GI Bleed Integrated Care Pathway

Instructions for use

This pathway is to be used in place of all previous documentation for patients with an Upper GI Bleed

It is a legal document, therefore all entries on the pathway, must be signed for, and every person using the pathway must complete the signature sheet at the front of the pathway.

Where possible the pathway has been based on clinical evidence. Where no evidence is available, a decision has been made to use best clinical practice.

The pathway is a prompt only, any deviations from the pathway, must be written in the variance column along with any action taken and the results of the action. The variance must also be signed. This process enables the practitioner to use their clinical judgement and also enables the pathway to be audited more easily.

The pathway follows the patient throughout his stay in hospital and includes discharge requirements. The anticipated length of stay is 3-5 days, should the patient remain in hospital longer, then extra pages must be added or revert to the clinical notes.

To use the pathway, just follow the prompts, fill in the relevant spaces, add any variances and then sign at the bottom of the sheet, to indicate that you have completed the pathway of care. If there has been no variance on your shift and all the boxes have already been ticked then all you need to do is sign, providing you have given all the care.

Remember that all assessments of handling, nutrition, pressure sore risk must be assessed at least once every shift. This is also a legal requirement.

Abbreviations used:

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| --- | --- |
| BP = Blood Pressure | N. = No |
| CVS = Cardiovascular system | N.A.D. = No Abnormality Detected |
| D.O.B. = Date of Birth | 02 = Oxygen |
| G.P. = General Practitioner | 02 Sats = Oxygen Saturation’s |
| HAA= Hospital Admission Sheet | OP = Out Patients Appointment |
| I.C.P. = Integrated Care Pathway | P.E. = Pulmonary Embolism |
| I.D. = Identification Band | R.R. = Respiratory Rate |
| I.V = Intravenous Site/ Infusion | T.E.D.S = Anti-Embolic Stockings |
| Min = Minute | T.P.R. = Temperature, Pulse and Respiration |
| MSW = Medical Social Worker | Y = Yes |
|  |  |

If you have any difficulties or problems with this pathway then please contact :-

Dr Juliette Loehry ext 4227

|  |
| --- |
| **Affix Pt label**  **Pt Name……………………………**  **Hospital number………………….** |

**SIGNATURE SHEET**

Please give your full name, designation, initials and full signature below, if you write in this pathway. This is for legal purposes.

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| FULL NAME | DESIGNATION | | FULL SIGNATURE | INITIALS |
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| ttac Affix Patient Label Here  Name:…..……………………………………….…….………...  Address:..…………………………………………………….…  …………………………………………………………………...  Hospital Number………………………………………………..  Date of Birth…………………………………………………….  GP details……………………………………………………… | | abc  **GI BLEED INTEGRATED CARE PATHWAY**  **Consultant………………………**  **Day 1** | | |

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| --- |
| Admitting Consultant |
| Continuing Consultant |
| Admitting doctor |
| Status Bleep |
| Signature |

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| --- | --- |
| Date of admission …/…/… Time …**:**…. | Haematemesis Yes / No |
| Ward | Melaena Yes / No |
| GI bay Y/NDate …/…/…. | Coffee Grounds Yes / No |
| Ward transfer ………… Date …/.../…. | Length of history |
| Date of discharge …./…/…. | Volume estimate (mls) |
| Clinical notes | |
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| **Past Medical History** | MedicationsName Dose Frequency |
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| Known peptic ulcer disease Y / N | NSAIDS Y / N |
| Known varices Y / N | Aspirin Y / N |
| Previous variceal bleed Y / N | Warfarin Y / N |
| Chronic liver disease Y / N | Clopidogrel Y / N |
| Cardiorespiratory morbidity Y / N | Dipyridamole Y / N |
| Diabetes Y / N | SSRI Y / N |
| Risk factors for Hep B/C HIV Y / N | Alcohol Y / N Units/week…... |
|  | Smoker Y / N |
| Family History | Social History |
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| **Clinical findings** | | | | | | | |
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| Anaemia Y / N | | Jaundice Y / N | | | Stigmata of chronic liver disease Y / N | | |
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| Encephalopathy Y / N | | |  | | |  | |
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| Temp | Respiratory rate | | | Saturations | | | Inspired O2 conc |
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| Pulse | | | Supine BP | | | Sitting BP | |
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RESULTS

