BLOODSAFE MEMORIAL HOSPITAL
INVESTIGATION

FACILITATOR INSTRUCTIONS

BloodSafe®
ELEARNING AUSTRALIA
www.bloodsafelearning.org.au

THE OBJECTIVE

Purpose of the Activity

This activity uses an investigative approach to explore how errors can occur during the transfusion of a blood component. Learners are presented with a patient folder containing clinical documentation, laboratory results, transfusion records, and other relevant information.

Working in groups, learners must determine:

- What type of error has occurred?
- What factors contributed to the error?
- What mitigation strategies could prevent future errors?

The focus of the activity is on developing critical thinking, clinical reasoning, and patient safety awareness rather than finding a single correct answer.

As the facilitator, your role is to:

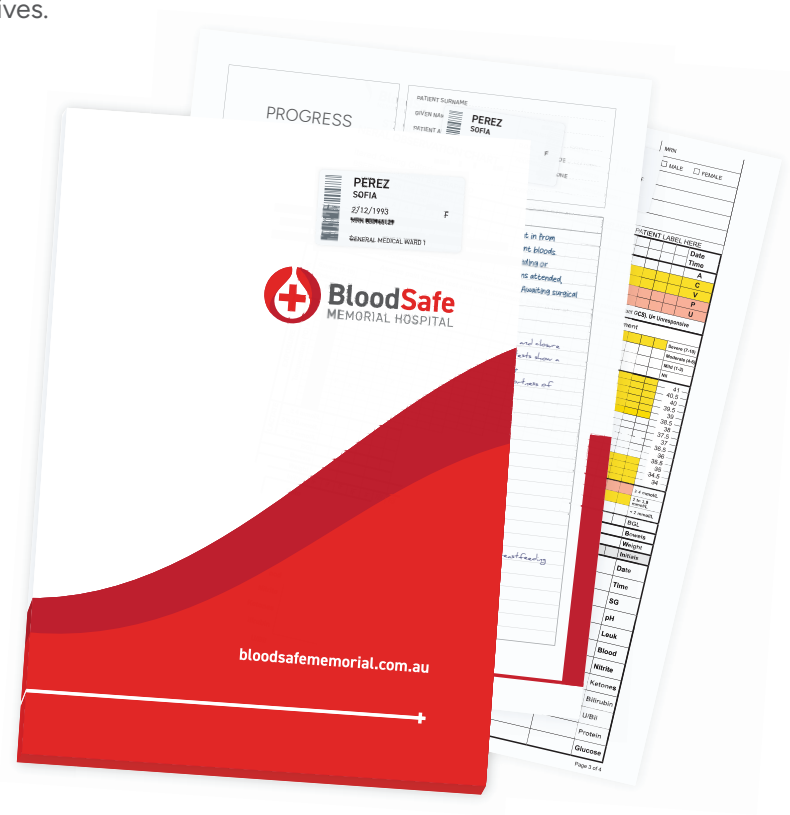
- guide discussion
- encourage participants to use evidence from the patient file to support their conclusions
- promote discussion
- encourage consideration of prevention and quality improvement strategies
- ensure all participants have an opportunity to contribute.

Avoid confirming or rejecting responses immediately.
Instead, use probing questions to help learners
justify their reasoning and explore alternative perspectives.

Length of Activity

20 minutes for investigating and completing the provided report.

30 minutes of discussion time.



HOW TO PLAY

Running the Activity

Break up learners into small groups of approximately 3-6 individuals.

Provide each group with a patient folder. You may choose to use different case scenarios for each group or the same patient for all groups. Explain the purpose of the activity.

Suggested introduction:

> "You have been provided with a patient file containing information related to a transfusion error. Your task is to review the available information and determine what occurred, how it happened, and what actions could prevent a similar event in the future. Be prepared to explain your reasoning using evidence from within the file."

Allow learners approximately 20 minutes to review the patient file and complete their report before discussion.

Running the discussion

Discussion should take approximately 30 minutes and should focus on 4–6 key discussion questions. Facilitators can use the provided questions as a guide, selecting or adapting questions based on the case and learners' needs. The facilitator's role is to encourage discussion, critical thinking, and reflection rather than provide answers. Learners should be prompted to support their conclusions using evidence from the patient's file, consider alternative perspectives, explore contributing factors, and identify opportunities for prevention and improvement.



Find out more about our Clinical Transfusion Practice courses here

BloodSafe® ELEARNING AUSTRALIA

www.bloodsafelearning.org.au

DISCUSSION QUESTIONS

Incident identification and clinical impact

1. What was the error that has occurred in this case?
2. What was the outcome for the patient?
3. Are there any other diagnoses or adverse events that should be considered?
4. Are there any ongoing risks to the patient that need to be considered?

Patient blood management

5. Was the transfusion appropriate? Why or why not?
6. Were there any other blood management strategies that could have been considered to avoid a transfusion?
7. How can clinicians balance the risk of transfusions against the perceived benefits when deciding to transfuse?
8. Were relevant transfusion policies, guidelines or patient blood management protocols followed? If not, why?

Origin of the error

9. Where in the transfusion process did the error occur? Could it have been avoided?
10. What checks or verification processes could have interrupted the error?
11. Are there existing safeguards to prevent this error that failed or were bypassed?

Contributing factors and root cause analysis

12. What are the key contributing factors?
13. What contributing factors may have increased the likelihood of the event occurring?
14. Were there any assumptions that may have been made that contributed to the event?
15. Was this a human error, systems error, communication failure, or a combination of factors? Why?
16. What workload, staffing fatigue, or environmental factors may have contributed to this event?
17. Were there any breakdowns in handover, documentation or verbal communications between teams or shifts?

Investigation and reporting

18. Is there any additional information that you would have liked to collect following this event?
19. How should this incident be reported?

Prevention and risk reduction

20. What mitigation strategies would have had the greatest impact?
21. What actions could have prevented this event from occurring?
22. What role could education and training play in avoiding future incidents or mistakes?

Recommendations and organisational learning

23. What recommendations would you make following this event?
24. How could this event be used as a learning opportunity for staff?
25. What barriers might exist to implementing these improvements?
26. What lessons could be learned from this case

FACILITATOR EVALUATION FORM

Please scan the QR code below to complete an evaluation survey on this activity. Thank you.

Facilitator

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www.bloodsafelearning.org.au

CONFIDENTIAL*

BLOODSAFE MEMORIAL HOSPITAL
INVESTIGATION

PATIENT FILES
KEVIN STEPHENS

BloodSafe
MEMORIAL HOSPITAL

*All cases and patient information presented in this investigation game are entirely fictional and have been created for educational purposes.

BloodSafe
MEMORIAL HOSPITAL

Haemovigilance Department
Floor 3, Zone A
BloodSafe Memorial Hospital
1572 Littleton Road,
Lyra Falls SA 5088 AUSTRALIA

bloodsafememorialhospital.com.au

Internal Communication to Clinical Staff:

Due to recent hospital demands and a surge of adverse events relating to blood transfusions, you have been selected to assist in a case review. All relevant patient information has been provided. Once you have reviewed the information, you will need to complete the incident investigation report and present your findings to the Haemovigilance Committee.

As you work through this case you will need to answer the following questions:

1. **Identify the adverse event that has occurred**

2. **Analyse the contributing factors**
   Consider all elements that may have led to the adverse event, including:
   - Human factors
   - System or process issues
   - Communication breakdowns

3. **Recommend mitigation strategies**
   - Identify practical actions that could prevent a similar event in the future.

Work through this case as you would with any clinical investigation, document your findings clearly and concisely. The purpose is not only to identify errors but to understand how and why they occurred. There may not always be an obvious single answer – your reasoning is just as important as your conclusions.

Should you need any assistance during this investigation, contact your haemovigilance lead.

Kind regards,

BBergamont

Belinda Bergamont
BloodSafe Memorial Hospital
Haemovigilance Committee

INCIDENT INVESTIGATION

PATIENT SURNAME

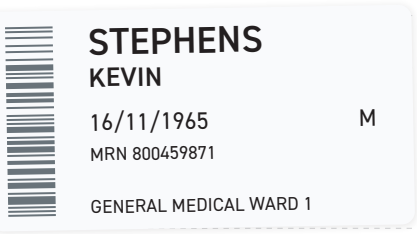
GIVEN NAME(S)

MRN

DATE OF BIRTH /

SEX

ROOM NUMBER



INVESTIGATOR NAME/S

IDENTIFY THE ADVERSE EVENT THAT HAS OCCURRED

ANALYSE THE CONTRIBUTING FACTORS

RECOMMEND MITIGATION STRATEGIES

CLEARVIEW
HEALTH CLINIC

August 8th 2026

Dear Dr Wilkens,

Re: Kevin Stephens, DOB: 16/11/1965

Thank you for seeing Mr. Stephens for opinion and management of a 4/7 history of melaena associated with newly diagnosed anaemia, with a Hb of 75g/L on most recent FBC.

