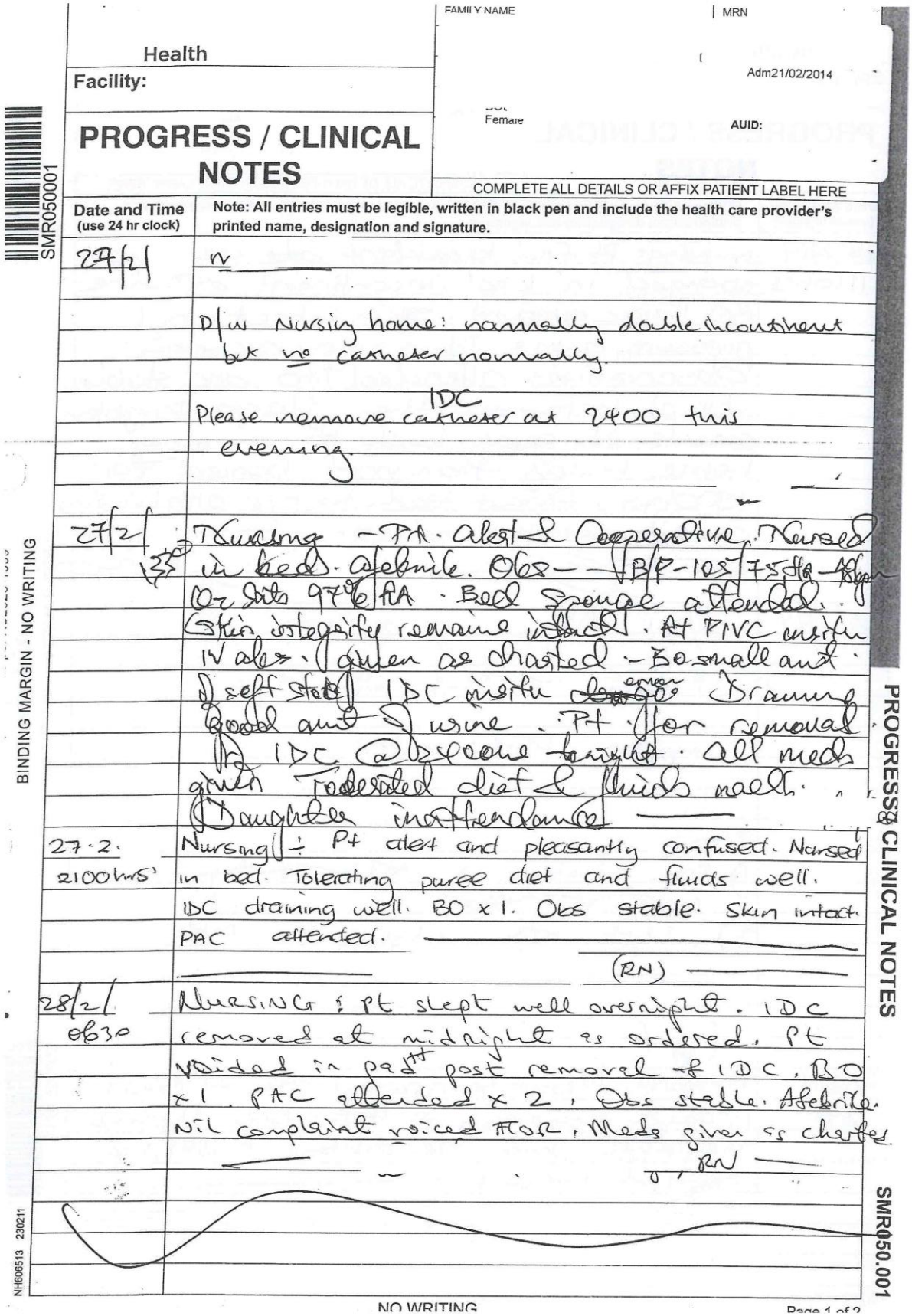
Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
	cont/d
	Nil problems overnight
	Obs NP 98 Afebrile Sat 96% RA BP 105/74 RR 20
	O/E  Chest - clear HSDNM  Abdo soft non-tender
	Plan: 1) Continue IV Abx 2) Check continuing status 3) If Nil IDC at morning IDC round at midnight. Will need to confirm with Nursing Home
27/2	PHYSIOTHERAPIST: See notes on 27/2

Page 2 of 2

NO WRITING

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

SMR050001



Health
Facility:

FAMILY NAME | MRN
Adm21/02/2014
Female
AUID:

PROGRESS / CLINICAL NOTES

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SMR050001

BINDING MARGIN - NO WRITING

PROGRESS / CLINICAL NOTES

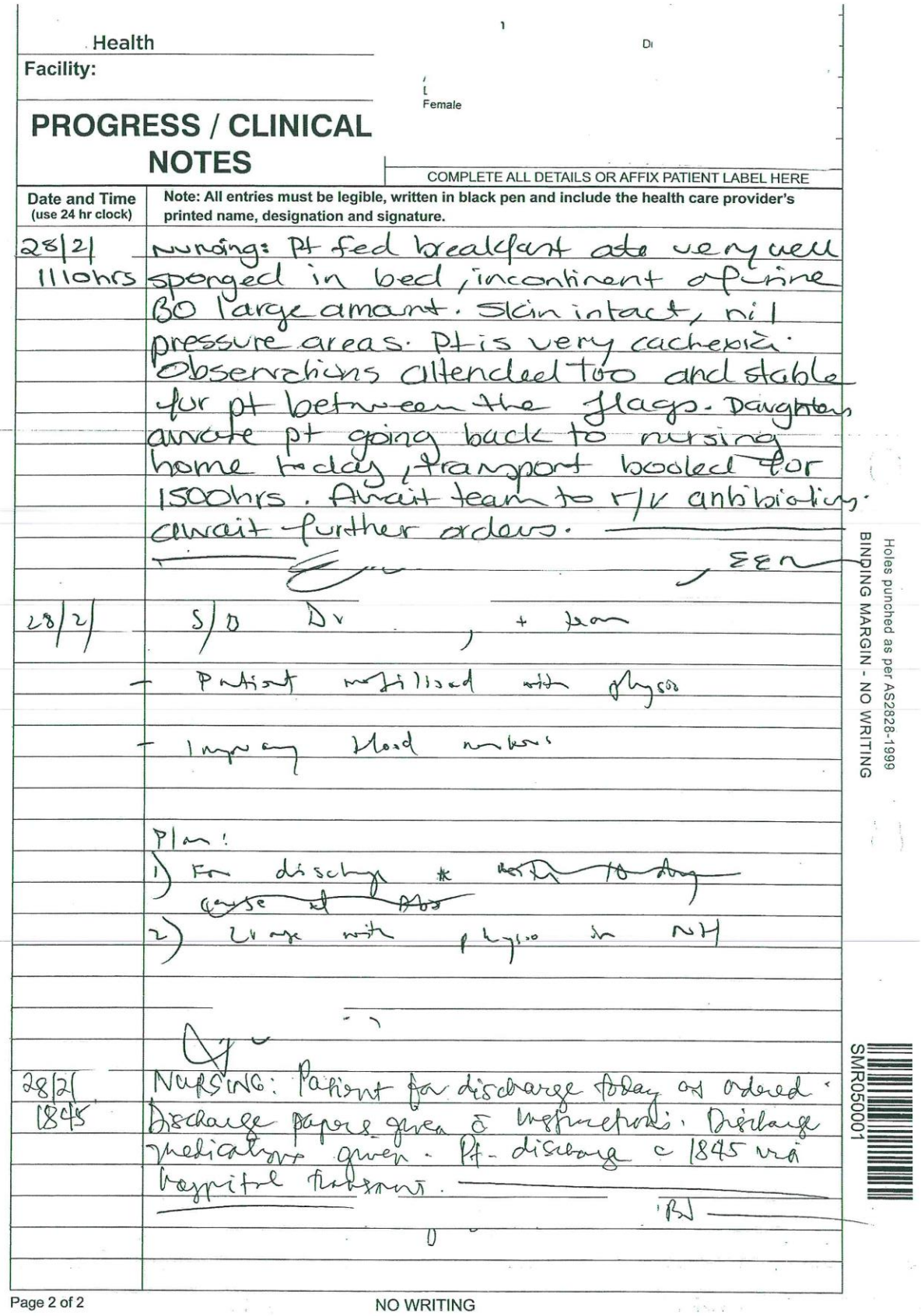
SMR050.001

NH606513 230211

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
27/2/	IV
	D/w Nursing home: normally double incontinent but no catheter normally.
	Please remove catheter at 2400 this evening. IDC
27/2/ 13:30	Nursing – Pt. alert & Cooperative. Nursed in bed. afebrile. Obs – BP-105/75 Hg HR 102 Sats 97% RA. Bed Sponge attended. Skin integrity remains intact. At PIVC with IV abx. given as charted – BO small amt. self cath IDC insitu ~~large~~ Draining good amt urine. Pt for removal IDC @ 2400 tonight. all meds given Tolerated diet & fluids well. Daughter in attendance
27.2. 2100hrs	Nursing / Pt alert and pleasantly confused. Nursed in bed. Tolerating puree diet and fluids well. IDC draining well. BO x 1. Obs stable. Skin intact. PAC attended. (RN)
28/2/ 0630	NURSING : Pt slept well overnight. IDC removed at midnight as ordered. Pt voided in pad post removal of IDC. BO x 1. PAC attended x 2. Obs stable. Afebrile. Nil complaint voiced FOR. Meds given as charted. RN

NO WRITING

Clinical record 5 – Sepsis (continued)



Health

Facility:

Female

PROGRESS / CLINICAL NOTES

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
28/2/ 1110hrs	Nursing: Pt fed breakfast ate very well sponged in bed, incontinent of urine BO large amount. Skin intact, nil pressure areas. Pt is very cachexic. Observations attended too and stable for pt between the flags. Daughter wrote pt going back to nursing home today, transport booked for 1500hrs. Await team to r/v antibiotics. await further orders. EEN
28/2/	S/D Dr , + Iron - Patient mobilised with physio - Improving blood numbers Plan: 1) For discharge * not Fri today cause of Mon 2) Liaise with physio in NH
28/2/ 1845	NURSING: Patient for discharge today as ordered. Discharge papers given & instructions. Discharge medications given. Pt discharge @ 1845 via hospital transport. BJ

Holes punched as per AS2828-1999

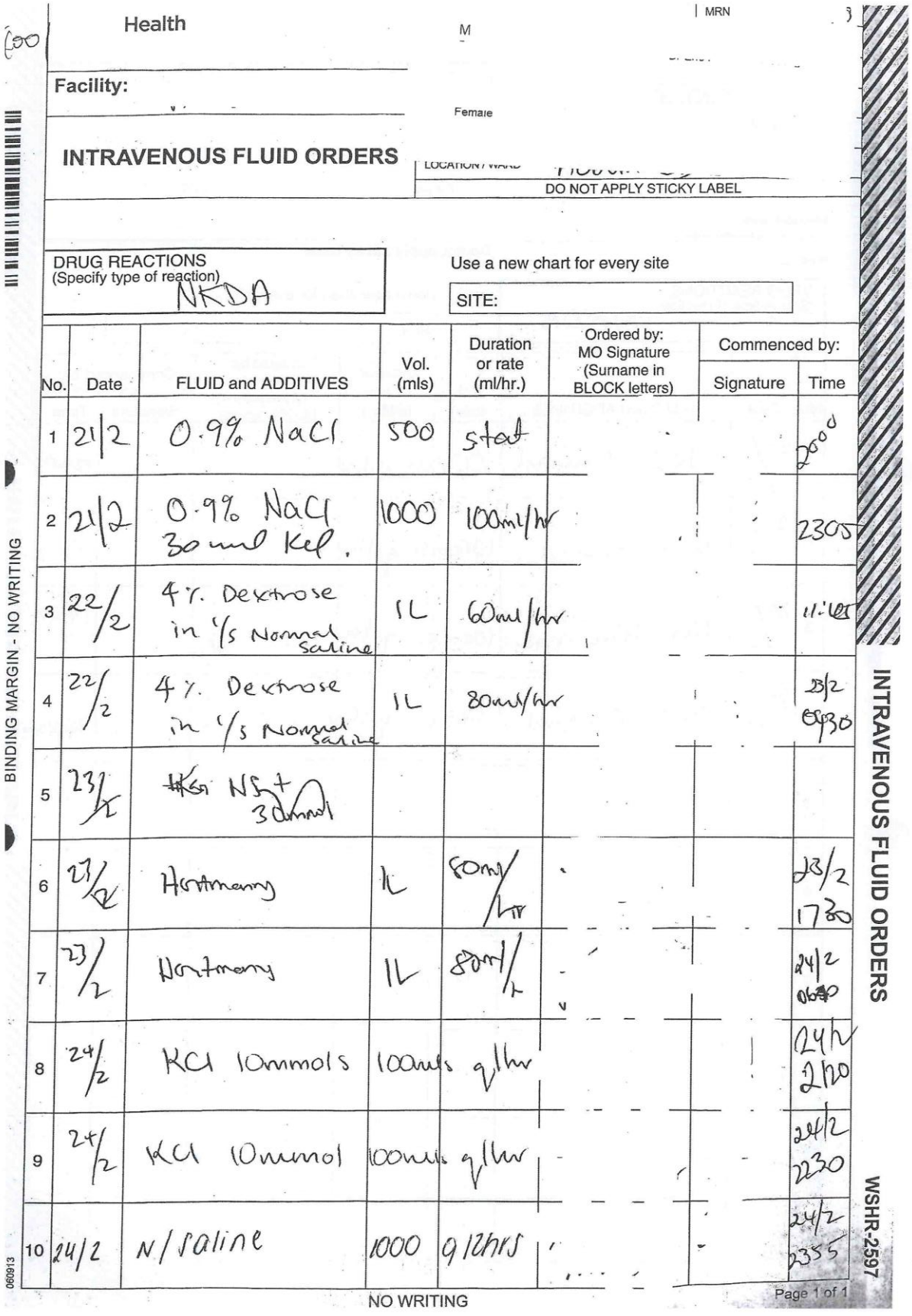
BINDING MARGIN - NO WRITING

SMR050001

Page 2 of 2

NO WRITING

Clinical record 5 – Sepsis (continued)



Health

Facility:

MRN

M

Female

DO NOT APPLY STICKY LABEL

INTRAVENOUS FLUID ORDERS

DRUG REACTIONS (Specify type of reaction): NKDA

Use a new chart for every site

SITE:

No.	Date	FLUID and ADDITIVES	Vol. (mls)	Duration or rate (ml/hr.)	Ordered by: MO Signature (Surname in BLOCK letters)	Commenced by: Signature	Commenced by: Time
1	21/2	0.9% NaCl	500	stat			2000
2	21/2	0.9% NaCl 30 mmol Kcl.	1000	100ml/hr			2305
3	22/2	4% Dextrose in ½ Normal saline	1L	60ml/hr			11:00
4	22/2	4% Dextrose in ½ Normal saline	1L	80ml/hr			23/2 0630
5	23/2	~~HKG~~ NS + 30mmol					
6	23/2	Hartmanns	1L	50ml/hr			23/2 1730
7	23/2	Hartmanns	1L	80ml/hr			24/2 0630
8	24/2	KCl 10mmols	100mls	q/hr			24hr 2120
9	24/2	KCl 10mmol	100mls	q/hr			24/2 2230
10	24/2	N/saline	1000	q 12hrs			24/2 2355

INTRAVENOUS FLUID ORDERS

BINDING MARGIN - NO WRITING

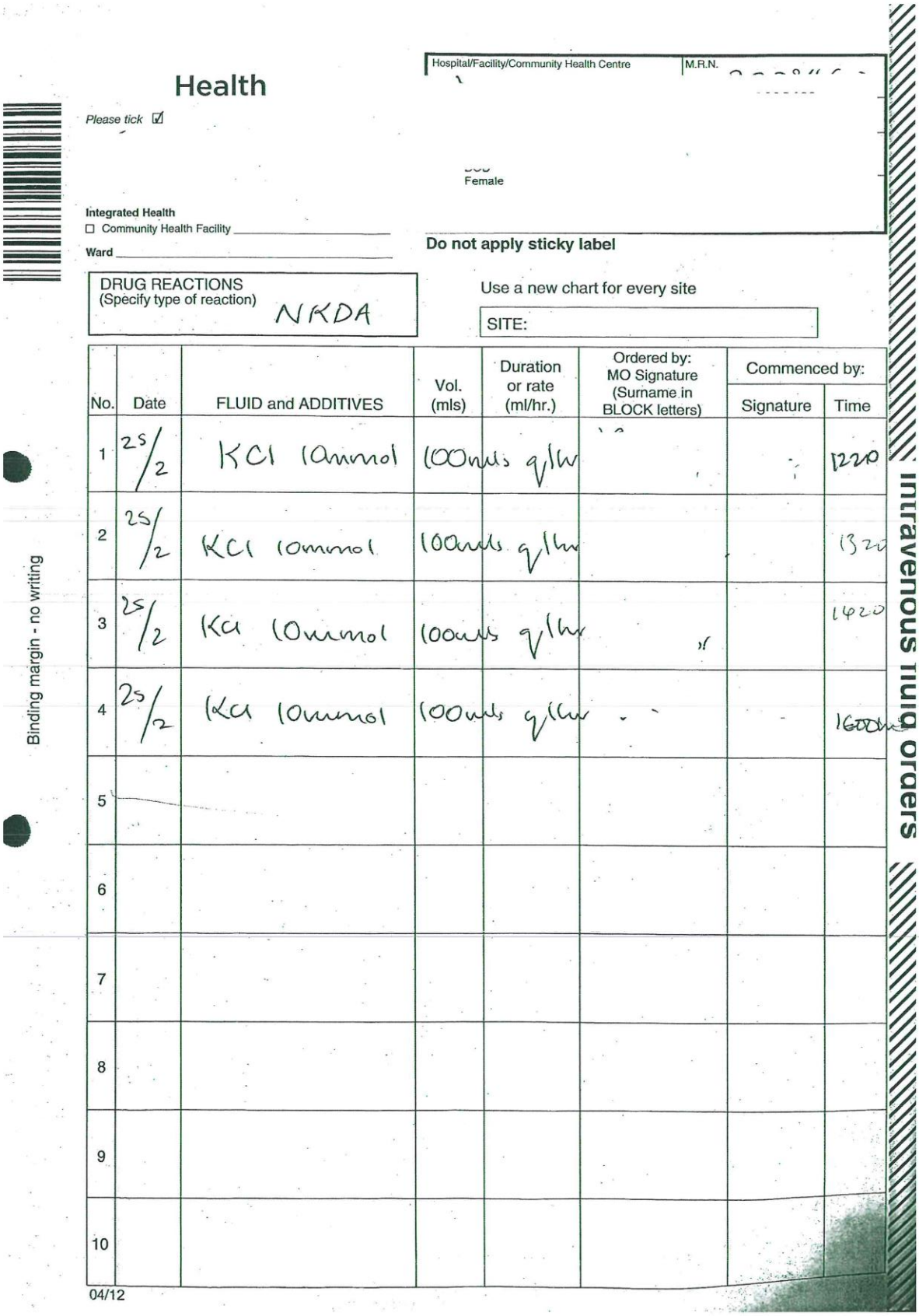
NO WRITING

060913

WSHR-2597

Page 1 of 1

Clinical record 5 – Sepsis (continued)



Health

Please tick ☑

Hospital/Facility/Community Health Centre | M.R.N.

Female

Integrated Health
☐ Community Health Facility _____
Ward _____

Do not apply sticky label

DRUG REACTIONS
(Specify type of reaction) NKDA

Use a new chart for every site

SITE:

No.	Date	FLUID and ADDITIVES	Vol. (mls)	Duration or rate (ml/hr.)	Ordered by: MO Signature (Surname in BLOCK letters)	Commenced by: Signature	Commenced by: Time
1	25/2	KCl 10mmol	100mls	q/hr			1220
2	25/2	KCl 10mmol	100mls	q/hr			1320
3	25/2	KCl 10mmol	100mls	q/hr			1420
4	25/2	KCl 10mmol	100mls	q/hr			1600
5							
6							
7							
8							
9							
10							

04/12

Binding margin - no writing

Intravenous fluid orders

Clinical record 5 – Sepsis (continued)

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

☒ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

SMR130002

Sign......... ......Print. Date... 21/2

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☒ FEMALE
D.O.B.	M.O.	
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber **to Print Patient Name and Check Label Correct:** Weight(kg):............ Height(cm):............

REGULAR MEDICATIONS

YEAR 20__ **DATE & MONTH** → 21/2, 22/2, 23/2, 24/2, 25/2, 26/2, 27/2, 28/2

VARIABLE DOSE MEDICATION

		21/2	22/2	23/2	24/2
Date: 22/2 · Medication (Print Generic Name): Gentamicin	Drug level				
Route: IV · Frequency: Daily (Prescriber to enter dose times and individual dose)	Time level taken				
Indication · Pharmacy	Dose		160 mg		
Prescriber Signature · Print Your Name · Contact	Prescriber		[illegible]		
	Time to be given		18:20		
	Time given & Sign		[illegible]		

WARFARIN (Marevan/Coumadin) select brand

Date		INR Result
Route · Prescriber to enter individual doses	Target INR Range	Dose: mg mg mg mg mg mg mg mg
Indication	Pharmacy	Prescriber
Prescriber Signature · Print Your Name	Contact	**1600** Nurse 1
DOCTORS MUST ENTER administration times		Nurse 2

Medication	Time	21/2	22/2	23/2	24/2	25/2	26/2	27/2	28/2
Date: 21/2 · Medication (Print Generic Name): Slow K · Route: PO · Dose: 2 tabs · Frequency & NOW enter times: BD · Indication: hypo K · Pharmacy: (3) x eedemy potassium chloride (Swallow whole)	0800	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	2000	→	[illegible]	[illegible]	[illegible]	(R)	[illegible]	[illegible]	
Date: 21/2 · Medication: Ceftriaxone · Route: IV · Dose: 1g · Frequency: BD · Indication: UTI	0800	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	2000	→	[illegible]	[illegible]	[illegible]	Bn	[illegible]	Bn	
Date: 21/2 · Medication: Ampicillin · Route: IV · Dose: 1g · Frequency: QID · Indication: UTI	0600	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	1200	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	1800	→	(WH)	[illegible]	[illegible]	Bn	[illegible]	Bn	
	2400	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
Date: 21/2 · Medication: Glyceryl Trinitrate · Route: dermal · Dose: 5mg · Frequency: Daily ON 8am OFF 8pm (Rotate patch site)	ON 0800	→	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	OFF 2000	→	[illegible]	[illegible]	[illegible]	Bn	[illegible]	Bn	

Continue on discharge Yes / No · Dispense Yes / No · Duration?.......days/Qty?.......

Pharmacist...... Date...... Contact...... Print Name...... Prescriber's Signature......

Pharmaceutical Review:

Check if patient has another Medication Chart

BINDING MARGIN - NO WRITING

Medication Chart (NIMC - Vet E) - 260711 - Ref No: 11959

RECO ADMINIST GUIDE

Morning	Mane
Night	Nocte
Twice a day	BD
Three times a day	TDS
Antibiotic 6 hourly	6 hrly
Antibiotic 8 hourly	8 hrly
Four times a day	QID

✓ Choc N/H [illegible]

WARFARIN EDU
Patient Educated
Sign: ....
Date: ....
Given Warfarin E
Sign: ....
Date: ....

Tick if Slow release — SR=Sust controlled If scored can be g Dose mu without c

REASON F NOT ADMI
Codes MUS

- Absent
- Fasting
- Refused – notify Dr
- Vomiting
- On leave
- Not available – obta or contact Dr
- Withheld – enter rea clinical record
- Self Administered

2

Clinical record 5 – Sepsis (continued)

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20__

FAMILY NAME	
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

***First Prescriber* to Print Patient Name and Check Label Correct:** ....

REGULAR MEDICATIONS

YEAR 20__ **DATE & MONTH** → 21/2, 22/2, 23/2, 24/2, 25/2, 26/2, 27/2, 28/2

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW enter times	Indication	Times	Administration
21/2	Poly Tears eye drops Dextran; hypromellose	eyes	1-2 drops	bilateral daily		0800	→ (N) — Changed to Systane
21/2	Digoxin	PO	62.5 microgram	mane	AF	0800	→ [illegible] (76); 24/2
21/2	Coloxyl + Senna	PO	2 tabs	BD	Constipation	0800, 2000	→ (R) [illegible]
23/2	Systane eyedrops	both eyes	1-2 drops	day		0800	→ [illegible]; Discard after 28 days; 24/2

Field labels on each entry: Tick if Slow Release; Pharmacy; Prescriber Signature; Print Your Name; Contact; Continue on discharge Yes / No; Dispense Yes / No; Duration?.........days/Qty?..........

Side margin codes: (A) (F) (R) (V) (L) (N) (W) (S)

Pharmaceutical Review:

Check if patient has another Medication Chart

3

NOT A VALID ORDER UNLESS LEGIBLE

BINDING MARGIN - NO WRITING

Clinical record 5 – Sepsis (continued)

Attach ADR Sticker

See front page for details

AS REQUIRED "PRN" MEDICATIONS

Year 20

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber to Print Patient Name and Check Label Correct:

REGULAR MEDICATIONS

YEAR 20 _ DATE & MONTH → 21/2 22/2 23/2 24/2 25/2 26/2 27/2 28/2

DOCTORS MUST ENTER administration times

Date	Medication (Print Generic Name)	Route	Dose	Frequency & NOW enter times	Indication	Pharmacy	Time	Notes
	Bisacodyl							
21/2	Fentanyl patch	Trans dermal	12 microgram	every 3 days	Pain	SP	0800	X X X 144 X X X; Rotate patch site
21/2	Ferrous sulfate	PO	1 tab	daily	= (1) × 325mg		0800	Take on an empty stomach – swallow whole –
21/2	Frusemide	PO	40mg	mane			0800	
21/2	Magnesium aspartate	PO	2 tab	nocte	= (2) × 500mg		2000	
21/2	Aspirin	PO	100mg	mane			0800	WITH FOOD

Continue on discharge Yes / No · Dispense Yes / No · Duration?.........days/Qty?.........