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| Creatinine |  |  |  |  |  |  |  |  |
| Glucose |  |  |  |  |  |  |  |  |
| CRP |  |  |  |  |  |  |  |  |
| TProtein |  |  |  |  |  |  |  |  |
| Albumin |  |  |  |  |  |  |  |  |
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| ALT |  |  |  |  |  |  |  |  |
| ALP |  |  |  |  |  |  |  |  |
| GGT |  |  |  |  |  |  |  |  |
| Units transfused |  |  |  |  |  |  |  |  |

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| **PRE-ENDOSCOPY ROCKALL SCORE =** | POST-ENDOSCOPY ROCKALL SCORE \* |

**\****to be completed by endoscopist*

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| **Rockall scoring** system for risk of rebleeding and death after admission to hospital for acute gastrointestinal bleeding | | | | |
| **Variable** | **Score**  **0** | **1** | **2** | **3** |
| Age | < 60 | 60-79 | > 80 |  |
| Shock | No shock  SBP >100  Pulse <100 | Tachycardia  SBP>100  Pulse >100 | Hypotension  SBP<100  Pulse>100 |  |
| Co-morbidity | Nil Major |  | Cardiac Failure/IHD  Any major co-morbidity | Renal failure  Liver failure  Disseminated malignancy |
| Diagnosis | MW tear  No lesion  No SRH | All other diagnoses | Malignancy of upper GI tract |  |
| Major SRH | None or dark spot |  | Blood in upper GI tract  Adherent clot, visible/spurting vessel |  |
| Each variable is scored and the total score calculated by simple addition  SRH, stigmata or recent haemorrhage Score <3 excellent prognosis, >8 high mortality | | | | |

**Date**

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| **Clinical Notes:** | | |
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| CXR results (if indicated) | | |
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| ECG report (if indicated) | | |
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| **Rockall score = (**see page 5) | | |
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| **Ensure the following (please tick box if done)** |  |  |
| Endoscopy form request completed and submitted |  |  |
| Results tabulated before endoscopy (page 5) |  |  |
| Patient consented to therapeutic endoscopy |  |  |
| Patient haemodynamically stable prior to transfer |  |  |
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| ttac Affix Patient Label Here  Name:…..……………………………………….…….………...  Address:..…………………………………………………….…  …………………………………………………………………...  Hospital Number………………………………………………..  Date of Birth…………………………………………………….  GP details……………………………………………………… | abc  **GI BLEED INTEGRATED CARE PATHWAY**  **Consultant………………………**  **Day 1 cont’d** |

**Date**

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| **Clinical Notes:** |
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| Nursing documentation (Day 1) on page 11 |
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| **Proceed to page 12** |

**INITIAL RESCUSCITATION GUIDELINES**



All stable patients will be endoscoped between 08:30-09:00 weekdays in Endoscopy unit.

Out of hours emergency endoscopy and endoscopy in unstable patients will take place in theatre, this must be co-ordinated with anaesthetic and theatre staff

**NON-VARICEAL BLEEDING**



#### Therapy Guidelines

**NB** There is no place for prescribing an IV Omeprazole infusion outside of these guidelines.

**H Pylori eradication**: Lansoprazole 30mg bd + Metronidazole 400mg bd + Clarithromycin 500mg bd 1 week.

**Duodenal ulcer**: Lansoprazole 30mg od 4 weeks.

Confirm HP eradication with 13C-urea breath test 4 weeks after completion of therapy.

**Gastric ulcer**: Lansoprazole 30mg od 8 weeks.

Repeat endoscopy 6 weeks to exclude malignancy.

**NSAID induced ulcers**: Stop NSAID/Aspirin, Rx Lansoprazole 30mg od 4-8 weeks.

Eradicate H Pylori if present.

If long term NSAID essential recommend Ibuprofen + PPI and consider FU endoscopy to confirm healing.

Consider stopping SSRI in confirmed bleed.

\* Recommend refer patient to gastroenterology team.

\*\*IV Omeprazole infusion: 80mg in 200 mls sodium chloride 0.9% over 30mins, then 80mg in 200 mls

sodium chloride 0.9% at 20 mls/hr.