He reports passing black, tarry stools without any frank bleeding. There is no reported history of haematemesis, nausea, or vomiting. He has been taking NSAIDs for 3 weeks following a musculoskeletal injury, otherwise is generally fit and well. On examination, he is haemodynamically stable with no abdominal tenderness.

I would appreciate your urgent review and management. I have included a copy of the pathology results.

Relevant past medical history: Hypertension, GORD

Current medications: Amlodipine 5mg daily, Pantoprazole 40mg daily and Ibuprofen 400mg PRN

Allergies: NKDA

Family history: bowel cancer (mother), ischaemic heart disease (father)

Please feel free to contact me if further information is required.

Kind regards,

KFrost

Dr Kate Frost
Clearview Health Clinic
04357190563

CLEARVIEW PATHOLOGY
42-48 STATION ST, CLEARVIEW SA 5085
CLEARVIEWPATHOLOGY.COM.AU
INFO@CLEARVIEWPATHOLOGY.COM.AU

Kevin Stephens

DOB: 16/11/1965
Sex: Male
PID: 555

Sample collection

Clinic: Clearview SA
Ref. by: Dr. Kate Frost

Registered on: 11:09 8/8/2026
Collected on: 11:15 8/8/2026
Reported on: 15:51 8/8/2026

RESULTS

Investigation	Result	Reference Ranges
Haemoglobin	75 g/L	115-165 g/L
HCT	0.35	0.37-0.47 L/L
Red cell count	4.5	4.4-5.8 x1012/L
MCV	78	80-100 fL
MCH	24	26.5-33.0 pg
MCHC	314	310-360 g/L
RDW	15.6	11.5-15.0
White Cell Count	6.89	3.5-11.0 109/L
Neutrophils	3.41	1.7-7.0 109/L
Lymphocytes	2.63	1.5-4.0 109/L
Monocytes	0.56	0.1-0.8 109/L
Eosinophils	0.24	0.04-0.44 109/L
Basophils	0.5	0.0-0.2 109/L

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RESULTS

Investigation	Result	Reference Ranges
Sodium	141	135-145 mmol/ L
Potassium	4.4	3.5-5.2 mmol/L
Chloride	103	95-110 mmol/L
Bicarbonate	27	22-32 mmol/L
Urea	5.0	3.0-7.0 mmol/L
Creatinine	58	45-90 umol/L
EGFR	>90	(> 59) mL/min/1.73m2
Calcium	2.35	2.10-2.60 mmol/L
Phosphate	1.13	0.75-1.50 mmol/L
Albumin	40	35-50 g/L
ALP	68	30-110 U/L
Bilirubin	9	3-20 umol/L
GGT	16	5-35 U/L
AST	21	5-30 U/L
ALT	21	5-35 U/L
LD	132	120-250 U/L

****End of Report****

Medical Lab Technician
(DMLT, BMLT)

Dr. J Smith
(MD, Pathologist)

Dr. C Cheen
(MD, Pathologist)

PATIENT REGISTRATION

PATIENT SURNAME
GIVEN NAME(S
PATIENT ADDR
DATE OF BIRTH
ROOM NUMBER



STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

OFFICE USE ONLY - ADMISSION INFORMATION

Admit Date: 09/08/2026
Admit Time: 09:45
Visit Number: 3
Primary Consultant: L WILKENS
Admit Location: GEN MED WARD 1
Bed No.: 6
Soursce of Referral: GP
Inter-Hospital Transfer - From:
Service: GASTRO
Visit Reason: MELAENA
Election: [X] Public [ ] Private
Funding Source:
Overnight / Day Admit
Re-admit in Last 7 Days: Yes / No
__No. of Days C/F
Related Admission: Yes / No

Medicare No.: 5 7 4 1 8 9 9 1 1
Reference No.: 1
Expiry Date: 06/27
Date of Birth: 16/11/1965
Age: 60
Country of Birth: AUSTRALIA
Marital Status: [ ] Never Married [X] Married/De Facto [ ] Widowed [ ] Divorced [ ] Separated [ ] Unknown/Not Stated
Maiden Name:
Other/Previous Names:

RESIDENTIAL ADDRESS
7 FICTIONAL LANE
Suburb: FAKEVILLE
State: SA
Postcode: 5087
Home Phone: ( )
Mobile Phone: 0415 418 1890
Business Phone:

POSTAL / TEMPORARY ADDRESS
Suburb:
State:
Postcode:
Home Phone: ( )
Mobile Phone:
Business Phone:

I would like to receive SMS notification of future appointments (where SMS is available) [X] Yes [ ] No
Mobile phone number to receive SMS notification: 0415 418 1890

Preferred Language / Dialect: ENGLISH
Interpreter Required: [ ] Yes [X] No
Interpreter Type: [ ] Female [ ] Male [ ] Either

Indigenous Status: [X] Not Aboriginal or TSI [ ] Aboriginal [ ] Not Stated / Unknown [ ] TSI [ ] Aboriginal and TSI

Religion (optional):
Clergy Visit: Yes / No
Ethnicity:

MAIN ACCOMMODATION/HOUSING IN THE LAST THREE MONTHS
[X] Private Residential
[ ] Independent Unit (part of retirement village or similar)
[ ] Residential Aged Care or Hostel
[ ] Homeless - Boarding / Rooming House
[ ] Homeless - No usual residence
[ ] Homeless - Shelter/Refuge
[ ] Unknown - Unable to determine
[ ] Other:

CONTACT 1 (eg. Person Responsible / Next of Kin)
Relationship to Patient: WIFE
Last Name: STEPHENS
First Name: BARBARA
Address: 7 FICTIONAL LANE
Suburb: FAKEVILLE
State: SA
Postcode: 5087
Home Phone: ( )
Mobile: 04218 520 9066
Business Phone: ( )

CONTACT 2 (eg. Contact for this Visit)
Relationship to Patient:
Last Name:
First Name:
Address:
Suburb:
State:
Postcode:
Home Phone: ( )
Mobile:
Business Phone: ( )

PATIENT REGISTRATION

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRESS

DATE OF BIRTH / /

ROOM NUMBER



PATIENT DIRECTIVE

Do you have an Advance Care Directive / Plan or Resus Plan? ☐ Yes ☒ No

If yes, please select from list below

- ☐ Advance Care Directive
- ☐ Anticipatory Direction
- ☐ Palliative Care Plan
- ☐ Resus Plan - 7 step pathway
- ☐ Enduring Power of Guardianship
- ☐ Interstate ACD
- ☐ Ulysses Agreement
- ☐ Other:
- ☐ Medical Power of Attorney
- ☐ Statement of Choices
- ☐ Facility Form

(Do not record Enduring Power of Attorney as an Advanced Care Directive).

Has an original certified copy been provided for this attendance? ☐ Yes ☐ No

HEALTH CONCESSION CARD DETAILS

Pension/Healthcare Card/Commonwealth Seniors Healthcare Card:

Card Number: Expiry Date:

DVA Card Number: DVA Card Colour: ☐ Gold ☐ White ☐ Orange ☐ Blue

PBS Safety Net Number: Expiry Date:

Private Health Fund: ☐ Yes ☒ No ☐ Hospital Cover

Fund Name: Membership Number:

Other Insurer: ☐ Yes ☒ No Details:

COMPENSABLE VISITS ONLY

☐ Work Injury Date of Injury:

Claim Number:

Employer Name:

Employer Address:

Contact Phone No.: ( )

☐ Motor Vehicle Accident Date of Injury:

Claim Number:

State:

CARE TEAM REFERRAL

GP DETAILS

Name: DR KATE FROST

Practice Name: CLEARVIEW HEALTH CLINIC

Address: 36 STATION STREET

Suburb: CLEARVIEW

State: SA Postcode: 5085

Phone Number: (+61) 0435 719 0563

REFERRER DETAILS

Name: DR KATE FROST

Practice Name: CLEARVIEW HEALTH CLINIC

Address: 36 STATION STREET

Suburb: CLEARVIEW

State: SA Postcode: 5085

Phone Number: (+61) 0435 719 0563

Consent to Notify GP this Visit: ☒ Yes ☐ No ☐ Not Asked ☐ Unable to Answer

PATIENT DECLARATION

I KEVIN STEPHENS certify that the information provided on this form is true and accurate.

