Richard Neil Fehr
RUH Patient Records
Dec. 2, 2021 —
Feb. 18, 2022

Seon Ko, CHIM
Health Information Management Practitioner
Royal University Hospital and Jim Pattison Children's Hospital
103 Hospital Drive
Saskatoon, SK S7N 0W8
P: 306-655-1745| F: 306-655-1930

26 April 2024

Richard Fehr
PO Box 38028
Saskatoon, SK S7N 1H2

Dear Richard Fehr

RE: NAME: FEHR, Richard
DOB: 23 February 1981

Thank you for your written request for personal health information, dated **5 April, 2024** and received at Royal University Hospital and Jim Pattison Children's Hospital on **5 April, 2024**; pursuant to section 32 of *The Health Information Protection Act* (HIPA) requesting access to **Richard Fehr for a complete records at RUH from December 2, 2021 to July 1, 2022:**

The Saskatchewan Health Authority (SHA) is pleased to provide you with your personal health information in accordance with subsection 36(1)(a) of HIPA. Subsection 36(1)(a) states:

> *36(1)(a) Within 30 days after receiving a written request for access, a trustee must respond to the request in one of the following ways: (a) by making the personal health information available for examination and providing a copy, if requested, to the applicant.*

Fee Payment
An itemized invoice for the amount of $806.00 is enclosed. Please forward your invoice and payment to the cashier. Retain one copy for your records.

If you have questions regarding this file, please contact the writer.

If you are not satisfied with the decision of the Health Information Services department, you may contact the SHA Privacy Office at 1-844-655-0259 for a further review of the file.

Yours truly,

Seon Ko, CHIM
Health Information Management Practitioner
Health Information Services

1138390

Saskatchewan
Health Authority

REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION

Access – is the right of the individual (or his/her lawfully authorized representative, per Section 56 HIPA) to view or obtain copies of records in custody or control of a Trustee. Health Information Protection Act, Section 32.

Patient Information:

First and Last Name (as appears on health card)		Health Services Number (province of issue included)
Richard Fehr ✓		540 228 788
Date of Birth (mmm-dd-yyyy)	Telephone Number	
Feb-23-1981 ✓	Home:	Cell: 306 229-7259
Mailing Address		
P.O. Box 38028		
City	Province/State	Postal or Zip Code
Saskatoon	Sask	S7N 1H2

Personal Health Information Requested:

Please list the site(s) you are requesting your information from (*this does not include private clinics*):

Royal University Hospital

Please provide specific information requested and dates of visits:

My full medical file while I was at RUH
From Dec 2, 2021 - July 1, 2022

Receipt of Personal Health Information:

How do you wish to access this information? Please select one:

☑ Receive copies of originals: ☐ Mail to address above or ☑ Pick-up only (Full name of person picking up: Doreen Fehr (If different than requestor)

☐ Examine original with a Saskatchewan Health Authority (SHA) representative (*appointment required*) 306 270-2948

Please note any personal health information selected for pick up that is left more than 90 days from date of request will be destroyed and a new request must be submitted.

Signature of applicant: RZ **Date:** Apr 5, 2024

You will be contacted within **30 days** of the receipt of request. If the information is available you will be charged a processing fee of **$20.00** *per Access request* and **$0.25** per photocopied page, or a **$20.00** fee for examining records with an SHA representative. **(GST/PST exempt)**

For facility mailing addresses, please refer to the Acute Care Facilities document found on the Health Information Services webpage.

For administrative use only:

Received by: SK **Date received:** APR 0 5 2024

Verify: ☐ Government issued identification ☐ Permission to contact by telephone ☐ Permission to leave message at above telephone number

Fees waived: _____ **Approved by:** _____

MySaskHealthRecord gives you quick and easy access to your personal health information through a secure website or mobile app. Visit ehealthsask.ca or call 1-844-767-8259.

Saskatchewan Health Authority

HOW TO COMPLETE AND SUBMIT A REQUEST FOR ACCESS TO PERSONAL HEALTH INFORMATION FORM IF YOU ARE THE PATIENT

Patient Information (if you are the patient)

- Enter your first and last name (as it appears on the Health Card).
- Enter your Health Services Number and date of birth.
- Enter your telephone number at which you may be contacted during business hours and your complete mailing address.