Pharmaceutical Review:

Check if patient has another Medication Chart

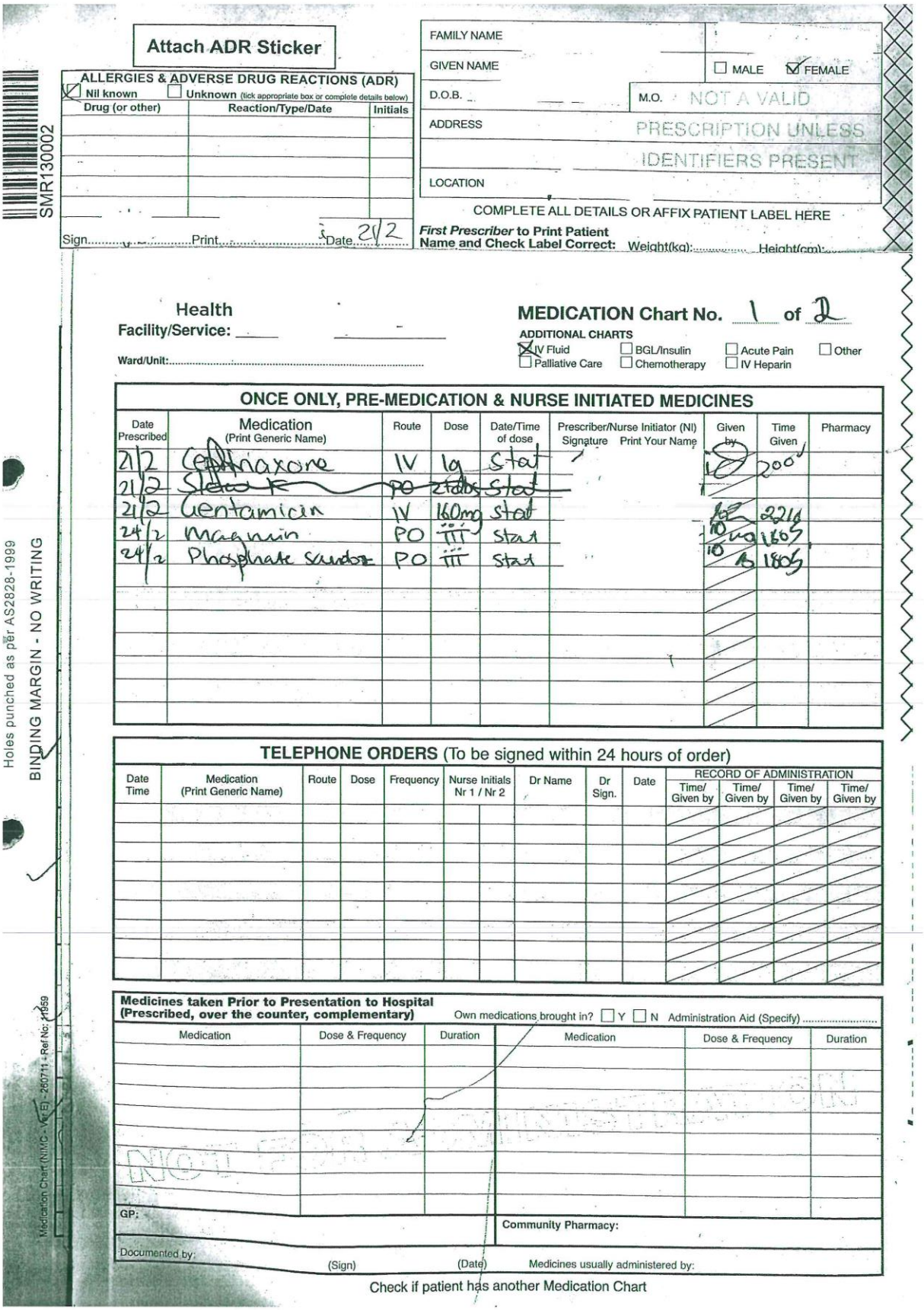
NOT A VALID ORDER UNLESS LEGIBLE

BINDING MARGIN - NO WRITING

Holes punched as per AS2828-1999

SMR130002

3



Attach ADR Sticker

SMR130002

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
☑ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

Sign..... Print..... Date 21/2

FAMILY NAME
GIVEN NAME
☐ MALE ☑ FEMALE
D.O.B.
M.O. NOT A VALID
ADDRESS PRESCRIPTION UNLESS
IDENTIFIERS PRESENT
LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

***First Prescriber* to Print Patient Name and Check Label Correct:** Weight(kg):..... Height(cm):.....

Health
Facility/Service:
Ward/Unit:

MEDICATION Chart No. 1 **of** 2

ADDITIONAL CHARTS
☑ IV Fluid ☐ BGL/Insulin ☐ Acute Pain ☐ Other
☐ Palliative Care ☐ Chemotherapy ☐ IV Heparin

ONCE ONLY, PRE-MEDICATION & NURSE INITIATED MEDICINES

Date Prescribed	Medication (Print Generic Name)	Route	Dose	Date/Time of dose	Prescriber/Nurse Initiator (NI) Signature Print Your Name	Given by	Time Given	Pharmacy
21/2	Ceftriaxone	IV	1g	Stat			2000	
21/2	Stesolid R	PO	2 tabs	Stat				
21/2	Gentamicin	IV	160mg	stat			2214	
24/2	Maxmin	PO	TTT	Start			1605	
24/2	Phosphate sandoz	PO	TTT	Start			1805	

TELEPHONE ORDERS (To be signed within 24 hours of order)

Date Time	Medication (Print Generic Name)	Route	Dose	Frequency	Nurse Initials Nr 1 / Nr 2	Dr Name	Dr Sign.	Date	RECORD OF ADMINISTRATION Time/ Given by	Time/ Given by	Time/ Given by	Time/ Given by

Medicines taken Prior to Presentation to Hospital (Prescribed, over the counter, complementary)
Own medications brought in? ☐ Y ☐ N Administration Aid (Specify).....

Medication	Dose & Frequency	Duration	Medication	Dose & Frequency	Duration

GP:
Community Pharmacy:
Documented by: (Sign) (Date) Medicines usually administered by:

Check if patient has another Medication Chart

Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING

Medication Chart (NIMC - Ver E) - 260711 - Ref No: 1559

3. Cystic fibrosis

3.1 Patients with cystic fibrosis and related complications should always have E84 *Cystic fibrosis* sequenced as the principal diagnosis. True or False?

3.2 Which of the following manifestation(s) are commonly associated with cystic fibrosis?

a) nasal polyps

b) pancreatic insufficiency

c) meconium ileus

d) all of the above

3.3 Which of the following codes would be assigned for a patient admitted for investigation of male infertility which is secondary to cystic fibrosis?

a) E84 *Cystic fibrosis*
and Z31.3 *Other assisted fertilisation methods*

b) N46 *Male infertility*
and E84 *Cystic fibrosis*

c) Z31.3 *Other assisted fertilisation methods*
and E84 *Cystic fibrosis*

d) E84 *Cystic fibrosis*
and N46 *Male infertility*

3.4 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM codes.

A sixteen year old female is admitted to hospital and treated for atelectasis which is complicating her underlying cystic fibrosis. She also has a background of other cystic fibrosis complications including sinusitis and cholelithiasis. During the episode of care, she experiences some abdominal pain and has a CT scan of the abdomen which confirms cholelithiasis only.

_____

_____

_____

_____

3.5 Clinical record 6

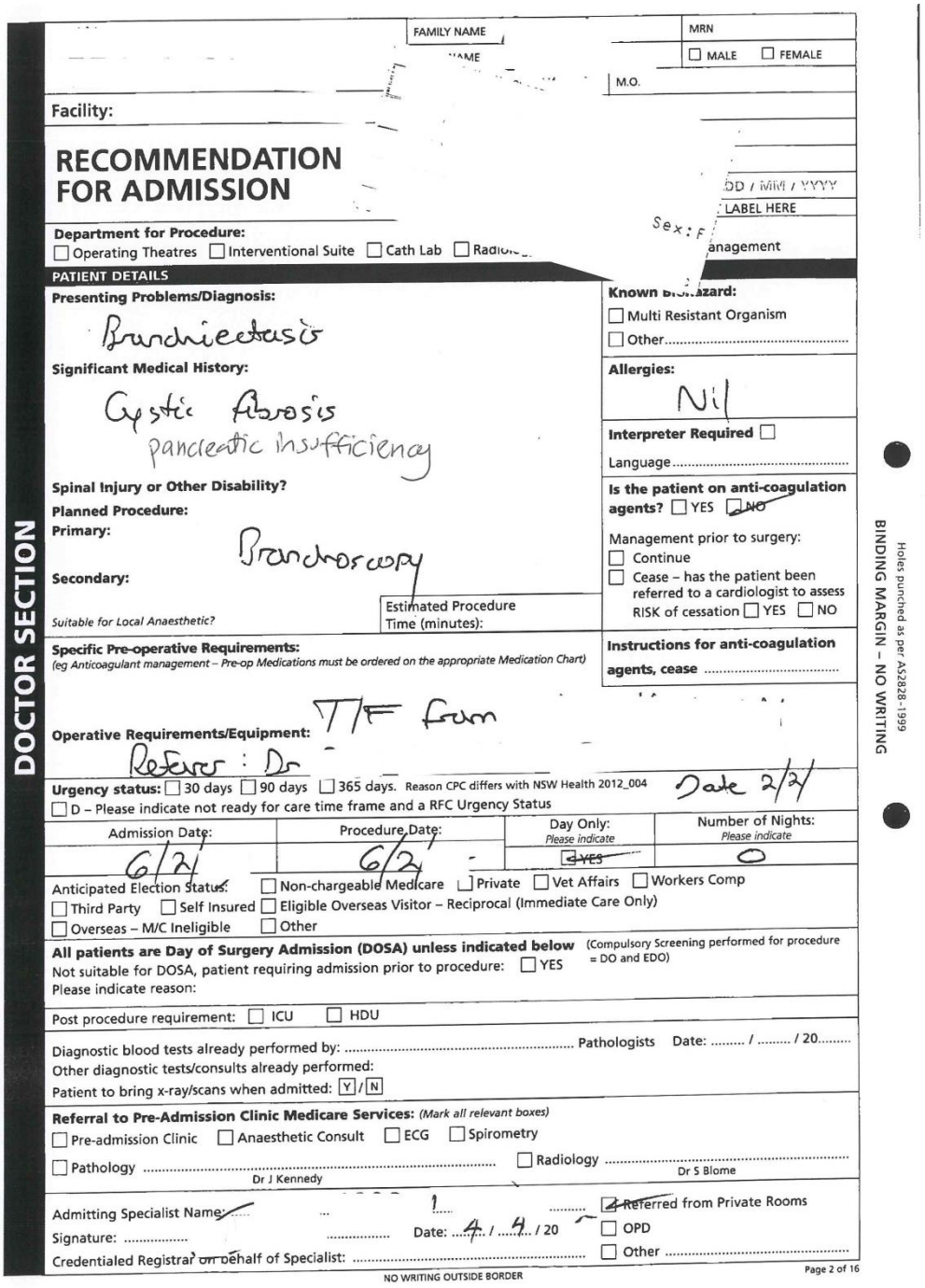
From the clinical record below, assign and sequence the appropriate ICD-10-AM codes.

_____

_____

_____

_____



FAMILY NAME

MRN

☐ MALE ☐ FEMALE

M.O.

Facility:

RECOMMENDATION FOR ADMISSION

LABEL HERE

Department for Procedure:
☐ Operating Theatres ☐ Interventional Suite ☐ Cath Lab ☐ Radio...

PATIENT DETAILS

Presenting Problems/Diagnosis:
Bronchiectasis

Significant Medical History:
Cystic fibrosis
pancreatic insufficiency

Spinal Injury or Other Disability?

Planned Procedure:
Primary: Bronchoscopy
Secondary:

Suitable for Local Anaesthetic?

Estimated Procedure Time (minutes):

Specific Pre-operative Requirements:
(eg Anticoagulant management – Pre-op Medications must be ordered on the appropriate Medication Chart)

Operative Requirements/Equipment: T/F from Refer : Dr

Known Biohazard:
☐ Multi Resistant Organism
☐ Other.....

Allergies: Nil

Interpreter Required ☐
Language.....

Is the patient on anti-coagulation agents? ☐ YES ☐ NO

Management prior to surgery:
☐ Continue
☐ Cease – has the patient been referred to a cardiologist to assess RISK of cessation ☐ YES ☐ NO

Instructions for anti-coagulation agents, cease .....

Urgency status: ☐ 30 days ☐ 90 days ☐ 365 days. Reason CPC differs with NSW Health 2012_004 Date 2/2
☐ D – Please indicate not ready for care time frame and a RFC Urgency Status

Admission Date:	Procedure Date:	Day Only: *Please indicate*	Number of Nights: *Please indicate*
6/2	6/2	☒ YES	0

Anticipated Election Status: ☐ Non-chargeable Medicare ☐ Private ☐ Vet Affairs ☐ Workers Comp
☐ Third Party ☐ Self Insured ☐ Eligible Overseas Visitor – Reciprocal (Immediate Care Only)
☐ Overseas – M/C Ineligible ☐ Other

All patients are Day of Surgery Admission (DOSA) unless indicated below (Compulsory Screening performed for procedure = DO and EDO)
Not suitable for DOSA, patient requiring admission prior to procedure: ☐ YES
Please indicate reason:

Post procedure requirement: ☐ ICU ☐ HDU

Diagnostic blood tests already performed by: ..... Pathologists Date: ..... / ..... / 20.....
Other diagnostic tests/consults already performed:
Patient to bring x-ray/scans when admitted: [Y] / [N]

Referral to Pre-Admission Clinic Medicare Services: *(Mark all relevant boxes)*
☐ Pre-admission Clinic ☐ Anaesthetic Consult ☐ ECG ☐ Spirometry
☐ Pathology ..... Dr J Kennedy ☐ Radiology ..... Dr S Blome

Admitting Specialist Name: .....
Signature: .....
Date: 4 / 4 / 20
Credentialed Registrar on behalf of Specialist: .....
☒ Referred from Private Rooms
☐ OPD
☐ Other .....

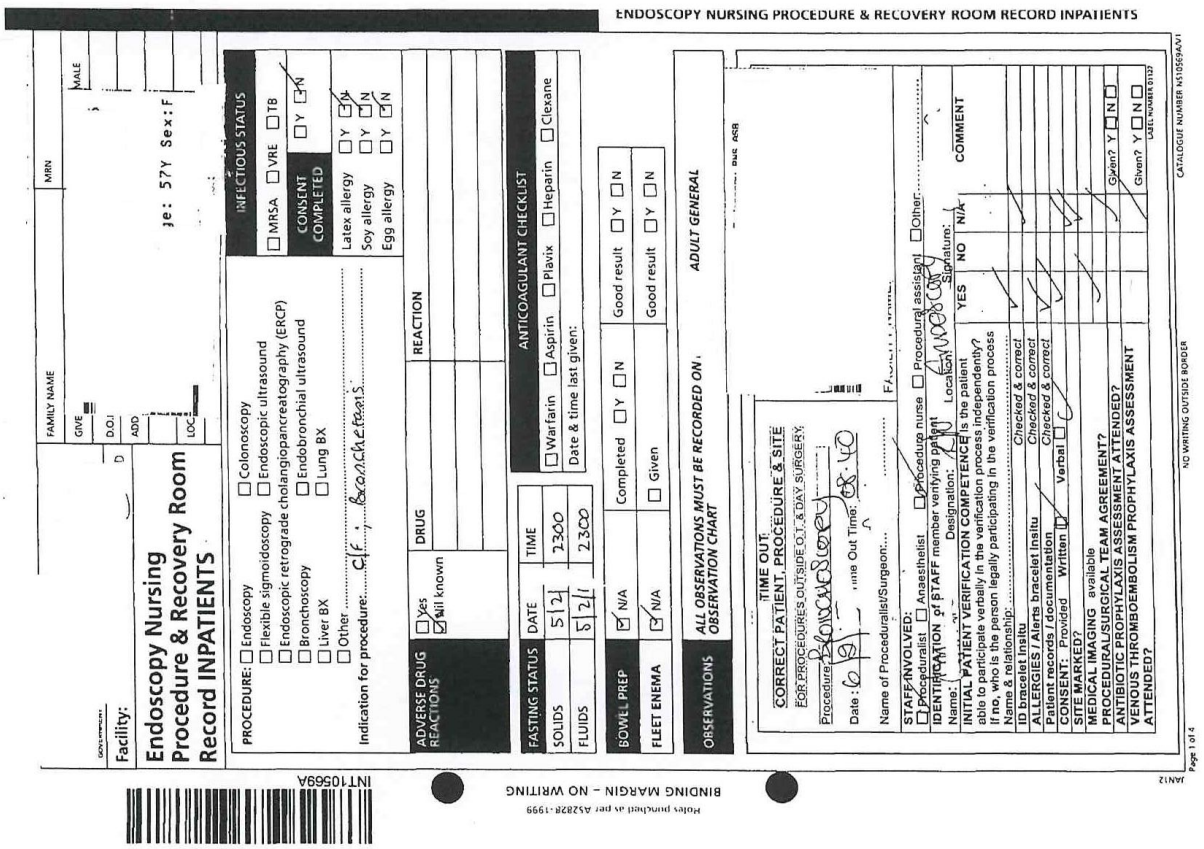
NO WRITING OUTSIDE BORDER

Page 2 of 16

DOCTOR SECTION

BINDING MARGIN – NO WRITING

Holes punched as per AS2828-1999


ENDOSCOPY NURSING PROCEDURE & RECOVERY ROOM RECORD INPATIENTS
Endoscopy Nursing Procedure & Recovery Room Record INPATIENTS
Facility:
FAMILY NAME
GIVE
D.O.B
ADD
MRN
MALE
LOC
INFECTIOUS STATUS
MRSA VRE TB
CONSENT COMPLETED
PROCEDURE:
Endoscopy
Flexible sigmoidoscopy
Endoscopic retrograde cholangiopancreatography (ERCP)
Bronchoscopy
Liver BX
Other
Colonoscopy
Endoscopic ultrasound
Endobronchial ultrasound
Lung BX
Indication for procedure:
Latex allergy
Soy allergy
Egg allergy
ADVERSE DRUG REACTIONS
DRUG
REACTION
FASTING STATUS
DATE
TIME
SOLIDS
FLUIDS
ANTICOAGULANT CHECKLIST
Warfarin
Aspirin
Plavix
Heparin
Clexane
Date & time last given:
BOWEL PREP
FLEET ENEMA
Completed
Given
Good result
OBSERVATIONS
ALL OBSERVATIONS MUST BE RECORDED ON OBSERVATION CHART
ADULT GENERAL
TIME OUT
CORRECT PATIENT, PROCEDURE & SITE
FOR PROCEDURES OUTSIDE OT & DAY SURGERY
Procedure
Date:
Time Out Time:
Name of Proceduralist/Surgeon:
STAFF INVOLVED:
Proceduralist
Anaesthetist
Procedure nurse
Procedural assistant
Other
IDENTIFICATION of STAFF member verifying patient
Name:
Designation:
Location:
Signature:
INITIAL PATIENT VERIFICATION COMPETENCE
Is the patient able to participate verbally in the verification process independently? If no, who is the person legally participating in the verification process
Name & relationship:
YES
NO
N/A
COMMENT
ID bracelet Insitu
ALLERGIES / Alerts bracelet Insitu
Patient records / documentation
CONSENT: Provided
Written
Verbal
SITE MARKED?
MEDICAL IMAGING available
PROCEDURAL/SURGICAL TEAM AGREEMENT?
ANTIBIOTIC PROPHYLAXIS ASSESSMENT ATTENDED?
VENOUS THROMBOEMBOLISM PROPHYLAXIS ASSESSMENT ATTENDED?
Given?
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Page 1 of 4
JAN12
INT10569A
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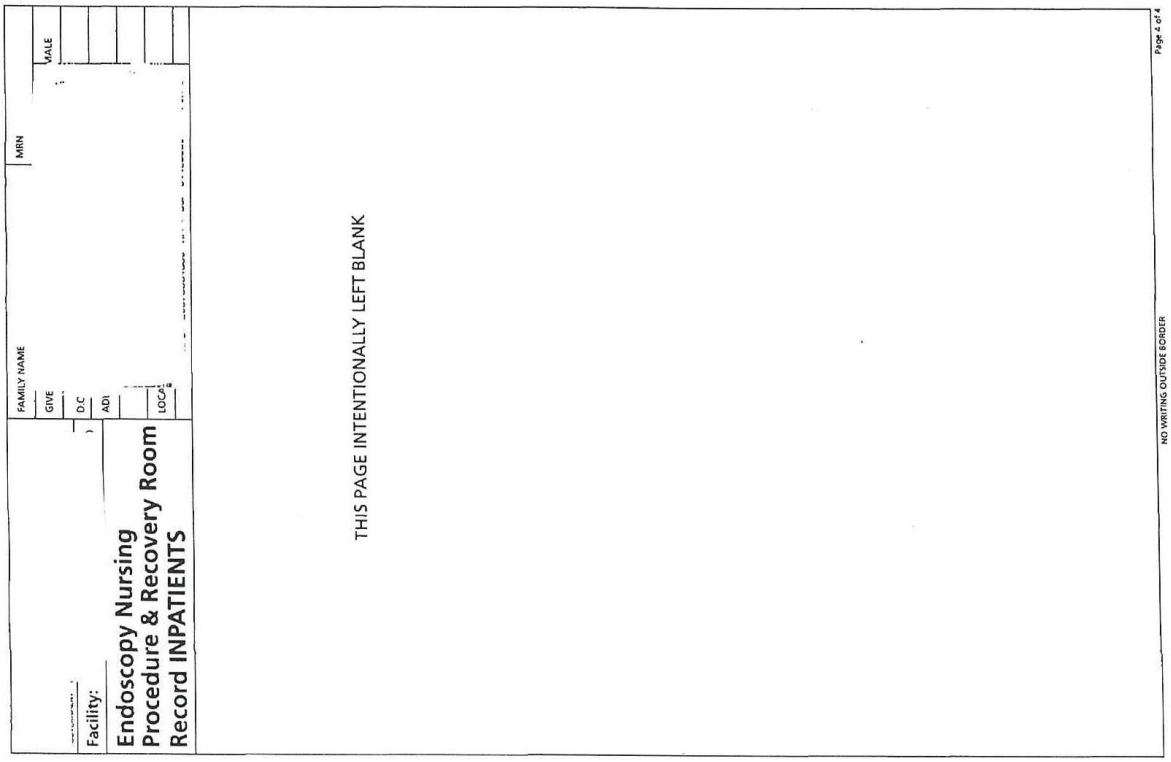
Endoscopy Nursing Procedure & Recovery Room Record INPATIENTS
Facility:
FAMILY NAME
GIVE
D.O.
ADI
MRN
MALE
LOC
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Page 4 of 4
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Facility:

Endoscopy Nursing Procedure & Recovery Room Record INPATIENTS

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

FEMALE

Procedure:	BRONCHOSCOPY
Time out Completed:	Y ☑ N ☐
Instrument No's:	1269

Time of Arrival in Pro Room:	8:30	
ATTENDING STAFF		
Endoscopist		
Registrar		
Airway Nurse		
Procedure Nurse		
Anaesthetist		
Anaesthetic Nurse		
Additonal Staff		

IVC (L) ARM

IV Cannula	Type PICC	Site (R) arm
Monitoring	Pulse Oximetry ☑	Automated BP ☑
	Capnography ☐	ECG ☐
	No Monitoring ☐	
Oxygen 6 L/Min (Oral)	Nasal Cannula ☑	Hudson Mask ☐
Throat Spray	Yes ☑ No ☐ Time: 08-35	

TIME	08:40	08:44	08:48	:	:	:	:	:	TOTAL
Midazolam mg	2	1	1						4 mg
Fentanyl mcg	50	—	25						75 mcg
Propofol mg									mg

This is a record of administration only. All medications must be charted on national in-patient medication chart & signed by medical officer

MEDICATION	DOSE	ROUTE	TIME
COPHENYLCAINE FORTE		Nasal/Oral	08:35
XYLOCAINE VISCOSE	2mls	Nasal	
XYLOCAINE ADRENALIN		VIA SCOPE	
IV FLUIDS	TYPE: VOLUME:	RATE:	

THERAPEUTIC INTERVENTIONS		SPECIMENS TAKEN	
☐ Dilatation	Site:	☐ Biopsies	Sites:
☐ Banding	Site:		
☐ Sclerotherapy	Site:	☐ Polypectomy	Sites:
☐ Clips			
☐ Gold probe		☐ EMR	Sites:
☐ APC		☐ FNA	Sites:
☐ Stent ☐ Plastic	Site: ☐ Metal	☐ Clo-test	
		☐ Cyto brushings	Sites:
☐ Diathermy pad		☐ Cyst Aspirate	Sites:
☐ Removed:	☐ Site inspected	☑ Washings ☐ Microbiology ☑ Cytology	
☐ Peg inserted	Size.......... Fr Type..........	Other: RLL. LLL. GENERAL WASHINGS	
Other:			

INFORMATION FOR RECOVERY

Consciousness: Awake/Alert ☐ Drowsy ☑ Other ☐ ....

SIP Test ☑ Time: 11:00

NBM ☐ Clear Fluids ☐ Full Fluids ☐ Soft Diet ☐ Normal Diet ☑

Additional Instructions:

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BINDING MARGIN – NO WRITING

Facility:

Endoscopy Nursing Procedure & Recovery Room Record INPATIENTS

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

☐ FEMALE

Recovery Arrival Time:	:	Receiving Nurse (Print Name):	
Date:		Signature:	
Oxygen Therapy ☐		Pulse Oximetry ☐	IV Therapy ☐

OBSERVATIONS *ALL OBSERVATIONS MUST BE RECORDED ON OBSERVATION CHART* *ADULT GENERAL*

NB: This is a record of administration only. All medications must be charted on national in-patient medication chart & signed by medical officer

MEDICATION	DOSE	ROUTE	TIME
			:
			:
			:
			:
			:
IV FLUIDS	TYPE: VOLUME:	RATE:	

INSTRUCTIONS FOR WARD	DISCHARGE REVIEW & INSTRUCTIONS
Observations on return to ward	Copy of Report ☐
Frequency:	Nursing Transfer Form ☐
Oxygen Y ☐ N ☐ ....L/Min	Dentures Returned ☐
SIP Test Y ☐ N ☐ Time:	Belongings Returned ☐
NBM ☐ Clear Fluids ☐ Full Fluids ☐	Post-bronchoscopy CXR Y ☐ N ☐
Soft Diet ☐ Normal Diet ☐	Transferred to:
IV Therapy ☐ Type:	Back to Ward ☐ Transit Lounge ☐ Other Hospital ☐
Rate:	

ADDITIONAL NOTES TTE ... PRIVATE –

Page 3 of 4 — NO WRITING OUTSIDE BORDER

/ **Health**

Procedure Venue:

Bronchoscopy Report

Date: 6/02/20 Start: 8:40:00 AM End: 8:55:00 AM
Duration: 15 minutes

ID:
Name:

Date of birth: 24/05/1957
Address:

Classification:

General practitioner:

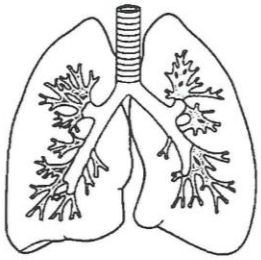
Referring doctor:

Bronchoscopist
Dr

Assistant
Registrar

Instruments
OLYMPUS 1269

Nurses



Medications Used
Co-Phenylcaine Forte nasal spray
Fentanyl 75 mcg
Midazolam 4mg
Xylocaine VISCOUS to nares
Xylocaine with ADRENALINE

Report Findings
There was nothing precluding the bronchoscopy on history or physical examination. Informed consent for the procedure was obtained. The risks and benefits were explained and the alternatives were outlined.

The patient tolerated the procedure well, and there were no complications. The posterior nasal space was examined and was normal. The larynx was examined and was normal.

Post operative instructions included routine post-operative observations, nil by mouth for 2 hours, sip test before food, oxygen therapy with monitoring and oximetry.

Preliminary Diagnosis
No diagnosis made.

Procedures
Vial 1: washing x 1 from Trachea for Microbiology
Vial 2: washing x 2 from L lower lobe for Cytology, Microbiology
Vial 3: washing x 2 from LEFT and R lower lobe for Cytology, Microbiology

General Comments
The airways were inflamed. There was frank pus throughout the bronchial tree bilaterally. Washings have been sent for analysis.

Signature:
Dr

Page 1 of 1

Cytology Report

* Final Report *

Result Type: Cytology Report
Result Date: 06 February 20 11:15
Result Status: Auth (Verified)
Result Title: Cytology (Fluids)
Encounter info: , Inpatient, 06/02/20 - 06/02/20
Contributor system:

* Final Report *

Cytology (Fluids)

LABORATORY NUMBER: 14-146-296-1
RECEIVED: 06-Feb- 11:37
SPECIMEN TYPE: Bronchioloalveolar LavageLeft Lower Lobe

REPORT NAME: CYTOLOGY
REPORTING PATHOLOGIST: Dr
VALIDATED BY:

CLINICAL NOTES:
Cystic fibrosis. Bronchiectasis. ? Eo. ? Charcot-Leyden.

MACROSCOPIC DESCRIPTION:
19mls cloudy bloodstained fluid received. 4c/s made.

MICROSCOPIC REPORT: 9/02/
LLL - No atypical or malignant cells are seen. No Charcot-Leyden crystals are identified.