SIGNATURE: K Stephens DATE: 9/8/26

Relationship to Patient: ☒ Self ☐ Parent ☐ Guardian ☐ Other:

BloodSafe
MEMORIAL HOSPITAL

GENERAL MEDICAL WARD 1

Sunday 8th August								
Bed	Patient Name	DOB	MRN	Specialty	Situation	Background	Assessment	Recommendation
1	Rose Klien	16/07/1951	800425698	Upper GI	Epigastric Pain	PMHX: Hypertension, high cholesterol, type 2 diabetes	1x Assist, Clear fluids, 2x PIVC day 2	PPI infusion, IVF, for CT abdo
2	Jose Sanchez	11/12/1959	800416985	Gen Med	Hyponatremia	PMHX: Depression, recent diarrhoeal illness	PIVC x1, Na 120 mmol 8/8, altered calling criteria HR yellow zone >120 red zone >130	strict FBC, Fluid restricted (<800m/L), continue salt tablets, monitor for seizure activity, daily electrolytes
3	Pam Beetle	12/10/1981	800472564	Respiratory	Infective exacerbation of asthma	PMHX: Asthma	DROPLET precautions awaiting respiratory swab, independent, PIVC x 1 day 2, CXR shows left lower lobe consolidation	resp swab pending, continue inhalers, IVabs, repeat CXR mane
4	Pearl Wyle	20/02/1928	800473651	Geriatrics	UTI	PMHX: recurrent UTIs, ischemic heart disease, asthma. high cholesterol, dementia	from nursing home PIVC x 1 day 0, 2x assist, falls risk GCS 13 (baseline), not for resuscitation	for 24 hours of IVabs, encourage fluid intake, pressure area care, aim for discharge back to nursing home on PO abs 10/8
5								
6	Kevin Stephens	16/11/1965	800459871	Gastroenterology	Melaena	PMHX: Hypertension, GORD	HB 75 g/L with GP, Vitally stable, stool chart	NBM, for repeat bloods and group and hold. For 1 unit of red cells, ? endoscopy mane
7	Betty Cook	13/01/1938	800417259	Renal	AKI	PMHX: Depression, anxiety, hypertension, high cholesterol, IBS	from nursing home, 2x assist, not for resuscitation, PIVC day, IDC	strict fluid balance chart, IVF, ? renal u/s, repeat bloods mane
8								
9	Trevor Stephenson	26/01/1965	800476358	Gastroenterology	Upper GI Bleed	PMHX: Asthma, Type 2 diabetes	HB 70g/L 1/7 ago. Assoc fatigue. 1x Melaena overnight. Stool chart	NBM, for repeat bloods and group and hold

PATHOLOGY RESULTS

Kevin Stephens

DOB: 16/11/1965
Sex: Male
MRN: 800459871

	7/4/2025 @ 1300	9/8/2026 @ 1315	9/8/2026 @ 1520	Reference Ranges
Haemoglobin	110	75	80	115-165 g/L
HCT	0.37	0.34	0.33	0.37-0.47 L/L
Red cell count	4.5	4.3	4.2	4.4-5.8 x1012/L
MCV	78	79	79	80-100 fL
MCH	24	20	21	26.5-33.0 pg
MCHC	314	250	272	310-360 g/L
RDW	15.6	15.7	15.8	11.5-15.0
White Cell Count	6.89	12	5	3.5-11.0 109/L
Neutrophils	3.41	8	2	1.7-7.0 109/L
Lymphocytes	2.63	3	1.1	1.5-4.0 109/L
Monocytes	0.56	0.7	0.5	0.1-0.8 109/L
Eosinophils	0.24	0.2	0.1	0.04-0.44 109/L
Basophils	0.1	0.8	0.1	0.0-0.2 109/L

	1/11/2025 @ 1030	3/11/2026 @ 1130	9/8/2026 @ 1520	Reference Ranges
Blood Group	B	A	Pending	
RhD	Positive	Positive	Pending	
Direct Antiglobulin Test	-	-	Pending	

	1/11/2025 @ 1030	9/8/2026 @ 1315	9/8/2026 @ 1520	Reference Ranges
Iron	15	14	-	5.0-30.4 umol/L
Transferrin	3.01	3.01	-	1.8-3.5 g/L
Saturation	18	20	-	15-45 %
Ferritin	18	20	-	15-200 ug/L
Sodium	141	140	138	135-145 mmol/ L

PATHOLOGY RESULTS

Kevin Stephens

DOB: 16/11/1965
Sex: Male
MRN: 800459871

	1/11/2025 @ 1030	9/8/2026 @ 1315	9/8/2026 @ 1520	Reference Ranges
Sodium	141	140	138	135-145 mmol/ L
Potassium	4.4	4.4	4.5	3.5-5.2 mmol/L
Chloride	103	102	105	95-110 mmol/L
Bicarbonate	27	28	26	22-32 mmol/L
Urea	5.0	4.8	4.9	3.0-7.0 mmol/L
Creatinine	58	61	60	45-90 umol/L
EGFR	>90	>90	>90	(> 59) mL/ min/1.73m2
Calcium	2.35	2.34	2.30	2.10-2.60 mmol/L
Phosphate	1.13	1.12	1.12	0.75-1.50 mmol/L
Albumin	40	45	46	35-50 g/L
ALP	68	75	74	30-110 U/L
Bilirubin	9	12	21	3-20 umol/L
GGT	16	20	20	5-35 U/L
AST	21	22	22	5-30 U/L
ALT	21	25	24	5-35 U/L
LD	132	140	255	120-250 U/L

	1/11/2025 @1030	9/8/2026 @1315	9/8/2026 @1520	Reference Ranges
PT	-	12	13	10-14 sec
INR	-	-	-	
APTT	-	30	32	27-35 sec
Fibrinogen	-	1.8	3.8	1.5-4.0 g/L

Kevin Stephens

DOB: 16/11/1965
Sex: Male
MRN: 800459871

URINALYSIS REPORT

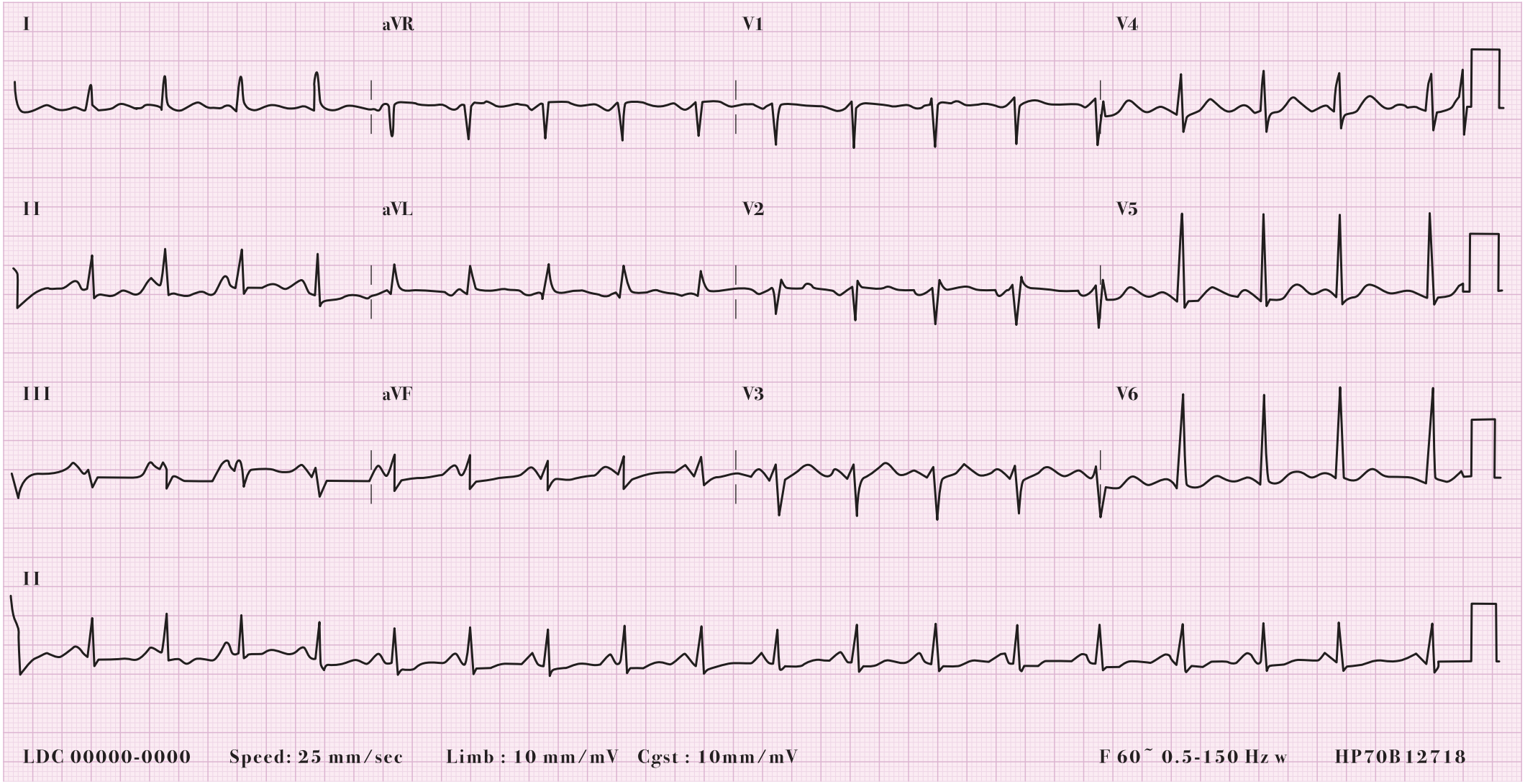
	9/8/2026 @ 1600	Reference ranges
Glucose	Normal	0-15 mg/dL
Bilirubin	+	Negative
Ketones	Negative	Negative
Specific Gravity	1.010	1.005-1.030
Blood	Negative	Negative
pH	6.0	5.0-8.0
Proteins	Negative	Negative
Urobilinogen	Negative	0.2-1.0 U/dL
Nitrite	Negative	Negative
Leukocytes	Negative	Negative