##### VARICEAL BLEEDING



\* Slow IV bolus over 3 minutes

\*\* Consider dose reduction in patients with IHD

**Date Day 1**

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| **NURSING NOTES (Write Variance on the Variance sheet)** | | | | |
| **Assessments** | | | | |
| Waterlow score Action taken | | | | |
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| Manual handling Action taken | | | | |
| Communication | | | | |
| Pain score Action taken | | | | |
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| Social Care Needs | | | | |
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| **OBSERVATIONS AND INTERVENTIONS** | | | | |
| Nil by mouth | | | | |
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| Patient ‘specialled’ Y / N GI bay Y / N Infectious risk Y/N | | | | |
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| Monitor BP /TPR / O2  saturation’s every 15-30 mins Y / N 4 Hourly Y/N | | | | |
| Monitor CVP/ Urine output hourly Y / N | | | | |
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| Commence fluid/stool chart Y / N | | | | |
| Catheterise Y / N | | | | |
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| Blood transfusion Y/N ……Units given | | | | |
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| TED stockings Y / N | | | | |
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| Inform NOK and give support Y / N  Name…………………………………    Contact details………………………. | | | | |
| Ward information given Y / N | | | | |
| Plan discussed with patient Y / N | | | | |
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| **PRE ENDOSCOPY CHECKLIST** | | | | |
| ***Time endoscopy booked for:*** | | | | |
| ID Band Y / N Correct X-rays Y / N | | | | |
| Correct Notes Y / N IV Fluid chart Y / N | | | | |
| Drug and Obs Chart Y / N Teeth: caps/crowns/dentures removed Y / N | | | | |
| Consent obtained Y / N Time last ate or drank……………… | | | | |
| Pulse and BP before transfer…………… (***Must be stable)*** | | | | |
| Signature and time | Signature and time | | Signature and time | |
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| ttac Affix Patient Label Here  Name:…..……………………………………….…….………...  Address:..…………………………………………………….…  …………………………………………………………………...  Hospital Number………………………………………………..  Date of Birth…………………………………………………….  GP details……………………………………………………… | | | abc  **GI BLEED INTEGRATED CARE PATHWAY**  **Consultant………………………**  **Day 2** | |

**Date**

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| **NURSING NOTES *(Endoscopy)* (Write Variance on the Variance sheet)** |
| POST-ENDOSCOPY CHECKLIST |
| Oxygen Saturation’s % |
| Pulse BP |
| IV fluids / blood transfused Y / N Details |
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| Verbal handover Y / N |
| Printed report completed and filed Y / N |
| Dentures/crowns returned Y / N |
| *Name* ***Signature*** |
| CLINICAL NOTES *Ensure that endoscopy report is filed on Page 13 and the result documented on this page* *(Free text for endoscopist if necessary)* |
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| **N.B Endoscopists PLEASE state Rockall Score on Page 5** | | |
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| Affix endoscopy report to this page | | |
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| **Clinical notes cont’d** | | | |
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| ttac Affix Patient Label Here  Name:…..……………………………………….…….………...  Address:..…………………………………………………….…  …………………………………………………………………...  Hospital Number………………………………………………..  Date of Birth…………………………………………………….  GP details……………………………………………………… | | abc  **GI BLEED INTEGRATED CARE PATHWAY**  **Consultant………………………**  **Day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Clinical notes** |
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**Variance**

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| Date & time | Variance | Action taken | Result of action | Signature |
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**Date**

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| NURSING NOTES Write Variance on the Variance sheet | | | | |
| **Assessments:** | | | | |
| Pain assessment and score Action | | | | |
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| Pressure sore assessment and score Action | | | | |
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| Manual handling Action | | | | |
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| **Medications:** | | | | |
| Oxygen……….l/min ……….% IV fluids Y / N | | | | |
| Blood transfusion Y / N .... units given Medications as prescribed Y / N | | | | |
| **Other comments:** | | | | |
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| **Observations:** | | | | |
| BP, TPR, O2 Sats 1 hourly Y / N 4 hourly Y / N | | | | |
| Urine output Measures Y / N 1 hourly Y / N 4 Hourly Y / N | | | | |
| Continued signs of bleeding Y / N If yes call doctor | | | | |
| Signs of agitation Y / N If yes call doctor | | | | |
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| **Diet:** | | | | |
| NBM Y / N Fluids only Y / N Full diet Y / N | | | | |
| Dietician referral Y / N | | | | |
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| **Interventions:** | | | | |
| Stool chart Y / N Personal hygiene / mouthcare PRN Y / N | | | | |
| Pressure area care as per policy Y / N Check IV, CVP, Catheter sites Y / N | | | | |
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| **Mobility:** | | | | |
| Bed rest Y / N Up and about Y / N | | | | |
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| **Education / Advice :** | | | | |
| Patient aware of investigations/results Y / N Relatives informed of progress Y / N | | | | |
| Alcohol/drug avoidance Y / N ADAS support Y / N | | | | |
| Advice on medications - storage / dosage Y / N H Pylori eradication and FU Y / N | | | | |
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| **Discharge Planning:** | | | | |
| Transport required Y / N Booked Y / N Time | | | | |
| HAA form completed Y / N TTA’s done Y / N | | | | |
| Repeat OP endoscopy Y / N Outpatient FU Y / N at weeks | | | | |
| Signature and time | Signature and time | | Signature and time | |
|  |  | |  | |
| ttac Affix Patient Label Here  Name:…..……………………………………….…….………...  Address:..…………………………………………………….…  …………………………………………………………………...  Hospital Number………………………………………………..  Date of Birth…………………………………………………….  GP details……………………………………………………… | | abc  **GI BLEED INTEGRATED CARE PATHWAY**  **Consultant………………………**  **Day \_\_\_\_\_\_\_\_\_\_\_\_** | |

