

78/CA.2/I

IN-PATIENT FOLLOW-UP  
AND  
OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

Patient 29

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		* Urology *
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		
→	25/1/16	Patient 29
Age		
URINE Protein Sugar Acetone		
WEIGHT		Personal Information redacted by the USI
kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT		Personal Information redacted by the USI
kg.		

HSS TRUST \_\_\_\_\_  
Hospital Unit \_\_\_\_\_

GP PRACTICE or other \_\_\_\_\_  
Primary Care Provider \_\_\_\_\_

**FORM 1 -- CONSENT FOR EXAMINATION, TREATMENT OR CARE****Personal details (or pre-printed label)**

Surname/family name .....  
First names .....  
Date of Birth .....  
☐ Male ☐ Female H+C No. (or other identifier) .....  
Special requirements (language or other) .....

Patient 29

**Statement of healthcare professional**

Responsible healthcare professional MR O'DONOGHUE Job Title CONSULTANT  
Name of proposed procedure or course of treatment (include site of body or site and brief explanation if medical term not clear)  
[REDACTED]

I have explained the procedure. In particular, I have explained:

The intended benefits [REDACTED]

Personal Information redacted by the USI

Possible additional procedures which may become necessary during the procedure.

☐ Blood transfusion ☐ other procedure (please specify) .....  
This procedure will involve: ☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

☐ The patient information leaflet/tape has been provided.

Signed [REDACTED] Date [REDACTED]  
Name (Print) Ullandhane Job Title Urol Sp1

Contact details (if patient wishes to discuss options later) .....

**Statement of interpreter (where appropriate)**

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed ..... Date .....  
Name (Print) .....

Copy accepted by person giving consent Yes/No (please circle)

**Statement of person giving consent**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

\*I agree that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. \*You may remove this sentence without affecting your care.

Signature [REDACTED] Date [REDACTED]  
Name (Print) [REDACTED]

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature ..... Date .....  
Name (Print) .....

**Confirmation of consent** (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature ..... Date .....  
Name (Print) ..... Job Title .....

**Important notes: (tick if applicable)**

☐ See also advance directive/living will (eg Jehovah's Witness form)

☐ Person has withdrawn consent ..... Date .....  
(ask person to sign/date here)



PREOPERATIVE ASSESSMENT

ASA status: 1 2 3 4 5 6 E

PERSONNEL

Anaesthetist (grade):

CYDCTI

Surgeon:

O'Donoghue

PROCEDURE DETAILS

Diagnosis:

Personal Information redacted by the USI

NCEPOD Scheduled

Urgent

Emergency

Personal Information redacted by the USI

POSTOPERATIVE INSTRUCTIONS/ MONITORING

SURGICAL PROCEDURE:

Oxygen @ ..... L/min ..... % for ..... hrs/overnight/humidified

Target SpO<sub>2</sub> ≥ ..... %

Personal Information redacted by the USI

ANALGESIA

Morphine IV (+)

Paracetamol L

Other -

ANTIEMETICS

Routine Observations

Discharge at Sister's advice

Only after D/W anaesthetist

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Anaesthetist's Signa

Please see:

Drug Kardex ☒

Fluid balance chart ☐

PCA Form ☐

Epidural Form ☐

Intrathecal opiate Form ☐

CVC Audit sheet ☐

POSTOP INVESTIGATIONS

Full ICU profile ☐

FBP, U&E

ABG

CXR

Other:

Patient 29

Time	Resp	SpO <sub>2</sub>	Pulse	BP	O <sub>2</sub> deliv.	Temp	Drugs	Notes
Personal Information redacted by the USI								



Patient Protection

- AAGBI Equipment Check
- WHO Safety Checklist
- Eye Protection ☒
- Pressure Points Padded
- Warming Mat
- Forced Air Warmer
- Blood Warmer
- Calf compression

Procedure

Personal Information redacted by the USI

Monitoring

Vascular Access

Arterial:

Airway Management

- PreO<sub>2</sub> ☐ IV induction ☐ RSI ☐ *ela. no facemask*
- Facemask ☐ Guedel ☐ NGT ☐
- SAD ☐ ETT ☐ Laryngoscopy
- Type & Size Type & Size Details