TOTAL CELL COUNT: 0.25 x 10[Super_9]/L

DIFFERENTIAL CELL COUNT: NB - Presence of blood may influence cell count.
Neutrophils - 97%
Macrophages - 3%

ML

Printed by:
Printed on:

4. Pressure injury

4.1 What is the correct code for stage III pressure injury of foot (NOS):

a) L89.07

b) L89.28

c) L89.13

d) L89.29

4.2 Match the following sites (1–4) to its corresponding pressure injury code (A–D):

1. toe – stage II	A. L89.37
2. ear – stage I	B. L89.18
3. outer heel – stage IV	C. L89.23
4. scapula – stage III	D. L89.01

4.3 Patients can be assigned more than one pressure injury code. True or False?

4.4 Which of the following codes should be assigned for pressure injury of ankle without documentation of the stage?

a) L89.09

b) L89.49

c) L89.59

d) L89.99

4.5 If a pressure injury heals before discharge, it does ***not*** need to be coded. True or False?

4.6 If a pressure injury is present on admission, but worsens during the episode, which condition onset flag (COF) value should be assigned?

a) 1 - Condition with onset during the episode of admitted patient care

b) 2 - Condition ***not*** noted as arising during the episode of admitted patient care

4.7 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM codes and corresponding condition onset flags.

A 75 year old male patient is admitted to hospital with pneumonia. He was admitted from home with stage I pressure ulcers on the ankle and sacrum. During the episode of care the pressure ulcer on the ankle heals, but the pressure area on the sacrum progresses to stage II.

_____

_____

_____

_____

4.8 Case scenario

From the case scenario below, assign and sequence the appropriate pressure injury codes and corresponding condition onset flags.

A 78 year old male patient is admitted to hospital from home with stage I pressure ulcers on the buttock and upper leg. On day three, the pressure ulcers have progressed to stage II buttock and upper leg, and a new stage I pressure ulcer has developed on his ankle.

_____

_____

_____

_____

5. Rehabilitation

5.1 Which code should be assigned for rehabilitation in Ninth Edition:

a) Z50.1 *Other physical therapy*

b) Z50.8 *Care involving use of other rehabilitation procedures*

c) Z50.9 *Care involving use of rehabilitation procedure, unspecified*

5.2 What should be assigned as the principal diagnosis in a rehabilitation episode?

a) Z50.9 *Care involving use of rehabilitation procedure, unspecified*

b) the underlying condition requiring rehabilitation

c) a code for history of the relevant condition

5.3 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM codes.

A patient admitted to a rehabilitation hospital for rehabilitation post fractured neck of femur after falling out of bed at home.

_____

_____

_____

_____

_____

5.4 Clinical record 7

From the clinical record below, assign and sequence the appropriate ICD-10-AM and ACHI codes.

_____

_____

_____

ADDRESSOGRAPH LABEL
HOSPITAL: UR:
71Y
ADM: 15/11/
R1D
Female

HOSPITAL

Discharge Planning and Summary

Date of Admission: 15/11
Date of Discharge: 20/11
Time of Discharge: 1030 hrs.
N.O.K: (husband) Tel:
GP: Dr Tel: Fax:
Diagnosis on admission: for spinal stenosis and lumbar radiculopathy
Rehab following, L2-L4 Laminectomy, Discectomy, Decompression
Investigations: Biochemistry: Attached ☐ Not Attached ☐ X-Rays: Attached ☐ Not Attached ☐
Pathology: Attached ☐ Not Attached ☐ Others
Allergies & Reactions: None Known.
Medical History: Hypertonic bladder, Breast lumpectomy, (R) THR
Hypertension, Arthritis, Tubal ligation
Discharge Destination: Home
Discharge in care of: Self ☑ Spouse ☑ Relative ☐ Other ☐
Condition on discharge: Alert & Oriented. Patient well.
Wound Condition: Healing - 3x little areas slightly wet. Steristrips applied to those areas
Wound Dressing: Steristrips + Opsite + Island Opsite
Wound Care Instructions: Keep clean and dry. Wound review in 5 days.
Pressure Areas: Intact
Comments: ✓
Level of Falls Risk: (Low) Med High (circle one)
Interventions implemented to reduce risk of fall: ✓
Diet: Normal Diet

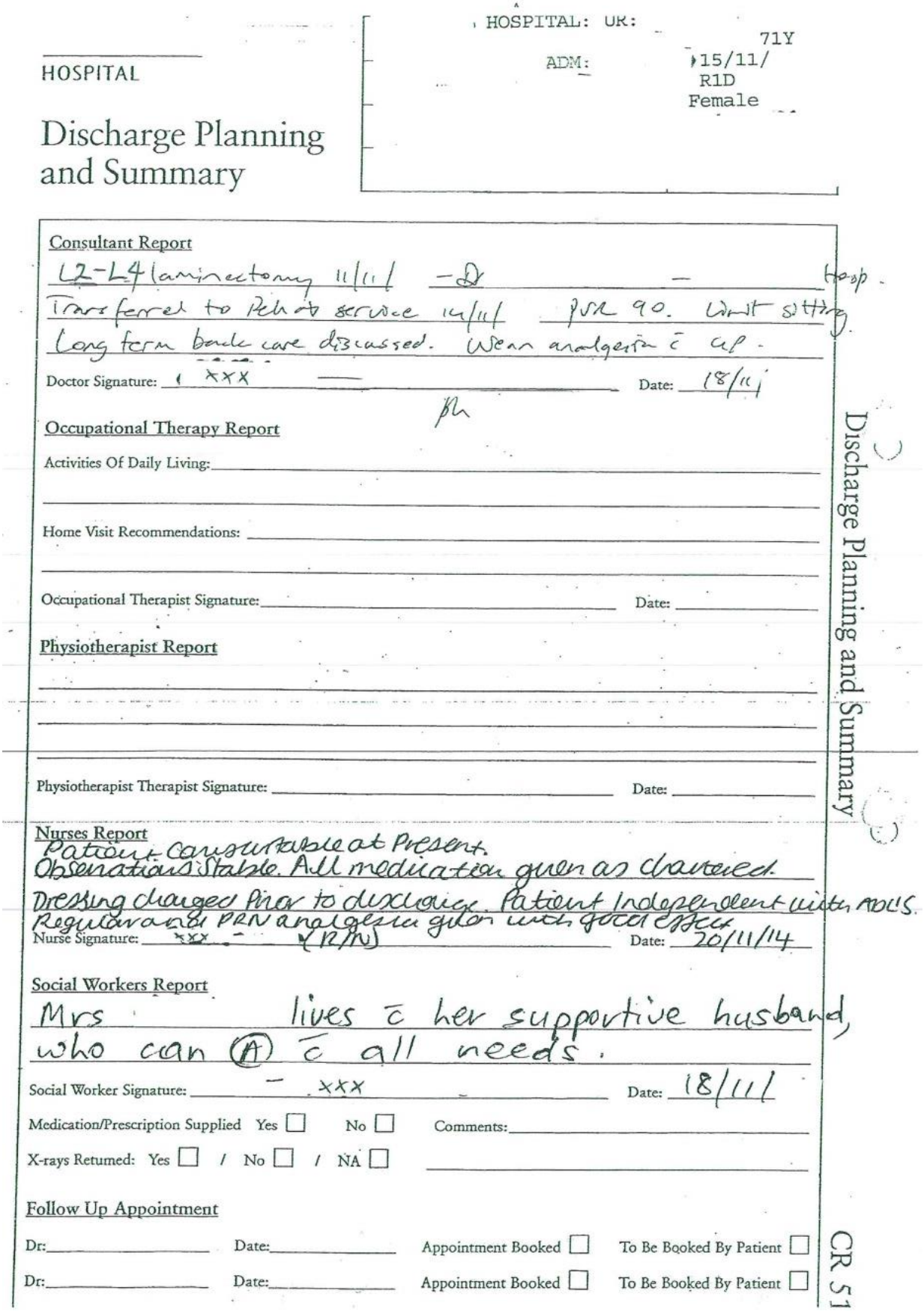
Services On Discharge

Service	Yes/No/NA	Comments
Community Nurse	✓	
Meals	✓	
Homecare	✓	
Transport	✓	
Local Physio	✓	
Day Only Rehab	✓	
Others a)	✓	
b)	✓	
c)	✓	

Discharge Planning and Summary

CR 5

Clinical record 7 – Rehabilitation care (continued)



HOSPITAL

HOSPITAL: UR:

71Y

ADM: 15/11/

R1D

Female

Discharge Planning and Summary

Consultant Report

L2-L4 laminectomy 11/11/ -Dr — Hosp.
Transferred to Rehab service 14/11/ PSR 90. Unit sitting.
Long term bowel care discussed. Wean analgesia ↓ up.

Doctor Signature: xxx Date: 18/11/

Ph

Occupational Therapy Report

Activities Of Daily Living:

Home Visit Recommendations:

Occupational Therapist Signature: Date:

Physiotherapist Report

Physiotherapist Therapist Signature: Date:

Nurses Report

Patient comfortable at Present.
Observations Stable. All medication given as charted.
Dressing changed Prior to discharge. Patient Independent with ADLS.
Regular and PRN analgesia given with good effect.

Nurse Signature: xxx (RN) Date: 20/11/14

Social Workers Report

Mrs lives ↓ her supportive husband, who can (A) ↓ all needs.

Social Worker Signature: xxx Date: 18/11/

Medication/Prescription Supplied Yes ☐ No ☐ Comments:

X-rays Returned: Yes ☐ / No ☐ / NA ☐

Follow Up Appointment

Dr: Date: Appointment Booked ☐ To Be Booked By Patient ☐

Dr: Date: Appointment Booked ☐ To Be Booked By Patient ☐

Discharge Planning and Summary

CR 51

HOSPITAL

Page 1 of 2

HOSPITAL: UR:

INPATIENT PHYSIOTHERAPY ASSESSMENT

AS
Female

CR 54

Date Of Admission: 15/11/11	Surgeon: Dr
Date of Surgery: 11/11/11	Operation: L2-4 laminectomy
Medical Diagnosis: Stenosis	
WB Status: WBAT	Specific Orders: A3 protocol
History of Present Complaint: Long Hx LBP - getting worse - had R/v c Dr 2yrs ago + then had THR done first.	
Associated Medical History: Prev (R) THR 2yrs ago, PMR, ? MI in past.	
Pre-morbid and Social Status: lives with husband, (I) mob + ADLs, have but single level c 1x step only. Mob not restricted by stenosis.	
Post-operative Progress: SOOB/ mob IDPO. No issues so far	
Pain: At rest 2/10	At worst 5/10
Observation: Alert + orientated.	

Bed Mobility	Log Rolling: AOI	Bridging: (I)	Move across bed: (I)
Transfers	Sit-Stand: (I)	Lying-Stand: AOI for log-roll	Standing-Lying: AOI for log-roll
Mobility	Walking Aid: (I) SBA / A FASF	Distance: (>)/ < 50 metres	

INPATIENT PHYSIOTHERAPY ASSESSMENT

CR 54

Hospital – CR 54

Updated: January

Page 2 of 2

INPATIENT PHYSIOTHERAPY ASSESSMENT

CR 54

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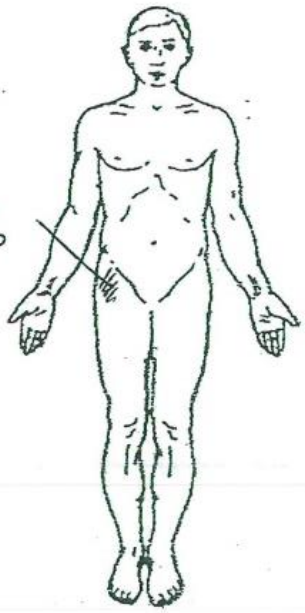
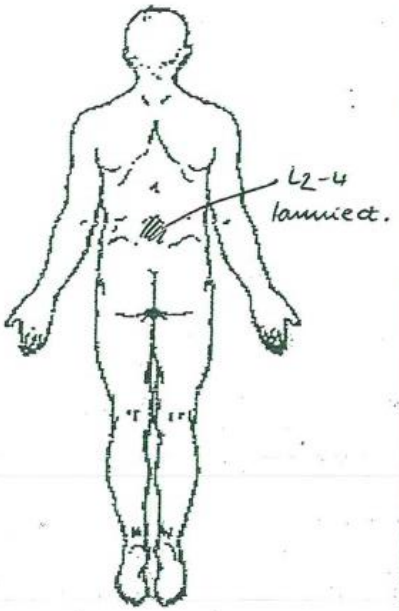
 R L	 L R

Objective Assessment:

- Log-rolling c AOI especially SCEOB → supine for correct technique. Advised not 100% essential
- STS (I). (I) c FASF
- Practised c 2x/5 4pt gait c SVOI

Plan: Gym from 15/11/14

Signature:	Print Name:
Designation: PHYSIO	Date: 15/11
Follow Up:	Date Goals Achieved:
Discharge Date:	Variance:

Hospital – CR 54 Updated: January

HOSPITAL

HOSPITAL: UR:

INPATIENT REHABILITATION PROGRAM WEEKLY CASE CONFERENCE

CR 16

ADM: ___ 71Y 15/11/ R1D Female

Date: 18/11/ Start: 0830hrs Finish: 0925hrs

Present: ☑ NUM/RN ☑ PT ☐ OT ☐ SW ☐ VMO ☐ Other

Patient and/or caregivers have been provided with the opportunity to participate in their care. ☑ Yes ☐ No

Comments:

DATE/TIME	Nursing:
~~18/11~~	
	Initials:
17/11	Occupational Therapy: Requiring (A) ± TDL's & would like Back Care resources from her Doctor. Keep for D/C. OT arranging scaling from ELP.
	Initials:
17/11	Physiotherapy: mobile (I), 2 sticks. (I) sit-stand. pain well controlled. managing low grade edx in btw 11 bars.
	Initials:
17/11	Social Work: Mrs ___ lives ± her supportive husband, who can (A) ± all needs. SW to assist ± flight bookings once D/C date confirmed.
	Initials:
	Medical:
18/11	- TDL @
	- proximal wound swelling
	- bowels working
	- WS x 2
	- pain variable
	- D/C Thursday 20/11/14
	Initials:

Hospital – CR 16 Inpatient Rehabilitation Program Weekly Case Conference Updated: May

Previous Week's Goals	Achieved Yes/No		Reason (if goal not achieved)
1. DP/ AX.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

This Week's Goals
1. To cont ↄ gym program
2.
3.
4.
5.
6.
7.
8.

FINAL CASE CONFERENCE

Discharge Plan:
- Referred to Physiotherapy services ☐
- Referred to Day Only Program ☐
- Referred to Outpatient Private Physio/OT ☑
- Home exercise programme ☑
- TACP ☐
- No further referral needed ☐

Support services needed:

Discharge Destination:
- Home to pre-admission address ☑
- Hostel/Nursing home ☐
- Respite accommodation ☐
- Other: .....

Discharge Date: 20 / 11 / 2ε

Name: ..... Signature: ..... Designation: UMO

Hospital – CR 16 Inpatient Rehabilitation Program Weekly Case Conference Updated: May 2014

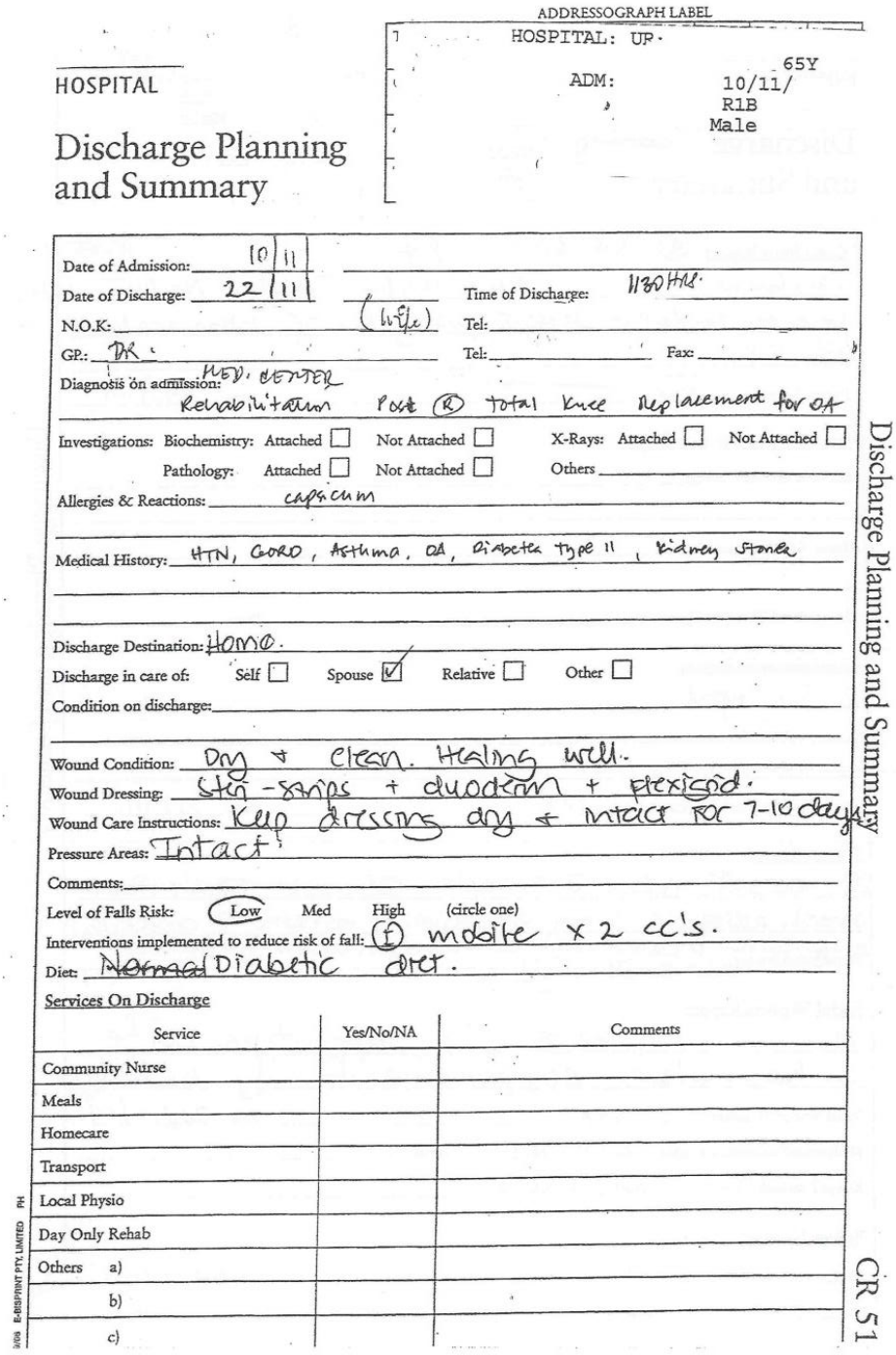
5.5 Clinical record 8

From the clinical record below, assign and sequence the appropriate ICD-10-AM and ACHI codes.

_____

_____

_____



ADDRESSOGRAPH LABEL

HOSPITAL: UP.

65Y

ADM: 10/11/

R1B

Male

HOSPITAL

Discharge Planning and Summary

Date of Admission: 10/11

Date of Discharge: 22/11

Time of Discharge: 1130 HRS.

N.O.K: (wife) Tel:

GP: DR Tel: Fax:

Diagnosis on admission: MED. CENTRE

Rehabilitation Post (R) Total Knee Replacement for OA

Investigations: Biochemistry: Attached ☐ Not Attached ☐ X-Rays: Attached ☐ Not Attached ☐

Pathology: Attached ☐ Not Attached ☐ Others

Allergies & Reactions: capsicum

Medical History: HTN, GORD, Asthma, OA, Diabetes Type II, Kidney Stones

Discharge Destination: Home.

Discharge in care of: Self ☐ Spouse ☑ Relative ☐ Other ☐

Condition on discharge:

Wound Condition: Dry & clean. Healing well.

Wound Dressing: Steri-strips + duoderm + flexigrid.

Wound Care Instructions: Keep dressing dry & intact for 7-10 days

Pressure Areas: Intact

Comments:

Level of Falls Risk: (Low) Med High (circle one)

Interventions implemented to reduce risk of fall: (f) mobile x 2 cc's.

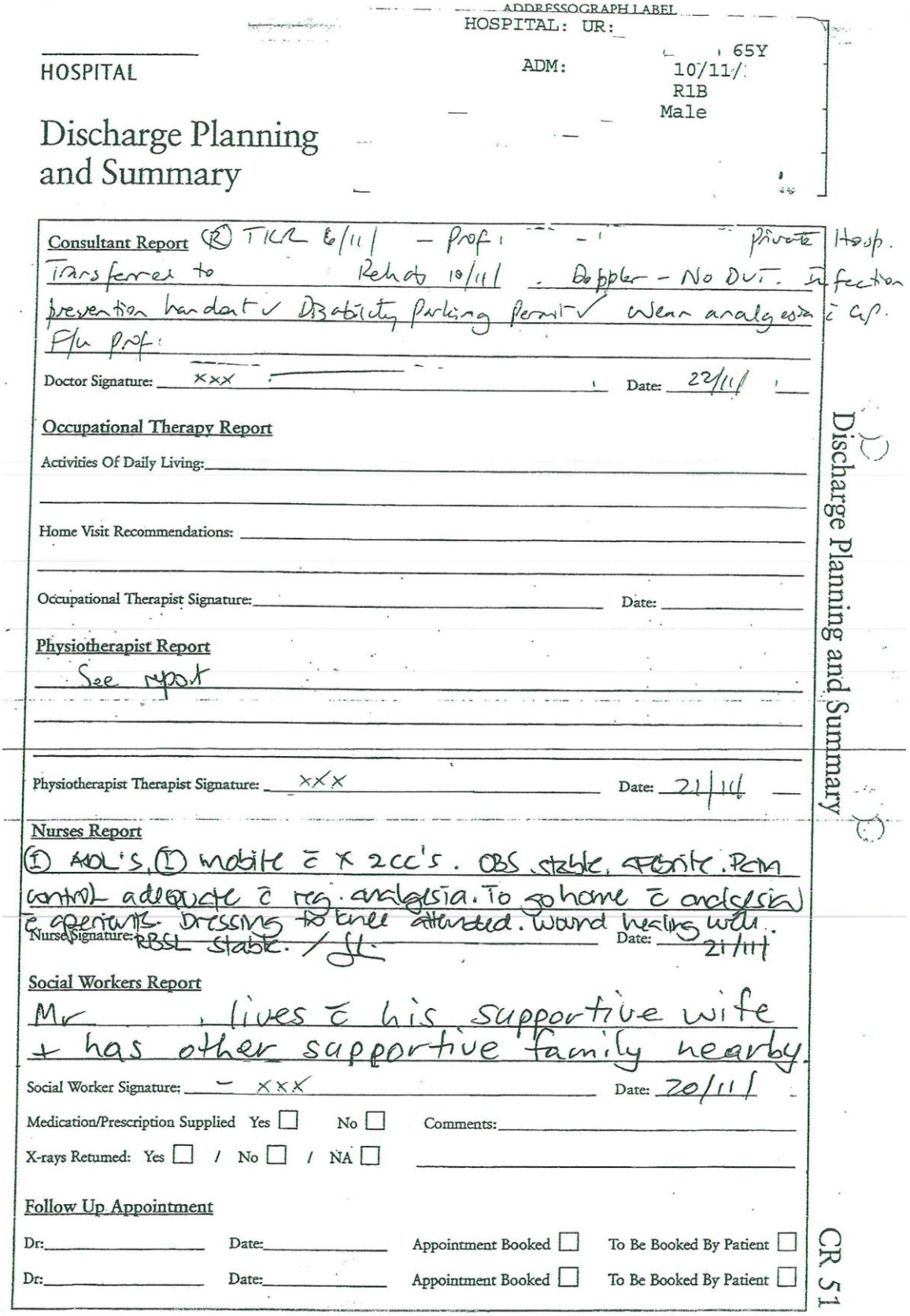
Diet: ~~Normal~~ Diabetic diet.

Services On Discharge

Service	Yes/No/NA	Comments
Community Nurse		
Meals		
Homecare		
Transport		
Local Physio		
Day Only Rehab		
Others a)		
b)		
c)		

Discharge Planning and Summary

CR 51



ADDRESSOGRAPH LABEL
HOSPITAL: UR:

HOSPITAL

ADM: 10/11/ , 65Y
R1B
Male

Discharge Planning and Summary

Consultant Report (R) TKR 6/11/ – Prof: – private Hosp.
Transferred to Rehab 10/11/ . Doppler – No DVT. Infection prevention handout ✓ Disability Parking Permit ✓ Wean analgesia i/c.
F/u Prof:

Doctor Signature: xxx Date: 22/11/

Occupational Therapy Report

Activities Of Daily Living:

Home Visit Recommendations:

Occupational Therapist Signature: Date:

Physiotherapist Report

See report

Physiotherapist Therapist Signature: xxx Date: 21/11/

Nurses Report

(I) ADL's, (I) mobile c 2 x 2cc's. OBS stable, afebrile. Pain control adequate c reg. analgesia. To go home c analgesia c aperients. Dressing to knee attended. Wound healing well.
RBSL stable. /jl

Nurse Signature: Date: 21/11/

Social Workers Report

Mr , lives c his supportive wife + has other supportive family nearby.

