PATIENT DEMOGRAPHICS

Hospital No		Service No/ Employment No		Gender	F / M
Surname		Rank/Title		Communication/ Language	
Forename(s)		Nationality		Interpreter Required	Y / N
Date of Birth/ Age		Transfer From		Religion	

Admission Date (DTG)		Consultant		Speciality	
Reason For Admission					
Mechanism Of Injury					
Ward		Bedspace		Wristband	Y / N

Unit In Theatre		Parent Unit	
Unit Contact Details		Unit Aware	Y / N

ADMISSION ASSESSMENT

Past Medical History / Plan							
Allergies	Y / N						
Current medication						Anti-malarials	Y / N / NA
Height		Weight		Waterlow Score			
MUST Score		Special Diet	Y / N				
Smoking	Y / N	No per day		Alcohol intake	Y / N	Units per week	
Seen by Welfare	Y / N / NA	Standing Orders Signed		Y / N			

Patient Property	PPE Location (Body Armour, Helmet, Weapon)

NURSE COMPLETING ADMISSION

Name		Rank/Grade		Signature	

OBSERVATION CHART - ADULT

NEWS key	Name			Hospital No.	
0 1 2 3	DoB		Rank	Service No.	

		Date:																													
		Time:																													
A + B Respirations Breaths/min	≥25																														
	21-24																														
	18-20																														
	15-17																														
	12-14																														
	9-11																														
	≤8																														
A + B SpO_2	≥96																														
	94-95																														
	92-93																														
	≤91																														
Air or Oxygen	A= Air																														
	O_2 L/min																														
	Device																														
C Blood Pressure mmHg Score uses systolic BP only	≥220																														
	201-219																														
	181-200																														
	161-180																														
	141-160																														
	121-140																														
	111-120																														
	101-110																														
	91-100																														
	81-90																														
	71-80																														
	61-70																														
	51-60																														
	≤50																														
C Pulse Beats/min	≥131																														
	121-130																														
	111- 120																														
	101-110																														
	91-100																														
	81-90																														
	71-80																														
	61-70																														
	51-60																														
	41-50																														
	≤40																														
D Consciousness	Alert																														
	Confusion																														
	VPU																														
E Temperature °C	≥39.1°																														
	38.1-39°																														
	37.1-38°																														
	36.1-37°																														
	35.1-36°																														
	≤35°																														
NEWS 2 TOTAL																															
Pain score																															
Bowels open Y/N																															
Monitoring frequency																															
Escalation of care Y/N *																															
Intials																															

* Record escalation of care in patients notes. See NICE CG50 (Jul 07) and QS161 (Sep 17)

PATIENT CONTINUOUS ASSESSMENT

NATIONAL EARLY WARNING SCORE 2 (NEWS 2) PARAMETERS - ADULT [1]

Physiology	3	2	1	0	1	2	3
Respiratory Rate (per minute)	≤ 8		9 - 11	12 - 20		21 -24	≥ 25
SpO_2 %	≤ 91	92 - 93	94 - 95	≤ 96			
Air or oxygen?		Oxygen		Air			
Systolic Blood Pressure (mmHg)	≤90	91 - 100	101 - 110	111 - 219			≥ 220
Pulse (per minute)	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
AVPU (Level of Consciousness)				Alert			V,P or U
Temperature (°C)	≤35		35.1 - 36	36.1 - 38	38.1 - 39	≥39.1	

CLINICAL RESPONSE TO NEWS TRIGGER THRESHOLDS

Score of 0	Score of 1 - 4	Score of 5 or more (or 3 in one parameter)	Score of 7 or more
• Monitor 12 hourly as minimum • Continue Routine NEWS monitoring	• Monitor 4 - 6 Hourly as minimum • Inform registered nurse who must assess the patient • Registered nurse to decide if increased frequency of monitoring and/or escalation of clinical care is required	• Monitor 1 hourly minimum • Registered nurse to immediately inform the medical team team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities	• Provide continuous monitoring of vital signs • Registered nurse to immediately inform the medical team caring for the patient • Emergency assessent by a team with critical care competencies, including practitioner(s) with advanced airway management skills. • Consider transfer of clinical care to higher dependecy or ITU with monitoring facilities