Ventilation/Position

- Circle System ☐ Other ☐
- Position *Lindberg* Arms <90° ☐
- SR ☒ PSV ☐ PCV ☐ VCV ☐
- TV: .....mls PAP: .....cmH<sub>2</sub>O
- RR: ...../min PEEP: .....cmH<sub>2</sub>O

WIT-10994

D

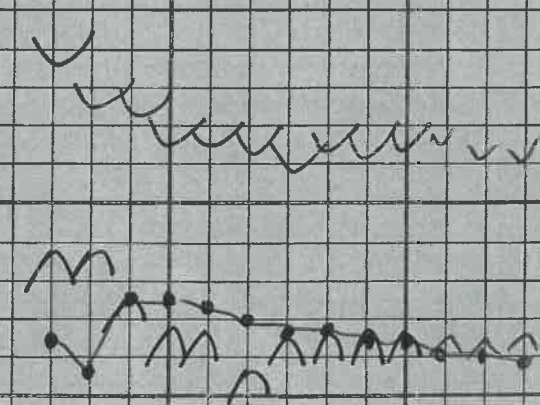
R

U

G

Personal Information redacted by the USI

1130 1200 1230 1300



⑪

ela	ela	ela	ela	ela
99	100	99	99	99
/	/	/	/	/

ETCO<sub>2</sub>  
PAP  
Temp



OPERATION NOTES

Affix Label

Patient 29

HOSPITAL: ..... CAH .....

Operations Performed

Personal Information redacted by the USI

Date

Personal Information redacted by the USI

Surgeon

John O'Donoghue

Anaesthetist

Dr. Winter

Assistant

Sister

Incision

Blood

Findings

Personal Information redacted by the USI

Drains

Packs

PROCEDURE

Personal Information redacted by the USI

Personal Information redacted by the USI

Signature of Surgeon: .....



Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

*Cancelled* *uslogich*

Signature of Surgeon: .....



# Elective Surgical Patients – Admission Checklist & Risk Assessments

WIT-10997

Patient ID: Patient 29

Name: ...

D.O.B.: ...

H&C No.:

Hospital:

Gender: Male ☐ Female ☐

Personal Information redacted by the USI

Date of Admission: ...

Procedure: ...

Consultant: O'Donoghue

Specialty: Urology

1) Any changes in health since Pre-Op Assessment? No ☒ Yes ☐ (if yes, please detail)

2) Any new medications commenced since Pre-Op Assessment? No ☒ Yes ☐ (if yes, please detail)

3) Drugs Kardex including Allergy status written up? Yes ☒

4) All Pre-Op investigations & Observations complete? Yes ☒ No ☐ (if no, please detail)

5) Acute Kidney Injury & VTE Risk Assessment completed? Yes ☒ N/A ☐ Day-Cases should NOT be risk assessed

6) ENT Patients ONLY - Consent Confirmed? Yes ☐

Additional Comments:

Print Name: Personal Information redacted by the USI Grade: FY1 Date: 18/2/15

## Acute Kidney Injury (AKI) Risk Assessment Tool for Elective General Surgical In-Patients aged 60 and over

Risk Factor	Score (circle each that applies)
Elective intra-abdominal or major vascular surgery	2
Emergency intra-abdominal or major vascular surgery	X
* Co-morbidities (≥ 2)	2
Baseline GFR < 60 mls/min	X
Systolic BP < 100mmHg	X
-- Nephrotoxic medications (Pre-admission)	X
<b>Total score on admission</b>	4

If risk score is ≥ 3 then patient is **AT RISK OF AKI**  
Follow guidance on Pre-emptive Management

\* Co-morbidities = IHD, Heart Failure, Hypertension, Diabetes, TIA/CVA, PVD -- Nephrotoxic medications = ACEi/ARB, NSAIDs, Diuretics