Social Worker Signature: xxx Date: 20/11/

Medication/Prescription Supplied Yes ☐ No ☐ Comments:

X-rays Returned: Yes ☐ / No ☐ / NA ☐

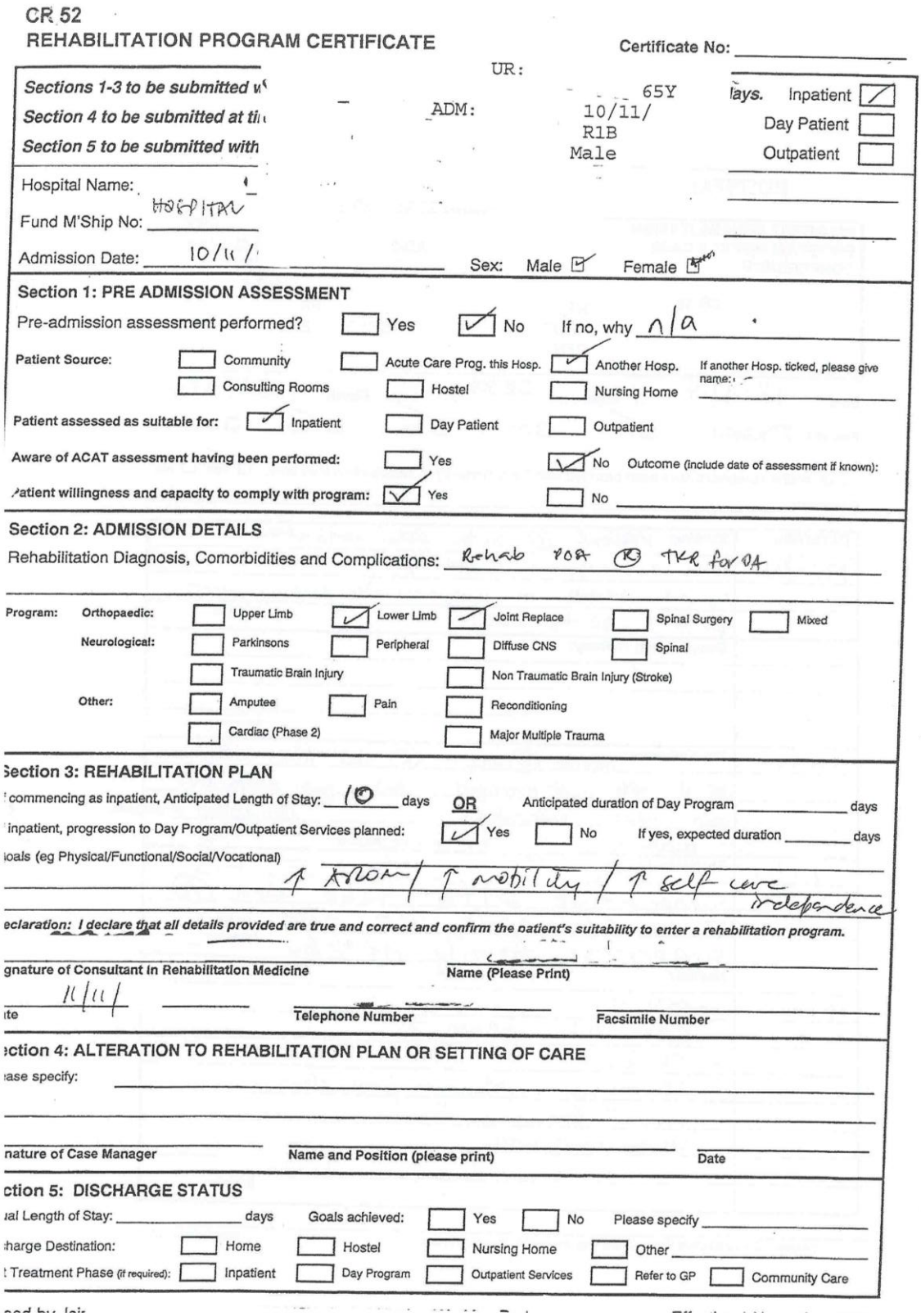
Follow Up Appointment

Dr: Date: Appointment Booked ☐ To Be Booked By Patient ☐

Dr: Date: Appointment Booked ☐ To Be Booked By Patient ☐

Discharge Planning and Summary

CR 51



CR 52

REHABILITATION PROGRAM CERTIFICATE

Certificate No: _____

UR:

Sections 1-3 to be submitted w
Section 4 to be submitted at ti
Section 5 to be submitted with

ADM: 10/11/ R1B Male 65Y

Inpatient ☑ Day Patient ☐ Outpatient ☐

Hospital Name: _____

Fund M'Ship No: HOSPITAL

Admission Date: 10/11/ Sex: Male ☑ Female ☐

Section 1: PRE ADMISSION ASSESSMENT

Pre-admission assessment performed? ☐ Yes ☑ No If no, why n/a

Patient Source: ☐ Community ☐ Acute Care Prog. this Hosp. ☑ Another Hosp. If another Hosp. ticked, please give name: _____
☐ Consulting Rooms ☐ Hostel ☐ Nursing Home

Patient assessed as suitable for: ☑ Inpatient ☐ Day Patient ☐ Outpatient

Aware of ACAT assessment having been performed: ☐ Yes ☑ No Outcome (include date of assessment if known):

Patient willingness and capacity to comply with program: ☑ Yes ☐ No _____

Section 2: ADMISSION DETAILS

Rehabilitation Diagnosis, Comorbidities and Complications: Rehab POR (R) TKR for OA

Program:

Orthopaedic: ☐ Upper Limb ☑ Lower Limb ☑ Joint Replace ☐ Spinal Surgery ☐ Mixed

Neurological: ☐ Parkinsons ☐ Peripheral ☐ Diffuse CNS ☐ Spinal ☐ Traumatic Brain Injury ☐ Non Traumatic Brain Injury (Stroke)

Other: ☐ Amputee ☐ Pain ☐ Reconditioning ☐ Cardiac (Phase 2) ☐ Major Multiple Trauma

Section 3: REHABILITATION PLAN

commencing as inpatient, Anticipated Length of Stay: 10 days **OR** Anticipated duration of Day Program _____ days

inpatient, progression to Day Program/Outpatient Services planned: ☑ Yes ☐ No If yes, expected duration _____ days

oals (eg Physical/Functional/Social/Vocational)

↑ AROM / ↑ mobility / ↑ self care independence

eclaration: *I declare that all details provided are true and correct and confirm the patient's suitability to enter a rehabilitation program.*

gnature of Consultant in Rehabilitation Medicine **Name (Please Print)**

11/11/ **te** **Telephone Number** **Facsimile Number**

ction 4: ALTERATION TO REHABILITATION PLAN OR SETTING OF CARE

ase specify: _____

nature of Case Manager **Name and Position (please print)** **Date**

ction 5: DISCHARGE STATUS

al Length of Stay: _____ days Goals achieved: ☐ Yes ☐ No Please specify _____

harge Destination: ☐ Home ☐ Hostel ☐ Nursing Home ☐ Other _____

Treatment Phase *(if required)*: ☐ Inpatient ☐ Day Program ☐ Outpatient Services ☐ Refer to GP ☐ Community Care

HOSPITAL

HOSPITAL: UR:

65Y

INPATIENT REHABILITATION PROGRAM WEEKLY CASE CONFERENCE

ADM: 10/11/14

R1B

Male

CR 16

Date: 18/11 Start: 0830hrs. Finish: 0925 hrs

Present: ☑ NUM/RN ☐ PT ☐ OT ☑ SW ☐ VMO ☐ Other

Patient and/or caregivers have been provided with the opportunity to participate in their care. ☑ Yes ☐ No

Comments:

DATE/TIME	
17/11	**Nursing:** Patient (I) with ADLs. ambulant with x2 CC. needs encouragement & take pain medications. dressing dry and intact. on regular ile pack. on CPM. 80 deg AFTE. Initials:
	Occupational Therapy: Initials:
17/11	**Physiotherapy:** mobile (I) 2CC. (E) HKS. AROM 75/90° flexion SR @ 100 just managed. cont c gym programme pain issue. Motivated. CPM applied 0-80° num. To speak to ... re: CPM request Initials:
17/11	**Social Work:** Mr ... lives c his supportive wife who can (A) c most needs. He also has supportive family nearby. Initials:
	Medical:
18/11	- ADL (I). - CPM 80° AROM 75°. - CC x2 - 2S house. Manages pool stairs. - Lives c family - Review next week Initials:

Hospital – CR 16 Inpatient Rehabilitation Program Weekly Case Conference Updated:

Previous Week's Goals	Achieved Yes/No		Reason (if goal not achieved)
1. NP ax			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

This Week's Goals
1. cont gym program to ↑ AROM + mm strength
2. CPM if consent.
3.
4.
5.
6.
7.
8.

FINAL CASE CONFERENCE

Discharge Plan:
- Referred to [redacted] Physiotherapy services ☐
- Referred to Day Only Program ☐
- Referred to Outpatient Private Physio/OT ☑
- Home exercise programme ☑
- TACP ☐
- No further referral needed ☐

Support services needed:

Discharge Destination:
- Home to pre-admission address ☑
- Hostel/Nursing home ☐
- Respite accommodation ☐
- Other: .....

Discharge Date: 22/11/.....

Name: [redacted] Signature: ..... Designation: VMO

6. Updates to cardiac Australian Coding Standards

6.1 Which standard contains the instructions for reoperation of coronary artery bypass grafts?

6.2 ACS 0941 *Arterial disease* has been updated to remove the criteria of over 50% obstruction for atherosclerosis. True or False?

6.3 Code assignment for complications (eg, occlusion) of CABG should be guided by:

a) the length of time since the original surgery (ie, within one month of surgery)

b) the documentation in the clinical record

6.4 Classification instructions for reoperation of peripheral vessels (arteries & veins) can be found in which ACS:

a) ACS 0909 *Coronary artery bypass grafts*

b) ACS 0934 *Cardiac and vascular revision/reoperation procedures*

c) ACS 0940 *Ischaemic heart disease*

d) ACS 0941 *Arterial disease*

7. ACHI Chapter 7 *Procedures on respiratory system*

7.1 Coding bronchoscopy requires identification of rigid or fibreoptic. True or False?

7.2 Which of the following code titles is appropriate for classification of 'Endoscopic insertion of endobronchial stent'?

a) *Endoscopic insertion of bronchial tool*

b) *Endoscopic insertion of bronchial appliance*

c) *Endoscopic insertion of bronchial device*

7.3 The newly created destruction procedures on bronchus are located in which ACHI block?

a) [545] *Other excision procedures on bronchus*

b) [546] *Repair procedures on bronchus*

c) [547] *Other procedures on bronchus*

7.4 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM and ACHI codes.

A patient with haemoptysis and a suspicious lesion of the main bronchus is admitted to hospital for an endoscopic needle biopsy of the bronchus. The biopsy results are returned and the patient is diagnosed with bronchial adenoma, carcinoid type.

_____

_____

_____

_____

_____

8. Dengue

8.1 Which code should be assigned for documentation of dengue haemorrhagic fever grade 2: A97.0 or A97.2?

8.2 Circle the correct word to complete the following code title:

with without

A97.1 *Dengue* _____ *warning signs*

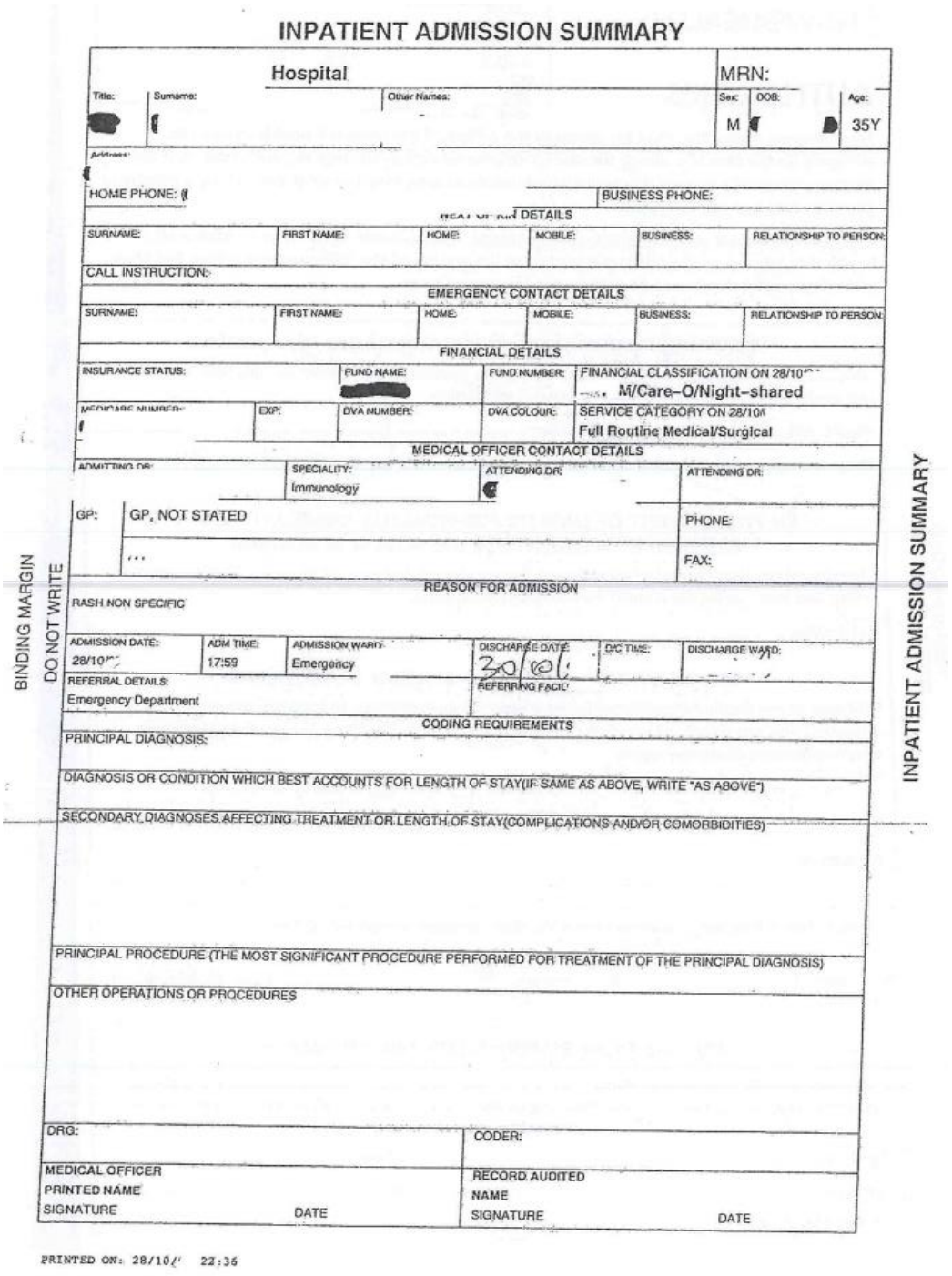
8.3 Clinical record 9

From the clinical record below, assign and sequence the appropriate ICD-10-AM codes.

_____

_____

_____



INPATIENT ADMISSION SUMMARY

Hospital | MRN:

Title: | Surname: | Other Names: | Sex: M | DOB: [redacted] | Age: 35Y

Address: [redacted]

HOME PHONE: [redacted] | BUSINESS PHONE:

NEXT OF KIN DETAILS

SURNAME:	FIRST NAME:	HOME:	MOBILE:	BUSINESS:	RELATIONSHIP TO PERSON:

CALL INSTRUCTION:

EMERGENCY CONTACT DETAILS

SURNAME:	FIRST NAME:	HOME:	MOBILE:	BUSINESS:	RELATIONSHIP TO PERSON:

FINANCIAL DETAILS

INSURANCE STATUS:	FUND NAME: [redacted]	FUND NUMBER:	FINANCIAL CLASSIFICATION ON 28/10/[redacted]: M/Care–O/Night–shared
MEDICARE NUMBER: [redacted]	EXP:	DVA NUMBER:	DVA COLOUR: / SERVICE CATEGORY ON 28/10/[redacted]: Full Routine Medical/Surgical

MEDICAL OFFICER CONTACT DETAILS

ADMITTING DR:	SPECIALITY: Immunology	ATTENDING DR: [redacted]	ATTENDING DR:

GP: GP, NOT STATED | PHONE:

FAX:

REASON FOR ADMISSION

RASH NON SPECIFIC

ADMISSION DATE: 28/10/[redacted]	ADM TIME: 17:59	ADMISSION WARD: Emergency	DISCHARGE DATE: 30/10/[redacted]	DIC TIME:	DISCHARGE WARD:

REFERRAL DETAILS: Emergency Department | REFERRING FACIL:

CODING REQUIREMENTS

PRINCIPAL DIAGNOSIS:

DIAGNOSIS OR CONDITION WHICH BEST ACCOUNTS FOR LENGTH OF STAY(IF SAME AS ABOVE, WRITE "AS ABOVE")

SECONDARY DIAGNOSES AFFECTING TREATMENT OR LENGTH OF STAY(COMPLICATIONS AND/OR COMORBIDITIES)

PRINCIPAL PROCEDURE (THE MOST SIGNIFICANT PROCEDURE PERFORMED FOR TREATMENT OF THE PRINCIPAL DIAGNOSIS)

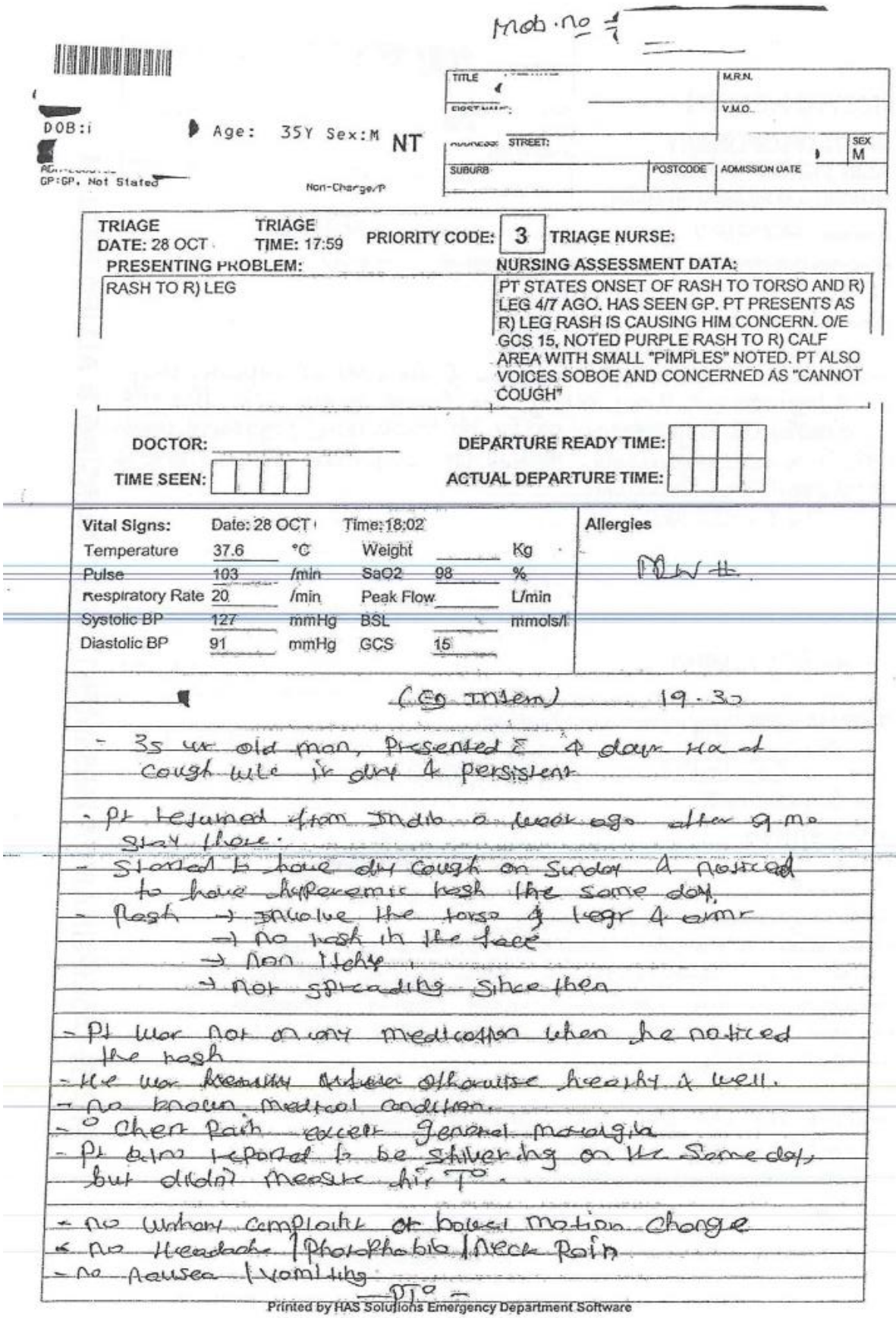
OTHER OPERATIONS OR PROCEDURES

DRG:	CODER:
MEDICAL OFFICER PRINTED NAME SIGNATURE DATE	RECORD AUDITED NAME SIGNATURE DATE

PRINTED ON: 28/10/[redacted] 22:36

BINDING MARGIN DO NOT WRITE

INPATIENT ADMISSION SUMMARY



Mob. no [redacted]

DOB: [redacted] Age: 35Y Sex: M NT

GP: GP, Not Stated

Non-Charge/P

TITLE | M.R.N. | V.M.O. | STREET: | SEX: M | SUBURB | POSTCODE | ADMISSION DATE

TRIAGE DATE: 28 OCT TRIAGE TIME: 17:59 PRIORITY CODE: 3 TRIAGE NURSE:

PRESENTING PROBLEM: RASH TO R) LEG

NURSING ASSESSMENT DATA: PT STATES ONSET OF RASH TO TORSO AND R) LEG 4/7 AGO. HAS SEEN GP. PT PRESENTS AS R) LEG RASH IS CAUSING HIM CONCERN. O/E GCS 15, NOTED PURPLE RASH TO R) CALF AREA WITH SMALL "PIMPLES" NOTED. PT ALSO VOICES SOBOE AND CONCERNED AS "CANNOT COUGH"

DOCTOR: [redacted] DEPARTURE READY TIME:

TIME SEEN: ACTUAL DEPARTURE TIME:

Vital Signs:	Date: 28 OCT		Time: 18:02		
Temperature	37.6	°C	Weight		Kg
Pulse	103	/min	SaO2	98	%
Respiratory Rate	20	/min	Peak Flow		L/min
Systolic BP	127	mmHg	BSL		mmols/l
Diastolic BP	91	mmHg	GCS	15	

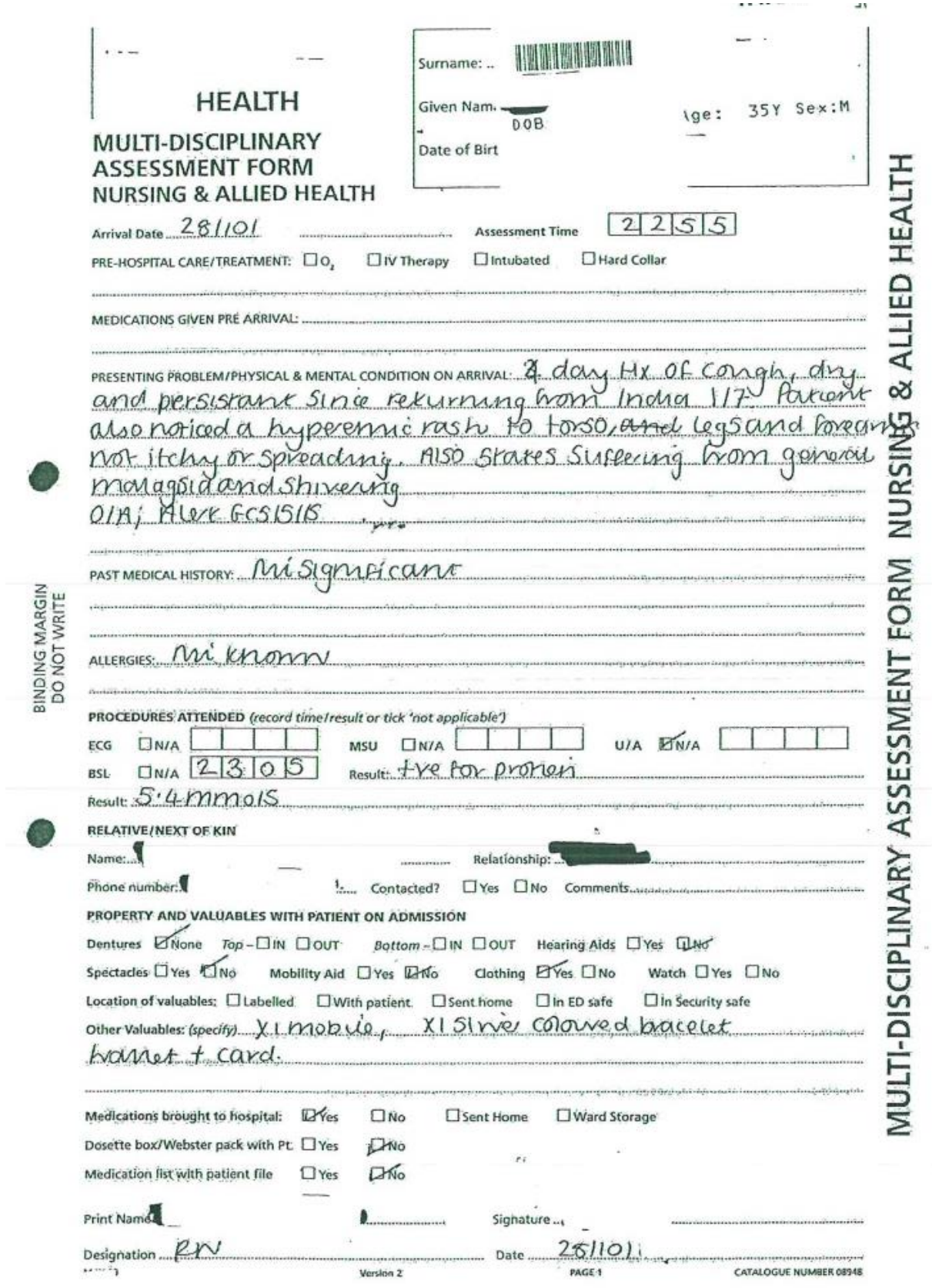
Allergies: NKDA

(CEO intern) 19.30

- 35 yr old man, Presented 4 days hx of cough wch is dry & persistent
- Pt returned from India a week ago after 9 mo stay there.
- Started to have dry cough on Sunday & noticed to have hyperemic rash the same day.
- Rash → involve the torso & legs & arms
  → no rash in the face
  → non itchy
  → not spreading since then
- Pt was not on any medication when he noticed the rash
- He was healthy otherwise healthy & well.
- No known medical condition.
- ○ Chest Pain except general myalgia
- Pt also reported to be shivering on the same day, but didn't measure his T°.
- No urinary complaint or bowel motion change
- No Headache / Photophobia / Neck Pain
- No Nausea / Vomiting

PTO

Printed by HAS Solutions Emergency Department Software



HEALTH

MULTI-DISCIPLINARY ASSESSMENT FORM
NURSING & ALLIED HEALTH

Surname: ..

Given Nam.. DOB

Date of Birt

Age: 35Y Sex:M

Arrival Date 28/1/01 Assessment Time 2255

PRE-HOSPITAL CARE/TREATMENT: ☐ O_2 ☐ IV Therapy ☐ Intubated ☐ Hard Collar

MEDICATIONS GIVEN PRE ARRIVAL:

PRESENTING PROBLEM/PHYSICAL & MENTAL CONDITION ON ARRIVAL: 7 day Hx of cough, dry and persistant since returning from India 1/7. Patient also noticed a hyperemic rash to torso, ~~and~~ legs and forearms not itchy or spreading. Also states suffering from general malaise and shivering
O/A; Alert GCS 15/15

PAST MEDICAL HISTORY: Nil significant

ALLERGIES: Nil known

BINDING MARGIN DO NOT WRITE

PROCEDURES ATTENDED *(record time/result or tick 'not applicable')*

ECG ☐ N/A MSU ☐ N/A U/A ☑ N/A

BSL ☐ N/A 2305 Result: +ve for protein

Result: 5.4mmol/L

RELATIVE/NEXT OF KIN

Name: Relationship:

Phone number: Contacted? ☐ Yes ☐ No Comments

PROPERTY AND VALUABLES WITH PATIENT ON ADMISSION

Dentures ☑ None Top – ☐ IN ☐ OUT Bottom – ☐ IN ☐ OUT Hearing Aids ☐ Yes ☑ No

Spectacles ☐ Yes ☑ No Mobility Aid ☐ Yes ☑ No Clothing ☑ Yes ☐ No Watch ☐ Yes ☐ No

Location of valuables: ☐ Labelled ☐ With patient ☐ Sent home ☐ In ED safe ☐ In Security safe

Other Valuables: *(specify)* X1 mobile, X1 silver coloured bracelet
Wallet + card.

Medications brought to hospital: ☑ Yes ☐ No ☐ Sent Home ☐ Ward Storage

Dosette box/Webster pack with Pt ☐ Yes ☑ No

Medication list with patient file ☐ Yes ☑ No

Print Name Signature

Designation RN Date 28/1/01

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MULTI-DISCIPLINARY ASSESSMENT FORM NURSING & ALLIED HEALTH

Clinical record 9 – Dengue (continued)

HEALTH

INITIAL FUNCTIONAL SCREEN
Complete in ED

Surname: ..... MRN: .....
Given Names: .....
Date of Birth: ..... Sex: .....
(Affix patient label here)

Cognitive & Psychological State
Alert ☑
Cooperative ☐
Hostile ☐
Withdrawn ☐
Anxious ☐
Confused ☐

Cognition
Orientated to time & Place ☑
Concerns re memory ☐
Inattentive ☐

Language & communication
Interpreter required? ☐ Yes ☑ No Arranged? ☐ Yes ☑ No
Preferred language: .....
Comment: .....
Comment on any clinical practices that may be affected by hospitalisation
.....
.....
Does patient have trouble communicating? ☐ Yes ☑ No
(if yes complete the Communication and Care Cues)
Comment: .....
.....