PAIN SCORE (AT REST AND ON MOVEMENT)

0	1	2	3
No pain	Mild	Moderate	Severe

LEVEL OF CONSCIOUSNESS ASSESSMENT - ACVPU

A	**A**lert	**C**	**C**onfusion (New onset)	**V**	Responds to **V**oice	**P**	Responds to **P**ain	**U**	**U**nresponsive

If Concious level is anything other than ALERT (C,V,P, or U) consider Neuro Observations - FMed 290

WATERLOW SCALE: To be completed within 6hrs of admission and repeated every 24hrs [2]

TOTAL SCORE: 10+ AT RISK; 15+ HIGH RISK; 20+ VERY HIGH RISK

Build/Weight sub-total		Continence sub-total		Appetite sub-total		Special Risks sub-total			
Average	0	Completed or catheterised	0	Average	0	**Tissue Malnutrition**		**Major Surgery Trauma**	
Above average	1	Occasional incontinence	1	Poor	1	E.g. Terminal cachexia	8	Orthopaedic - below waist, spinal	5
Obese	2	Incontinent faeces	2	NG feeds & fluids	2	Cardiac failure	5	On table > 2 hours	5
Below average	3	Doubly incontinent	3	NBM or anorexic	3	Peripheral Vascular Disease	5		
						Anaemia	2		
						Smoking	1		
Skin Type sub-total		**Mobility sub-total**		**Sex/Age sub-total**		**Neuro Deficit sub-total**		**Medication sub-total**	
Healthy	0	Full	0	Male	1	eg Diabetes, MS, CVA, Motor or sensory deficit paraplegia	6	Cytotoxics	4
Tissue paper	1	Restless	1	Female	2				
Dry	1	Apathetic	2	14 - 49	1			Steroids	4
Oedematous	1	Restricted	3	50-64	2				
Clammy/temp increased	1	Bedbound	4	65 - 74	3			High dose anti - inflammatory	4
Discoloured	2	Chairbound	5	75 - 80	4				
Broken/spot	3			81+	5			**TOTAL SCORE**	

RECOMMENDATIONS

10+ AT RISK	15+ HIGH RISK	20+ VERY HIGH RISK
• Inspect skin at least twice a day. • Encourage/assist patient to stand, mobilise or reposition 4-6 hou • Commence repositioning chart. • Consider use of pressure relieveing devices/ barrier creams • To not exceed 4 hours sitting out. • Maintain adequate nutrician and hydration	• Inspect skin 4-6 hourly • Encourage/assist patient to stand,mobilise or reposition 4 hourly • Commence repositioning chart • Impliment appropriate presure relieveing devices/ barrier creams • To not exceed 2 hours sitting out • Maintain adequate nutrician and hydration, start food and fluid chart	• Inspect skin 2-4 hourly • Encourage/assist patient to stand,mobilise or reposition 2-4 hourly • Commence repositioning chart • Impliment appropriate presure relieveing devices/ barrier creams • Consider MDT consultation from dietician, skin specialist, & physio. • Maintain adequate nutrician and hydration, start food and fluid chart

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

Step 1	BMI Score	BMI kg/m2: > 20 = 0 18.5 - 20 = 1 <18.5 = 2	
Step 2	Unplanned weight loss in 3-6 months	<5% = 0 5 - 10% = 1 >10% = 2	
Step 3	Acute Disease Effect Score	If patient is acutely ill there has been or is likely to be no nutritional intake >5 days : Score 2	
Step 4	Overall Risk of Malnutrition	Add Scores together to calculate overall risk of malnutrition: Score 0 Low Risk Score 1 Medium Risk Score 2 or more High Risk	
Step 5	Management Guidelines	0 Low Risk - Routine Clinical Care 1 Medium Risk - Observe 2 or more High Risk - Treat	Repeat screening weekly in hospital. Document dietary intake for 3 days, if adequate repeat screening weekly or set goals and improve intake. Refer to reachback dietician for advice. Set goals and improve intake, monitor and review weekly.