**Step 1: Assess for level of mobility – All Patients**

Intended surgical day-case patient	Tick	Surgical inpatient	Tick	Medical patient expected to have ongoing reduced mobility relative to normal state	Tick	Medical patient NOT expected to have significantly reduced mobility relative to normal state	Tick
			<input checked="" type="checkbox"/>				
Do not risk assess		Assess for thrombosis and bleeding risk below (Complete steps 2 – 5)			Risk assessment complete (Go to step 5)		

**Step 2: Review thrombosis risk**

Any tick for thrombosis risk factors should prompt consideration for thromboprophylaxis

Patient related	Tick	Admission related	Tick
Active cancer or cancer treatment		Significantly reduced mobility for 3 days or more	
Age >60	<input checked="" type="checkbox"/>	Hip or knee replacement	
Dehydration		Hip fracture	
Known thrombophilias		Total anaesthetic + surgery time > 90 minutes	
Personal history/first degree relative with history of VTE		Surgery involving pelvis or lower limb with anaesthetic + surgery time > 60 minutes	
One or more significant medical comorbidities (eg heart disease; metabolic, endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)	<input checked="" type="checkbox"/>	Acute surgical admission with inflammatory or intra-abdominal condition	
Obesity (BMI > 30 kg/m <sup>2</sup> )		Critical care admission	
Use of hormone replacement therapy		Surgery with significant reduction in mobility	
Use of oestrogen-containing oral contraceptive therapy		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Varicose veins with phlebitis			
Pregnancy or < 6 weeks post partum (see Obstetric risk assessment for VTE)			

**Step 3: Review bleeding risk**

Any tick should prompt staff to consider if bleeding risk is sufficient to preclude pharmacological intervention

Patient related	Tick	Admission related	Tick
Active bleeding		Neurosurgery, spinal surgery or eye surgery	
Acquired bleeding disorder (such as acute liver failure)		Lumbar puncture/epidural/spinal anaesthesia expected in the next 12 hours	
Concurrent use of anticoagulants known to increase risk of bleeding (such as warfarin with INR > 2)		Lumbar puncture/epidural/spinal anaesthesia within the previous 4 hours	
Acute stroke		Other procedure with high bleeding risk	
Thrombocytopaenia (Platelets < 75 x 10 <sup>9</sup> /l)		The above risk factors are not exhaustive, additional risks may be considered. Other:	
Uncontrolled systolic hypertension (> 230/120)			
Untreated inherited bleeding disorder (such as haemophilia and von Willebrand's disease)			

**Step 4: Choose Appropriate Risk Category & Follow Recommended Thromboprophylaxis**


**\*\* Please refer to "SHSCT VTE Prevention Guidelines for Elective & Emergency Surgical Inpatients" for guidance re: the commencement & duration of thromboprophylaxis \*\***

Risk	Tick	Recommended Thromboprophylaxis
High risk of VTE with low risk of bleeding	<input checked="" type="checkbox"/>	Enoxaparin & Knee-length TEDS If enoxaparin is contraindicated, consider alternative drug. If TEDS are contraindicated, do not use.

High risk of VTE with significant risk of bleeding and NO contraindication to TEDS		Knee-length TEDS
--	--	------------------

High risk of VTE and significant risk of bleeding and contraindication to TEDS		Mobilise & maintain hydration
Low risk of VTE		

**Step 5: Signature**

VTE risk assessed on admission	Signature: 	Print Name: <b>McMAHON</b>	Date/Time: <b>18/2/15</b>
Received from Dr Maria O'Kane on 29/03/22. Annotated by the Oncology Services Inquiry.			



IN-PATIENT FOLLOW-UP  
AND  
OUT-PATIENT NOTES

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

Patient 29

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		Personal Information redacted by the USI
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

Personal Information redacted by the USI

average

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18th  
Feb.

Jan

Personal Information redacted by the USI

Personal Information redacted by the USI



	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein Sugar Acetone		Personal Information redacted by the USI
WEIGHT		
kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		

Affix Label  
or Enter in  
Block Letters  
Full Name  
Date of Birth  
Unit No.  
Ward/Dept.  
Address  
Consultant

## NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		
→		
Age		
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WEIGHT		
kg.		
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT		
kg.		