Personal Health Information Requested

Please be as specific as possible in completing this part of the form. This will assist the Saskatchewan Health Authority in responding to your request accurately, completely and quickly.

- List the precise records or information you are requesting (example: records relating to an outpatient visit).
- Provide the name of the facility that provided the health services (example: Saskatoon City Hospital).
- Specify the time period when the patient received health services (this will allow staff to retrieve records relating to those services).
- Identify the clinic, program or area that provided the services (example: Emergency; Immunization; Social Work Services).
- Indicate how you wish to receive the information.
- *Sign and date your request.*

Authorization

When you make a request for health information, you will be asked to provide proof of your identity before the records are provided to you.

If you are a Legal Guardian or Medical Decision Maker, you will be asked to provide evidence of your authority to exercise that power (example: guardianship order; proxy; medical decision-making documentation; excerpts from a will naming you as executor and the date and signature of the will).

Payment

All requests for health information are subject to a processing fee of **$20.00 plus $0.25** per photocopied page, or a **$20.00** fee for examining records with an SHA representative. **(GST/PST exempt).**

Submission of Request

Submit your request by delivering in person, mailing, or faxing to the facility you are making the request to. In order to assist you, an *Acute Care Facilities* contact list is located online or via the QR code below. Please contact the location where you received health services. If your request involves more than one location, you will only be subject to a single processing fee.

Acute Care Facilities contact list

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: SHUMILAK, GEOFFREY
FAM: FRASER,JILLIAN

CONSENT TO SURGERY DIAGNOSTIC & TREATMENT PROCEDURES

1. I, _____ consent to and authorize Dr. Y. Luo
(Name of patient or guardian)

and/or such assistants as may be selected by the physician/dentist, to perform the following procedure(s) on _____ Procedure(s): _____
(Name of patient or MYSELF)

Laparoscopy, washout, +/- bowel resection.

2. The procedure(s) listed in paragraph 1 have been explained to me and I understand the nature of the procedure(s).

3. I recognize that, during the procedure(s), unforseen or unknown conditions may require additional or different procedures than those described in paragraph 1. I therefore further authorize and request that the above named physician/dentist, his/her assistants, or his/her designate perform such procedures as are in his/her professional judgement, immediately necessary and desirable, and such that delay is not feasible and would endanger my life or health.

4. I consent to the administration of an appropriate anaesthetic.

5. I acknowledge that no guarantees have been made to me as to the results of the procedure(s).

6. I agree to the retention of any tissue that may be removed during the procedure(s) for diagnosis, study for quality assurance or improvement purposes, and the disposal of any removed tissue according to approved SHR/SPH practice.

7. I acknowledge that this is a teaching facility and that my physician/dentist may allow professional trainees to participate in the procedure(s) under supervision.

8. In the event a health care worker is exposed to my blood or bodily fluids, I consent to being tested for blood borne pathogens (e.g., HIV, Hepatitis B & C, etc.). I understand that the results of the test will be used to provide appropriate treament for the health care worker. In the event of a positive result, I will be contacted by the appropriate health care personnel and offered follow up treament. I also understand that the Saskatoon Health Region is obligated by law to inform Public Health in the event of a positive result for the purposes of providing appropraite follow up.

9. X _____ Dec. 21, 2021
(Signature of patient or guardian) (Date)

CERTIFICATION BY THE PHYSICIAN/DENTIST OBTAINING CONSENT

10. I hereby certify that the nature, effect, risks and alternatives of the procedure(s) named in paragraph 1 have been explained to the above named patient or guardian who has consented to it.

_____ Dec. 21, 2021
(Signature of physician/dentist obtaining consent) (Date)

See Reverse Side for Facsimile, Letter or Telephone Use; For Use in an Emergency Situation When Unable to Obtain Consent, or for a Mentally Incompetent Adult; Certification by Interpreter; and treatment for Non-Canadian Residents

CONSENT TO SURGERY
DIAGNOSTIC & TREATMENT PROCEDURES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: SHUMILAK, GEOFFREY
FAM: FRASER,JILLIAN

Indicate below the method of receiving consent, if received by facsimile, letter or telephone. In case of letter or facsimile please attach. In case of telephone consent, there should be two witnesses' signatures obtained below, one of whom shall be a physician/dentist.

