Medical Patient Review

Review the patient's notes

- **Demographics:** name and age
- **Patient's background** i.e. co-morbidities, medical history
- **Admission detail:** date of admission, the presenting complaint
- **Diagnosis**/ diagnoses/ differentials made so far
- **Management**
    - **Past management:**
        - Results of important investigations the patient has had in hospital so far
        - Management so far
    - **Planned management:** management plan, patients stage in plan, why they are still in hospital

Check latest investigation results

- **Latest bloods and trend**
    - **Haemoglobin**
    - **Inflammatory markers** (WCC, CRP)
    - **Electrolytes**
    - **Other relevant results** e.g. LFTs (if liver problem), INR (if on warfarin)
- **Other investigation results**

Assess the patient

- **Questioning**
    - **Current symptoms:** determine current symptoms, explode them as usual
    - **Changes since last review/coming into hospital**
    - **Concerns**
    - **Functional assessment**
        - Eating and drinking
        - Bowel habit
        - Mobilising
- **Nursing charts**
    - **Observations:** review current condition and trends on observation chart
    - **If being recorded & relevant**
        - **Stool chart:** check when last opened bowels and the stool type
        - **Capillary glucose chart** (if diabetic): check the range of glucose levels
        - **Fluid chart**: check input, output and balance
        - **Food intake/ MUST chart**
- **Examination**
    - **Relevant system examinations** (determine if improving)

Review medications

- Review current medications

Document review with a plan

- Date and time, assessors name & role, review day
- Summary
  - Patient's age & background
  - Admission date and presenting complaint
  - Diagnosis/diagnoses/differentials made so far
  - Important investigation results so far
  - Management so far and stage in planned management
- Latest investigation results
- Subjective: what patient says
- Objective: how patient appears, nursing chart information
- Examination (including vital signs)
- Diagnosis/differentials
- Problem list
- Plan
  - Investigations (with tick-boxes)
  - Management (include doses and timeframes)
  - Other aspects to plan
- Sign with your name, role, bleep number

07.02.2013 13.44
Day 2 Patient Review (FY1 Mansbridge)

SUMMARY:

BG: -Asthma -HTN
-Vascular dementia -Angina
-Recurrent UTIs -Lives alone, no carers

Admitted 5/2 with ⇧ SOB + yellow sputum
Δ = infective exacerbation of asthma
CXR 5/2 = signs of RHF (unchanged from previous CXRs) but no consolidation.
On day 2 of 7 amoxicillin and day 2 of 5 prednisolone.
LATEST Ix:
Bloods today WCC 14.1 (16.0), CRP 113 (122), Hb 132, U&Es NAD
Sputum culture = no growth
SUBJECTIVE: Pt. feels better today, SOB reduced and less sputum production. Cough continues. E&D variably. Not mobilising around ward. Admits she is finding it more difficult to cope at home.
OBJECTIVE: Pt. appears well, lying in bed, minimal sputum in sputum bowl. Mild confusion. Bowels opened yesterday type 4. No nursing concerns.
O/E: OBS: SpO_2 97% RA, RR 18/min, HR 97bpm,
BP 140/85mmHg, apyrexial. No temp spikes.
No cyanosis, warm peripheries, cap refill <2s

Chest expansion normal
Resonant to percussion
Normal air entry, mild wheeze, no added sounds
PEFR: 400ml (normal for patient)
CVS: No heaves/thrills
HS I + II + 0
Pitting oedema up to ankles
DIAGNOSIS: Infective exacerbation of asthma
PROBLEM LIST: 1) LRTI
2) Uncontrolled asthma
3) S_{ix} of RHF
4) Lack of home support (lives alone)
PLAN: 1) Investigations
-Order echocardiogram ☐
-Repeat bloods mane ☐
-MMSE ☐
2) Management
-Continue amoxicillin 250mg 8hrly PO x 5/7
-Continue prednisolone 40mg OD PO x 3/7
-Change nebs to PRN
3) Physio and OT assessment
4) D/W NOK functional baseline and need for social input

CJM
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Respiratory Team 2 FY1 (bleep 6554)
GMC number 7112454

Tips!

- Reviews must be *patient centred* (treat the patient, not the disease). Consider:
  - Disease
  - Co-morbidities
  - Social factors: home, family, carers (involve nurses and occupational therapists)
  - Occupation: e.g. type of work if epileptic
  - Mobilisation status (involve physiotherapists)
  - Polypharmacy (involve pharmacist)
  - Strength/habitus and diet (involve dietician)

  Consider making a problem list.
- Ensure you always think about why a patient is still in hospital and think about their case with a view to discharge
- It can be difficult to build and maintain good patient relationships while you are busy and have a long list of jobs to do. Some tips: introduce yourself properly; shake patients hand at start and end; check what they like to be called and use their name throughout consultation; ensure you ask for their concerns/questions at the end.