AIDAN O'BRIEN FRCSI  
Consultant Urologist

Personal Information redacted by the USI

Tel:

Personal Information redacted by the USI

27<sup>th</sup> May 2016

Personal Information redacted by the USI

Dear Dr

Personal Information redacted by the USI

Patient 29

Personal Information redacted by the USI

DOB  
UN

Personal Information redacted by the USI

Personal Information redacted by the USI

*dictated but not signed by*

Mr Aidan O'Brien  
Consultant Urologist

Date dictated: 27<sup>th</sup> May 2016

Date typed: 27<sup>th</sup> May 2016/LH

WIT-11003

ern Health  
cial Care Trust

URODYNAMIC CLINIC

Patient 29

Date:

27.5.16.

Consultant:

Mr O'Brien

Urodynamic Staff:

JMcMahon  
Kulcheersch

Allergy: NKDA

Check allergy to latex

Personal Information redacted by the USI





**Filling /Voiding Cystometry:**

Filling position: Standing ☒ Seated ☐ Lying ☐

Filling rate: 30 mls / min. Filling Fluid: 0.9% Sodium Chloride ☒

Personal Information redacted by the USI

Post urodynamics advice leaflet given ☒ Yes ☐ No

Signature/s:

Personal Information redacted by the USI

Patient 29

Personal Information redacted by the USI

Bladder chart      Name:      Hospital No:

	Day 1	Day 2	Day 3	Day 4	
	Personal Information redacted by the USI			In	Out
6am					
7am					
8am					
9am					
10am					
11am					
12md					
1pm					
2pm					
3pm					
4pm					
5pm					
6pm					
7pm					
8pm					
9pm					
10pm					
11pm					
12mn					
1am					
2am					
3am					
4am					
5am					

In                    =    Type / amount of fluid that you drink that day (in mls)  
Out                 =    Amount of urine that you pass (in mls) / When you experience urine leakage.



Southern Health  
 Social Care Trust

URODYNAMIC CLINIC

27-5-16

Siemens  
 Clinical Status  
 Serial Patient 29  
 963  
 Patient  
 Multistix 10 SG  
 Test date 27-05-2016  
 Time 09:20  
 Operator  
 Test number 1538  
 Color Not Entered  
 Clarity Not Entered

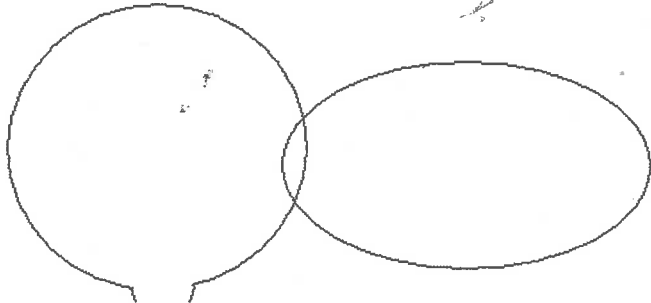
GLU Negative  
 BIL Negative  
 KET Negative  
 SG 1.010  
 BLO Negative  
 pH 7.0  
 PRO Negative  
 URO 1.0 E.U./dL  
 NIT Negative  
 LEU Negative

Patient 29

DATE: 27.5.16

FINDINGS:

SCOPE USED AT: 10<sup>25</sup>am



Personal Information redacted by the USI

Personal Information redacted by the USI

Patient 29

DATE: 27.5.16

Confirm patient details:

Personal Information redacted by the USI

signature

Consent form signed:

signature

Cystoscopy performed by:

Personal Information redacted by the USI

Print name/signature

Any known allergies:

NADA

Any allergy to latex or nickel

Yes / No

**History of CJD...**

Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?

Yes / No

*If yes, refer to infection control for advice and refer to guidance available, Transmissible Spongiform Encephalopathy Agents: Safe Working and the Prevention of Infection: Annex J (Revised 2013).  
If No, no further action required*


**Insert: Urinalysis results / Cystoscopy Traceability Label/s**

Personal Information redacted by the USI

Flexible Cystoscopy documentation - Update



Personal Information redacted by the USI



HSS TRUST \_\_\_\_\_  
Hospital Unit \_\_\_\_\_GP PRACTICE or other \_\_\_\_\_  
Primary Care Provider \_\_\_\_\_**FORM 3 – CONSENT FOR EXAMINATION, TREATMENT OR CARE**  
(Procedures where consciousness not impaired)**Personal details (or pre-printed label)**

Surname/family name.....