PATIENT ASSESSMENT – TO BE COMPLETED ON ADMISSION (in ED or Ward/Unit)

Pressure Area
WaterLow Score .....
Dietitian required Yes/No
Falls Score .....
INTERVENTIONAL STRATEGIES
(Low) Medium High

Vision Adequate (Yes)/No
Wears glasses? Yes/(No)

Hearing adequate (Yes)/No
Hearing aid? Yes/(No)
Left Right Both

Mouth
Clean ☑
Ulcerated ☐
Other ☐
Dentures? Yes/No

Breathing
Normal ☑
Distressed ☐
Short of Breath ☐

Mobility prior to Admission
Independent ☑
Using equipment ☐
Requiring assistance ☐
Bed Bound ☐
Completely dependent ☐

Swabs done? Yes/No

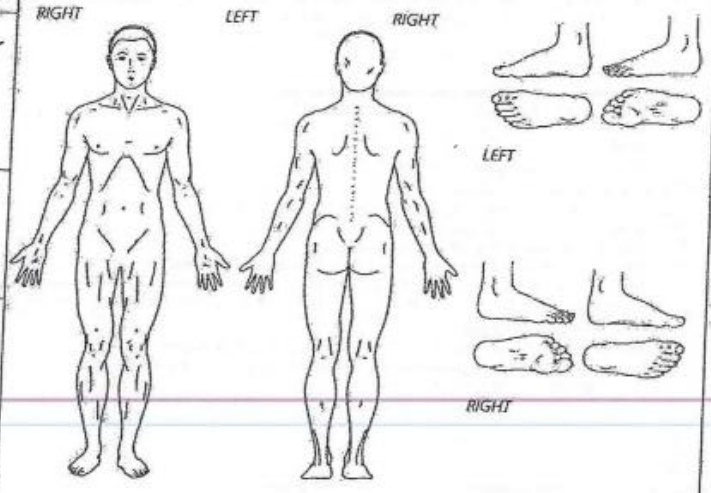
Continence Urine (Yes)/No
Able to pass urine? (Yes)/No
Indwelling catheter? Yes/(No)
Type:
Date last changed:

Prosthesis Yes/(No)
Type:
(illustrate if applicable)

Continence Faeces (Yes)/No
Stoma Yes/(No)
Type
(illustrate if applicable)
Constipation Yes/(No)

Dressing Required Yes/(No)
Type:
(illustrate if applicable)

Tears / Pressure areas / Ulcers *(please illustrate)*



If skin integrity is poor, commence Pressure Risk Protocol – page 5

Nurse Print Name .....
Signature .....
Designation RN
Date 28/10/1
Time 28/10/1

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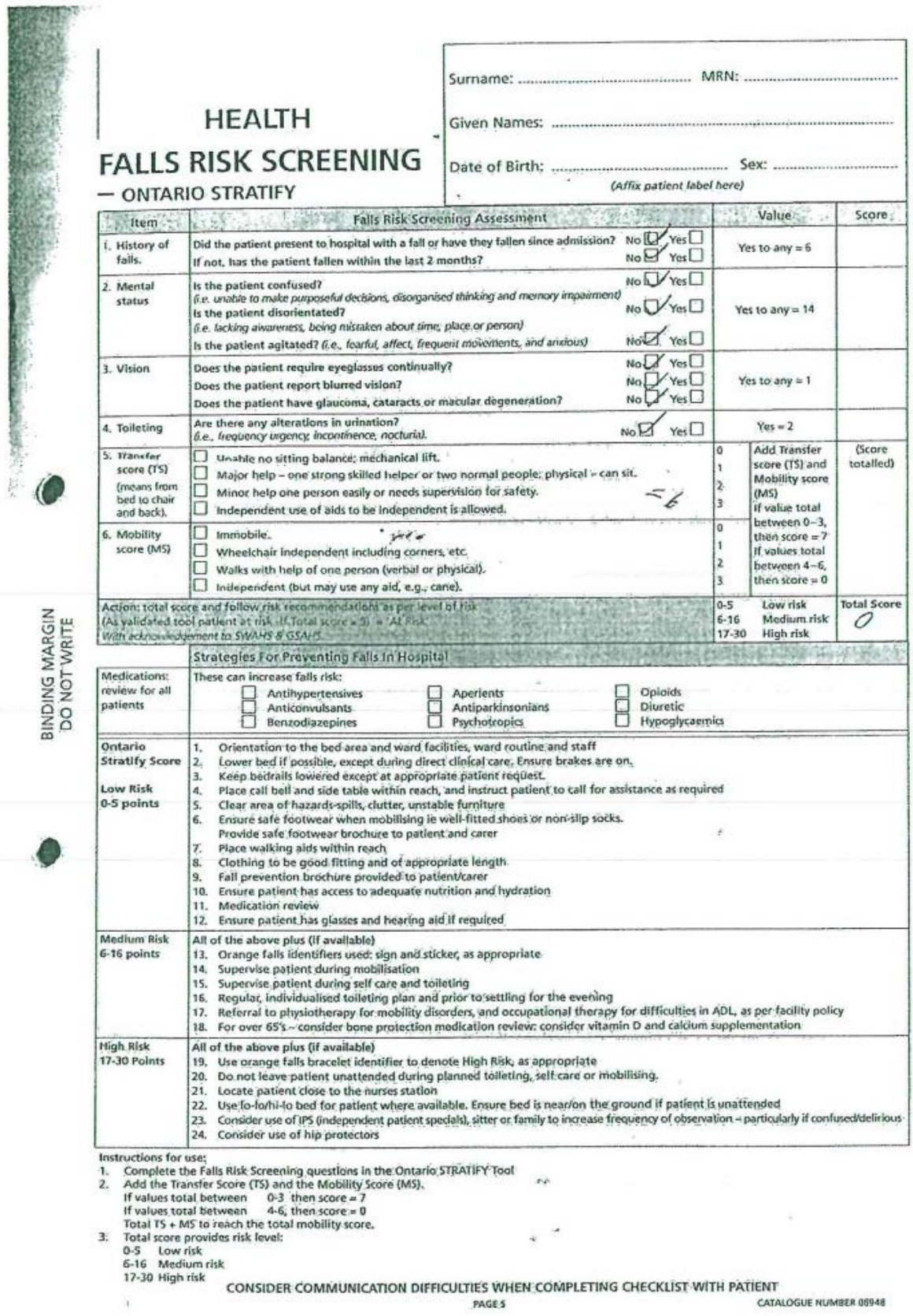

HEALTH

FALLS RISK SCREENING

— ONTARIO STRATIFY

Surname: ..... MRN: .....

Given Names: .....

Date of Birth: ..... Sex: .....

(Affix patient label here)

Item	Falls Risk Screening Assessment	Value	Score
1. History of falls.	Did the patient present to hospital with a fall or have they fallen since admission? No ☑ Yes ☐ If not, has the patient fallen within the last 2 months? No ☑ Yes ☐	Yes to any = 6	
2. Mental status	Is the patient confused? *(i.e. unable to make purposeful decisions, disorganised thinking and memory impairment)* No ☑ Yes ☐ Is the patient disorientated? *(i.e. lacking awareness, being mistaken about time, place or person)* No ☑ Yes ☐ Is the patient agitated? *(i.e., fearful, affect, frequent movements, and anxious)* No ☑ Yes ☐	Yes to any = 14	
3. Vision	Does the patient require eyeglasses continually? No ☑ Yes ☐ Does the patient report blurred vision? No ☑ Yes ☐ Does the patient have glaucoma, cataracts or macular degeneration? No ☑ Yes ☐	Yes to any = 1	
4. Toileting	Are there any alterations in urination? *(i.e., frequency, urgency, incontinence, nocturia).* No ☑ Yes ☐	Yes = 2	
5. Transfer score (TS) (means from bed to chair and back).	☐ Unable no sitting balance; mechanical lift. ☐ Major help – one strong skilled helper or two normal people; physical = can sit. ☐ Minor help one person easily or needs supervision for safety. ☐ Independent use of aids to be independent is allowed.	0 1 2 3	Add Transfer score (TS) and Mobility score (MS) If value total between 0–3, then score = 7 If values total between 4–6, then score = 0 (Score totalled)
6. Mobility score (MS)	☐ Immobile. ☐ Wheelchair independent including corners, etc. ☐ Walks with help of one person (verbal or physical). ☐ Independent (but may use any aid, e.g., cane).	0 1 2 3	
Action: total score and follow risk recommendations as per level of risk (A validated tool patient at risk if Total score ≥ 5) = 'At Risk'. *With acknowledgement to SWAHS & GSAHS*		0-5 Low risk 6-16 Medium risk 17-30 High risk	Total Score 0

Strategies For Preventing Falls In Hospital

Medications: review for all patients

These can increase falls risk:

☐ Antihypertensives ☐ Aperients ☐ Opioids
☐ Anticonvulsants ☐ Antiparkinsonians ☐ Diuretic
☐ Benzodiazepines ☐ Psychotropics ☐ Hypoglycaemics

Ontario Stratify Score

Low Risk 0-5 points

1. Orientation to the bed area and ward facilities, ward routine and staff
2. Lower bed if possible, except during direct clinical care. Ensure brakes are on.
3. Keep bedrails lowered except at appropriate patient request.
4. Place call bell and side table within reach, and instruct patient to call for assistance as required
5. Clear area of hazards-spills, clutter, unstable furniture
6. Ensure safe footwear when mobilising ie well-fitted shoes or non-slip socks.
   Provide safe footwear brochure to patient and carer
7. Place walking aids within reach
8. Clothing to be good fitting and of appropriate length
9. Fall prevention brochure provided to patient/carer
10. Ensure patient has access to adequate nutrition and hydration
11. Medication review
12. Ensure patient has glasses and hearing aid if required

Medium Risk 6-16 points

All of the above plus (if available)

13. Orange falls identifiers used: sign and sticker, as appropriate
14. Supervise patient during mobilisation
15. Supervise patient during self care and toileting
16. Regular, individualised toileting plan and prior to settling for the evening
17. Referral to physiotherapy for mobility disorders, and occupational therapy for difficulties in ADL, as per facility policy
18. For over 65's – consider bone protection medication review: consider vitamin D and calcium supplementation

High Risk 17-30 Points

All of the above plus (if available)

19. Use orange falls bracelet identifier to denote High Risk, as appropriate
20. Do not leave patient unattended during planned toileting, self care or mobilising.
21. Locate patient close to the nurses station
22. Use lo-lo/hi-lo bed for patient where available. Ensure bed is near/on the ground if patient is unattended
23. Consider use of IPS (independent patient specials), sitter or family to increase frequency of observation – particularly if confused/delirious
24. Consider use of hip protectors

Instructions for use:

1. Complete the Falls Risk Screening questions in the Ontario STRATIFY Tool
2. Add the Transfer Score (TS) and the Mobility Score (MS).
   If values total between 0-3 then score = 7
   If values total between 4-6, then score = 0
   Total TS + MS to reach the total mobility score.
3. Total score provides risk level:
   0-5 Low risk
   6-16 Medium risk
   17-30 High risk

CONSIDER COMMUNICATION DIFFICULTIES WHEN COMPLETING CHECKLIST WITH PATIENT

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WATERLOW PRESSURE AREA RISK ASSESSMENT TOOL

Add totals to obtain risk score. Several scores per category can be calculated.

Does patient currently have any pressure areas? ☐ Yes ☑ No

Has the patient previously had a pressure area? ☐ Yes ☑ No

PATIENT WEIGHT: .....kgs *(once per week)* PATIENT HEIGHT: .....cms *(once only – see ulnar arm conversion table)*

SEX/AGE		BUILD/WEIGHT FOR HEIGHT		SPECIAL RISKS	
Male	1	BMI		**Tissue Malnutrition**	
Female	2	Normal (18.5 – 24.9)	0	Terminal cachexia	8
14 – 49	1	Overweight (25 – 29.9)	1	Multiple organ failure	8
50 – 64	2	Obese (>30)	2	Single organ failure, i.e resp, renal, cardiac, liver	5
65 – 74	3	Underweight (<18.5)	3	Peripheral vascular disease	5
75 – 80	4	BMI = Wt (kg) / Ht (m²)		Anaemia *(HB<8)*	2
81 +	5	>65 yrs normal BMI range 22 – 27		Smoking	1
				NEUROLOGICAL DEFICIT	
MOBILITY		**CONTINENCE**		Diabetes, MS, CVA	
Fully	0	Complete/catheterised	0	Motor/sensory paraplegia	4–6
Restless/fidgety	1	Urine incontinence	1	*(Maximum score 6)*	
Apathetic	2	Faecal incontinence	2	**MAJOR SURGERY OR TRAUMA**	
Restricted	3	Urinary and faecal incontinence	3	Orthopaedic/spinal	5
Bed bound *(eg traction)*	4			On table >2 hours *(past 48 hours)*	5
Chairbound *(eg wheelchair)*	5			On table >6 hours *(past 48 hours)*	8

NUTRITIONAL STATUS *Malnutrition Screening Tool*		SKIN TYPE VISUAL RISK AREAS		MEDICATION	
A: Has patient lost weight recently?	B: Weight loss score	Healthy	0	Cytoxics	4
Yes – Go to B	0.5 – 5kg = 1	Tissue paper	1	Steroids	
No – Go to C	5 – 10kg = 2	Dry	1	Anti-inflammatory high dose and/or long term	
Unsure – Go to C and score 2	10 – 15kg = 3	Oedematous	1		
	15kg = 4	Clammy, pyrexia	1	*(maximum score 4)*	
C: Is patient eating poorly or lack of appetite	Total Nutrition Score	Discoloured Stage 1	2		
No = 0 Yes = 1		Pressure area Stage 2 – 4	3		

Total Score – Record on Arrival	<10 Low Risk	10+ At Risk	15+ High Risk	20+ Very High Risk

(Adapted with permission from Judith Waterlow 1994 – Revised 2004 and the Queensland Department of Health 2004)

- Patients with spinal cord injury are considered to be a very high risk (20+)
- In all cases, however, alternating air matresses are contraindicated in acurate spinal cord injury as complete spinal immobility cannot be achieved. I would hope this is not required and that clinicians in an acute setting dealing with acute cord injuries would know this already.

STRATEGIES FOR PRESSURE AREA PREVENTION			
RISK LEVEL		PREVENTATIVE MEASURES	
A	Low level of Risk <10	1	Daily skin inspection, no other action required.
		2	Re-assess when there is a change in the patient's condition.
		3	Document in notes/care plan the patient's skin condition and interventions instigated
		4	Patient/carer education on basic prevention
		5	Promote activity as clinical condition indicates
		6	If Total Nutrition Score ≥ 2 refer to a dietitian
B	At Risk 10+ Client at risk of developing a pressure area if strategies not implemented	↑	All of the above plus:
		7	Individual repositioning regime, 30° turns
		8	Pain assessment
		9	Protective padding between bony prominences
		10	Avoid shear and friction damage by using correct manual handling equipment
		11	Minimise exposure to moisture (incontinence use absorption pads), use mild cleaning agents, moisturise skin, use protective barrier creams.
		12	Assessment of nutritional status – monitor oral intake, appetite, self-feeding ability, unintentional weight loss – see nutritional screen.
		13	Patient should be managed on static pressure – relieving mattress or alternating pressure – relieving air mattress overlay/mattress replacement
		14	Seated patient to shift weight every 15 minutes (sitting forward for 2 minutes reduces pressure on ischial tuberosity). Reposition hourly if patient unable to do so.
C	High Risk 15+	↑	All of the above plus:
		15	Implement an alternating pressure – relieving air mattress overlay/mattress replacement. Use pressure – relieving cushion if sitting out of bed.
D	Very High Risk 20+	↑	All of the above plus:
		16	Implement an alternating large cell air mattress replacement plus cushion as above

(See also Pressure Ulcer Prevention Policy statements and Pressure Prevention Guidelines f
Full guidelines and product selection in Pressure Ulcer Resource Manual

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Clinical record 9 – Dengue (continued)

HEALTH

EMERGENCY NURSING PROGRESS NOTES

Surname: ..... MRN: .....

Given Names: .....

Date of Birth: ..... Sex: .....

(Affix patient label here)

Date/Time	Sign Print and Designation for all entries
2305hrs	obs ✓ BSL ✓ mi clo panmored. Patient moved to side room as coughing ++, Surgical mask given to patient, ~~DO~~ + sandwich and oral fluids

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PAGE 7 CATALOGUE NUMBER 08948

Clinical record 9 – Dengue (continued)

HEALTH

Surname: ..... MRN: .....

Given Names: .....

Date of Birth: ..... Sex: .....

(Affix patient label here)

TRANSFER TO WARD FROM THE EMERGENCY DEPARTMENT

Date 28/10/ Time 2315 Verbal hand over given to: ..... Ward/Bed 116

General Condition on Transfer:

Alert oriented GCS 15/15, Mi clopani / discomfort

Patient coughing ++ Surgical mask insitu

Infection Control Alert Indicated for this patient? ☑ Yes ☐ No Comments.....

Are medications written up? ☑ Yes ☐ No Reason.....

Analgesia ordered? ☑ Yes ☐ No Reason.....

Are there enough fluids ordered? ☐ Yes ☑ No Reason.....

☑ Clerical Admission ☑ Identification Band O_2 Therapy ☐ Yes ☑ No ☐ Other (specify).....

Special OBS: ☐ Neuro Obs ☐ Blood Sugar ☐ Neurovasc Circ Checks

☐ Alcohol Wiothdrawal ☐ PV Chart ☐ Stool chart

☑ Discharge risk assessment ☐ No Reason..... ☐ Waterlow ☐ No Reason.....

☑ Functional Assessment ☐ No Reason..... ☐ Falls Risk ☐ No Reason.....

☑ Delirium Risk Screen ☐ No: Reason.....

Other instructions: Doxycanin + Tamiflu given, nasopharyngeal Swabs & blood culture ☑

Diet: Full diet

Medical Record ☐ Yes ☑ No Hospital X-Rays ☐ Yes ☐ N/A Private X-Rays ☐ Yes ☐ N/A

Relatives notified: ☑ Yes ☐ No Dispensed Medication: ☐ Sent to ward ☐ Chart in Pharmacy

Discharged from ED

Valuables: *(including glasses, dentures and hearing aids)*

☐ Still with patient ☐ Already sent home ☐ Retrieved (from safe) & given to patient

Treatment Completed ☐ Yes ☐ No LMO follow up ☐ Yes ☐ No OPD Follow Up ☐ Yes ☐ No

Comments.....

Nurse Print Name [redacted] Signature [redacted] Designation RN Date 28/10

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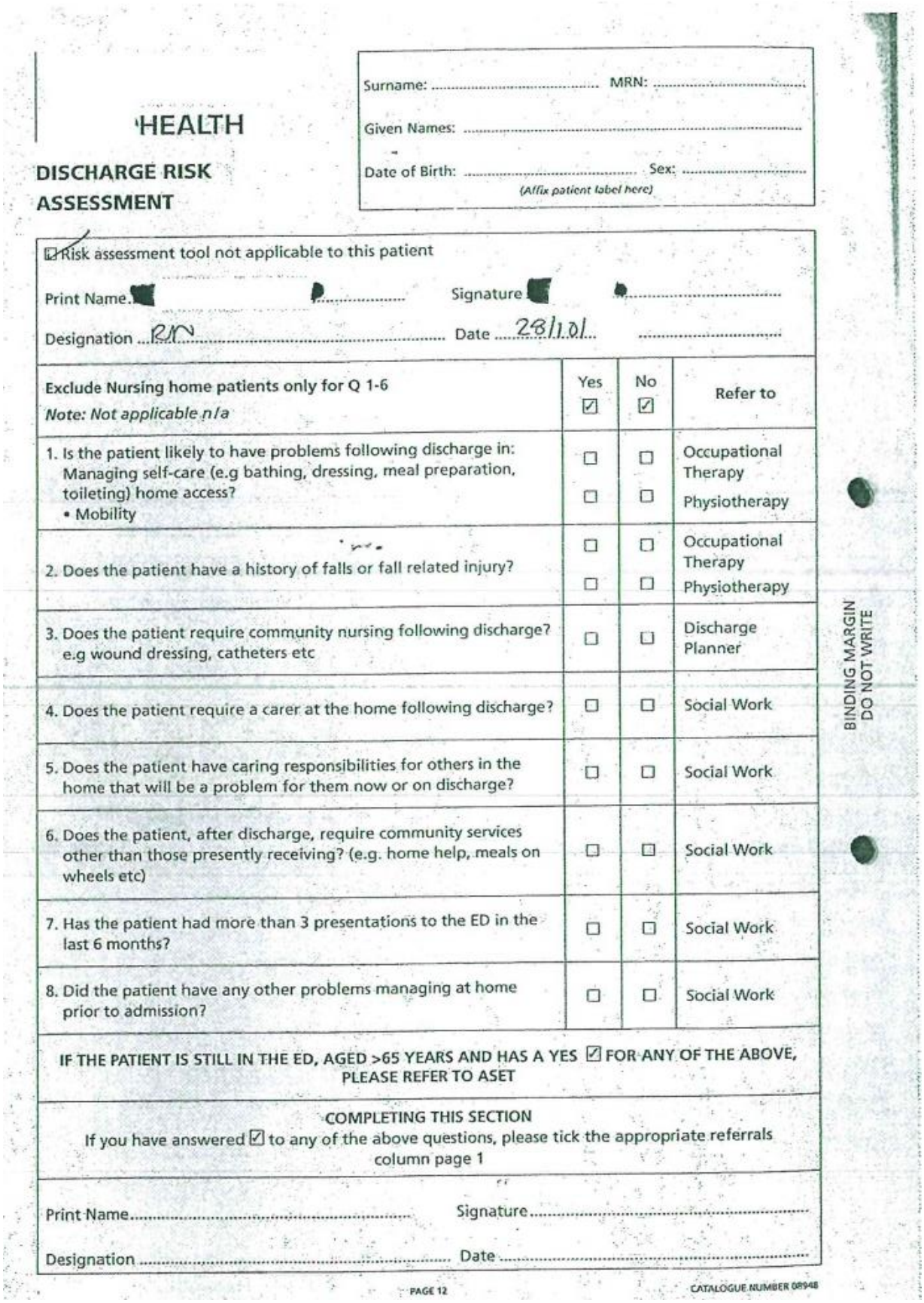
Clinical record 9 – Dengue (continued)



HEALTH

DISCHARGE RISK ASSESSMENT

Surname: ..... MRN: .....

Given Names: .....

Date of Birth: ..... Sex: .....

(Affix patient label here)

☑ Risk assessment tool not applicable to this patient

Print Name: [redacted] ..... Signature [redacted] .....

Designation ...RN..... Date ...28/10/... .....

Exclude Nursing home patients only for Q 1-6 *Note: Not applicable n/a*	Yes ☑	No ☑	Refer to
1. Is the patient likely to have problems following discharge in: Managing self-care (e.g bathing, dressing, meal preparation, toileting) home access? • Mobility	☐ ☐	☐ ☐	Occupational Therapy Physiotherapy
2. Does the patient have a history of falls or fall related injury?	☐ ☐	☐ ☐	Occupational Therapy Physiotherapy
3. Does the patient require community nursing following discharge? e.g wound dressing, catheters etc	☐	☐	Discharge Planner
4. Does the patient require a carer at the home following discharge?	☐	☐	Social Work
5. Does the patient have caring responsibilities for others in the home that will be a problem for them now or on discharge?	☐	☐	Social Work
6. Does the patient, after discharge, require community services other than those presently receiving? (e.g. home help, meals on wheels etc)	☐	☐	Social Work
7. Has the patient had more than 3 presentations to the ED in the last 6 months?	☐	☐	Social Work
8. Did the patient have any other problems managing at home prior to admission?	☐	☐	Social Work

IF THE PATIENT IS STILL IN THE ED, AGED >65 YEARS AND HAS A YES ☑ FOR ANY OF THE ABOVE, PLEASE REFER TO ASET

COMPLETING THIS SECTION

If you have answered ☑ to any of the above questions, please tick the appropriate referrals column page 1

Print Name..... Signature.....

Designation ..... Date .....

PAGE 12

CATALOGUE NUMBER 08948

BINDING MARGIN DO NOT WRITE

Clinical record 9 – Dengue (continued)

HEALTH

Surn

Give DOB: [redacted] Age: 35Y Sex:M

Date

PROGRESS NOTES

DATE & TIME	
28/10/	Intern continue..
19.30	- no chest pain
	- no Hx of contact c a person who
	has febrile or coughing.
	- Vaccinated for measles, didn't have
	Pinna - nil chickenpox
	Medication - Celestone 0.02% (Betha-
	methason valerate) bd
	→ given for the rash by GP.
	- Clarithromycin 250mg PO Bd
	- Telfast (Fexofenadine HCl)
	Allergy → NKA
	O/E → GA → looks well
	obs - BP 128/90 Pulse → 94/min
	Temp. RR → 18/min.
	- no pallor / conjunctivitis
	- Throat are not inflammed
	- Ear - normal
	- no neck LAP
	CVS → Dual HS
	→ no (M) or (G)
	Chest → ↓ed air entry on the (R) posterior
	lower chest c fine crepitations.
	- Hyperemic macular rash all over
	Also the back & front chest.
	Abd → Soft & non-tender
	→ no HSM

PROGRESS NOTES

BINDING MARGIN DO NOT WRITE

— PTO Version 2.0206

Catalogue No. 09024

HEALTH

Sur

Giv DOB: Age: 35Y Sex:M

Dat

PROGRESS NOTES

DATE & TIME	
	Intern cont ---
	- Hyperemic macular rash all over the abdomen.
	UL → Scattered rash over both ULs.
	LL → " " over the limbs, more on the (R) upper calf area.
	→ no calf tenderness
	→ no swollen joints
	Neurology → Grossly normal
	→ Pt Alert & well oriented
	Plan – FBC / EUC / LFT / CRP
	– GRV Serology
	– U/A
	– CXR
	Ix [redacted]
	U/A → trace Protein
	→ no nitrite / leucocyte / RBC.
	[redacted]
	Hgb 151
	WBC 4.5 – Neu 2.4 (54%), Lymph 1.6 (35%)
	PLT 185 LFT → Prot 83 ↑
	Na 140 Alb 46 ↑
	K 4.2 ALP 114
	Urea 2.6 AST 55 ↑
	Crea n 72 ALT 77 ↑
	CRP 14 → ↑ GGT 164 → ↑ (5–65)
	TBiL 12

– PTO –

BINDING MARGIN DO NOT WRITE

Clinical record 9 – Dengue (continued)

HEALTH

St

Gi DOB [redacted] Age: 35Y Sex:M

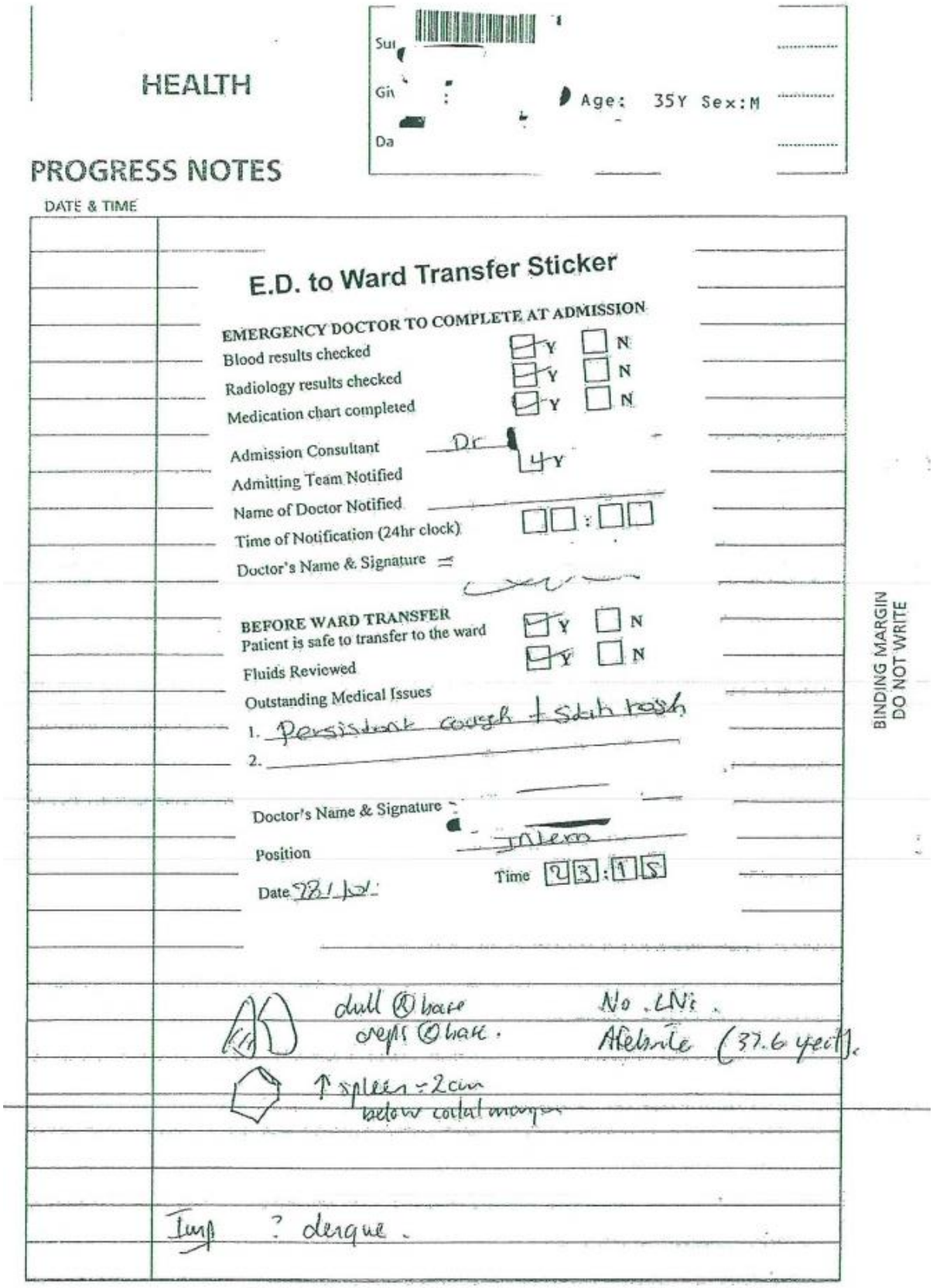
D

PROGRESS NOTES

DATE & TIME	
28/10	Intern cont -
	CXR → normal
	Plan – D/W ED consultant & advised ID consult:
	Discussed c̄ Dr [redacted] (ID consultant)
	Plan – Admit ID
	+ bloods for malaria, Dengue fever, HEP, HAV? measles, rubella, chicken pox (varicella)
	– Doxycycline 100mg BD (po)
	– Tamiflu 75mg po BD
	– nasopharyngeal swab
	– blood culture
29/10	S/B Dr (ID).
	35♂
	Unwell since Sunday (2/7 after return fr India).
	Cough (dry), rash
	No diarrhoea, myalgia, arthralgia, HA
	No mouth ulcers.
	Returned fr India 1/52 ago.
	→(city) 8/12 for work
	OE Trunk non-pruritic hyperaemic rash blanching & thighs

Version 2 0206 Catalogue No. 09024

Clinical record 9 – Dengue (continued)



HEALTH

Sur
Giv
Da

Age: 35Y Sex: M

PROGRESS NOTES

DATE & TIME

E.D. to Ward Transfer Sticker

EMERGENCY DOCTOR TO COMPLETE AT ADMISSION

Blood results checked ☒ Y ☐ N
Radiology results checked ☒ Y ☐ N
Medication chart completed ☒ Y ☐ N

Admission Consultant Dr [redacted] ☒ Y
Admitting Team Notified
Name of Doctor Notified
Time of Notification (24hr clock) ☐☐:☐☐
Doctor's Name & Signature [redacted]

BEFORE WARD TRANSFER

Patient is safe to transfer to the ward ☒ Y ☐ N
Fluids Reviewed ☒ Y ☐ N

Outstanding Medical Issues
1. Persistent cough + skin rash
2.