PR	140
QRSD	82
QT	324
QTc	438

--AXIS--

P	84
QRS	16
T	-32

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1



PROGRESS NOTES

PATIENT SURNAME

GIVEN NAI

PATIENT A

DATE OF BI

ROOM NUMBER



Date / Time	Notes
9/8/2026 @ 1000	NURSING. New admission to Gen Med Ward 1. 60-year-old gentlemen from home sent in by his GP for unexplained melaena for the past 4/7. Associated dizziness and mild shortness of breath on exertion. Denies any abdominal pain, nausea or vomiting. Alert and orientated, independent with all ADLs. Vital signs attended to all within normal parameters, afebrile and pain free. Orientated to the ward. Awaiting gastroenterology review and plan. M. Weiss RN
9/8/2026 @ 1030	GASTROENTEROLOGY WARD ROUND 60-year-old man sent in by the GP with a 4/7 history of black tarry stools consistent with melaena and Hb on recent bloods with the GP of 75 g/L. He reports associated shortness of breath on exertion, general light headedness, and mild fatigue. Denies any frank PR bleeding, abdominal pain, nausea or vomiting. States recent use of NSAIDS (Ibuprofen 400mg 4 times a day) over the last 3 weeks for calf strain post cycle. He had previously been prescribed pantoprazole for GORD but has self-ceased this six months ago as he was not experiencing any symptoms. PMHX: Hypertension Gastro-oesophageal reflux disorder (GORD) Medications: Amlodipine 5mg PO daily Pantoprazole 40mg daily – self ceased Ibuprofen PRN Allergies: Nil known drug allergies

PROGRESS NOTES

PATIENT SURNAME

GIVEN NA

PATIENT A

DATE OF

ROOM NUMBER



Date / Time	Notes
	Social history:
	Occasional alcohol consumption on weekends
	Denies smoking or illicit drug use
	Lives independently at home with wife
	Physical Examination:
	Neurological: Alert and orientated
	Gastrointestinal: epigastric pain present on palpation, dull, non-radiating. Denies any
	nausea or vomiting over the past 4/7. PR exam attended black tarry stools noted consistent
	with melaena, nil fresh blood.
	Skin: pale. No jaundice or unexplained bruising.
	Differential:
	Peptic ulcer disease most likely caused by NSAID use
	Plan:
	Urgent group and hold and repeat bloods (FBC, UEC, CMP, LFT and iron studies)
	2x PIVC
	Pantoprazole infusion
	Strict stool chart
	Nil by Mouth
	Cease Ibuprofen
	For 1 unit of red cells
	For consideration of an endoscopy inane
	L. Wilkens Gastroenterology registrar.

BloodSafe
MEMORIAL HOSPITAL
bloodsafememorial.com.au

PROGRESS NOTES

PATIENT SURNAME

GIVEN

PATIEN

DATE O

ROOM NUMBER

CODE

PHONE



Date / Time	Notes
9/8/2026 @1100	NURSING: Informed Mr. Stephens that he is nil by mouth until he is re-reviewed by the gastroenterology team this evening. Mr. Stephens requested to have his arm band removed and replaced on his right hand because he is left-handed, and it was irritating him. The identification band was removed. M. Weiss RN
9/8/2026 @ 1315	GASTRO INTERN: Delay in collection of group and hold due to high workload and competing clinical priorities during a busy shift. Bloods were obtained from the patient while he was resting and sent to the laboratory as per request form. Nursing and medical teams are aware. Plan remains unchanged. Q. Xu Gastroenterology Intern
9/8/2026 1345	NURSING: Very busy shift. Mr. Stephens is resting comfortably in bed. IV pantoprazole infusion commenced as per chart. Identification band replaced on the patient's right arm. M. Weiss RN
9/8/2026 @1400	NURSING: 1 unit of red cells has been requested from the transfusion laboratory. M. Weiss RN
9/8/2026 @ 1430	NURSING: Baseline vital signs attended –all within normal parameters. 1 unit of red cells commenced over 1 hour as per medical order. Patient identity, pack, and prescription checked by two registered nurses as per hospital policy. Mr. Stephens educated on possible side effects and advised to use his call bell to report any changes. M. Weiss RN
9/8/2026 @ 1435	NURSING: Mr. Stephens reports feeling feverish, moderate back and flank pain. He reports feeling that something has gone wrong. Appears very anxious. Vital signs are rechecked and noted to have a temperature of 38.6oC. Red cell transfusion immediately stopped and disconnected. MET call is activated. Patient identification, pack and prescription rechecked and all correct. Await medical review. M Weiss RN
9/8/2026 @ 1445	GASTROENTEROLOGY: MET call for sudden onset of fever 5 minutes into a red cell transfusion approximately 20 mL of blood has been transfused.
	A: patent own. Nil swelling or angioedema present.
	B. spontaneous, equal air entry bilaterally. Nil wheeze, crackles or stridor.

PROGRESS NOTES

PATIENT SURNAME

GIVEN NAME(S)

MRN

PATIENT ADDRESS

DATE OF BIRTH

PHONE

ROOM NUMBER

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

Date / Time	Notes
	C: warm and well perfused centrally and peripherally, HR 100 bpm – regular
	D: alert and orientated, GCS 15
	E: nil rashes noted.
	Suspected acute transfusion reaction following administration of red cells. The transfusion stopped immediately. Subsequent bedside checks and review of historical blood group records identified a discrepancy between the issued unit and the patient's known blood group history. Findings are highly suggestive of a possible ABO-incompatible transfusion reaction. Transfusion laboratory notified. Patient managed as per acute transfusion reaction protocol.
	Plan:
	For repeat bloods (FBC, UEC, LFTs, coagulation studies, LD, bilirubin, blood group and crossmatch, direct antiglobulin test (DAT))
	U/A
	Strict fluid balance chart
	IVF
	Aim for a urine output of >1ml/kg/hr
	1g Paracetamol
	Hourly vital signs for the next 4 hours
	Will re-review in four hours
	L. Wilkens Gastroenterology registrar.
9/8/2026 @ 1500	NURSING: Patient remains vitally stable and pain free, states no longer has back pain and feels a lot less anxious. IVF commenced @ 250ml/hr. Local incident reporting complete as per policy. Incident report number 5689. M. Weiss RN
9/8/2026 @ 1520	GASTROENTEROLOGY: Open disclosure performed with Mr. and Mrs. Stephens. Repeat bloods sent Q. Xu Gastroenterology intern

PROGRESS NOTES

PATIENT SURNAME

GIVEN NAME(S) MRN

PATIENT ADDRESS

DATE OF BIRTH PHONE

ROOM NUMBER

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

Date / Time	Notes
9/8/2026 @1600	NURSING TOC of Mr. Stephens from the morning staff. Vitals signs attended, all within normal parameters. Afebrile and pain free. IVF continues. U/A attended nil haemoglobinuria. S. Blakemore RN
9/8/2026 @1715:	GASTROENTEROLOGY: Mr. Stephens reviewed following an acute transfusion reaction secondary to a suspected ABO incompatible red cell transfusion. On review, Mr. Stephens is clinically stable. No further rigors or febrile episodes were reported. Haemodynamically stable. Denies any chest pain, back pain, or dyspnea. Urine output remains adequate. U/A showed no signs of haemoglobinuria. Patient reports ongoing fatigue but otherwise symptomatically improved from earlier. Blood results show slightly elevated bilirubin and LD levels. Will continue to monitor, for repeat bloods in the morning. Transfusion laboratory and haematology teams involved for ongoing transfusion strategy. Plan: Continue strict fluid balance chart Monitor urine output (aim urine output > 1ml/kg/hr) Continue IVF 2/24 vital signs overnight Repeat bloods mane Will review in the morning L. Wilkens Gastroenterology registrar.