First names.....

Date of Birth.....

☐ Male ☐ Female H+C No. (or other identifier) .....

Special requirements (language or other) .....

Patient 29

**Statement of healthcare professional**Responsible healthcare professional Mr O'Brien Job Title Consultant

Name of proposed procedure or course of treatment (include side of body or site and brief explanation if medical term not clear)

Personal Information redacted by the USI

I have explained the procedure. In p.....

The intended benefits.....

Serious or frequently occurring risks.....

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples that may be taken and any particular concerns of those involved.

☐ The following leaflet/tape has been provided.....

Personal Information redacted by the USI

Signed ..... Date 27/5/16Name (PRINT) McMahon Job Title Sp Nurse**Statement of interpreter (where appropriate)**

I have interpreted the information above to the best of my ability and in a way which I believe s/he/they can understand.

Signed..... Date.....

Name (PRINT).....

**Statement of person giving consent or with parental responsibility for child**

I agree to the procedure or course of treatment described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature X..... Date.....

Name (PRINT)..... Relationship to child.....

Copy accepted Yes/ No (please circle)

Craigavon  
Urology  
Clinician: MR OBRIEN  
Operator: J McMahon  
Study Date: 27/05/2016 10:15

Patient 29  
DOB: [Redacted] Age: [Redacted] Years  
Patient ID: [Redacted]

500

Vura  
ml

Personal Information redacted by the USI



Craigavon  
Urology  
Clinician: MR OBRIEN  
Operator: J McMahon  
Study Date: 27/05/2016 10:37



Patient 29

DOB:

Personal Information  
redacted by the USI

Age

Personal  
Information

Personal Information redacted  
by the USI

Patient ID

Personal Information redacted by the USI

Craigavon  
Urology  
Clinician: MR OBRIEN  
Operator: J McMahon  
Study Date: 27/05/2016 10:37



Patient 29  
DOB: [Redacted] Age [Redacted] Years  
Patient ID [Redacted]

Personal Information redacted by the USI

Craigavon  
Urology  
Clinician: MR OBRIEN  
Operator: J McMahon  
Study Date: 27/05/2016 10:37

Patient 29  
DOB: [Redacted] Age [Redacted] Years  
Patient ID [Redacted]

Personal Information redacted by the USI

Craigavon  
Urology  
Clinician: MR OBRIEN  
Operator: J McMahon  
Study Date: 27/05/2016 11:05

Patient 29

DOB:

Personal Information  
redacted by the USI

Patient ID

Age:   
Personal Information redacted  
by the USI

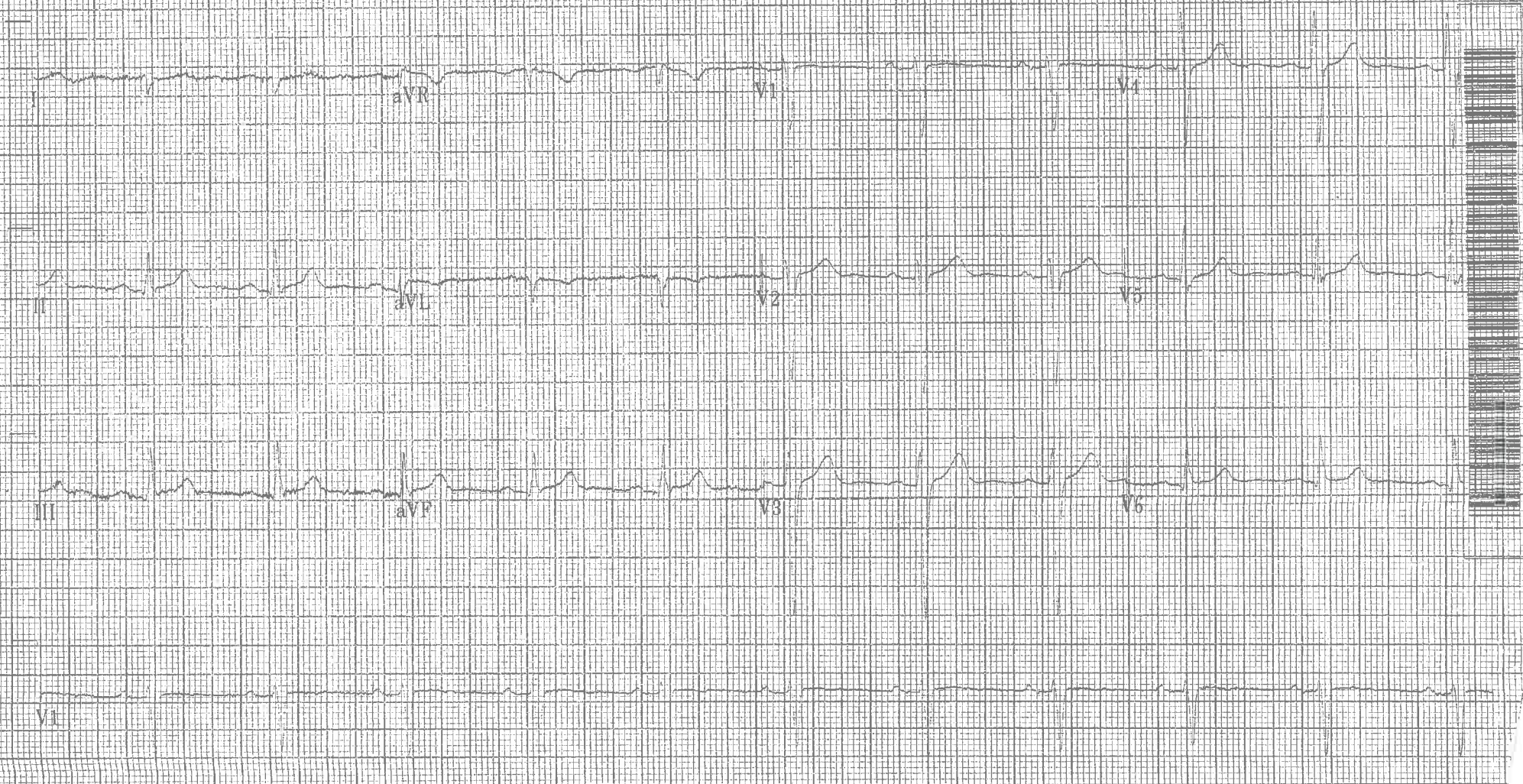
Personal Information redacted by the USI



Technician: PMC

Referred by: DR O BRIEN

Unconfirmed





HSS TRUST \_\_\_\_\_  
Hospital Unit \_\_\_\_\_

GP PRACTICE or other \_\_\_\_\_  
Primary Care Provider \_\_\_\_\_

FORM 1 -- CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or name of patient if patient is a minor)

Surname/family name .....  
First names .....  
Date of Birth .....  
☐ Male ☐ Female H+C No. (or other iden) .....  
Special requirements (language or other) .....  
.....

Statement of healthcare professional

Responsible healthcare professional ..... Job Title.....  
Name of proposed procedure or course of treatment (include side of body or site and brief explanation if medical term not clear)

Personal Information redacted by the USI

I have explained the procedure. In particular, I have explained:

The intended benefits .....  
.....

Personal Information redacted by the USI

Possible additional procedures which may become necessary during the procedure.

☒ Blood transfusion ☐ other procedure (please specify).....  
This procedure will involve: ☐ general and/or regional anaesthesia ☐ local anaesthesia ☐ sedation

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment), any samples of tissue that may be taken and any particular concerns of this individual.

☐ The following information has been provided: .....  
.....

Signed .....  
Name (Print) .....

Contact details (if patient wishes to discuss options later) .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.  
Signed ..... Date .....  
Name (Print) .....

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

\*I agree that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. \*You may remove this sentence without affecting your care.