Consent Received by: ☐ Letter ☐ Facsimile ☐ Telephone

From: (name) _____ Relationship to patient: _____

Witness: Witness: (Physician)

A. For use when unable to obtain consent in emergency situations.

A. I certify that delay in doing this procedure will seriously endanger the health or life of the patient.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

B. For use when a mentally incompetent adult patient without a guardian is in need of treatment.

B. I certify that this patient, who is a mentally incompetent adult, is in need of treatment and to my knowledge has not previously withheld consent to this treatment. This treatment is necessary and in the best interests of this patient. To my knowledge, this patient does not have a legal guardian.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

CERTIFICATION BY INTERPRETER

I hereby certify that I was present and interpreted consent by Dr. _____ who explained the procedure(s) described in paragraph 1 on reverse.

_____ _____
(Signature of Interpreter) (Date)

TREATMENT FOR NON-CANADIAN RESIDENTS

The patient acknowledges that the treatment/service was performed in the Province of Saskatchewan and that the Courts of the Province of Saskatchewan shall have jurisdiction to entertain any complaint, demand, claim, or cause action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patier hereby agrees that he/she will commence any such legal proceedings in the Province of Saskatchewan and only in the Province of Saskatchewan and hereby submits to the jurisdiction of the Courts in the Province of Saskatchewan.

_____ _____
(Signature of Patient or Guardian) (Date)

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☑ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

CONSENT TO SURGERY DIAGNOSTIC & TREATMENT PROCEDURES

1. I, _____ consent to and authorize Dr. Zheng
(Name of patient or guardian)

and/or such assistants as may be selected by the physician/dentist, to perform the following procedure(s) on _____. Procedure(s): _____
(Name of patient or MYSELF)
Biliary tube insertion

2. The procedure(s) listed in paragraph 1 have been explained to me and I understand the nature of the procedure(s).
3. I recognize that, during the procedure(s), unforseen or unknown conditions may require additional or different procedures than those described in paragraph 1. I therefore further authorize and request that the above named physician/dentist, his/her assistants, or his/her designate perform such procedures as are in his/her professional judgement, immediately necessary and desirable, and such that delay is not feasible and would endanger my life or health.
4. I consent to the administration of an appropriate anaesthetic.
5. I acknowledge that no guarantees have been made to me as to the results of the procedure(s).
6. I agree to the retention of any tissue that may be removed during the procedure(s) for diagnosis, study for quality assurance or improvement purposes, and the disposal of any removed tissue according to approved SHR/SPH practice.
7. I acknowledge that this is a teaching facility and that my physician/dentist may allow professional trainees to participate in the procedure(s) under supervision.
8. In the event a health care worker is exposed to my blood or bodily fluids, I consent to being tested for blood borne pathogens (e.g., HIV, Hepatitis B & C, etc.). I understand that the results of the test will be used to provide appropriate treament for the health care worker. In the event of a positive result, I will be contacted by the appropriate health care personnel and offered follow up treament. I also understand that the Saskatoon Health Region is obligated by law to inform Public Health in the event of a positive result for the purposes of providing appropraite follow up.
9. verbal (Signature of patient or guardian) Feb 2/22 (Date)

CERTIFICATION BY THE PHYSICIAN/DENTIST OBTAINING CONSENT

10. I hereby certify that the nature, effect, risks and alternatives of the procedure(s) named in paragraph 1 have been explained to the above named patient or guardian who has consented to it.

_____ (Signature of physician/dentist obtaining consent) _____ (Date)

See Reverse Side for Facsimile, Letter or Telephone Use; For Use in an Emergency Situation When Unable to Obtain Consent, or for a Mentally Incompetent Adult; Certification by Interpreter; and treatment for Non-Canadian Residents

CONSENT TO SURGERY
DIAGNOSTIC & TREATMENT PROCEDURES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

Indicate below the method of receiving consent, if received by facsimile, letter or telephone. In case of letter or facsimile please attach. In case of telephone consent, there should be two witnesses' signatures obtained below, one of whom shall be a physician/dentist.