[1] https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

[2] NICE QS89, Jun 15

Name				Hospital No.	
DoB		Rank		Service No.	

IN-DWELLING DEVICES

Record Input and Output on Daily Fluid Balance Chart FMED 100

IV Cannula(s)	1			2			3			4		
Date inserted												
Cannula site												
VIP Scoring	Date:			Date:			Date:			Date:		
Time (score every shift)	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night
Score (1-5 as below)												
VIP Scoring	Date:			Date:			Date:			Date:		
Time	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night
Score (1-5 as below)												
VIP Scoring	Date:			Date:			Date:			Date:		
Time (score every shift)	AM	PM	Night	AM	PM	Night	AM	PM	Night	AM	PM	Night
Score (1-5)												
Date removed												

IV site appears healthy	0	No signs of phlebitis	**Observe Cannula**
One of the following is evident: • Slight pain near IV site or • Slight redness near IV site	1	Possible first signs	**Observe Cannula**
Two of the following are evident: Pain at IV site • Erythema • Swelling	2	Early stage of phlebitis	**Resite Cannula**
All of the following signs are evident: • Pain along path of cannula • Erythema • Induration	3	Mid-stage of phlebitis	**Resite Cannula** **Consider Treatment**
All of the following signs are evident and extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord	4	Advanced stage of phlebitis or start of thrombophlebitis	**Resite Cannula** **Consider Treatment**
All of the following signs are evident and extensive: • Pain along path of cannula • Erythema • Induration • Palpable venous cord • Pyrexia	5	Advanced stage of thrombophlebitis	**Initaite Treatment**

Urinary Catheter	Y / N	Date inserted		Size		Make	
Additional information							
Urine Dip Test	Y / N	**Sample Sent**	Y / N				

NG/NJ Tube	Y / N	Date inserted		Size		Make	Fine Bore/Widebore
	Tube position	cm	Left / Right	Nostril		**Chest x-ray confirmation**	Y / N
	Treatment management/ direction	Free Drainage/ Regular Aspiration					

Drain(s)	Y / N	Number of drains		Documented on wound care chart (Page 5)	Y / N
Additional information					

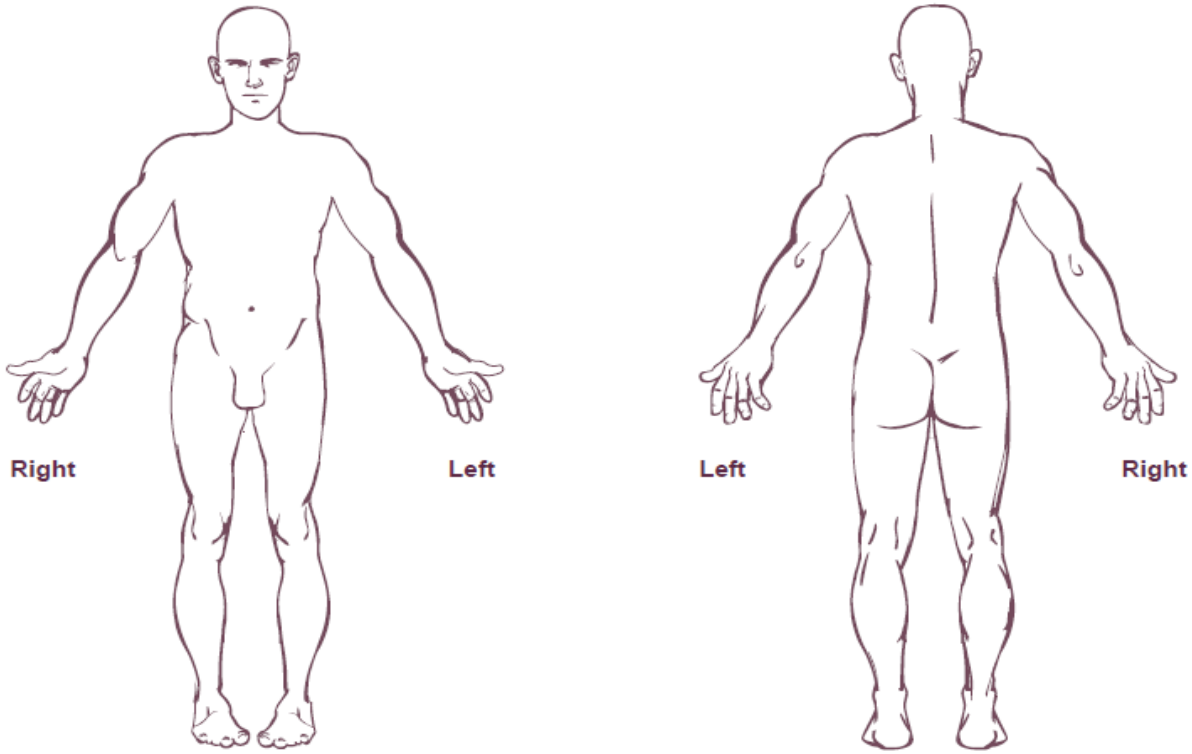
Chest Drain	Y / N	Position		Date Inserted	
Reason for Insertion					

