

Patient Name Stanley Carby

Contact Record

Date	Problem No.	Time	Record of contact, with, Signature and designation
27/6/99		pm	<p>Very tired on admission. Visited by wife & daughter - provisional care plan explained. Very agitated after family left. Pulling himself down in bed, throwing any & all objects left in reach. Small amount of supper eaten with assistance. <i>ML</i></p>
27/4/99			<p>Unable to get Stan to swallow any fluid (thickened) due to patient holding his head back and not appearing to be alert enough to swallow. Unable to assess swallowing - referred to speech and language therapists. Dr. hand contacted, suggests that we give 2.5mg Midazolam and sub-cutaneous fluids, and Dr. Barton to see at lunch time.</p>
27/4/99			<p>Patient's breathing very shallow - colour poor peripheral cyanosis B/P $\frac{90}{70}$ Glucocheck 14.8. Dr. Bar contacted - rates requested from Haslar.</p>
		10am	<p>Dr Barton aware & will attend in approx 1 hour wife & daughter notified & coming in <i>[Signature]</i></p>

Patient Name STANLEY CARBY

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27/4/99.			S/B R. Barton, family spoken to regarding previous strokes and probably extension of this CVA. Patient extremely cyanosed and very clammy. Wife thinks he will not survive this episode, this confirmed as the probable outcome. Decision made with family to make the patient comfortable. wife feels that Mr. Carby is in pain because he is gripping her hand. Difficult to tell if this is so, but sub-cutaneous analgesia commenced, together with Midazolam. Joice
27/4/99			Patient died at 13.00, death confirmed by S.N. Nevill & S.N. Joice, family present and aware very distressed and distraught about their father's death. wife present and aware. Information given to relatives re: bereavement.

Patient Name Stanley Carby

The Barthel ADL Index

Date:

26/4/99

Bowels

- 0 = Incontinent
- 1 = Occasional accident
- 2 = Continent

0									
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Bladder

- 0 = Incontinent or catheterised & unable to manage
- 1 = Occasional accident (max 1 per 24 hours)
- 2 = Continent (for over 7 days)

0									
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Grooming

- 0 = Needs help
- 1 = Independent, face / hair / teeth / shaving

0									
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Toilet

- 0 = Dependent
- 1 = Needs some help but can do something
- 2 = Independent

0									
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Feeding

- 0 = Unable
- 1 = Needs help cutting, spreading butter etc.
- 2 = Independent

1									
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Transfer

- 0 = Unable
- 1 = Major help (1-2 people, physical)
- 2 = Minor help (verbal or physical)
- 3 = Independent

0									
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Mobility

- 0 = Unable
- 1 = Wheelchair independent, including corners etc.
- 2 = Walks with help of **one** person (verbal or physical)
- 3 = Independent, (but may use any aid, e.g. stick)

0									
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Dressing

- 0 = Dependent
- 1 = Needs help, but can do half unaided
- 2 = Independent

0									
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Stairs

- 0 = Unable
- 1 = Needs help (verbal, physical, carrying aid)
- 2 = Independent, up and down

0									
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Bathing

- 0 = Dependent
- 1 = independent

0									
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Total

1									
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Patient Name ... Stanley Carby ...

Abbreviated Mental Study

Hospital No:				Study No:			
Adm	Day 7-10		Interim		Optional		Disch

Please fill in the date (day/month)

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Age | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Time (to the nearest hour) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Give address for recall at end of test. This should be repeated by the patient to ensure it has been heard correctly.
42 West Street | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Year | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Name of institution | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Recognition of two persons,
(Doctor, Nurse etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Date of birth, (day & month sufficient) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Year of the First World War | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Name of the present Monarch | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Count backwards 20 to 1 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Don't forget the address for recall

Total Score

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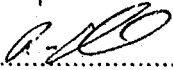
If assessment not possible, please give reason

- | | | | | | |
|-------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Coma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A/Dysphasia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Refusal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Specify

Centre:

EVALUATION

MOVEMENT	EVALUATION		
	RAG	AT BEST	AT WORST
1. Turning/Rolling	R	2 Nurses	
2. Up/down Bed	R	2 nurses + Glide Sheet	
3. In to bed	R	Hoist	
4. Out of bed	R	Hoist	
5. Sit to Stand/Standing	R	Not to be attempted	
6. On/Off Toilet/Commode	R	Hoist	
7. In/Out of Chair	R	Hoist	
8. Walking	X	Not to be attempted	
9. Bath/Shower	R	Hoist	
Signature of Assessor Print Name Designation Date of Assessment	 26/2/99	RE-EVALUATION	