Consent Received by: ☐ Letter ☐ Facsimile ☐ Telephone

From: (name) _____ Relationship to patient: _____

Witness: Linda Rodriguez RTR Witness: (Physician) _____

A. For use when unable to obtain consent in emergency situations.

A. I certify that delay in doing this procedure will seriously endanger the health or life of the patient.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

B. For use when a mentally incompetent adult patient without a guardian is in need of treatment.

B. I certify that this patient, who is a mentally incompetent adult, is in need of treatment and to my knowledge has not previously withheld consent to this treatment. This treatment is necessary and in the best interests of this patient. To my knowledge, this patient does not have a legal guardian.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

CERTIFICATION BY INTERPRETER

I hereby certify that I was present and interpreted consent by Dr. _____ who explained the procedure(s) described in paragraph 1 on reverse.

_____ _____
(Signature of Interpreter) (Date)

TREATMENT FOR NON-CANADIAN RESIDENTS

The patient acknowledges that the treatment/service was performed in the Province of Saskatchewan and that the Courts of the Province of Saskatchewan shall have jurisdiction to entertain any complaint, demand, claim, or cause action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patient hereby agrees that he/she will commence any such legal proceedings in the Province of Saskatchewan and only in the Province of Saskatchewan and hereby submits to the jurisdiction of the Courts in the Province of Saskatchewan.

_____ _____
(Signature of Patient or Guardian) (Date)

5033! 1959
5402208788

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☑ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: KANTHAN (CHANDRAKANTHAN), SELLIAH
FAM: FRASER,JILLIAN

CONSENT TO SURGERY DIAGNOSTIC & TREATMENT PROCEDURES

1. I, Richard Fehr (Name of patient or guardian) consent to and authorize Dr. S. Kanthan

and/or such assistants as may be selected by the physician/dentist, to perform the following procedure(s) on _____ (Name of patient or MYSELF). Procedure(s): _____

N. J. Tube.

2. The procedure(s) listed in paragraph 1 have been explained to me and I understand the nature of the procedure(s).
3. I recognize that, during the procedure(s), unforseen or unknown conditions may require additional or different procedures than those described in paragraph 1. I therefore further authorize and request that the above named physician/dentist, his/her assistants, or his/her designate perform such procedures as are in his/her professional judgement, immediately necessary and desirable, and such that delay is not feasible and would endanger my life or health.
4. I consent to the administration of an appropriate anaesthetic.
5. I acknowledge that no guarantees have been made to me as to the results of the procedure(s).
6. I agree to the retention of any tissue that may be removed during the procedure(s) for diagnosis, study for quality assurance or improvement purposes, and the disposal of any removed tissue according to approved SHR/SPH practice.
7. I acknowledge that this is a teaching facility and that my physician/dentist may allow professional trainees to participate in the procedure(s) under supervision.
8. In the event a health care worker is exposed to my blood or bodily fluids, I consent to being tested for blood borne pathogens (e.g., HIV, Hepatitis B & C, etc.). I understand that the results of the test will be used to provide appropriate treament for the health care worker. In the event of a positive result, I will be contacted by the appropriate health care personnel and offered follow up treament. I also understand that the Saskatoon Health Region is obligated by law to inform Public Health in the event of a positive result for the purposes of providing appropraite follow up.
9. _____ (Signature of patient or guardian) FEB 0 9 2022 (Date)

CERTIFICATION BY THE PHYSICIAN/DENTIST OBTAINING CONSENT

10. I hereby certify that the nature, effect, risks and alternatives of the procedure(s) named in paragraph 1 have been explained to the above named patient or guardian who has consented to it.

_____ (Signature of physician/dentist obtaining consent) FEB 0 9 2022 (Date)

See Reverse Side for Facsimile, Letter or Telephone Use; For Use in an Emergency Situation When Unable to Obtain Consent, or for a Mentally Incompetent Adult; Certification by Interpreter; and treatment for Non-Canadian Residents

CONSENT TO SURGERY
DIAGNOSTIC & TREATMENT PROCEDURES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: KANTHAN (CHANDRAKANTHAN), SELLIAH
FAM: FRASER,JILLIAN

Indicate below the method of receiving consent, if received by facsimile, letter or telephone. In case of letter or facsimile please attach. In case of telephone consent, there should be two witnesses' signatures obtained below, one of whom shall be a physician/dentist.