CONSENT TO BLOOD AND BLOOD PRODUCTS

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRESS

DATE OF BIRTH /

ROOM NUMBER



THIS FORM IS TO BE USED FOR INFUSION OF:

- [X] Red Blood Cells (RBC)
- [ ] Platelets
- [ ] Other (please specify):
- [ ] Fresh Frozen Plasma (FFP)
- [ ] Cryoprecipitate

CLINICAL CONDITION/INDICATION FOR ADMINISTRATION OF BLOOD AND BLOOD PRODUCTS

?Ongoing UGI bleed

DURATION OF CONSENT:

- [X] This hospital admission
- [ ] 12 months (recurrent transfusion/infusion to manage chronic illness)

Consent for blood and blood products is valid for 12 months from date of consent **unless** the clinical condition changes OR consent is withdrawn by the patient.

PATIENT DECLARATION

1. I understand that a blood or blood product transfusion/infusion may be a necessary part of my treatment.
2. I have been provided with a **patient transfusion/infusion information** brochure in a language I can understand.
3. I acknowledge that the doctor has discussed the potential benefits, risks and appropriate alternative treatments.
4. I understand that I am receiving a biological product, therefore, it comes with potential risks and complications.
5. I have had the opportunity to ask questions and request further information related to transfusion/infusion and that my specific queries and concerns have been answered.

PATIENT'S FULL NAME (PRINT) KEVIN STEPHENS

PATIENT'S SIGNATURE K Stephens DATE 9/8/26 TIME 10.40

SUBSTITUTE DECISION MAKER RESPONSIBLE FOR GIVING CONSENT IF NOT THE PATIENT

Risks and benefits of the anaesthetic have been discussed with the patient and relevant consent discussions are documented within this form and within the patient's medical record should additional space be required.

SUBSTITUTE DECISION MAKER'S FULL NAME (PRINT)

RELATIONSHIP TO PATIENT

SUBSTITUTE DECISION MAKER'S SIGNATURE DATE TIME

DECLARATION OF DOCTOR/HEALTH PRACTIONER

I have explained the following information to the patient and/or their substitute decision maker:

- risks and benefits associated with transfusion/infusion
- appropriate alternative treatments
- risks of non-transfusion/infusion

DOCTOR/HEALTH PRACTITIONER'S FULL NAME (PRINT) LAUREI WILKENS

POSITION/TITLE Registrar

DOCTOR/HEALTH PRACTITIONER'S SIGNATURE LWilkens DATE 9.8.26 TIME 1040

INTERPRETER'S DECLARATION (IF APPLICABLE)

I declare I have interpreted the dialogue between the patient and doctor/health practitioner to the best of my ability and have advised the doctor/health practitioner of any concerns about my interpreting of this dialogue.

INTERPRETER'S FULL NAME (PRINT) SPECIFIC LANGUAGE REQUIRED

AGENCY NAATI NUMBER

INTERPRETER'S SIGNATURE DATE TIME

BLOOD COMPONENT ADMINISTRATION CHECKLIST

PATIENT SURNAME

GIVEN NAME(S)

PATIENT ADDRES

DATE OF BIRTH

ROOM NUMBER



1 Preparation for transfusion	Outcome		If 'NO' complete the following action
Staff and equipment are available	☒ OK	☐ NO	Ensure these are sufficient and transfusion is being performed in a clinical area
Informed consent discussion has occurred and is documented	☒ OK	☐ NO	Confirm that the patient understands the procedure and consent has been obtained
Prescription is valid	☒ OK	☐ NO	Obtain valid prescription
IV access is patent	☒ OK	☐ NO	Ensure IV access is patent and sufficient
Patient ID band is attached and correct – ask the patient or carer if possible	☐ OK	☐ NO	Ensure correct patient ID band is attached
Record baseline observations in the 60 minutes before transfusion	☒ OK	☐ NO	Observe and record temperature, pulse, respirations, blood pressure, and any rashes
2 Blood component collection	**Outcome**		**If 'NO' complete the following action**
Check patient identification, component type and special requirements details are present	☒ OK	☐ NO	Take documented patient identification, component type and special requirements details to collect pack
Check special requirements (if any) on the prescription have been met	☒ OK	☐ NO	Do not proceed and contact Transfusion Service Provider
Check documented patient details and compatibility label attached to pack are identical	☒ OK	☐ NO	Do not proceed and contact Transfusion Service Provider
3 Patient, prescription and pack check	**Outcome**		**If 'NO' complete the following action**
Inspect pack for: • Leaks or splits • Clots, discolouration, cloudiness • Expiry date and time	☒ OK	☐ NO	Do not proceed and contact Transfusion Service Provider. Note: Fresh frozen plasma (FFP) and cryoprecipitate will have two expiry dates; one when frozen and another date once thawed. Use the date that expires first.
Identical patient, component and compatibility labels: • Patient first and family names • Patient DOB • Patient MRN/URN • ABO blood group compatibility • Blood donation number	☒ OK	☐ NO	Involve the patient, if possible. If any discrepancies arise, do not proceed and contact Transfusion Service Provider or senior nurse or medical officer.
Identical patient and prescription: • Patient first and family names • Patient DOB • Patient MRN/URN	☒ OK	☐ NO	Do not proceed and contact Transfusion Service Provider or senior nurse or medical officer
Identical prescription, component and compatibility labels: • Patient first and family names • Patient DOB • Patient MRN/URN • Component type • Special requirements met (if any)	☒ OK	☐ NO	Do not proceed and contact Transfusion Service Provider or senior nurse or medical officer
All above checks were performed uninterrupted by two independent checkers and have been documented. Both must compare and confirm this is the right pack for the right patient.	☒ OK	☐ NO	Do not proceed and perform all above checks again and document

BLOOD COMPONENT ADMINISTRATION CHECKLIST

PATIENT SURNAME

GIVEN N

PATIENT

DATE OF

ROOM NUMBER



STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

CODE

PHONE

4 Blood component administration	Outcome	If 'NO' complete the following action
Blood component administration to be started by a person who has completed all checks	☒ OK ☐ NO	Do not proceed and perform all checks before starting administration
Administer component as per prescription specific infusion rates	☒ OK ☐ NO	Confirm blood component specific infusion rates with prescriber. For stable patients start slowly and usually administer: • Red cells: 2–3 hours per pack • Platelets: 30 minutes per pack • FFP: 30 minutes per pack • Cryoprecipitate: 30–60 minutes per dose
Transfusion completed within 4 hours and/or prior to component expiry	☐ OK ☐ NO	Consult senior nurse/medical officer if transfusion likely to take over 4 hours
5 Post-transfusion processes	**Outcome**	**If 'NO' complete the following action**
Ensure patient has received all the prescribed component	☐ OK ☐ NO	Consider clearing IV line with minimum volume of 0.9% sodium chloride solution (normal saline). Exercise caution in at-risk patients, i.e. neonates, infants, patients at risk of circulatory overload.
Monitor patient as required post-transfusion	☐ OK ☐ NO	Monitor patient according to local protocols and clinical indications post-transfusion
Dispose of blood component pack safely if transfusion uneventful	☐ OK ☐ NO	Dispose of blood component pack as per local health service protocols
Complete documentation: • Start and finish dates and times • Blood donation number • Transfusion observations and outcomes in patient records (electronic/paper)	☐ OK ☐ NO	Complete all relevant documentation

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BLOOD TRANSFUSION RECORD SHEET

IF TRANSFUSION REACTION OCCURS: Recognise, Respond, Report

1. **Stop** the blood transfusion immediately: **assess** vital signs, **notify** the doctor, change line and maintain IV access
2. **Recheck** patient and pack details - see Bedside Check above
3. **Contact** your local Transfusion Service and if required:
   - complete transfusion reaction report
   - return blood pack with clamped giving set intact in a sealed zip lock plastic bag
   - collect blood/urine specimens as ordered
4. **Monitor** the patient closely
5. **Document** outcome in patient record

PATIENT SU
GIVEN NAM
AREA/WAR
TANT

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

BEDSIDE CHECK

WARNING! A responsible qualified staff member must set up every transfusion. In every instance two responsible, qualified persons must perform the bedside check and sign on the reverse side of this sheet along with the relevant pack/product number, declaring that:

1. The patient's identity has been checked against the patient compatibility labels, MO prescription and the attached ID band. Ask the patient (if able) to state and spell their full name and date of birth. Ensure they are all identical and correct.
2. Correct type of blood product. Special requirements have been met. Check against MO prescription, blood component label and patient compatibility labels.
3. The blood group of the patient and donor, the pack/ donation number and the expiry date and time shown on the patient compatibility labels and on the blood component label are identical/compatible.

For further information:
Contact your local Transfusion Service Intranet site.