Doctor's Name & Signature [redacted]
Position Intern
Date 28/1/15 Time 23:15

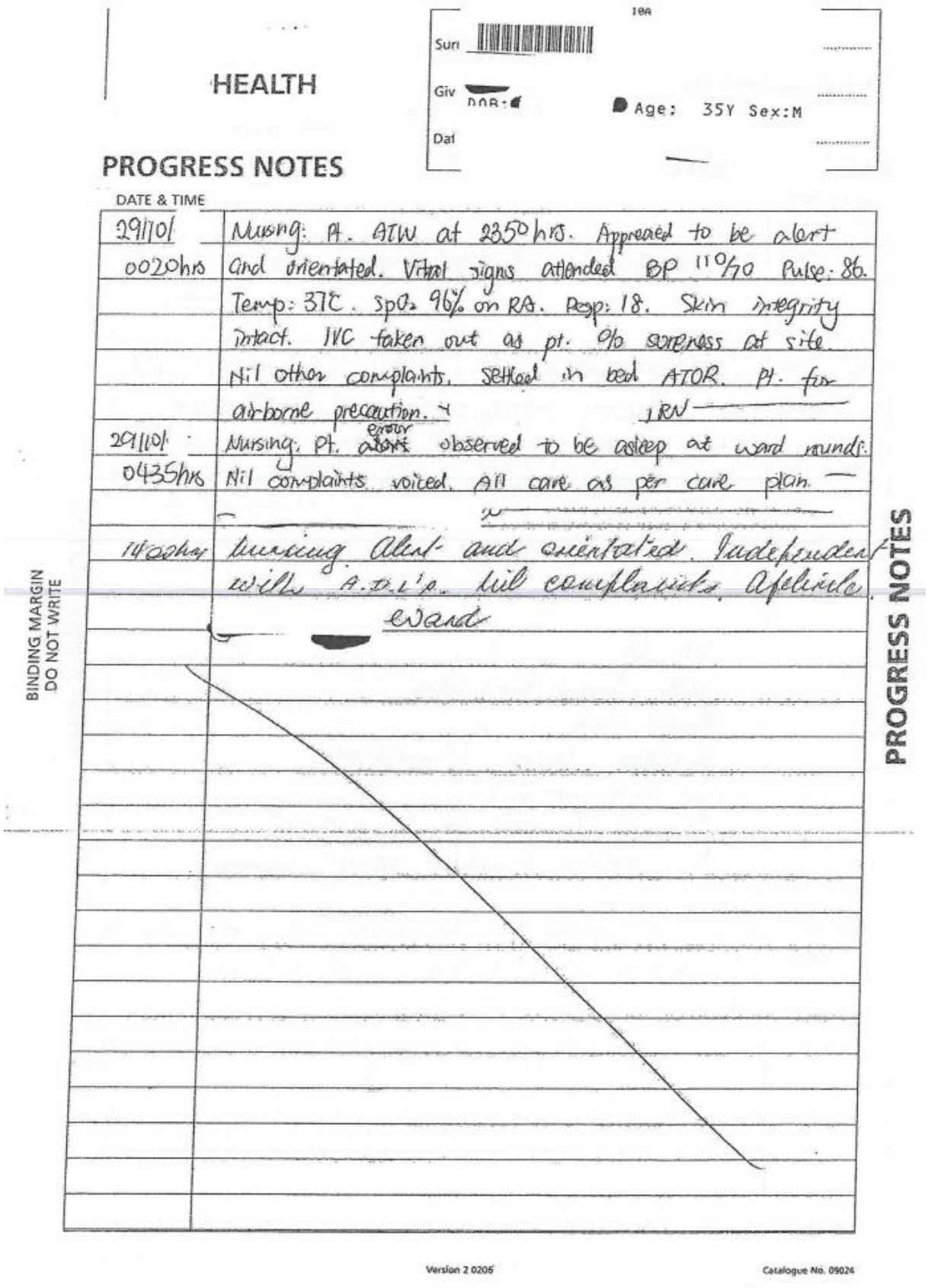
dull @ base
crepts @ bas.
No. LN's.
Afebrile (37.6 yest).

↑ spleen ~ 2cm below costal margin

Imp ? dengue.

BINDING MARGIN
DO NOT WRITE

Clinical record 9 – Dengue (continued)



HEALTH

Surn [redacted]

Giv [redacted] DOB: [redacted] Age: 35Y Sex: M

Dat [redacted]

PROGRESS NOTES

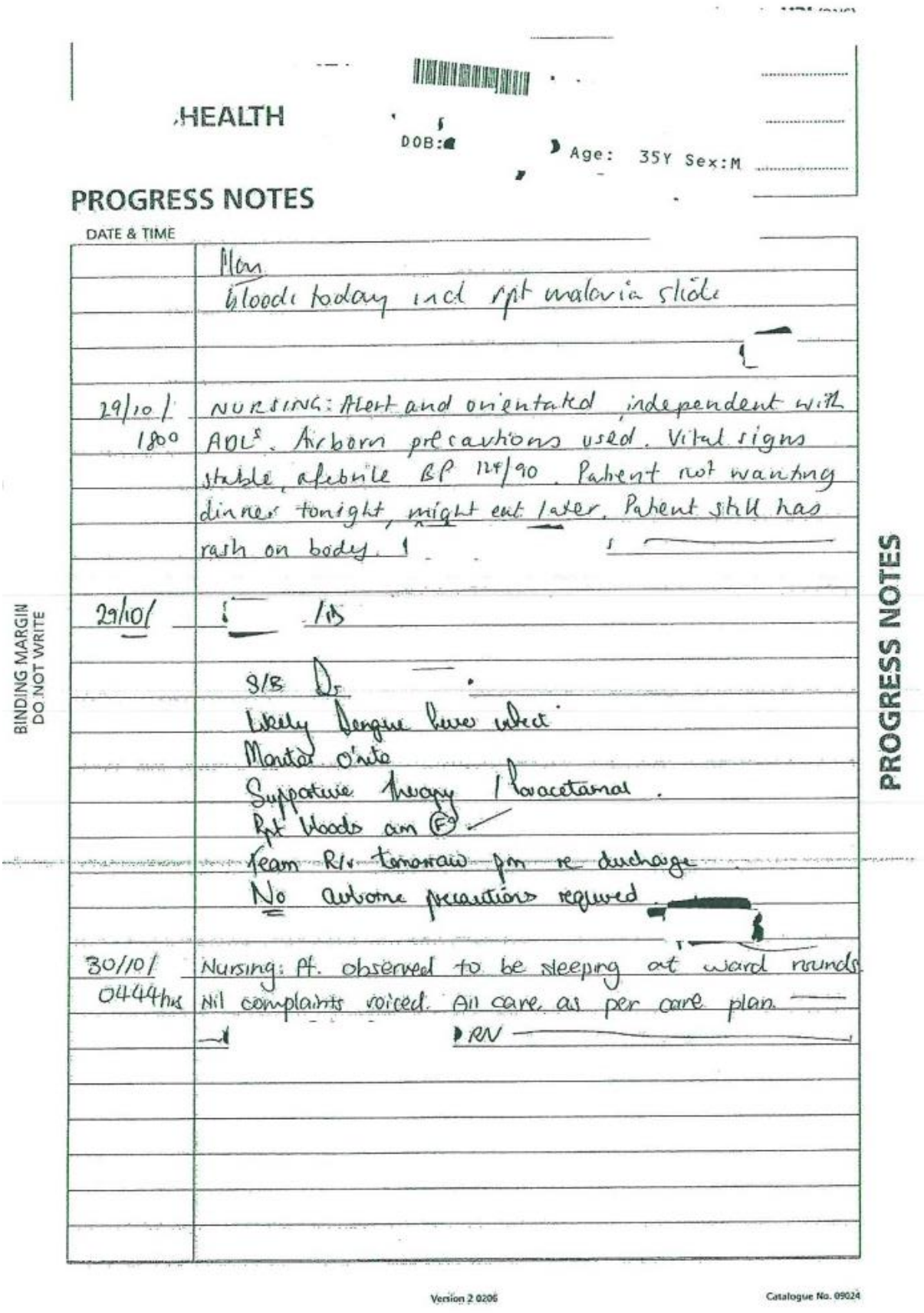
DATE & TIME	
29/10/ 0020hrs	Nursing: Pt. ATW at 2350 hrs. Appeared to be alert and orientated. Vital signs attended BP 110/70 Pulse: 86. Temp: 37°C. SpO2 96% on RA. Resp: 18. Skin integrity intact. IVC taken out as pt. c/o soreness at site. Nil other complaints. Settled in bed ATOR. Pt. for airborne precaution. [redacted] RN [redacted]
29/10/ 0435hrs	Nursing: Pt. ~~alert~~ error observed to be asleep at ward rounds. Nil complaints voiced. All care as per care plan. [redacted]
1400hrs	Nursing Alert and orientated. Independent with A.D.L's. Nil complaints. Afebrile. [redacted] ward

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

Version 2 0205 Catalogue No. 09024

Clinical record 9 – Dengue (continued)



HEALTH

DOB: Age: 35Y Sex: M

PROGRESS NOTES

DATE & TIME	
	Plan Bloods today incl rpt malaria slide
29/10/ 1800	NURSING: Alert and orientated, independent with ADL's. Airborn precautions used. Vital signs stable, afebrile BP 114/90. Patient not wanting dinner tonight, might eat later. Patient still has rash on body.
29/10/	18 3/8 Dr Likely Dengue fever infect Monitor o/nite Supportive therapy / Paracetamol. Rpt bloods am (F) Team R/v tomorrow pm re discharge No airborne precautions required
30/10/ 0444hrs	Nursing: Pt. observed to be sleeping at ward rounds Nil complaints voiced. All care as per care plan RN

BINDING MARGIN DO NOT WRITE

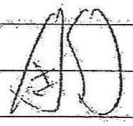
PROGRESS NOTES

Version 2 0206 Catalogue No. 09024

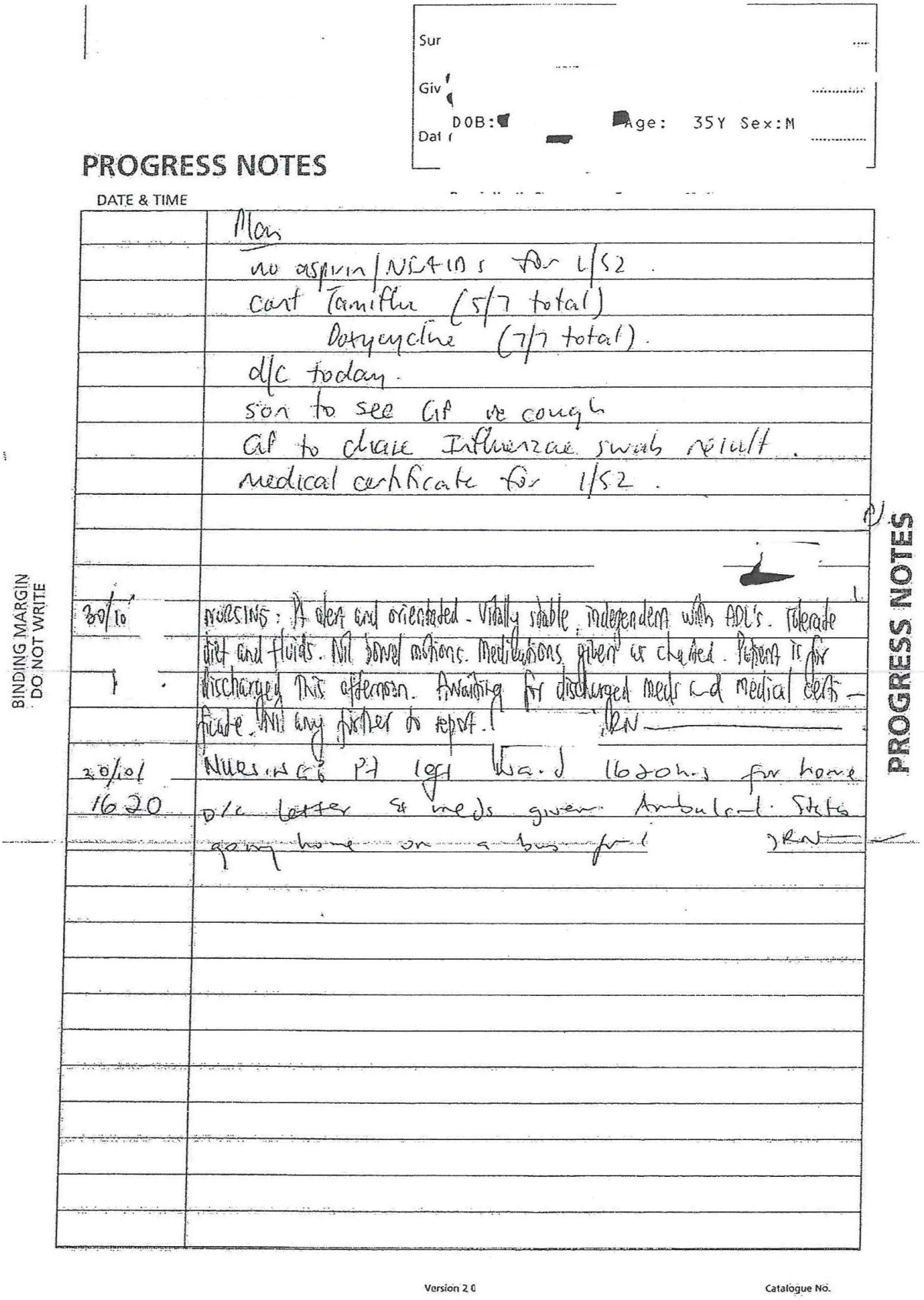
Clinical record 9 – Dengue (continued)

Surnam .....
Given [redacted] DOB: [redacted] Age: 35Y Sex: M .....
Date of ....

PROGRESS NOTES

DATE & TIME	
30/10/	[redacted] (10 yea)
	Bloods yest.
	Cat 159 (162) CRP 11
	ALT 81 (71) WAC & Neut. ↑.
	AST 64 (57). Malaria film -ve.
	B/Cx +ve. Dengue +ve
	Ongoing dry cough.
	Otherwise OK
	Rash improving.
	 crept ⊗ base
	Plan
	await bloods today → if stable/improved d/c in afternoon.
	[redacted]
30/10/	S/B Dr [redacted] /1.
	Feels tired
	Neut 1.0 today. Hct stable.
	Rash better. ? dermatographia +ve.
	Son has cough also.
	Dx Dengue Fever.

BINDING MARGIN DO NOT WRITE



Sur ....
Giv ....
Dat DOB: [redacted] Age: 35Y Sex:M

PROGRESS NOTES

DATE & TIME

Plan
no aspirin/NSAIDs for 1/52.
cont Tamiflu (5/7 total)
Doxycycline (7/7 total).
d/c today.
Son to see GP re cough
GP to chase Influenzae swab result.
medical certificate for 1/52.

30/10 — nursing: Pt alert and orientated. Vitally stable, independent with ADL's. Tolerate diet and fluids. Nil bowel motions. Medications given as charted. Reports ↑ for discharged this afternoon. Awaiting for discharged meds and medical certificate. Nil any further to report. RN

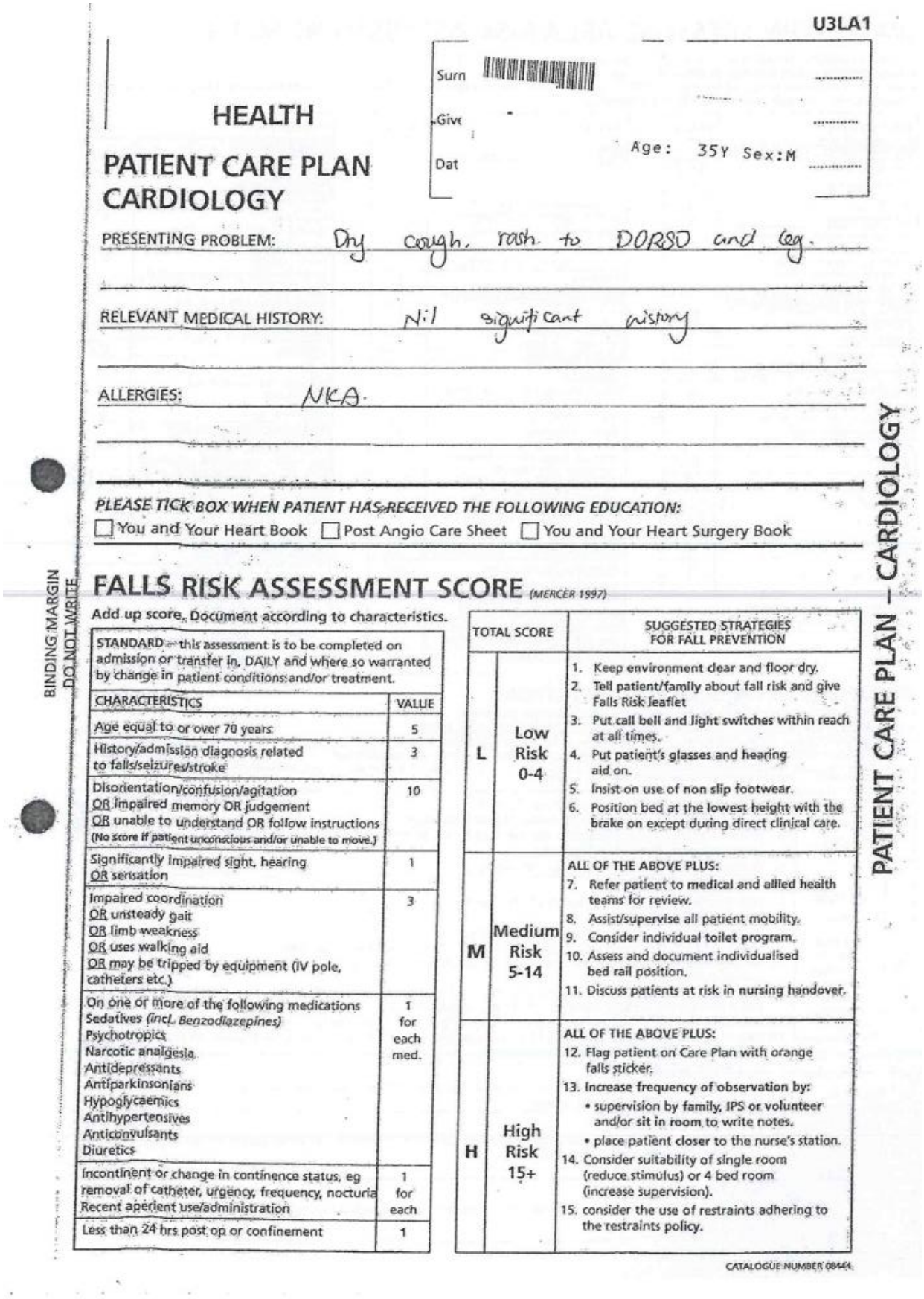
30/10 1620 — Nursing: Pt left ward 1620hrs for home d/c letter & meds given. Ambulant. States going home on a bus. RN

BINDING MARGIN DO NOT WRITE

PROGRESS NOTES

Version 2.0 Catalogue No.

Clinical record 9 – Dengue (continued)



U3LA1

Surn

Give

Dat

Age: 35Y Sex:M

HEALTH

PATIENT CARE PLAN
CARDIOLOGY

PRESENTING PROBLEM: Dry cough, rash to DORSO and leg.

RELEVANT MEDICAL HISTORY: Nil significant history

ALLERGIES: NKA.

PLEASE TICK BOX WHEN PATIENT HAS RECEIVED THE FOLLOWING EDUCATION:

☐ You and Your Heart Book ☐ Post Angio Care Sheet ☐ You and Your Heart Surgery Book

BINDING MARGIN DO NOT WRITE

PATIENT CARE PLAN – CARDIOLOGY

FALLS RISK ASSESSMENT SCORE *(MERCER 1997)*

Add up score. Document according to characteristics.

STANDARD – this assessment is to be completed on admission or transfer in, DAILY and where so warranted by change in patient conditions and/or treatment.

CHARACTERISTICS	VALUE
Age equal to or over 70 years	5
History/admission diagnosis related to falls/seizures/stroke	3
Disorientation/confusion/agitation OR impaired memory OR judgement OR unable to understand OR follow instructions (No score if patient unconscious and/or unable to move.)	10
Significantly impaired sight, hearing OR sensation	1
Impaired coordination OR unsteady gait OR limb weakness OR uses walking aid OR may be tripped by equipment (IV pole, catheters etc.)	3
On one or more of the following medications Sedatives *(incl. Benzodiazepines)* Psychotropics Narcotic analgesia Antidepressants Antiparkinsonians Hypoglycaemics Antihypertensives Anticonvulsants Diuretics	1 for each med.
Incontinent or change in continence status, eg removal of catheter, urgency, frequency, nocturia Recent aperient use/administration	1 for each
Less than 24 hrs post op or confinement	1

TOTAL SCORE		SUGGESTED STRATEGIES FOR FALL PREVENTION
L	Low Risk 0-4	1. Keep environment clear and floor dry. 2. Tell patient/family about fall risk and give Falls Risk leaflet 3. Put call bell and light switches within reach at all times. 4. Put patient's glasses and hearing aid on. 5. Insist on use of non slip footwear. 6. Position bed at the lowest height with the brake on except during direct clinical care.
M	Medium Risk 5-14	ALL OF THE ABOVE PLUS: 7. Refer patient to medical and allied health teams for review. 8. Assist/supervise all patient mobility. 9. Consider individual toilet program. 10. Assess and document individualised bed rail position. 11. Discuss patients at risk in nursing handover.
H	High Risk 15+	ALL OF THE ABOVE PLUS: 12. Flag patient on Care Plan with orange falls sticker. 13. Increase frequency of observation by: • supervision by family, IPS or volunteer and/or sit in room to write notes. • place patient closer to the nurse's station. 14. Consider suitability of single room (reduce stimulus) or 4 bed room (increase supervision). 15. consider the use of restraints adhering to the restraints policy.

CATALOGUE NUMBER 08444

WATERLOW PRESSURE AREA RISK ASSESSMENT SCALE

- Identify patient's risk factors per category (multiple values per category if required).
- Add numerical values together to obtain a pressure area risk score.
- Document Waterlow Score and interventions implemented DAILY onto the Nursing Care Plan or whenever there is a change in the patient's health status that could potentially effect skin integrity.

DESCRIPTION	VALUE
BUILD/WEIGHT FOR HEIGHT	
Average	(1)
Above average	2
Obese	3
Below average	4
(If unable to weigh, use professional judgement in allocating a score.) (Visual assessment – perspective of weight and height ratio, muscle wasting.)	
SKIN TYPE VISUAL RISK AREA	
Healthy	(0)
Tissue paper	1
Dry/Oedematous	1
Clammy – raised temperature	1
Discoloured *(bruised)*	2
Broken spot *(break in the continuity of the skin – wound, skin tear, pressure area)*	3
SEX	
Male	(1)
Female	2
AGE	
14-49	(1)
50-64	2
65-74	3
75-80	4
81+	5

DESCRIPTION	VALUE
SPECIAL RISKS	
Tissue malnutrition	
Terminal Cachexia *(chronic diseases, burns, terminal disease)*	8
Cardiac failure *(CCF, LVF, APO)*	5
Peripheral Vascular Disease	5
Anemia *(Normal HB male 135-180) (Normal HB female 115-160)*	2
Smoking	1
MAJOR TRAUMA/SURGERY	
Orthopaedic – below waist, spinal	5
On table >2 hours	5
MEDICATIONS	
Cytotoxics *(Chemotherapy incl. Methotrexate oral/IM, oral Cyclophosphamide, Azathioprine)*	4
High dose steroids *(incl. IV methylprednisolone, Hydrocortisone, Dexamethasone, oral longer that 4 weeks)*	4
Anti Inflammatory *(High dose Aspirin >300mg/day, NSAIDs –Diclofenac, Indomethacin, Prioxican, Ibuprofen, Celecoxib, Rrofecoxib)*	4
CONTINENCE	
Complete/Catheterised	(0)
Occasion incontinence *(Urgency to void, stress incontinence, occasional faecal incontinence)*	1
Catheter/Incontinence faeces *(Incl. if patient on a bowel regime)*	2
Double Incontinence	3

DESCRIPTION	VALUE
MOBILITY	
Fully mobile	(0)
Restless fidgety	1
Apathetic *(Depressed/sedated)*	2
Restricted *(limited by drains, IV therapies, IDC, splints, chronic disease)*	3
Inert/traction *(sedated unable to move naturally)*	4
Chairbound *(unable to mobilise from chair independently)*	5
APPETITE	
Average	(0)
Poor	1
NG Tube for aspiration/ fluids only	2
NBM/Anorexic	3
NEUROLOGICAL DEFICIT	
Motor Sensory Deficit (eg diabetic neuropathy, paraplegia, CVA, MS, dementia and other neuro degenerative conditions.) (assign score dependent on severity of deficit: min = 4, max = 6	4-6

TOTAL SCORE	3
<10	Low Risk
10+	At Risk
15+	High Risk
20+	Very High Risk

ADAPTED WITH PERMISSION FROM J WATERLOW 1994 – REVISED JUNE 1996

STRATEGIES FOR PRESSURE AREA PREVENTION

- Choose the appropriate intervention/s according to the Waterlow Risk Score.
- Document in the case notes and the care plan the intervention/s implemented daily.
- Patients with SPINAL CORD INJURY are considered to be a VERY HIGH RISK (20+) IN ALL CASES, however, alternating air mattresses are CONTRAINDICATED in ACUTE spinal cord injury as complete spinal immobility cannot be achieved.