Consent Received by: ☐ Letter ☐ Facsimile ☐ Telephone

From: (name) _____ Relationship to patient: _____

Witness: Witness: (Physician)

A. For use when unable to obtain consent in emergency situations.

A. I certify that delay in doing this procedure will seriously endanger the health or life of the patient.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

B. For use when a mentally incompetent adult patient without a guardian is in need of treatment.

B. I certify that this patient, who is a mentally incompetent adult, is in need of treatment and to my knowledge has not previously withheld consent to this treatment. This treatment is necessary and in the best interests of this patient. To my knowledge, this patient does not have a legal guardian.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

CERTIFICATION BY INTERPRETER

I hereby certify that I was present and interpreted consent by Dr. _____ who explained the procedure(s) described in paragraph 1 on reverse.

_____ _____
(Signature of Interpreter) (Date)

TREATMENT FOR NON-CANADIAN RESIDENTS

The patient acknowledges that the treatment/service was performed in the Province of Saskatchewan and that the Courts of the Province of Saskatchewan shall have jurisdiction to entertain any complaint, demand, claim, or cause action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patient hereby agrees that he/she will commence any such legal proceedings in the Province of Saskatchewan and only in the Province of Saskatchewan and hereby submits to the jurisdiction of the Courts in the Province of Saskatchewan.

_____ _____
(Signature of Patient or Guardian) (Date)

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan
☒ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 41y IP V#10521726 M
ATN: SHAW, JOHN
FAM: UNKNOWN,FAMILY

CONSENT TO SURGERY DIAGNOSTIC & TREATMENT PROCEDURES

1. I, Fehr, Richard (Name of patient or guardian) consent to and authorize Dr. K. Stevenson and/or such assistants as may be selected by the physician/dentist, to perform the following procedure(s) on _____ (Name of patient or MYSELF). Procedure(s): NJ Placement

2. The procedure(s) listed in paragraph 1 have been explained to me and I understand the nature of the procedure(s).

3. I recognize that, during the procedure(s), unforseen or unknown conditions may require additional or different procedures than those described in paragraph 1. I therefore further authorize and request that the above named physician/dentist, his/her assistants, or his/her designate perform such procedures as are in his/her professional judgement, immediately necessary and desirable, and such that delay is not feasible and would endanger my life or health.

4. I consent to the administration of an appropriate anaesthetic.

5. I acknowledge that no guarantees have been made to me as to the results of the procedure(s).

6. I agree to the retention of any tissue that may be removed during the procedure(s) for diagnosis, study for quality assurance or improvement purposes, and the disposal of any removed tissue according to approved SHR/SPH practice.

7. I acknowledge that this is a teaching facility and that my physician/dentist may allow professional trainees to participate in the procedure(s) under supervision.

8. In the event a health care worker is exposed to my blood or bodily fluids, I consent to being tested for blood borne pathogens (e.g., HIV, Hepatitis B & C, etc.). I understand that the results of the test will be used to provide appropriate treament for the health care worker. In the event of a positive result, I will be contacted by the appropriate health care personnel and offered follow up treament. I also understand that the Saskatoon Health Region is obligated by law to inform Public Health in the event of a positive result for the purposes of providing appropraite follow up.

9. _____ (Signature of patient or guardian) MAR 0 8 2022 (Date)

CERTIFICATION BY THE PHYSICIAN/DENTIST OBTAINING CONSENT

10. I hereby certify that the nature, effect, risks and alternatives of the procedure(s) named in paragraph 1 have been explained to the above-named patient or guardian who has consented to it.

_____ (Signature of physician/dentist obtaining consent) MAR 0 8 2022 (Date)

See Reverse Side for Facsimile, Letter or Telephone Use; For Use in an Emergency Situation When Unable to Obtain Consent, or for a Mentally Incompetent Adult; Certification by Interpreter; and treatment for Non-Canadian Residents

CONSENT TO SURGERY
DIAGNOSTIC & TREATMENT PROCEDURES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 41y IP V#10521726 M
ATN: SHAW, JOHN
FAM: UNKNOWN,FAMILY

Indicate below the method of receiving consent, if received by facsimile, letter or telephone. In case of letter or facsimile please attach. In case of telephone consent, there should be two witnesses' signatures obtained below, one of whom shall be a physician/dentist.