TRANSFUSION SERVICE

NAME: STEPHENS KEVIN	BLOOD PRODUCT RED CELLS
UR:800459871 DOB:16/11/1965	BATCH/DONOR NO. = A53002520343700
LOCATION GEN MED WARD 1	PATIENT GROUP A RhD POSITIVE
	DONOR GROUP A RhD POSITIVE
XMATCH DATE 08/08/2026	EXP DATE/TIME 12/08/2026

REQUIRES: LEUCODEPLETED

PEEL AND STICK INTO PATIENT NOTES

AFFIX LABEL HERE

AFFIX LABEL HERE

AFFIX LABEL HERE

AFFIX LABEL HERE

AFFIX LABEL HERE

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BLOOD TRANSFUSION RECORD SHEET

Ensure that blood products are given only when clearly indicated - when the expected benefits to the patient are likely to outweigh the potential hazards, when in doubt check with senior clinician. For more information refer to National Patient Blood Management Guidelines.

PATIENT SU
GIVEN NAM
AREA/WAR

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

ANT

Transfusion Requirements

Consent documented
☑ Yes ☐ No
Provide patient leaflet (on consent form)

History of Tranfusion Reaction
☐ Yes ☑ No
If yes, ensure documented on alert sheet

Special Product Requirements
☑ None ☐ Irradiated ☐ CMV Neg

Other
☐ Pre-med ☐ Diuretics ☐ Other
If yes - see Medication Chart

URGENCY (circle):
Emergency - Life threatening
Urgent - Clinical deterioration/potential for
(Routine) - Avoid overnight if possible
Overnight (circle): Yes (No)

Red Cells - Not dictated by Hb alone, but also based on clinical assessment of patient
- **Where indicated, a single unit of red cells, followed by clinical reassessment, is appropriate**
- In iron deficiency, iron therapy is required to replenish stores regardless of whether transfusion is indicated

Hb 75 g/L Associated factors/symptoms SOB Complete indication below:

☐ **Haemorrhage**
Refer to Critical Bleeding Protocol

Adult Medical:
☐ Hb < 70g/L
☐ Hb < 80g/L with Acute Coronary Syndrome (ACS)
☐ Hb 80-100g/L with ACS & benefits outweigh risk
☑ Hb 70-100g/L to relieve significant signs/symptoms anaemia and benefits outweigh risk
☐ BM failure/suppression/chronic transfusion regime
☐ Other _____ (benefits outweigh risk)

Adult Perioperative:
☐ Hb < 70g/L
☐ Hb 70-100g/L acute myocardial ischaemia
☐ Hb 70-100g/L acute cerebrovascular ischaemia
☐ Hb < 80g/L with significant ongoing blood loss or to relieve significant signs/symptoms of anaemia
☐ Other _____ (benefits outweigh risk)

Anti-D (shared care clinic)
Dose of vials: _____ No. of vials: _____
Date required: _____
Drs name: _____
Surgery address: _____
Phone number: _____

For Warfarin reversal see guidelines.

Fresh Frozen Plasma (FFP):
(Recommended dosage 10-15mL/kg)
INR _____ APTT _____
Indication: _____

Platelets: Pl _____ x10g/L
(1 adult dose = 1 adult pack)
Indication: _____

Cryoprecipitate:
(1 adult dose = 5 apheresis or 10 whole blood packs)
Fibrinogen level: _____ g/L
Indication: _____

Other Product:
Indication: _____

Date	Patient Location	Blood Product	Dose	Route	Rate Max 4hrs	Prescriber Sign	Prescriber Name	Prescriber Pager	Collector (Sign, Date, Time)	Receiver Clinical Area (Sign, Date, Time)	Serial Number of Pack	Bedside Check Sign & Print Name 1	Bedside Check Sign & Print Name 2	Date & Time Started	Date & Time Ended	Volume Given
9.8.26	GM	RBC	1	IV	1hr	Williams	Wilkens	5920	9.8 1420	Weiss 9.8 14.35		MW	AS	9/8/26 1430		

PLEASE USE A NEW SHEET FOR EACH TRANSFUSION EPISODE (eg when the indication and/or laboratory parameters have changed)

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FLUID BALANCE AND PRESCRIPTION CHART

PATIENT SURNAME STEPHENS
GIVEN NAME(S) KEVIN
PATIENT ADDRESS 16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

DATE 9.8.26

WEIGHT (KG) 75kg

SPECIAL INSTRUCTIONS

FOR HOURLY, CUMULATIVE FLUID RECORDING TODAY YES ☐

ADULT
16 YEARS AND ABOVE

FLUID INPUT (mL)

	ORAL FLUID				INTRAVENOUS FLUID AND MEDICINES *INCLUDE VOLUME OF INFUSED MEDICINES								HOURLY AMOUNT IN	GRAND TOTAL IN
	ORAL		ENTERAL		RBC		CSL							
	FLUID TYPE		FLUID TYPE		FLUID TYPE		FLUID TYPE		FLUID TYPE		FLUID TYPE			
	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL		
08:00														
09:00														
10:00														
11:00														
12:00														
13:00														
14:00					250									
15:00	20						250	250						
16:00							250	500						
17:00														
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20:00														
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23:00														
24:00														
01:00														
02:00														
03:00														
04:00														
05:00														
06:00														
07:00														

FLUID OUTPUT (mL)

URINE		BOWEL								HOURLY AMOUNT OUT	GRAND TOTAL OUT	OVERALL BALANCE	INITIALS
AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL	AMOUNT	TOTAL				
200													
500	700												

INTAKE	8am DAY	8pm NIGHT	8am TOTAL
ORAL			
ENTERAL			
INTRAVENOUS			
GRAND TOTAL IN			

−

OUTPUT	8am DAY	8pm NIGHT	8am TOTAL
URINE			
BOWEL			
OTHER			
OTHER			
GRAND TOTAL OUT			

=

24 HOUR FLUID BALANCE (mL)

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FLUID BALANCE AND PRESCRIPTION CHART

PATIENT SURNAME
GIVEN NAME(S)
PATIENT ADDRESS

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

INDICATIONS - ALL THAT APPLY

FLUID BOLUS VOLUME, DEFICIT, ON-GOING LOSS VOLUME, MAINTENANCE, DRUG PRESCRIPTION

*MEDICINES MUST BE RECORDED IN DRUG KARDEX

**MODEL NAME, SERIAL NUMBER

	DATE	TIME	VOLUME	INFUSION FLUID/TYPE	ADDITIVES*	RATE ML/HOUR RANGE	PRESCRIBER'S SIGNATURE	ADMINISTERED BY	CHECKED BY	BATCH/LOT NO. & EXPIRY DATE	PUMP DETAILS**	START TIME	FINISH TIME	VOLUME GIVEN
	9/8	1500	1L	A CSL	—	250mL/hr	[illegible]S	LW	AS	Jun 27		1500		
	9/8	1500	1L	B CSL		250mL/hr	[illegible]S							
				C										
				D										
				E										
				F										
				G										
				H										

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STOOL CHART

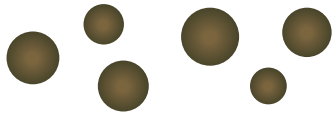
PATIENT SURNAME
GIVEN NAME(S)
PATIENT ADDRESS



Date	Time	Consistency	Colour	Amount	Notes
		1 2 3 4 5 6 7			
		1 2 3 4 5 6 7			
		1 2 3 4 5 6 7			
		1 2 3 4 5 6 7			
		1 2 3 4 5 6 7			
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BRISTOL STOOL CHART

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

BloodSafe
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Floor 3, Zone 6 BEA Building,
1572 Littleton Road, Lyra Falls SA 5088
bloodsafememorialpathlab.com.au
contact@bloodsafememorialpathlab.com.au

BLOOD PRODUCT REQUEST

(Not for Pre-Transfusion Pathology Requests)

ALL FIELDS ARE MANDATORY

PATIENT DETAILS - Clinical Staff to complete or affix patient label



LAST NAME

GIVEN NAME(S)

DATE OF BIRTH

WEIGHT (KG) 75

CLINICAL NOTES ?UGI bleed

URGENT or CRITICAL requests including MTPs MUST be phoned to Blood Bank.

To minimise delays this form must be completed.

PLEASE COMPLETE - This information ensures timely blood supply to correct location

Patient Location/Ward Gen Med Ward 1

Contact Person M. Weiss

Date/Time 9.8 1400

Prescribing Dr L. Wilkens (Print Full Name)

BLOOD PRODUCT REQUIRED

Order ALL fresh products in Units or mL		Type/Name	Dose/Qty/Vol
Red Cells*	1 unit	Coagulation Factor	
Platelets*		Beriplex	
FFP*		RhD Immunoglobulin	
Cryoprecipitate*	dose(s)	Immunoglobulin	
Cryoprecipitate* paediatric/neonatal	vol	Albumin 5%	
		Albumin 20%	
MTP/Critical Bleed Pack/ECMO		Other	

Special Requirements Irradiated ☐ CMV Neg ☐ Washed RC ☐ IgA Def ☐ HLA/HPA-Matched ☐

PTS DISPATCH OR BLOOD BANK COLLECTION VERIFICATION

Collected by Hospital Staff ✓

Products and Patient ID checked ☐

Person dispatched or collecting to complete below:

Name B. Smith

Signature B Smith

Date/Time 9/8/2026 1420

**OK to be sent by Pneumatic Transport System (PTS)*

Mandated patient bedside checks must be completed prior to infusion of product.