**Date**

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| **Clinical Notes:** |
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| Date & time | Variance | Action taken | Result of action | Signature |
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**Date**

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| NURSING NOTES Write Variance on the Variance sheet | | | | |
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| **Assessments:** | | | | |
| Pain assessment and score Action | | | | |
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| Pressure sore assessment and score Action | | | | |
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| Manual handling Action | | | | |
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| **Medications:** | | | | |
| Oxygen……….l/min ……….% IV fluids Y / N | | | | |
| Blood transfusion Y / N .... units given Medications as prescribed Y / N | | | | |
|  | | | | |
| **Observations:** | | | | |
| BP, TPR, O2 Sats 1 hourly Y / N 4 hourly Y / N | | | | |
| Urine output Measures Y / N 1 hourly Y / N 4 Hourly Y / N | | | | |
| Continued signs of bleeding Y / N If yes call doctor | | | | |
| Signs of agitation Y / N If yes call doctor | | | | |
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| **Diet:** | | | | |
| NBM Y / N Fluids only Y / N Full diet Y / N | | | | |
| Dietician referral Y / N | | | | |
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| **Interventions:** | | | | |
| Stool chart Y / N Personal hygiene / mouthcare PRN Y / N | | | | |
| Pressure area care as per policy Y / N Check IV, CVP, Catheter sites Y / N | | | | |
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| **Mobility:** | | | | |
| Bed rest Y / N Up and about Y / N | | | | |
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| **Education / Advice :** | | | | |
| Patient aware of investigations/results Y / N Relatives informed of progress Y / N | | | | |
| Alcohol/drug avoidance Y / N ADAS support Y / N | | | | |
| Advice on medications - storage / dosage Y / N H Pylori eradication and FU Y / N | | | | |
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| **Discharge Planning:** | | | | |
| Transport required Y / N Booked Y / N Time | | | | |
| HAA form completed Y / N TTA’s done Y / N | | | | |
| Repeat OP endoscopy Y / N Outpatient FU Y / N at weeks | | | | |
| Signature and time | Signature and time | | Signature and time | |
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| ttac Affix Patient Label Here  Name:…..……………………………………….…….………...  Address:..…………………………………………………….…  …………………………………………………………………...  Hospital Number………………………………………………..  Date of Birth…………………………………………………….  GP details……………………………………………………… | | abc  **GI BLEED INTEGRATED CARE PATHWAY**  **Consultant………………………**  **Day \_\_\_\_\_\_\_\_\_\_\_\_** | |

**Date**

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| **Clinical Notes:** |
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| Date & time | Variance | Action taken | Result of action | Signature |
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**Date**

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| NURSING NOTES Write Variance on the Variance sheet | | | | |
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| **Assessments:** | | | | |
| Pain assessment and score Action | | | | |
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| Pressure sore assessment and score Action | | | | |
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| Manual handling Action | | | | |
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| **Medications:** | | | | |
| Oxygen……….l/min ……….% IV fluids Y / N | | | | |
| Blood transfusion Y / N .... units given Medications as prescribed Y / N | | | | |
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| **Observations:** | | | | |
| BP, TPR, O2 Sats 1 hourly Y / N 4 hourly Y / N | | | | |
| Urine output Measures Y / N 1 hourly Y / N 4 Hourly Y / N | | | | |
| Continued signs of bleeding Y / N If yes call doctor | | | | |
| Signs of agitation Y / N If yes call doctor | | | | |
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| **Diet:** | | | | |
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| Signature and time | Signature and time | | Signature and time | |
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**Date**

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| **Clinical Notes:** |
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| Date & time | Variance | Action taken | Result of action | Signature |
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**Date**

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| NURSING NOTES Write Variance on the Variance sheet | | |
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| Signature and time | Signature and time | Signature and time |
|  |  |  |