Surname: WALKER URN: 165943

Given Name(s): SELWYN

Age: 89 years Sex: M

Address: UPTOWN RESIDENTIAL AGED CARE

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(Affix Patient Label Here)

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Address:

						DOE	3:			Š	Sex:	
ADMISSION D	ETAI	LS										
Date of Admissi	on:											
Admitting Deta	ils: 89	YO MALE. I	PRESEN	TED TO ED. E	BIBA FRO	M NL	IRSING H	OME P	OST FALL	WITH # L)	NO	F.
PMHX OF DEMI	ENTIA											
PATIENT PERS	ONA	L DETAILS										
Title: MR	R Surname: WALKER		R		First Name: SELWYN							
Other Names:	ames: Preferred Name:			Name:	SELWYN							
Address: UPTOWN RESIDENTIAL AGED CARE FACILITY S				Sub	urb: L	JPTOW	PTOWN					
Home Phone: 1818 2838 Mobile Phone:		hone:	N/A			Work Pho		N/	/A			
Religion: NOT SPECIFIED			original and Torres Strait Islander:									
Primary Language: ENGLISH												
Occupation:		RETIRED										
Medicare Number: 5319 2468 5973						DVA Number: N/A		4	Pension:		16374953	
Private Health F	und:	N/A					Membe	rship N	ship Number: N/A			
MEDICAL HIST	ORY											
Medical Conditi	ons:	DEMENTIA;	TIA (1 y	ear ago); FA	LL 1 YEAI	R AGC) - # R) UL	.NA + ⁻	TBI (CEREB	RAL CON	ΓUSI	ONS IDENTIFIED
ON CT HEAD) –	NO R	ESIDUAL DEI	FICITS; A	AF, MR.								
Current Medica	tion:	AWAITING I	MEDICA	TION LIST F	ROM RES	IDEN	ΓIAL AGEΩ	CARE	FACILITY.			
Allergies: NIL K	NOW	N										
CONTACTS												
First Emergence	y Con	tact										
Name: MRS	LAUR	A HUDSON				Rela	tionship 1	to Pati	ent:	DAUGHT	ER	
Home Phone:	045	3 649 561		Mobile P	hone:	045	3 649 561		Work	Phone:	N/	′ A
Second Emerge	ncy C	ontact										
Name: MR J	инс	WALKER				Rela	tionship 1	to Pati	ent:	SON		
Home Phone:	046	5 194 657		Mobile P	hone:	046	5 194 657	•	Work	Phone:	04	65 194 657
General Practit	ioner	(GP)										
Doctor Name: DR JONATHON BARRETT Practice: UPT					JPTOWN GENERAL MEDICAL PRACTICE							
Address: 16/1440 THOMPSON STREET Su				Sub	urb:	UPT	UPTOWN					
Work Phone:	108	1 2222				Mol	ile Phone	e: As	S PER PRAC	CTICE PHO	NE	NO



National Simulation Health Service

PROGRESS NOTES INPATIENT

(Affix Patient Label Here))
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URN:

Family Name:

Given Name(s):

Address:

DOB:

Sex:

DATE & TIME	Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
DD/MM/YY	NURSING: 89yo M admitted post fall with # L) NOF. PMHx: Dementia; TIA (1yr ago); Fall 1
XX:XXhrs	year ago - # R) ulna and TBI (cerebral contusion on CT head) – nil residual deficits; AF, MR
	SHx: Lives in residential aged care facility. Requires full assist for all ADLs.
	Reviewed by PT & OT. Noted poor mobility (for 2 person transfers) and severe cognitive
	impairment. Swallow reviewed by speech. For Soft diet (cut up extra sauces/gravy) and
	Thin fluids. Meds given as charted. Tolerating cares ATOR. RN
DD/MM/YY	PHYSIOTHERAPY: REVIEW. Recent cares noted with thanks. Nil changes on Ax this am.
XX:XXhrs	Recommend: Continue with 2 person assist sit-to-stand with steady standing hoist. 2 person
	assist for bed mobility. C/o ++ L) hip pain with poor mobility and poor positioning. Note
	NOT FOR ROLLATOR. PLAN: R/v 2-3/7. (PT)
DD/MM/YY	OCCUPATIONAL THERAPY: REVIEW ASSESSMENT: Recent cares noted with thanks. Pt
XX:XXhrs	continues to require full assist for all personal hygiene tasks. Presentation ++ impacted by
	fluctuating LOA and confusion. Severe cognitive deficit on assessment. Pt inconsistently
	following single-step commands. PLAN: For ongoing r/v while on ward. (OT)
DD/MM/YY	NURSING: NS observed ++ decreased LOA with ++ associated confusion. Pt demonstrating
XX:XXhrs	difficulty food and fluid. RN downgraded diet/fluids - now for minced and moist diet and
	mildly thick fluids. Awaiting speech review. (RN)
DD/MM/YY	SPEECH PATHOLOGY: Thank you for handover. Noted recent Nursing entry and PRN change
XX:XXhrs	of diet/fluids. Attempted to r/v pt this pm however pt ++ drowsy and unresponsive ATOR.
	Unsuitable for oral trials ATOR. RECOMMENDED: (1) Continue on minced and moist diet
	and mildly thick fluids. (2) Upright and alert for all oral intake. (3) Full assist with close
	supervision for all oral intake. (4) Monitor for signs of aspiration. PLAN: R/v 1/7. (SP)
DD/MM/YY	SPEECH PATHOLOGY: R/v Ax. Unable to assess 1/7 ago secondary to pt ++ drowsy and
XX:XXhrs	unresponsive. Reattempt this am to assess suitability for diet/fluids. O/E: Pt SUIB and
	improved LOA. NS report ++ improved status. Reduced confusion. Ongoing cognitive
	impairment as per OT. Consent to review implied by participation



National Simulation Health Service

PROGRESS NOTES INPATIENT

(Affix	Patient	Label	Here
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DATE & TIME	Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT Leave no gaps between entries
DD/MM/YY	SP CONT: SWALLOW Ax: Trialled with biscuit, bread, mildly thick fluids, thin fluids
CONT'D	ORAL PHASE: Reduced lip seal, increased oral transit time on normal texture foods, nil oral
	residue post swallow. PHARYNGEAL PHASE: Likely delayed swallow initiation (mild); overt
	evidence of penetration +/- aspiration on thin fluids (++coughing post swallow and voice
	changes observed). Improved tolerance of mild thick fluids. Note silent aspiration unable
	to be excluded on clinical swallow examination (CSE). IMPRESSIONS: Ongoing mild-
	moderate oropharyngeal dysphagia. RECOMMEND: (1) Upgrade to soft texture diet; extra
	sauces and gravy; cut up. (2) Continue on mildly thick fluids. (3) Full assist and supervision
	for oral intake. (4) Upright and alert for oral intake. (5) Monitor for signs of aspiration.
	PLAN: For d/c back to RACF. SP to send d/c summary. Recommend follow up by RACF SP in
	1-2/52 for ongoing management of dysphagia. (SP)
DD/MM/YY	NURSING: Noted r/v by speech and for upgrade of diet. To stay on mildly thick fluids. MO
XX:XXhrs	authorised d/c to RACF. Pt moved to d/c lounge awaiting ambulance transfer. (RN)
XX:XXhrs	authorised d/c to RACF. Pt moved to d/c lounge awaiting ambulance transfer. (RN)
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