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MEDICARE CARE NO.

BloodSafe Memorial Pathology
Floor 3, Zone 6 BEA Building
1572 Littleton Road, Lyra Falls SA 5088
bloodsafememorialpathlab.com.au | contact@bloodsafememorialpathlab.com.au

PATIENT SURNAME
GIVEN NAME(S)
PATIENT ADDRESS
DATE OF BIRTH / /

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

REFERRING DOCTOR
(NAME, PROVIDER NUMBER, ADDRESS)

DOCTOR CODE

COPY TO:
(NAME, PROVIDER NUMBER, ADDRESS)

COPY TO:
(NAME, PROVIDER NUMBER, ADDRESS)

HC FACILITY

WARD
Gen Med Ward 1

COLLECTION CENTRE

☐ Public ☐ MBS

TEST REQUESTED

URGENT ☐

PHONE FAX #5920

FBC
UEC
LFT
LD
Bilirubin

Coagulation studies

CLINICAL NOTES

Post ABO incompatible blood transfusion

FASTING YES ☐ NO ☒
PREGNANT YES ☐ Weeks
MEDICATION / TLD

☐ Do not send report to My Health

DOCTOR'S SIGNATURE AND REQUEST DATE

X Wmins 9 / 8 / 26

Hospital status of patient at specimen collection or date of service

Private patient in a private hospital or approved day hospital facility	YES ☐	NO ☐
Private patient in a recognised hospital	YES ☐	NO ☐
Public patient in a recognised hospital	YES ☐	NO ☐
Outpatient of a recognised hosptial	YES ☐	NO ☐

I certify that I collected the accompanying specimen from the above patient whose identity was confirmed by enquiry and/or examination of their ID wristband, and that I labelled the specimen immediately following collection before leaving the patient.

SIGNED: NAME (Print):

PATIENT'S SIGNATURE AND DATE
By this declaration I assign my right to benefits to the Approved Pathology Practitioner who will render the requested pathology service(s).

X / /

LOCATION	INITIALS
C V A I S D	
DATE	TIME

TUBES								URINE				SWABS					SLIDES		CONTAINERS			OTHER
GEL	PLAIN	EDTA	EDTA	FLOX	CITRATE	HEPARIN	TRACE	BACTO	CYTO	24HR	PCR	ORANGE	WHITE	GREEN	RED	PINK	BACTO	CYTO	FAECES	SEMEN	HISTO	DESCRIBE
			9mL																			

Affix patient identification label in this box

UR Number:.....
Surname: .....
Given name: .....
Second given .....
D.O.B.: ...../...../..... Sex/Gender .....

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

Attach ADR sticker

See front page for details

As required PRN medicines

Year: 20 26

First prescriber to print patient name and check label correct: .....

Date	Medicine (print generic name)		Date
Route	Dose Hourly frequency **PRN**	Max PRN dose/24 hrs	Time
Indication	Pharmacy		Dose
			Route
Prescriber signature	Print your name	Contact	Sign

Continue on discharge? Yes / No
Dispense? Yes / No Qty:
Duration: days
Date:
Pharmacist:

Date | Medicine (print generic name) | Date
Route | Dose Hourly frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose
Route
Prescriber signature | Print your name | Contact | Sign
Continue on discharge? Yes / No
Dispense? Yes / No Qty:
Duration: days
Date:
Pharmacist:

Date | Medicine (print generic name) | Date
Route | Dose Hourly frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose
Route
Prescriber signature | Print your name | Contact | Sign
Continue on discharge? Yes / No
Dispense? Yes / No Qty:
Duration: days
Date:
Contact:

Date | Medicine (print generic name) | Date
Route | Dose Hourly frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose
Route
Prescriber signature | Print your name | Contact | Sign
Continue on discharge? Yes / No
Dispense? Yes / No Qty:
Duration: days
Date:
Print your name:

Date | Medicine (print generic name) | Date
Route | Dose Hourly frequency PRN | Max PRN dose/24 hrs | Time
Indication | Pharmacy | Dose
Route
Prescriber signature | Print your name | Contact | Sign
Continue on discharge? Yes / No
Dispense? Yes / No Qty:
Duration: days
Date:
Prescriber's signature:

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

NOT A VALID ORDER UNLESS LEGIBLE

BloodSafe MEMORIAL HOSPITAL

Facility/Service: B-M

Ward/Unit: Gen Med Ward 1

Medication chart number ..... of .....

Additional charts
☐ IV fluid ☐ Palliative care ☐ BGL/insulin ☐ Chemotherapy ☐ Acute pain ☐ IV heparin ☐ Other

Once only, pre-medication, telephone orders and nurse initiated medicines
(Telephone orders MUST be signed within 24 hrs of order)

Date / time prescribed	Medicine (print generic name)	Route	**Dose**	Date/time of dose	Telephone orders Check initials N1	N2	Prescriber/Nurse Initiator (NI) Signature	Print your name	Given by	Time given	Pharmacy
9.8	Paracetamol	PO	1g	9/8 1445			Wmims	WILKENS	MW	1500	

Medicines taken prior to presentation to hospital
(Prescribed, over the counter, complementary) Own medicines brought in? Y ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP: **Community pharmacy:**

Sign: Print: Date: Medicines usually administered by:

NIMC - ACUTE METRO

Check if patient has another Medication Chart OFFICIAL: Sensitive//Medical in confidence Hospital Only Prescription

OFFICIAL: Sensitive//Medical in confidence

Attach ADR sticker

Allergies and Adverse Drug Reactions (ADR)

☒ Nil known ☐ Unknown (tick appropriate box or complete details below)

Medicine (or other)	Reaction / type / date	Initials

COMPLETE ALERT SHEET IN MEDICAL RECORD

Sign Wilkens Print WILKENS Date 9.8

Affix patient identification label in this box

UR Number:.....

Surname: .....

Given name: .....

Second given na

D.O.B.: ...../ ...

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

First prescriber to print patient name and check label correct:

Weight (kg): 75 Height (cm): .....

Regular medicines

Year 20..26..... Date and month → 9/8

Variable dose medicine

Date | Medicine (print generic name)

Route | Frequency
Prescriber to enter dose time and individual doses

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Drug level

Time level taken

Dose

Prescriber

Time to be given: .....

Time given

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

VTE risk assessed: Yes ☐ Prophylaxis not required ☐ Contraindicated ☐ Signature: Date:

Date | Medicine (print generic name)

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

VTE prophylaxis

Prescriber signature | Print your name | Contact

Mechanical prophylaxis

Prescriber/NI signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

Medication

Date | **Warfarin** | **Marevan / Coumadin** select brand

Route **oral** | Prescriber to enter individual doses | Target INR Range

Indication | Pharmacy

Prescriber signature | Print your name | Contact

AM check

PM check

INR Result

Dose mg mg mg mg mg mg mg mg

Prescriber

1600 Initial 1

Initial 2

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

Contact:

PRESCRIBER MUST ENTER administration times

Date 9/8 | Medicine (print generic name) AMLODIPINE | Tick if slow release

Route PO | Dose 5mg | Frequency and NOW enter times daily mane | 0800

Indication | Pharmacy

Prescriber signature Wilkens | Print your name WILKENS | Contact #5920

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

Print your name:

Date 9/8 | Medicine (print generic name) PANTOPRAZOLE | Tick if slow release

Route PO | Dose 40mg | Frequency and NOW enter times daily mane | 0800

Indication | Pharmacy

Prescriber signature Wilkens | Print your name WILKENS | Contact 5920

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

Prescriber's signature:

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

Pharmaceutical review:

Recommended administration times
Guidelines only

Morning	Mane	0800			
Night	Nocte			1800 or 2000	
Twice a day	BD	0800		2000	
Three times a day	TDS	0800	1400	2000	
Regular 6 hourly	6 hrly	0600	1200	1800	2400
Regular 8 hourly	8 hrly	0600	1400	2200	
Four times a day	QID	0600	1200	1800	2200

Tick if slow release

SR = Sustained, modified or controlled release formulation.

If scored tablet, then half can be given.

Dose must be swallowed without crushing.

Anticoagulant education record

Medicine:.....