Signature .....  
Name (Print) .....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature ..... Date .....  
Name (Print) .....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to .....  
.....

Signature .....  
Name (Print) .....

Important notes: (tick if applicable)  
☐ See also advance directive/living will (eg Jehovah's Witness form)  
☐ Person has withdrawn consent ..... Date.....  
(ask person to sign/date here)

PREOPERATIVE ASSESSMENT		ASA status: 1 (2) 3 4 5 6 E
Sur Fir Se Ad DC H8 Hosp	Patient 29	
	PERSONNEL	PROCEDURE DETAILS
	Anaesthetist (grade): Bennett - C	Diagnosis: TURP Operation:
	Surgeon: A O'Brien - C	NCEPOD : Scheduled Urgent Emergency

Personal Information redacted by the USI



POSTOPERATIVE INSTRUCTIONS/ MONITORING	
Personal Information redacted by the USI	<p><i>Please see:</i></p> <p>Drug Kardex <input checked="" type="checkbox"/></p> <p>Fluid balance chart <input checked="" type="checkbox"/></p> <p>PCA Form <input type="checkbox"/></p> <p>Epidural Form <input type="checkbox"/></p> <p>Intrathecal opiate Form <input type="checkbox"/></p> <p>CVC Audit sheet <input type="checkbox"/></p> <p><b>POSTOP INVESTIGATIONS</b></p> <p>Full ICU profile <input type="checkbox"/></p> <p>FBP, U&amp;E <input type="checkbox"/></p> <p>ABG <input type="checkbox"/></p> <p>CXR <input type="checkbox"/></p> <p>Other : <input type="checkbox"/></p>

Personal Information redacted by the USI

Drug Kardex	<input checked="" type="checkbox"/>
Fluid balance chart	<input checked="" type="checkbox"/>
PCA Form	<input type="checkbox"/>
Epidural Form	<input type="checkbox"/>
Intrathecal opiate Form	<input type="checkbox"/>
CVC Audit sheet	<input type="checkbox"/>

	Patient 29
Full ICU profile	
FBP, U&E	
ABG	
CXR	
Other :	

Patient 29

[illegible]