RISK LEVEL		PREVENTATIVE MEASURES A B C D
A	Low Risk <10	1. Daily skin inspection, no other action required. 2. Re-assess when there is a change in the patient's condition. 3. Document in case notes/care plan the patient's skin condition and interventions instigated. 4. Pt/carer education on basic prevention. 5. Promote activity as clinical condition indicates.
B	At Risk 10+ *Client at risk of developing a pressure area if strategies not implemented*	☐ ALL OF THE ABOVE PLUS: 6. Individualised repositioning regime, 30 degree turns. 7. Pain assessment. 8. Protective padding between bony prominences. 9. Avoid shear and friction damage by using correct manual handling equipment. 10. Minimise exposure to moisture (incontinence use absorbent pads), use mild cleaning agents, moisturise skin, use protective barrier creams. 11. Assessment of nutritional status – monitor oral intake, appetite, self-feeding ability, unintentional weight loss. Refer to Dietitian if patient thought to be at nutritional risk. 12. Select an appropriate support mattress overlay – Alphaxcell, Autoexcell, *Eggcrate 13. Seated patient to shift weight every 15 minutes *(sitting forward for 2 mins reduces pressure on Ischial tuberosity)*, reposition hourly if patient unable to do so.
C	High Risk 15+	☐ ALL OF THE ABOVE PLUS: 14. Alternating mattress replacement – Autoexcell, Trinova *Consider for spinal patients 15. Use chair cushion if sitting out of bed.
D	Very High Risk 20+	☐ ALL OF THE ABOVE PLUS: 16. Large cell pressure relieving mattress – *Nimbus, Cairwave *Consider these mattresses for spinal cord injured patients if grade 1 pressure areas present.

*Denotes interventions for spinal cord injury patients.
Interventions for C & D should be cleared by and documented by the primary orthopaedic/neurosurgical medical team prior to implementing for spinal patients.

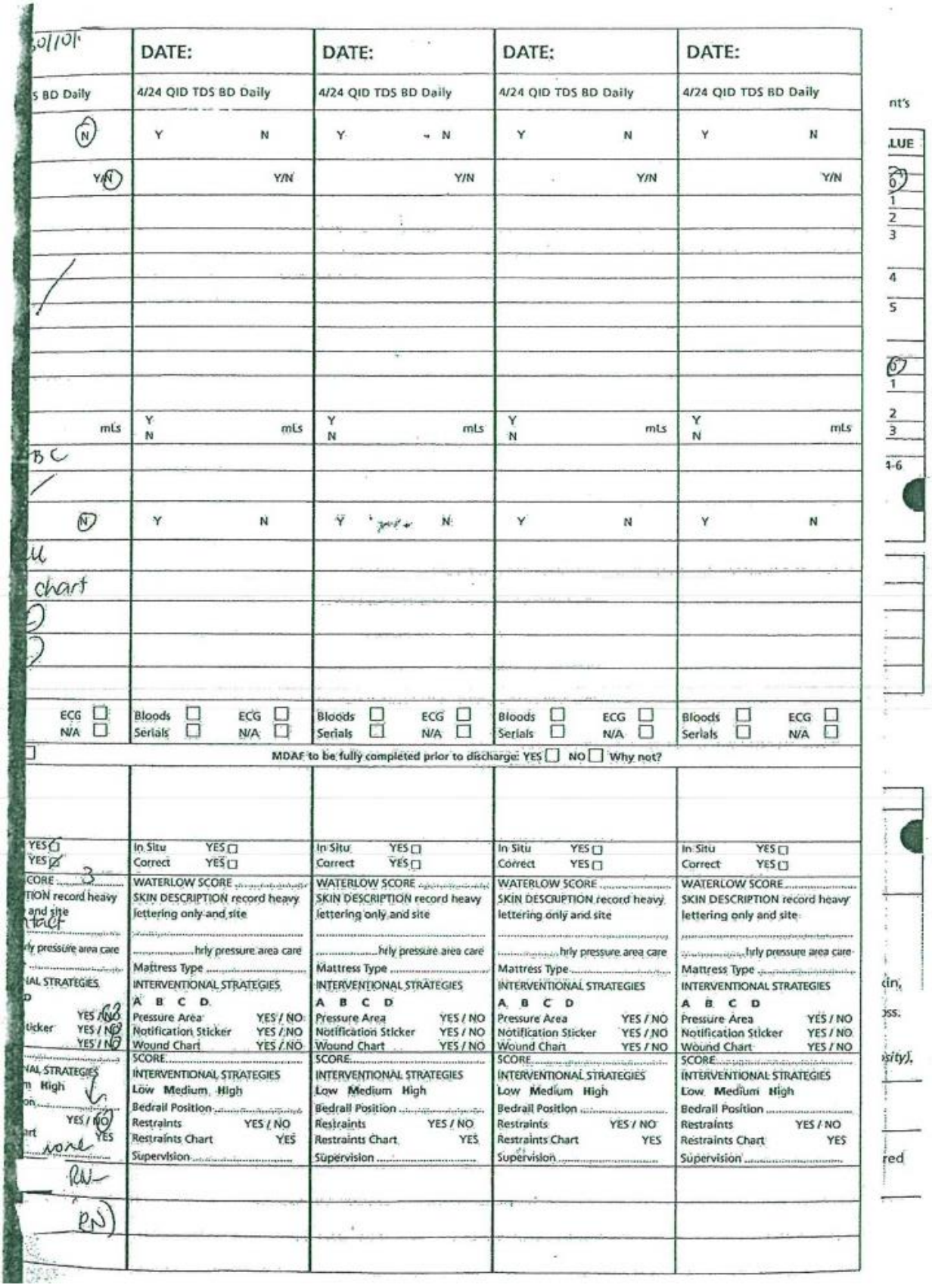
Adapted from the European Pressure Ulcer Advisory Panel and National Pressure Ulcer Taskforce. Pressure Ulcer Primary Prevention Guidelines; © Primary Prevention Guidelines 02/2004

Clinical record 9 – Dengue (continued)

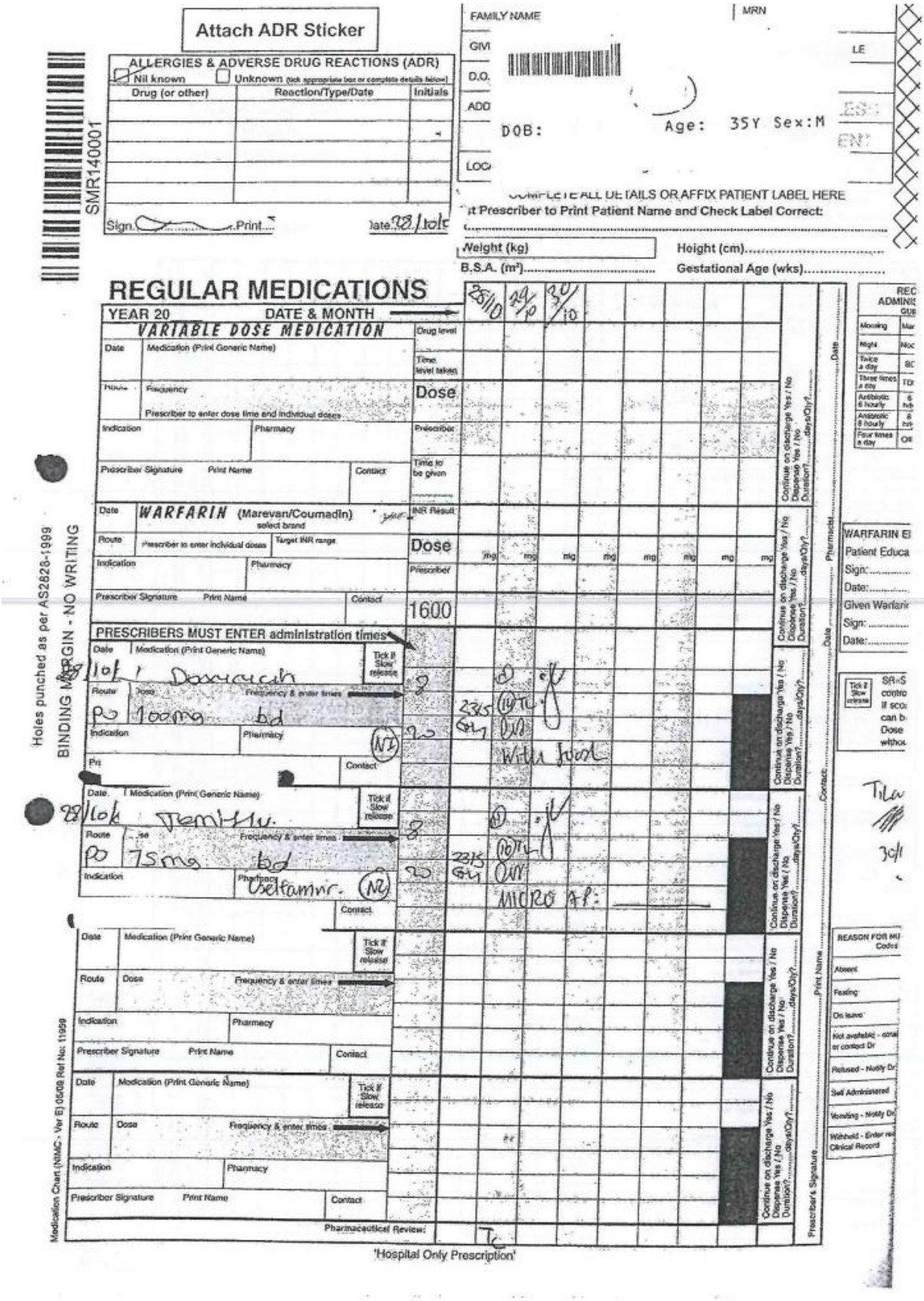
PROBLEM	GUIDELINES FOR ASSESSMENT	DATE: 28/10/	DATE: 29/10/	DATE:
General Observations	Determine frequency of observation (circle frequency)	4/24 QID TDS BD Daily	4/24 QID TDS BD Daily	4/24 QID
Telemetry	Is telemetry required? Y/N (circle) Ensure medical order is documented q 24hrs	Y (N)	Y (N)	Y
Diabetes	Document frequency of BSL Is patient on insulin? Y/N	(N)	Y/N	
Miscellaneous	Variable intervention may be documented here			
IV Access	Type eg. Peripheral/CVAD			
	Position/location of cannula			
	Condition of site	/	/	
	Insertion Date			
	Date cannula needs to be replaced			
	Line change due date			
	Dressing change due date (CVADs only)			
Fluid Balance Chart FBC	Check for fluid restriction Check FBC daily Y/N (circle)	(Y) N mLs	(Y) N mLs	(Y) N
	Document intake/output regularly	FBC	FBC	
Intravenous	Fluids/medications	/	/	
Daily Weigh	Determine if patient requires daily weighing	Y (N)	Y (N)	Y
Diet	Indicate type of diet	full	full	f
Bowel chart	Determine bowel elimination status	bowel chart	bowel chart	Bowe
Hygiene	Aim for independence	(I)	(I)	
Mobility	Determine if level of assistance is required	(I)	(I)	
Procedures	Document specific procedures (if required)			
Pathology/Serials/ECG	Ensure bloods/serials/ECG are attended on time	Bloods ☐ ECG ☐ Serials ☐ N/A ☐	Bloods ☐ ECG ☐ Serials ☐ N/A ☐	Bloods Serials
MDAF commenced and partially completed within 24 hours of admission			MDAF commenced: YES ☐	
Discharge Planning	Plan EDD with team from day of admission Ensure pt has discharge medication/ script, LMO letter and appointment (if required) day before discharge			
ID Band	If ID Band missing or incorrect please action appropriately	In Situ YES ☑ Correct YES ☑	In Situ YES ☑ Correct YES ☑	In Situ Correct
Skin Pressure Area Risk Assessment – Waterlow Score	- General condition - Waterlow Score - Strategies Implemented - Pressure Area Skin Descriptions Intact Blanching Erythema	WATERLOW SCORE 8 SKIN DESCRIPTION record heavy lettering only and site self intact hrly pressure area care Mattress Type INTERVENTIONAL STRATEGIES (A) B C D Pressure Area YES / NO Notification Sticker YES / NO Wound Chart YES / NO	WATERLOW SCORE 8 SKIN DESCRIPTION record heavy lettering only and site self intact hrly pressure area care Mattress Type INTERVENTIONAL STRATEGIES (A) B C D Pressure Area YES / NO Notification Sticker YES / NO Wound Chart YES / NO	WATERLO SKIN DES lettering self Mattress INTERVEN A B Pressure Notificati Wound C
Falls Risk Assessment	Daily Risk Assessment Interventional Strategies Needed Bedrail up/down – both – Half – R/L Restraints Applied Restraints Observation Chart Implemented Supervision required Family/IPS/Volunteer	SCORE INTERVENTIONAL STRATEGIES (Low) Medium High Bedrail Position Restraints YES / NO Restraints Chart YES Supervision	SCORE INTERVENTIONAL STRATEGIES (Low) Medium High Bedrail Position Restraints YES / NO Restraints Chart YES Supervision	SCORE INTERVEN Low Me Bedrail Po Restraints Restraints Supervisi
AM Signature, Print Surname Designation				
PM Signature, Print Surname Designation			RN	
ND Signature, Print Surname Designation		RN	RN	

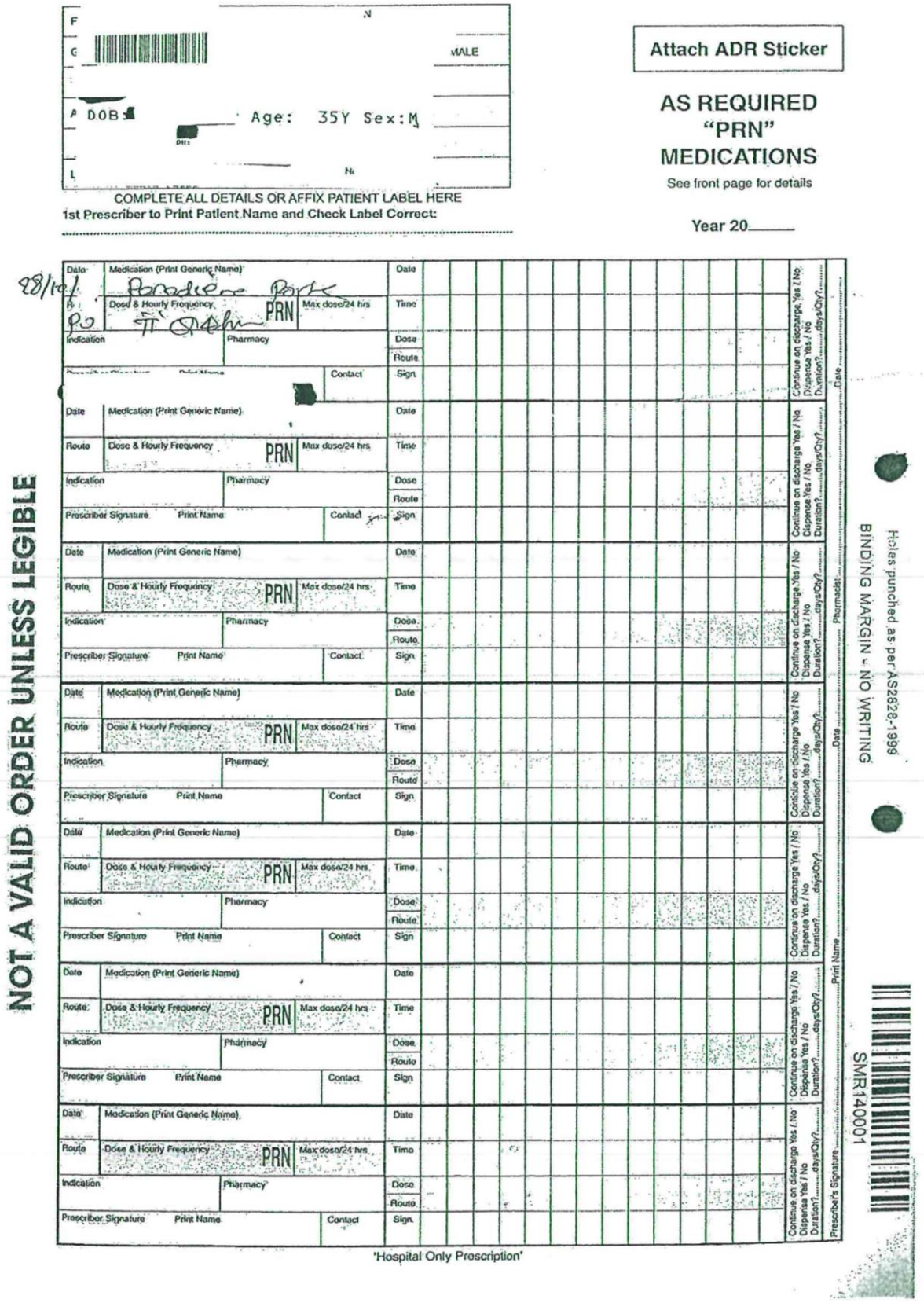
BINDING MARGIN DO NOT WRITE

Clinical record 9 – Dengue (continued)

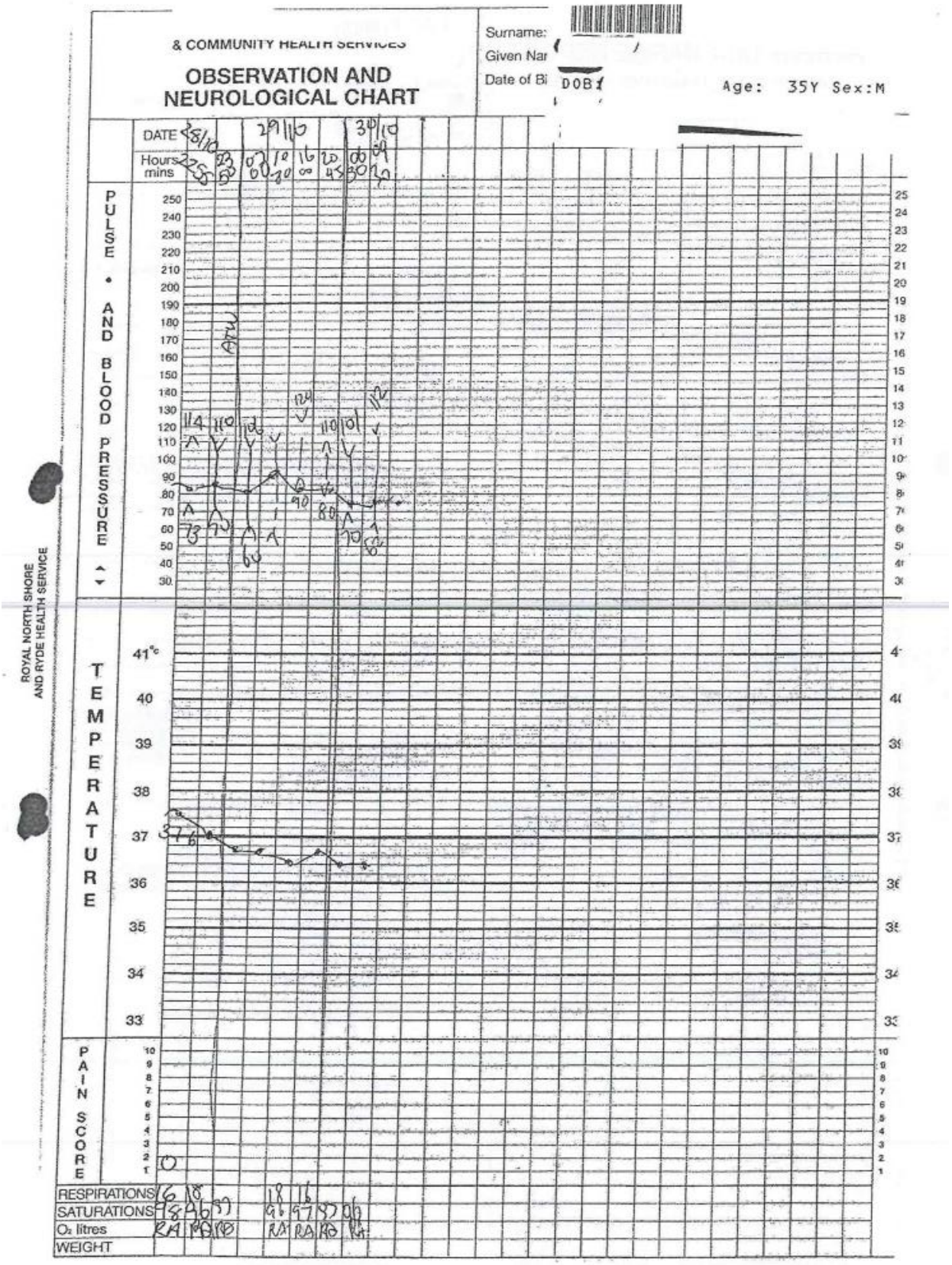


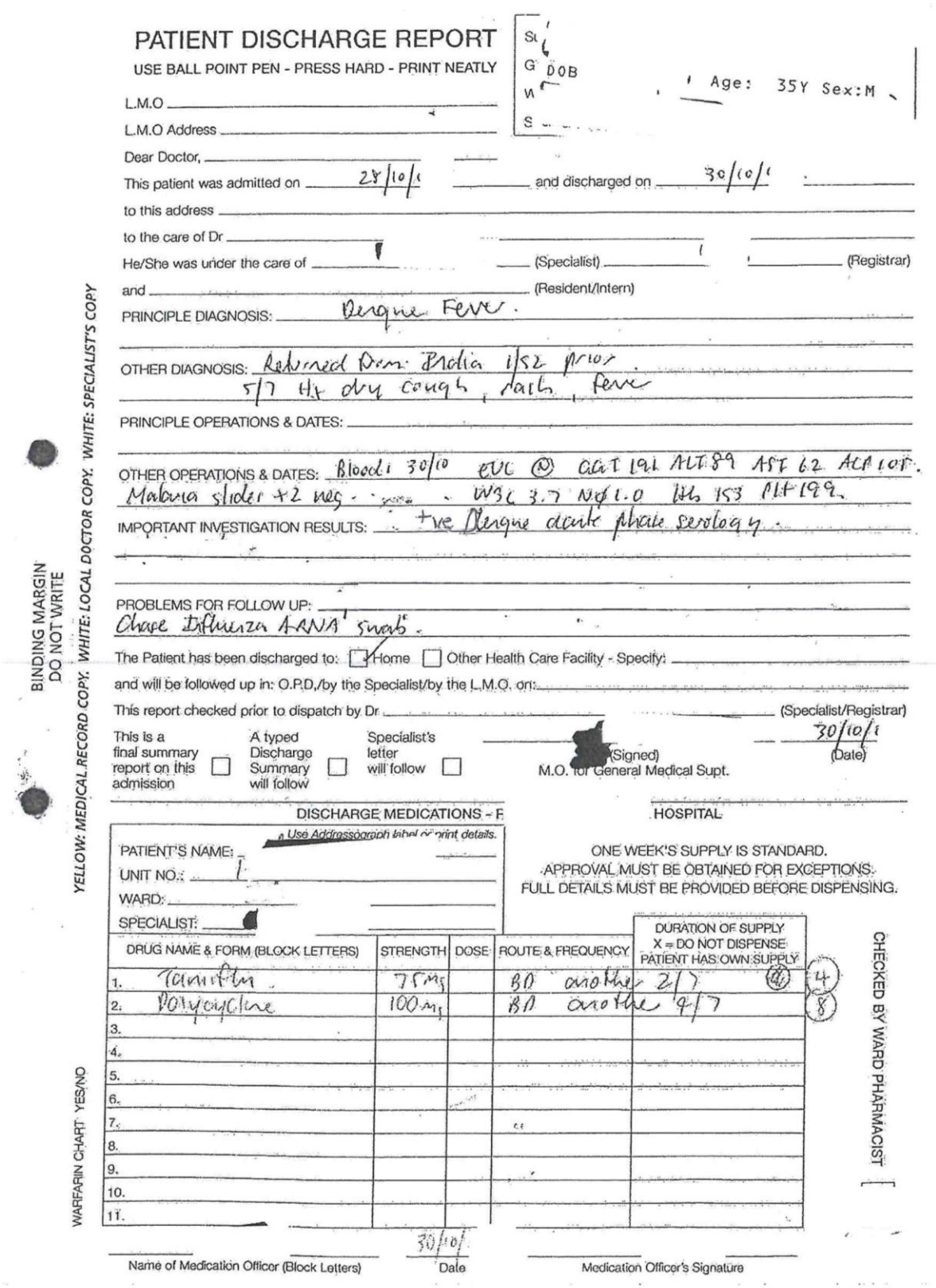
	DATE:	DATE:	DATE:	DATE:
5 BD Daily	4/24 QID TDS BD Daily	4/24 QID TDS BD Daily	4/24 QID TDS BD Daily	4/24 QID TDS BD Daily
(N)	Y N	Y N	Y N	Y N
Y/N	Y/N	Y/N	Y/N	Y/N
mLs	Y N mLs	Y N mLs	Y N mLs	Y N mLs
(N)	Y N	Y N	Y N	Y N
ECG ☐ N/A ☐	Bloods ☐ Serials ☐ ECG ☐ N/A ☐	Bloods ☐ Serials ☐ ECG ☐ N/A ☐	Bloods ☐ Serials ☐ ECG ☐ N/A ☐	Bloods ☐ Serials ☐ ECG ☐ N/A ☐
☐	MDAF to be fully completed prior to discharge: YES ☐ NO ☐ Why not?			
YES ☐ YES ☒	In Situ YES ☐ Correct YES ☐	In Situ YES ☐ Correct YES ☐	In Situ YES ☐ Correct YES ☐	In Situ YES ☐ Correct YES ☐
CORE 3	WATERLOW SCORE	WATERLOW SCORE	WATERLOW SCORE	WATERLOW SCORE
TION record heavy and site	SKIN DESCRIPTION record heavy lettering only and site	SKIN DESCRIPTION record heavy lettering only and site	SKIN DESCRIPTION record heavy lettering only and site	SKIN DESCRIPTION record heavy lettering only and site
ly pressure area care	hrly pressure area care	hrly pressure area care	hrly pressure area care	hrly pressure area care
AL STRATEGIES	Mattress Type	Mattress Type	Mattress Type	Mattress Type
	INTERVENTIONAL STRATEGIES A B C D	INTERVENTIONAL STRATEGIES A B C D	INTERVENTIONAL STRATEGIES A B C D	INTERVENTIONAL STRATEGIES A B C D
YES / NO	Pressure Area YES / NO	Pressure Area YES / NO	Pressure Area YES / NO	Pressure Area YES / NO
ticker YES / NO	Notification Sticker YES / NO	Notification Sticker YES / NO	Notification Sticker YES / NO	Notification Sticker YES / NO
YES / NO	Wound Chart YES / NO	Wound Chart YES / NO	Wound Chart YES / NO	Wound Chart YES / NO
	SCORE	SCORE	SCORE	SCORE
AL STRATEGIES	INTERVENTIONAL STRATEGIES	INTERVENTIONAL STRATEGIES	INTERVENTIONAL STRATEGIES	INTERVENTIONAL STRATEGIES
n High	Low Medium High	Low Medium High	Low Medium High	Low Medium High
on	Bedrail Position	Bedrail Position	Bedrail Position	Bedrail Position
YES / NO	Restraints YES / NO	Restraints YES / NO	Restraints YES / NO	Restraints YES / NO
rt YES	Restraints Chart YES	Restraints Chart YES	Restraints Chart YES	Restraints Chart YES
none	Supervision	Supervision	Supervision	Supervision
RN				
RN)				


Attach ADR Sticker
ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
Nil known
Unknown
Drug (or other)
Reaction/Type/Date
Initials
SMR140001
FAMILY NAME
MRN
DOB:
Age: 35Y Sex:M
Weight (kg)
Height (cm)
B.S.A. (m²)
Gestational Age (wks)
REGULAR MEDICATIONS
YEAR 20
DATE & MONTH
VARIABLE DOSE MEDICATION
WARFARIN (Marevan/Coumadin)
PRESCRIBERS MUST ENTER administration times
Paracetamol
100mg bd
Ibuprofen
75mg bd
Ceftamin.
MICRO AF:
Pharmaceutical Review:
'Hospital Only Prescription'
Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING
Medication Chart (NMC - Ver E) 05/08 Ref No: 11999


Attach ADR Sticker
AS REQUIRED "PRN" MEDICATIONS
See front page for details
Year 20
MALE
DOB
Age: 35Y Sex:M
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE
1st Prescriber to Print Patient Name and Check Label Correct:
Date
Medication (Print Generic Name)
Dose & Hourly Frequency
PRN
Max dose/24 hrs
Route
Indication
Pharmacy
Prescriber Signature
Print Name
Contact
Time
Dose
Route
Sign
Continue on discharge Yes / No
Dispense Yes / No
Duration?
days/Qty?
Pharmacist
Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING
NOT A VALID ORDER UNLESS LEGIBLE
'Hospital Only Prescription'
SMR140001

Clinical record 9 – Dengue (continued)





PATIENT DISCHARGE REPORT

USE BALL POINT PEN - PRESS HARD - PRINT NEATLY

S
G DOB
W Age: 35Y Sex:M
S

L.M.O

L.M.O Address

Dear Doctor,

This patient was admitted on 28/10/ and discharged on 30/10/

to this address

to the care of Dr

He/She was under the care of (Specialist) (Registrar)

and (Resident/Intern)

PRINCIPLE DIAGNOSIS: Dengue Fever.