Education

Provided ☐ Declined ☐

Not appropriate ☐

Written Information

Provided ☐ Declined ☐

Written information provided:

CMI ☐ Other: ☐ .....

Signature: .....

Designation: .....Date: .....

Reason for not administering
Codes MUST be circled

Absent	A
Fasting	F
Refused – notify prescriber	R
Vomiting	V
On leave	L
Not available – obtain supply or contact prescriber	N
Withheld – enter reason in clinical record	W
Self administered	S

Regular medicines

Year 20..... Date and month →

PRESCRIBER MUST ENTER administration times

Date | Medicine (print generic name) | Tick if slow release

Route | Dose | Frequency and NOW enter times →

Indication | Pharmacy

Prescriber signature | Print your name | Contact

Continue on discharge? Yes / No
Dispense? Yes / No
Duration: ..... days Qty: .....

Date:

Pharmacist:

Contact:

Print your name:

Prescriber's signature:

Refer overleaf for PRN medicines

Pharmaceutical review:

NOT A VALID ORDER UNLESS LEGIBLE

Check if patient has another Medication Chart OFFICIAL: Sensitive//Medical in confidence Hospital Only Prescription

BloodSafe
MEMORIAL HOSPITAL

STANDARD ADULT GENERAL OBSERVATION CHART

FAMILY NAME
GIVEN NAME
D.O.B. ____/____
ADDRESS

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

MRN
☐ FEMALE
LOCATION

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

		Date	9.8										Date
		Time	1000	1030	1215	1400	1435	1445	1500	1530	1600	1700	Time
Patient / Family Concern Are you worried they are getting worse?		Yes					×	×	×				Yes
		No	×	×	×	×				×	×	×	No
		Not asked											Not asked
AIRWAY/BREATHING	Respiratory Rate	35–5	×	×	×	×	×	×	×	×	×	×	35–5
	SpO_2%	100–85	×	×	×	×	×	×	×	×	×	×	100–85
	Oxygen	O_2Lpm											O_2Lpm
		Device / mode	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	Device / mode
		Key: RA = Room Air, NP = Nasal Prongs, FM = Simple facemask, NRB = Non Re-breather, VM = Venturi Mask											
CIRCULATION	Blood Pressure (mmHg) SBP is trigger > <	230–50											230–50
	Heart Rate •	Rhythm											Rhythm
		160–40											160–40
Initials			MW	MW	MW	MW	MW	MW	MW	MW	MW	MW	Initials

BloodSafe
MEMORIAL HOSPITAL

STANDARD ADULT GENERAL OBSERVATION CHART

FAMILY NAME
GIVEN NAME
D.O.B. ____/____
ADDRESS

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

MRN
☐ FEMALE
LOCATION

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

		Date	9.8										Date
		Time	1000	1030	1215	1400	1435	1445	1500	1530	1600	1700	Time
DISABILITY	Neurological	A	×	×	×	×	×	×	×	×	×	×	A
		C											C
		V											V
		P											P
		U											U
		A= Alert, C= new confusion/change in behaviour, V= Rousable by voice (conduct GCS). P= Rousable only by pain (conduct GCS). U= Unresponsive											
PAIN		Assess pain level at rest and with movement. Enter R for at rest, M for movement											
		Severe (7-10)					RM	RM	RM				Severe (7-10)
		Moderate (4-6)								RM			Moderate (4-6)
		Mild (1-3)									RM	RM	Mild (1-3)
		Nil	RM	RM	RM	RM							Nil
EXPOSURE	Temperature (°C) •	41–34					×	×	×				41–34
		36.5	×	×	×	×				×	×		36.5
LACTATE		≥ 4 mmol/L											≥ 4 mmol/L
		2 to 3.9 mmol/L											2 to 3.9 mmol/L
		< 2 mmol/L											< 2 mmol/L
		BGL											BGL
		Bowels											Bowels
		Weight											Weight
		Initials	MW	MW	MW	MW	MW	MW	MW	MW	MW	MW	Initials

URINALYSIS	Date									Date
	Time									Time
	SG									SG
	pH									pH
	Leuk									Leuk
	Blood									Blood
	Nitrite									Nitrite
	Ketones									Ketones
	Bilirubin									Bilirubin
	U/Bil									U/Bil
	Protein									Protein
	Glucose									Glucose

BINDING MARGIN - NO WRITING

BSM29062026 061126

BloodSafe
MEMORIAL HOSPITAL

STANDARD ADULT GENERAL OBSERVATION CHART

FAMILY NAME | MRN
GIVEN NAME | EMALE
D.O.B. ____/____
ADDRESS

STEPHENS
KEVIN
16/11/1965 M
MRN 800459871
GENERAL MEDICAL WARD 1

LOCATION

☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED | COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

OTHER CHARTS IN USE

☐ Neurological Observation ☐ Insulin Infusion ☐ Alcohol Withdrawal
☐ Fluid Balance ☐ Pain / Epidural / Patient Control Analgesia ☐ Resuscitation Plan
☐ Anticoagulant ☐ Neurovascular ☐ Other _____

PRESCRIBED FREQUENCY OF OBSERVATIONS

Observations must be performed routinely at least 6th hourly, unless advised below

DATE:	dd/MM/yy	9.8.26	9.8.26		
Time:	hh:mm	1500	1730		
Frequency Required	Twice daily	1/24	2/24		
Medical Officer Name (BLOCK letters)	A. CHANG	L. Wilkens	L. Wilkens		
Medical Officer Signature	A. Chang	Wilkins	Wilkins		
Attending Medical Officer Signature	J. Doe				

Alterations to calling criteria (ACC)
Acute ACC changes can be set for up to 12 hours. Chronic ACC changes apply for the episode of care
Any alterations MUST be signed by a Medical Officer and confirmed by the Attending Medical Officer
Document rationale for altering CALLING CRITERIA in the patient's health care record

DATE:	dd/MM/yy					
TIME:	hh:mm					
Next review due Date & Time	dd/MM/yy hh:mm					
ACUTE / CHRONIC	**ACUTE**					
Yellow Zone	XXX-XXX					
Red Zone	<= or >=XXX					
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Yellow Zone						
Red Zone						
Medical Officer Name (BLOCK letters)	A. CHANG					
Medical Officer Signature	A. Chang					
Attending Medical Officer Signature	J. Doe					

INTERVENTIONS / COMMENTS / ACTIONS

	Date	Time	
1.			
2.			
3.			
4.			

STANDARD ADULT GENERAL OBSERVATION CHART BSMOC150

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF YOUR PATIENT

Yellow Zone Response

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU MUST

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by your patient's condition
3. Consult promptly with the **NURSE IN CHARGE** to decide whether a **CLINICAL REVIEW** (or other CERS) call should be made

Consider the following:

- What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criterion?
- Are you concerned about your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
3. Inform the Attending Medical Officer that a call was made as soon as it is practicable

***Additional YELLOW ZONE Criteria**

- Increasing oxygen requirement
- Poor peripheral circulation
- Excess or increasing blood loss
- Decrease in Level of Consciousness or new onset of confusion
- Low urine output persistent for 4 hours (< 100mLs over 4 hours or < 0.5mL/kg/hr via an IDC)
- Polyuria, in the absence of diuretics (urine output > 200mL/hr for 2 hours)
- Greater than expected fluid loss from a drain
- New, increasing or uncontrolled pain (including chest pain)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with no decrease in Level of Consciousness
- Ketonaemia > 1.5mmol/L or Ketonuria 2 + or more
- **Concern by patient or family member**
- **Concern by you or any staff member**

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, A NEW ARRHYTHMIA, HYPOVOLAEMIA/HAEMORRHAGE, PULMONARY EMBOLUS/DVT. PNEUMONIA/ATELECTASIS, AN AMI, STROKE, OR AN OVERDOSE/OVER SEDATION

Red Zone Response

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS) AND

1. Initiate appropriate clinical care
2. Inform the **NURSE IN CHARGE** that you have called for a **RAPID RESPONSE**
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

#Additional RED ZONE Criteria

- **Cardiac or respiratory arrest**
- **Airway obstruction or stridor**
- **Patient unresponsive**
- Deterioration not reversed within 1 hour of Clinical Review
- Increasing oxygen requirements to maintain oxygen saturation > 90%
- Arterial Blood Gas: PaO_2 < 60 or $PaCO_2$ > 60 or pH < 7.2 or BE < -5
- Venous Blood Gas: $PvCO_2$ > 65 or pH < 7.2
- Only responds to Pain (P) on the ACVPU scale
- Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS)
- New or prolonged seizure activity
- Low urine output persistent for 8 hours (< 200mLs over 8 hours or < 0.5mL/kg/hr via an IDC)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with a decreased Level of Consciousness
- **Serious concern by any patient or family member**
- **Serious concern by you or any staff member**

BINDING MARGIN - NO WRITING