Consent Received by: ☐ Letter ☐ Facsimile ☐ Telephone

From: (name) _____ Relationship to patient: _____

Witness: Witness: (Physician)

A. For use when unable to obtain consent in emergency situations.

A. I certify that delay in doing this procedure will seriously endanger the health or life of the patient.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

B. For use when a mentally incompetent adult patient without a guardian is in need of treatment.

B. I certify that this patient, who is a mentally incompetent adult, is in need of treatment and to my knowledge has not previously withheld consent to this treatment. This treatment is necessary and in the best interests of this patient. To my knowledge, this patient does not have a legal guardian.

_____ _____
(1st Physician/Dentist) (2nd Physician/Dentist)

_____ _____
(Date) (Time in hours)

Medical-dental staff to indicate what efforts were made to obtain valid consent and why unobtainable.

_____

_____

CERTIFICATION BY INTERPRETER

I hereby certify that I was present and interpreted consent by Dr. _____ who explained the procedure(s) described in paragraph 1 on reverse.

_____ _____
(Signature of Interpreter) (Date)

TREATMENT FOR NON-CANADIAN RESIDENTS

The patient acknowledges that the treatment/service was performed in the Province of Saskatchewan and that the Courts of the Province of Saskatchewan shall have jurisdiction to entertain any complaint, demand, claim, or cause of action, whether based on alleged breach of contract or alleged negligence arising out of the treatment. The patient hereby agrees that he/she will commence any such legal proceedings in the Province of Saskatchewan and only in the Province of Saskatchewan and hereby submits to the jurisdiction of the Courts in the Province of Saskatchewan.

_____ _____
(Signature of Patient or Guardian) (Date)

SASKATCHEWAN HEALTH AUTHORITY
INPATIENT ADMISSION RECORD

ROYAL UNIVERSITY HOSPITAL

ADM CLERK: ANDRIAMIADANAN

PATIENT INFORMATION:

Name: **FEHR, RICHARD NEIL**
Address: PO BOX 38028
SASKATOON, SK S7N 1H2
Phone: (306)229-7259
Religion:
Alerts: VRE; MDRO

Medical Record #: **1315031**
Visit #: 10521726
HSN #: SK UNKNOWN
DOB: Feb-23-1981
Sex: M
Age: 41y

PRIMARY CONTACT:

Name: FEHR, ANDREA
Address: PO BOX 38028
SASKATOON,SK S7N 1H2
Home Ph: (306)229-7205
Secondary Contact:
Home Ph:

Relationship: SPOUSE
Work Ph:
Relationship:
Work Ph:

ADMISSION INFORMATION:

Nursing Unit: 50U4-5039-1
Admit Date/Hr: Dec-02-2021 08:20
Admitting Diagnosis: CARDIAC ARREST
Att Physician: GILL, DILIP
Fam Physician: UNKNOWN, FAMILY
Resp. For Payment: 10SK
Other Insurance:

Requested Accom: NASK
Admit Category: EMERGENCY
Ref Physician:
Con. Physician: ACUTE CARE, SURGERY

VISIT HISTORY: (LAST 3 VISITS)

Type	*Attending Physician*	*Discharge Date*
1)		
2)		
3)		

MRN	VISIT	HSN
1315031	10521726	SK UNKNOWN

Discharge Summary Dictated: ☐ YES ☐ NO
Operative Report Dictated: ☐ YES ☐ NO

Chart to be dictated by Dr. _____
[Must be Most Responsible Physician, not a Resident]

Date of D/C: MARCH 29, 2022
Initials:

Prepped: Wilma
Scanned: _____
Indexed: _____

Assembled: _____
Coded/Abs'd: _____

1315031

[Date of Service: 29-Mar-2022 00:00, Authored: 29-Mar-2022 00:00]Discharge Summary/Transfer [Charted Location: RUH-5000-Unit 4-5039-01]- for Visit: 10521726, [Signed by: Gill, Dilip (MD) 30-Mar-2022 22:09]; [Entered by: Filed by, Interfaces (Other) 30-Mar-2022 21:50]; [Signed by: Pon, Kendell (Resident) 30-Mar-2022 22:09] General, *Complete, Entered, Signed in Full, General*

MRN: 1315031
NAME: FEHR, RICHARD NEIL
DOB: 23-FEB-1981
VISIT ID: 10521726
HSN:
ATN PHYS: Dilip Gill, MD
FAM PHYS: FAMILY UNKNOWN
ADMITTED: 02-DEC-2021
DISCHARGED: 29-MAR-2022
Royal University Hospital
Discharge Summary/Transfer

MOST RESPONSIBLE DIAGNOSIS: Cardiac arrest secondary to occluded LAD. He had a drug-eluting stent placed on December 2, 2021 and has been anticoagulated since then.

SECONDARY DIAGNOSIS:
1. Ischemic colitis requiring a subtotal colectomy also on December 2, 2021.
2. HIT for which Hematology had been following. Infected intraabdominal hematoma and sigmoid stump leak. Cultures from these collections have grown VRE as well as Bacteroides.
3. Common bile duct stricture, likely secondary to ischemia.
4. Delayed gastric emptying, requiring a prolonged course of TPN as well as nasojejunal feeds.

COURSE IN HOSPITAL: Richard is a 41-year-old male who has been in hospital since December 2, 2021 with a fairly complicated course in hospital. He initially presented December 2, 2022 after a cardiac arrest outside the hospital and received bystander CPR. His resuscitation continued in hospital with ventral ROSC and it seems that he received approximately 9 rounds of CPR and 8 defibrillations. This was found to be secondary to an anterior MI, with an occluded LAD and a drug-eluting stent was placed and he was taken to the CCU postprocedure. He was found to have a rising lactate, hemodynamic instability and a CT showing extensive ischemic colitis with pneumatosis and perforation. He was therefore taken to the operating room later that day on December 2, 2021 for laparotomy, subtotal colectomy, washout and ABThera VAC dressing.

He received ongoing care in the intensive care unit and on December 2, 2021 was taken for formation of an end ileostomy and abdominal closure. He continued to receive care in the ICU for his ongoing sepsis, decreased cardiac function and ventilation needs. On December 22, 2021 he was taken back to the operating room for a relook laparotomy, evacuation of an infected hematoma and repair of a sigmoid stump leak. He was transferred out of ICU to the General Surgery ward on December 25, 2021. A brief summary of his issues in hospital will be detailed below.
1. Cardiac: As detailed above, he had an MI secondary to an occluded LAD and had a drug-eluting stent placed and was on dual antiplatelet therapy. At one point, his echo post MI showed an ejection fraction of 10-15% and he did require on dobutamine for an extended period of time in the ICU. A repeat echo showed improved cardiac function and he was eventually able to be weaned off of vasopressors and inotropes. He, unfortunately, developed HIT while on heparin and fondaparinux and was therefore, treated for a short period on

_____ Cardiology and Hematology were both consulted several times throughout his stay for anticoagulation management periprocedure. Currently, he has been on warfarin, aspirin and Plavix. His INR goal is 2-3 and he was receiving daily dosing of warfarin while in hospital to achieve this goal now. I should also note that he did require intermittent transfusions throughout his stay, as our hemoglobin goal was greater than 90, given his post cardiac arrest status.

2. GI: His surgeries are as detailed above and further details may be found in operative reports; however in summary on December 2, 2021 he had the laparotomy, subtotal colectomy and placement of an ABThera dressing and was taken back to the operating room on December 7, 2022, for his relook abdominal closure and end ileostomy. Subsequently, while he was in the ICU he also had a left upper quadrant percutaneous drain placed into what was seen to be a hematoma. He unfortunately had ongoing sepsis and was taken back to the operating room on December 21, 2021, at which time, an infected hematoma was evacuated and a sigmoid stump leak was oversewn. That previously placed percutaneous drain was left in place at the time of that OR and continues to be left in situ. There is ongoing purulent and feculent material being drained and this percutaneous drain will continue to be left in place in the meantime. At the time of his OR, his pancreas was also seen to be ischemic in appearance, however, did not require much further intervention or therapies. All the rest of the drains that had been placed at the time of the procedure on December 21, 2021, have been removed and his only remaining drain is the left upper quadrant percutaneous drain.