OTHER DIAGNOSIS: Returned Dem. Bhutia 1/52 prior.
5/7 Hx dry cough, rash, fever

PRINCIPLE OPERATIONS & DATES:

OTHER OPERATIONS & DATES: Blood: 30/10 EUC ⓝ CAT 191 ALT 89 AST 62 ACP 107.
Malaria slide +2 neg. WBC 3.7 Neut 1.0 Hb 153 Plt 199.

IMPORTANT INVESTIGATION RESULTS: +ve Dengue acute phase serology.

PROBLEMS FOR FOLLOW UP:
Chase Influenza ANA swab.

The Patient has been discharged to: ☑ Home ☐ Other Health Care Facility - Specify:

and will be followed up in: O.P.D./by the Specialist/by the L.M.O. on:

This report checked prior to dispatch by Dr (Specialist/Registrar)

This is a final summary report on this admission ☐ A typed Discharge Summary will follow ☐ Specialist's letter will follow ☐

(Signed)
M.O. for General Medical Supt.

30/10/ (Date)

BINDING MARGIN DO NOT WRITE

YELLOW: MEDICAL RECORD COPY. WHITE: LOCAL DOCTOR COPY. WHITE: SPECIALIST'S COPY

DISCHARGE MEDICATIONS - F HOSPITAL

Use Addressograph label or print details.

PATIENT'S NAME:
UNIT NO.:
WARD:
SPECIALIST:

ONE WEEK'S SUPPLY IS STANDARD.
APPROVAL MUST BE OBTAINED FOR EXCEPTIONS.
FULL DETAILS MUST BE PROVIDED BEFORE DISPENSING.

	DRUG NAME & FORM (BLOCK LETTERS)	STRENGTH	DOSE	ROUTE & FREQUENCY	DURATION OF SUPPLY X = DO NOT DISPENSE PATIENT HAS OWN SUPPLY	
1.	Tamiflu	75mg		BD another 2/7	(4)	4
2.	Doxycycline	100mg		BD another 4/7		8
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						

CHECKED BY WARD PHARMACIST

WARFARIN CHART YES/NO

Name of Medication Officer (Block Letters) 30/10/ Date Medication Officer's Signature

9. Allergen challenges

9.1 Three codes for allergen challenges have been created at category Z41.8 *Other procedures for purposes other than remedying health state*. True or False?

9.2 Allergen desensitisation (immunotherapy) is the same as allergen challenge. True or False?

9.3 Circle the correct word below to complete the following ACS title:

monitoring challenge

ACS 2115 *Admission for allergen* _____

9.4 Match the following diagnosis (1-4) to the ICD-10-AM code (A-D):

1.	food challenge	A.	Z51.61
2.	desensitisation – bee venom	B.	Z51.63
3.	dust mite immunotherapy	C.	Z41.81
4.	drug challenge	D.	Z41.82

9.5 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM codes.

A five year old male patient is admitted to hospital for a food challenge to test an egg allergy. The patient has previously been reactive to eggs and the challenge is to confirm whether the allergy is continuing. The challenge is performed and the patient has no reaction.

_____

_____

_____

9.6 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM codes.

A seven year old female is admitted to hospital for a food challenge to test a seafood allergy. The patient was previously reactive to prawns and the challenge is to confirm whether the allergy is continuing. The challenge is performed and the patient experiences hives.

_____

_____

_____

10. Obesity procedures

10.1 Case scenario

From the case scenario below, assign and sequence the appropriate ACHI code(s).

Patient underwent laparoscopic adjustable gastric band surgery 3 months ago. A lap band fill of 0.75ml was performed without incident.

_____

_____

_____

10.2 Case scenario

From the case scenario below, assign and sequence the appropriate ACHI code(s).

Patient underwent insertion of adjustable gastric band under general anaesthesia without incident.

_____

_____

_____

10.3 Match the following procedure (1-4) to the corresponding ACHI code (A-D):

1.	Addition of fluid to gastric band reservoir	A.	90950-03
2.	Laparoscopic nonadjustable gastric band	B.	30511-12
3.	Removal of gastric balloon (for obesity)	C.	31587-00
4.	Repositioning of gastric band	D.	30511-13

11. ACS updates relating to Chapter 21 *Factors influencing health status and contact with health services*

11.1 What is the Ninth Edition title of ACS 2103?

a) *Admission for convalescence*

b) *Admission for aftercare*

c) *Admission for post acute care*

11.2 What is the correct code to assign for a patient transferred for medical aftercare?

a) Z51.88 *Other specified medical care*

b) Z75.5 *Holiday relief care*

c) Z75.0 *Medical services not available in home*

11.3 Which standard provides classification instructions for respite care?

a) ACS 2107

b) ACS 2105

c) ACS 2117

11.4 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM codes.

An 84 year old female is admitted to a small rural hospital for medical aftercare after having being initially treated for pneumonia at the teaching hospital. During admission, the patient receives ongoing clinical support and physiotherapy.

_____

_____

_____

_____

12. ACS 0031 *Anaesthesia*

12.1 Only one code from block [1909] *Conduction anaesthesia* may be assigned for each 'visit to theatre'. True or False?

12.2 Case scenario

From the case scenario below, assign and sequence the appropriate ACHI code(s).

Patient underwent bilateral inguinal hernia repair under GA and transversus abdominis plane (TAP) block. ASA recorded as 1/2.

_____

_____

_____

12.3 Case scenario

From the case scenario below, assign and sequence the appropriate ACHI code(s).

Patient underwent bilateral knee replacements under a spinal anaesthetic and femoral nerve block. ASA recorded as 1.

_____

_____

_____

_____

13. ACS 1006 *Ventilatory support*

13.1 Complete the following sentence from ACS 1006 *Ventilatory support*: Weaning is

_____

13.2 When calculating the duration of continuous ventilatory support (CVS) for patients with a tracheostomy, where CVS via the tracheostomy recommences > 24 hours following cessation of CVS, a new period of ventilation commences. True or False?

13.3 A patient that is intubated and ventilated for < 1 hour is <u>not</u> assigned code 13882-00 [569] *Management of continuous ventilatory support, < 24 hours*. True or False?

13.4 A patient is admitted to the intensive care unit (ICU) and is intubated and ventilated via an endotracheal tube (ETT) then extubated 20 hours later. Two days later, the patient is taken to the operating theatre and returns to ICU still ventilated. The patient is extubated 16 hours later. Three days later, the patient is transferred to theatre again. This time, the patient returns to ICU still ventilated for a further 8 hours. Which of the following codes would be assigned?

a) 13882-00 [569] *Management of continuous ventilatory support, ≤ 24 hours*

b) 13882-01 [569] *Management of continuous ventilatory support, > 24 and < 96 hours*

c) 13882-02 [569] *Management of continuous ventilatory support, ≥ 96 hours*

14. ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs*

14.1 The fetal presentations and positions listed in ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs* are all abnormal positions. True or False?

14.2 Abnormal fetal presentations should always be coded. True or False?

14.3 Codes from categories O64-O66 (excluding uterine scar) should be assigned where care and/or intervention is required in which circumstances?

a) when first diagnosed before labour

b) when first diagnosed during labour

c) regardless of when the condition is first diagnosed

14.4 Which ICD-10-AM code(s) should be assigned for a patient admitted for a trial of scar due to a previous caesarean section, who delivers vaginally?

a) O34.2 *Maternal care due to uterine scar from previous surgery*

b) O75.7 *Vaginal delivery following previous caesarean section*

c) both a) and b)

15. ACS 1552 *Premature rupture of membranes, labour delayed by therapy*

15.1 O42.2 *Premature rupture of membranes, labour delayed by therapy* should be assigned when steroids are administered to the mother. True or False?

15.2 O42.2 *Premature rupture of membranes, labour delayed by therapy* can be assigned with which of the following codes:

a) O42.0 *Premature rupture of membranes, onset of labour within 24 hours*

b) O42.11 *Premature rupture of membranes, onset of labour between 1-7 days later*

c) both a) and b)

15.3 Codes for premature rupture of membranes can be assigned based on times for the establishment of labour. True or False?

16. Other updates to ICD-10-AM, ACHI and ACS

16.1 The '*Use additional code'* instruction for hypertension has been removed from code range I20-I25. True or False?

16.2 A single spontaneous vaginal delivery with manual removal of placenta should be assigned which of the following ICD-10-AM codes?

a) O80 *Single spontaneous delivery*

b) O81 *Single delivery by forceps and vacuum extractor*

c) O82 *Single delivery by caesarean section*

d) O83 *Other assisted single delivery*

16.3 37217-01 *Implantation of fiducial markers* is located in which ACHI chapter?

a) Chapter 12: *Procedures on male genital organs*

b) Chapter 18: *Radiation oncology procedures*

16.4 Case scenario

From the case scenario below, assign and sequence the appropriate ICD-10-AM and ACHI codes.

A 57 year old female is admitted to hospital with long history of left leg varicose veins for removal. The varicose veins are removed through stab avulsions under intravenous (IV) sedation (ASA 1).

_____

_____

_____

_____

16.5 Complete the following code title:

G83.81 *Facial paralysis due to* _____

16.6 Which of the following codes have been expanded in Ninth Edition:

a) L02.4 *Cutaneous abscess, furuncle and carbuncle of limb*

b) L84 *Corns and callosities*

c) L97 *Ulcer of lower limb, not elsewhere specified*

d) all of the above

16.7 38488-09 [628] *Percutaneous replacement of mitral valve with bioprosthesis* includes cardiac catheterisation. True or false?

16.8 Administration of IV dextrose in a neonate should be coded. True or false?

16.9 Which of the following is the appropriate extension code to 96199 [1920] *Intravenous administration of pharmacological agent* for IV administration of iron in a same day episode of care?

a) -07 *Nutritional substance*

b) -08 *Electrolyte*

c) -09 *Other and unspecified pharmacological agent*

16.10 Insert the correct word to complete the following ACS code title:

never always

ACS 0049 *Disease codes that must* _____ *be assigned*

17. Answers

1 Supplementary codes for chronic conditions

1.1 (c). ACS 0003 *Supplementary codes for chronic conditions* has been created to provide background and instructions for assignment of supplementary U codes.

1.2 Supplementary/codes for chronic conditions

1.3 Supplementary codes are not to be assigned:

a) in addition to another chapter code for the same condition
c) for a past history of a condition
d) for an acute condition

1.4 False. Supplementary 'U' codes have been mapped to be excluded from DRG allocation.

1.5 Where the decision is unclear whether a code from U78.- to U88.- should be assigned do not assign the code.

1.6 The following conditions would not be eligible for assignment of U codes:

(c) acute renal failure – this is an acute condition. Supplementary codes are only for chronic conditions

(d) breast cancer – cancers have not been included in the list of supplementary codes as current cancers will usually meet the ctirteria for code assignment

(h) psychosis – psychosis has not been included in the list of supplementary codes as it is usually an acute condition

1.7 Answers**:**

a) Alzheimer's dementia – U79.1
b) intellectual impairment – U79.4
c) epilepsy – U80.3
d) coronary atherosclerosis – U82.1
e) hypertension – U82.3
f) multiple sclerosis – U80.2
g) depression – U79.3

1.8 Case scenario answer:

Acute appendicitis	No – code as per ACS 0001 *Principal diagnosis*
Hypertension	Yes – assign U82.3 *Hypertension*
Down's syndrome	Yes – assign U88.2 *Down's syndrome*

1.9 Clinical record 1 answer:

Hypertension	Yes – U82.3 *Hypertension*
Obesity	Yes – U78.1 *Obesity*
Persistent atrial fibrillation	No – Code as per ACS 0001 *Principal diagnosis*
ARF	No – Code as per ACS 0002 *Additional diagnoses*
Hypercholesterolaemia	No – ACS 0002 *Additional diagnoses* – don't code
Shingles	No – ACS 0002 *Additional diagnoses* – don't code
Dilated ascending aorta	No – ACS 0002 *Additional diagnoses* – don't code

1.10 Clinical record 2 answer:

S09.9	Unspecified injury of head
S01.88	Open wound of head
W22	Striking against or struck by other objects
W18.9	Unspecified fall on same level
Y92.05	Place of occurrence – home, bedroom
U73.2	Activity – dressing
E11.40	Type 2 diabetes mellitus with unspecified neuropathy
U82.3	Hypertension
U82.1	Ischaemic heart disease
U86.2	Arthritis and osteoarthritis
U79.3	Depression
U80.5	Tetraplegia, paraplegia, diplegia, monoplegia and hemiplegia, due to any cause

1.11 Clinical record 3 answer:

M75.1	Rotator cuff syndrome
E11.61	Type 2 diabetes mellitus with specified diabetic musculoskeletal and connective tissue complication
B18.1	Chronic viral hepatitis B without delta-agent
Z86.43	Personal history of tobacco use disorder
U82.3	Hypertension
U86.1	Rheumatoid arthritis
U83.3	Asthma, without mention of chronic obstructive pulmonary disease

2 Sepsis

2.1 R65.1

2.2 (c) A41.9 and K83.0

2.3 False. ACS 0110 *SIRS, sepsis, severe sepsis and septic shock* notes: Severe sepsis is inherent in septic shock and therefore severe sepsis does not need to be coded if R57.2 *Septic shock* is assigned.

2.4 Clinical record 4 answer:

A41.52	Sepsis due to *Pseudomonas*
A40.1	Sepsis due to streptococcus, group B
R57.2	Septic shock
L89.14	Pressure injury, stage II, lower back
B95.6	*Staphylococcus aureus* as the cause of diseases classified to other chapters
Z06.67	Resistance to multiple antibiotics
N39.0	Urinary tract infection, site not specified
N20.0	Calculus of kidney
U80.2	Multiple sclerosis
U80.5	Quadriplegia

2.5 Clinical record 5 answer:

A41.51	Sepsis due to *Escherichia coli* [*E. Coli*]
N39.0	Urinary tract infection, site not specified
E87.6	Hypokalaemia
R64	Cachexia
R15	Faecal incontinence
R32	Unspecified urinary incontinence
U79.1	Dementia (including in Alzheimer's disease)

3 Cystic fibrosis

3.1 False. Assign E84 *Cystic fibrosis* and codes for its manifestations according to the guidelines in ACS 0001 *Principal diagnosis* and ACS 0002 *Additional diagnoses*.

3.2 (d) all of the above

3.3 (b) N46 and E84

3.4 Case scenario answer:

J98.1	Pulmonary collapse
E84	Cystic fibrosis
K80.20	Cholelithiasis

3.5 Clinical record 6 answer:

J47	Bronchiectasis
E84	Cystic fibrosis

4 Pressure injury

4.1 (d) L89.29 *Pressure injury, stage III, other site of lower extremity (excluding heel and toe)*

4.2 1B, 2D, 3A, 4C

4.3 True. Assign multiple pressure injury codes as appropriate to identify all pressure injuries, however, do not double code (ie repeat code in the code string for the same site and severity as per ACS 0025 *Double coding*).

4.4 (d) L89.99. Pressure injuries without documentation of the stage should be assigned as L89.9- *Pressure injury, unspecified stage*. Assignment of L89.4- *Pressure injury, unstageable, so stated* or L89.9- *Suspected deep tissue injury, depth unknown, so stated* require clinical documentation of specific terminology to be assigned.

4.5 False. Pressure injuries may improve or deteriorate during hospitalisation. If different stages are documented for a pressure injury of the same site, assign a code for the highest stage for that site.

4.6 (b) COF 2. If pressure injuries are present on admission, assign a condition onset flag of 2.

4.7 Case scenario answer:

J18.9 (2) Pneumonia, unspecified
L89.09 (2) Pressure injury, stage I, other site of lower extremity (excluding heel and toe)
L89.14 (2) Pressure injury, stage II, lower back

4.8 Case scenario answer:

L89.15 (2) Pressure injury, stage II, ischium
L89.19 (2) Pressure injury, stage II, other site of lower extremity (excluding heel and toe)
L89.09 (1) Pressure injury, stage I, other site of lower extremity (excluding heel and toe)

5 Rehabilitation care

5.1 (c) Z50.9 *Care involving use of rehabilitation procedure, unspecified*. Details of the specific rehabilitation will be indicated by the appropriate intervention codes.

5.2 (b) the underlying condition requiring rehabilitation. This would previously have been sequenced as the first listed additional diagnosis.

5.3 Case scenario answer:

S72.00 Fracture of neck of femur, part unspecified
W06.9 Fall involving unspecified bed
Y92.05 Place of occurrence, bedroom
U73.2 While resting, sleeping, eating or engaging in other vital activities
Z50.9 Care involving use of rehabilitation procedure, unspecified

5.4 Clinical record 7 answer:

M48.06† Spinal stenosis, lumbar region
G55.3* Nerve root and plexus compressions in other dorsopathies (M45 – M46†, M48.-†, M53 – M54†)
Z50.9 Care involving use of rehabilitation procedure, unspecified
U82.3 Hypertension
U86.2 Arthritis and osteoarthritis
95550-02 [1916] Allied health intervention, occupational therapy
95550-03 [1916] Allied health intervention, physiotherapy
95550-01 [1916] Allied health intervention, social work

5.5 Clinical record 8 answer:

M17.1 Other primary gonarthrosis
Z50.9 Care involving use of rehabilitation procedure, unspecified
Z96.65 Presence of knee implant
E11.9 Type 2 diabetes mellitus without complication
U82.3 Hypertension
U83.3 Asthma
95550-03 [1916] Allied health intervention, physiotherapy
95550-01 [1916] Allied health intervention, social work

6 Updates to cardiac Australian Coding Standards

6.1 This information is now located in ACS 0934 *Cardiac and vascular revision/reoperation procedures* which is more appropriate.

6.2 True. ACS 0941 *Arterial disease* has been updated and this criteria has been removed. Coders should assign a code from category I25.1- when coronary artery disease is documented and the clinical documentation indicates that it is significant.

6.3 (b). ACS 0909 *Coronary artery bypass grafts* has been updated regarding assignment for complications of CABG. Coders should code complications based on the clinical documentation provided rather than a specific timeframe.

6.4 (b). ACS 0934 *Cardiac and vascular revision/reoperation procedures* includes specific instructions for reoperation of peripheral vessels.

7 ACHI Chapter 7 *Procedures on respiratory system*

7.1 False. Ninth Edition does not distinguish between rigid and fibreoptic bronchoscopies.

7.2 (c). The correct code title is 41905-06 [546] *Endoscopic insertion of bronchial device*.

7.3 (c). ACHI block [547] *Other procedures on bronchus* includes two new codes for destruction procedures on bronchus.

7.4 Case scenario answer:

C34.0 Malignant neoplasm of bronchus and lung, main bronchus
M8240/3 Carcinoid tumour NOS
41898-04 [544] Endoscopic [needle] biopsy of bronchus

8 Dengue

8.1 A97.0 *Dengue without warning signs*

8.2 with

8.3 Clinical record 9 answer:

A97.9 Dengue, unspecified

9 Allergen challenges

9.1 True

9.2 False. ACS 2115 *Admission for allergen challenge* notes "Allergen desensitisation (immunotherapy) is different to allergen challenge as it involves the ongoing administration of gradually increasing doses of allergen extracts in order to reduce sensitivity. Allergen desensitisation is assigned a code from Z51.6- *Desensitisation to allergens.*"

9.3 challenge

9.4 1D, 2A, 3B, 4C

9.5 Case scenario answer:

Z41.82 Food challenge
Z88.8 Personal history of allergy to other drugs, medicaments and biological substances

9.6 Case scenario answer:

Z41.82 Food challenge
L50.0 Allergic urticaria
Y57.9 Drug or medicament, unspecified
Y92.22 Place of occurrence, Health service area

10 **Obesity procedures**

10.1 Case scenario answer:

31587-00 [1895] Adjustment of gastric band

10.2 Case scenario answer:

30511-14 [889] Gastric banding
92514-99 [1910] General anaesthesia, ASA 9, nonemergency

10.3 1C, 2D, 3A, 4B

11 **ACS updates relating to Chapter 21 *Factors influencing health status and contact with health services***

11.1 (c) ACS 2103 *Admission for post acute care*

11.2 (a) Z51.88 *Other specified medical care*

11.3 (c). ACS 2117 *Non-acute care* has been created to provide classification instructions for multiple types of non-acute care.

11.4 Case scenario answer:

Z51.88 Other specified medical care
J18.9 Pneumonia

12 **ACS 0031 *Anaesthesia***

12.1 False. ACS 0031 *Anaesthesia* has been updated to allow more than one code to be assigned from block [1909] *Conduction anaesthesia* for each ‘visit to theatre’. However each type of conduction anaesthesia should be assigned once only.

12.2 Case scenario answer:

30614-03 [990] Repair of inguinal hernia, bilateral
92514-29 [1910] General anaesthesia, ASA 2, nonemergency
92510-29 [1909] Regional block, nerve of trunk, ASA 29
Note: ACS 0031 Anaesthesia has been updated to include the following instruction: “An ASA score where a single ASA value is not clearly documented (eg 2/3 or 2-3) is an incorrect use of the ASA status. Such a score should be clarified with the anaesthetist, however, if this is not possible, assign the code representing the higher score.”

12.3 Case scenario answer:

49519-00 [1518]	Total arthroplasty of knee, bilateral
92508-19 [1909]	Neuraxial block, ASA 19
92512-19 [1909]	Regional block, nerve of lower limb, ASA 19

13 **ACS 1006 *Ventilatory support***

13.1 Weaning is the process of reducing the ventilatory support, leading to complete discontinuation of the CVS.

13.2 True. Where CVS via the tracheostomy recommences > 24 hours following cessation of CVS a new period of ventilation commences.

13.3 True. This includes patients who die or are discharged or transferred.

13.4 (a) 13882-00 [569] *Management of continuous ventilatory support, ≤ 24 hours*. ACS 1006 *Ventilatory support* (point 1f) states: Where a patient has multiple visits to theatre requiring ventilation, each period of ventilation should be considered individually. If the period of ventilation post surgery is less than or equal to 24 hours, a code for ventilation is not assigned and not used cumulatively with other periods of ventilation in the episode of care.

14 **ACS 1506 *Fetal presentation, disproportion and abnormality of maternal pelvic organs***

14.1 False. They include both abnormal and normal positions.

14.2 False. ACS 1506 instructs that codes for abnormal fetal presentations should only be assigned if they meet the criteria for code assignment in ACS 0001 *Principal diagnosis* or ACS 0002 *Additional diagnoses*.

14.3 (c). Where care and/or intervention is required during labour, they should be assigned regardless of when the condition is first diagnosed (with the exception of uterine scar).

14.4 (b). Where a patient proceeds to vaginal delivery after trial of scar, assign O75.7 *Vaginal delivery following previous caesarean section*. Code O34.2 is not assigned as per the excludes note.

15 ACS 1552 *Premature rupture of membranes, labour delayed by therapy*

15.1 False. Steroids are administered to the mother to mature the baby's lungs, not to delay pre-term labour/delivery. O42.2 should only be assigned when tocolytic agents are administered.

15.2 (a). The excludes note at O42.11 precludes it from being assigned with O42.2.

15.3 False. The Tabular List note at O42 *Premature rupture of membranes* states: 'Premature/pre-labour rupture of membranes' must be documented; a code from this category should not be assigned based on documentation of the times for the establishment of labour alone.

16 Summary of other updates

16.1 True. The *'use additional code'* instruction has been removed. I10 *Hypertension* should now be assigned when it meets the criteria for code assignment in ACS 0002 *Additional diagnoses*.

16.2 (d). The includes list at O83 *Other assisted single delivery* has been updated to include single delivery assisted (facilitated) by manual removal of placenta.

16.3 (b). Ninth Edition contains a new generic code for implantation of fiducial markers and the specific code for prostate has been deleted.

16.4 Case scenario answer:

I83.9 Varicose veins of lower extremities without ulcer or inflammation
32504-00 [727] Interruption of varicose veins of multiple tributaries
92515-19 [1910] Sedation, ASA 19

16.5 G83.81 *Facial paralysis due to cerebrovascular accident*

16.6 (d). These codes have been expanded to specify foot which qualify the assignment of diabetic foot.

16.7 True. The coding conventions have been updated at several codes in ACHI Chapter 8: *Procedures on cardiovascular system*. Some have been updated to include cardiac catheterisation and others have removed the instruction 'Code also when performed: coronary angiography'.

16.8 True. ACS 1615 *Specific diseases and interventions related to the sick neonate* has been updated at Parenteral fluid therapy to specify that administration of dextrose should be coded in neonates.

16.9 (c). Inclusion terms for dextrose and iron have been added to the extension -09 *Other and unspecified pharmacological agent* at ACHI block [1920].

16.10 never. ACS 0049 *Disease codes that must never be assigned* provides a centralised list of codes never to be assigned based on existing classification instructions.