Appendix 4: Examples of Documentation Templates:

1. Laceration repair

Wound cleansed with betadine

Anaesthetised with xylocaine 1% (+- adrenaline)

Sterile drape

Copiously irrigated with N/Saline

Description of lac- *eg 3cm jagged wound to right forearm, contaminated with dirt, partial thickness*

Wound explored, no evidence of other FB

Wound edges debrided then well approximated

Closed with 4-0 nylon x #X interrupted sutures

Good wound closure

Wound cleaned, steri-strips

Sterile dressing

Pt tolerated well.

2. Incision and Drainage (I&D)

Consent obtained

Area sterilised by using betadine and normal saline (or chlorhexadine)

Anaethetised with 1% xylocaine (+-adrenaline)

Sterile drape

Incision made with #11 scalpel blade

Loculations broken up

X mls purulent discharge drained

Area copiously irrigated with N/saline

Area packed with ¼ inch gauze

Sterile dressing in situ

Pt tolerated well

3. Lumbar Puncture

Aseptic technique, consent obtained

Pt lying in left lateral position/sitting position (whichever used)

Landmarks found prior to sterilising area

Area sterilised with betadine swabs x 3

Sterile drape

Anaesthetised with 1% xylocaine

LP needle on 1st pass (or however many) in the L4/5 or L3/4 interspace.

Opening pressure at ____mmHg

CSF Fluid clear (or blood stained, cloudy, purulent)

Fluid collected in tubes #1-4

Pt tolerated well

Sterile dressing

Nil complications (or list them if there are)

4. Intubation

Intubation performed by Dr Mulligan at 0900 hrs

Glidescope/laryngoscope Size 3 or 4 Mac blade used

Grade 1-4 view

ETT size 7.5 inserted first pass to 22 cm at the lips, No difficulty

Fogging of tube, equal breath sounds

Confirmed with capnography

CXR ordered to confirm placement

5. Procedural Sedation – Anaesthetic component

Scribed notes for Dr O'Mullane

Thanks for your referral of this patient for procedural sedation for reduction of a dislocated shoulder

No past medical history, no previous anesthetics, no family history of anaesthetic disorders

No reflux, no allergies, last meal 08:00 - toast and coffee

Own teeth, good condition; normal neck and jaw

Normal CVS and respiratory exam, MP3, normal jaw opening, ASA 1

Consent obtained for sedation - discussed risk of anaphylaxis, risk of cardiovascular and respiratory complications, risk of dental damage, risk of awareness of the procedure

Sedation using Fentanyl 100mcg and propofol 150mg, monitoring NIBP, ET CO_2, oximetry and telemetry, Nasal prong oxygenation and Hudson face mask, spontaneous ventilation throughout

No Anaesthetic complications experienced, oxygen saturation and bp normal throughout

Recovered well

May go home when able to eat and drink and walk normally

Home into adult's care and not to drive for 24 hours

Suggest paracetamol and Endone script on discharge for pain management at home.