Personal Information redacted by the USI

OPERATION NOTES

Affix Label

Patient 29

WIT-11022

HOSPITAL: CAH

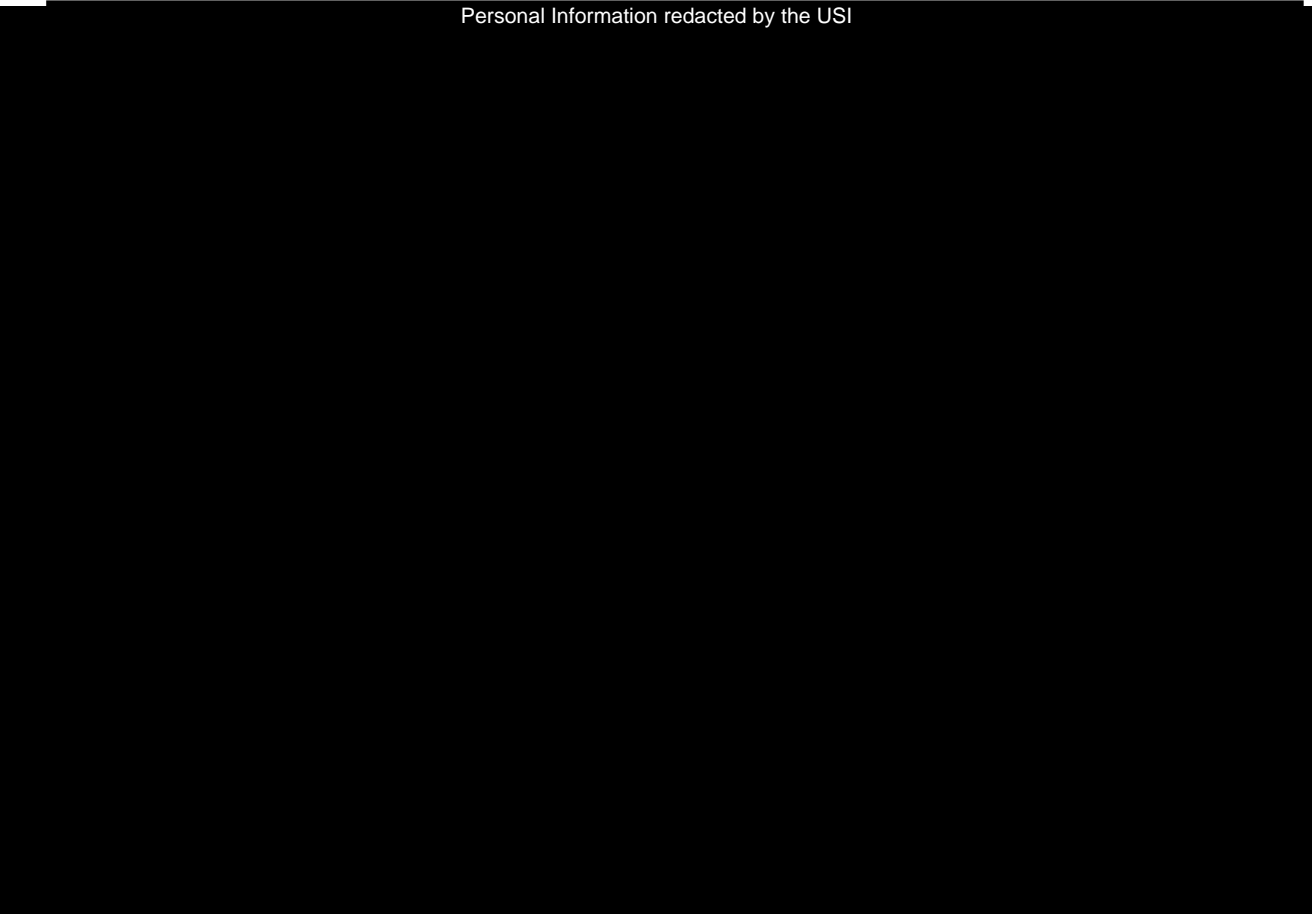
Operations Performed

Date

Personal Information redacted by the USI

Signature of Surgeon: .....

Personal Information redacted by the USI



*[Handwritten signature]*

Signature of Surgeon: .....



HSC

SHSCT

Patient 29

ANAESTHESIA RECORD

Main Theatre

PROCEDURE DATE

27-07-2016

H&C

Personal Information redacted by the USI

DATE OF BIRTH

Personal Information redacted by the USI

PATIENT/CASE DATA (PLANNED PROCEDURE)

H&C Number

Personal Information redacted by the USI

Height

ASA

3

Service

Urology

Age

Personal Information redacted by the USI

Weight

Type of admission

Theatre Location

Theatre 4

Gender

Personal Information redacted by the USI

Body Mass Index

Visit ID

CAH THEA. 4 1-3

Discharge to

Blood group

Planned Procedure

Pending 2016-07-27 09:45:00 T U R PROSTATE

ALLERGIES

No known allergies

ANAESTHETIC TECHNIQUES

I Regional anaesthesia

II Sedation

Induction Type: None

PERSONNEL

Trainee Anaesthetist: christopher.wasson

Anaesthetist: margaret.rea: emergencies

Surgeon: aidan.o'brien

LINES (Time 1= Insertion T Time 2= Drain T) TUBES AND DRUGS

Personal Information redacted by the USI

POSITIONING

Personal Information redacted by the USI

PROTECTION

Personal Information redacted by the USI

TIMES

Personal Information redacted by the USI

EQUIPMENT

Personal Information redacted by the USI

LOCAL AND REGIONAL

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PROCEDURAL EVENTS

FLUID BALANCE

BLOOD OUT

TOTAL IN

13.5 mL

URINE OUT

TOTAL OUT

OTHER OUT

BALANCE

13.5 mL

TOTALS OF GIVEN DRUGS AND SUPPLIES

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Received from Dr Maria O'Kane on 29/03/22. Annotated by the Urology Services Inquiry.