Date/Time														
Swinging														
Bubbling														
Flushed														

Additional information

Name				Hospital No.	
DoB		Rank		Service No.	

WOUND CARE



Mark the body map with location of wounds and number these detailing below.

Wounds Mark positions on body map	Topical Negative Pressure (TNP) Dressing or drains applied			Pump Number/s
Wound 1 Type				
Dressing Applied	**Number of drains/ports:**			
	Pump settings:			
	Pressure:		**mmHg**	
	Frequency of change:			
Wound 2 Type				
Dressing Applied	**Number of drains/ports:**			
	Pump settings:			
	Pressure:		**mmHg**	
	Frequency of change:			
Wound 3 Type				
Dressing Applied	**Number of drains/ports:**			
	Pump settings:			
	Pressure:		**mmHg**	
	Frequency of change:			
Wound 4 Type				
Dressing Applied	**Number of drains/ports:**			
	Pump settings:			
	Pressure:		**mmHg**	
	Frequency of change:			

Dressing Options			
Paraffin Gauze (Jelonet)	Duoderm Thin/Granuflex	Betadine	Acticoat
Gauze/Propax/Kerlix	Cosmopore/Mepore	Saline	Kaltostat
Cotton wool	Melgisorb	Sorbsan	Inadine
Crepe Bandage	Tegaderm Adhesive film	Mefix	Opsite

Name				Hospital No.	
DoB		Rank		Service No.	

ADDITIONAL INFORMATION

DISCHARGE PLAN

FMED 14 complete	Y / N	Cannula removed	☐	
FMED 7 complete	Y / N	Personal belongings/ PPE returned	☐	
FMED 85 required?	Y / N	Discharge destination/ Method of transport	(UK Role 4/Other MTF/ Return to Unit in theatre/ return to unit in UK)	
Medications given and explained	Y / N	Completed patient satisfactory survey	☐	
Light duties proforma	Y / N / NA			
Follow up arrangements				

AEROMEDICAL EVACUATION

Seen by AELO / AECO	Y / N	Flight Time:		TF Depature Tin	
Confirmed discharge destination/ plan					

CHECKLIST					
Passport	☐	Yellow Fever Certificate (if applicable)	☐	CD from radiology	☐
MOD 90 / ID Card	☐	TTO'S - 48 / 72 Hour supply	☐	Helmet / Body Armour	☐
Identity Discs	☐	Photocopy of ALL medical / nursing notes	☐	Small daysack with overnight kit	☐
Personal baggage and clothing checked for banned substances			☐		

PRE-FLIGHT CHECKS					
Observations	☐	TED Stockings / Enoxoparin	☐	Analgesia given 1 hour before departure	☐
Hb ≥ 80	☐	Antiemetics given 1 hour before departure	☐	Copy of patients fit to fly	☐

NURSE COMPLETING DISCHARGE

Name		Rank/Grade		Signature	