3. Intraabdominal sepsis and bacteremia: Infectious Disease has been closely following Richard intermittently throughout his stay. They have very detailed progress notes on SCM detailing of his cultures and changes in antibiotic management, especially regarding multidrug resistant bacteria. Most recently, he has grown VRE and Enterobacter cloacae, for which he will be continued on meropenem and daptomycin. He has also struggled with PICC line infections and Infectious Disease has given recommendations regarding his ongoing antimicrobial therapy.

4. Common bile duct stricture thought to be secondary to ischemia: After his transfer out of the intensive care unit to the ward, Richard began to develop significant jaundice and increasing liver enzymes. There was a mixed picture where this was thought to be potentially secondary to his prolonged course on TPN. However, this was able to be weaned and he continued to have increasing enzymes and jaundice. He did undergo some extensive investigations for this including an ultrasound, which showed mild intrahepatic duct dilatation and a common bile duct measuring 6 mm on January 17, 2022. Unfortunately, his percutaneous drain was MRI incompatible and was exchanged on January 25, 2022. He subsequently underwent an MRCP on January 28, 2022, which demonstrated a fairly long common bile duct stricture. Gastroenterology was consulted, who initially attempted ERCP on January 31, 2022, which was not successful due to significant swelling. He therefore went on to have an internal external biliary drain placed on February 2, 2022 by Interventional Radiology, which did provide had the necessary biliary head decompression. This did need to be revised on February 14, 2022 and on February 22, 2022, he had a repeat ERCP at which time a common bile duct stent was placed and his PTC removed. He did have repeat ERCP on March 25, 2022, at which time the CBD stent was removed; however, at this time, the dictation from this procedure is pending.

5. Delayed gastric emptying: Richard did struggle significantly with nutrition and delayed gastric emptying throughout his stay, after transfer out of the ICU. He had not been fed in a very long time and was quite hesitant to begin eating again. This was slowly increased; however, he was unable to tolerate any significant amount of oral intake to maintain his nutritional status. Dietary was very involved in his care and he was continued on TPN for a very long time, before this was eventually weaned a few weeks prior to his discharge. He did struggle with ongoing intermittent vomiting and did not tolerate NG feeds. I should note that he was trialled on several prokinetics during his stay, as well as a variety of antiemetics and did not seem to receive much benefit from any of these. He therefore had an NG placed and seemed to tolerate this better. Unfortunately, this needed to be replaced and revised several times, both in the interventional radiology suite as well as in endoscopy. Eventually, he was meeting his calorie count and protein count goals, just with a regular diet and as he had no ongoing troubles with vomiting, he was able to just be maintained on a regular diet, without the help of tube feeds or parenteral nutrition in the week leading up to his

discharge.
6. Wounds: Richard also developed several superficial abscesses at the site of his prior drain site replaced at his December 21st OR. These were superficial and mostly did decompress spontaneously draining pus. He did get daily packing changes to these areas and these did also dry up near the end of his stay and did not require and any further intensive wound care.
7. Deconditioning: Richard was severely deconditioned coming out of his long stay in the intensive care unit. I he did work quite intensively with the physiotherapist and occupational therapy to regain his strength and again in the several weeks leading up to his discharge, was ambulating well with no additional support and there were no outstanding concerns regarding his functionality to return home.

DISCHARGE PLAN:
1. From a General Surgery point of view, he will follow up with Dr. Gill in 6 weeks' time for review. His percutaneous drain is to remain in place at the current time, pending upcoming reassessment.
2. We have spoken to Dr. Peermohamed from Infectious Disease, who has given recommendations regarding his antibiotic management. Richard will require a PICC line for long-term IV antibiotics including daptomycin and meropenem, which are to continue for at least 4 weeks. Per Dr. Peermohamed's request, we have arranged for an outpatient CT scan in 4 weeks' time to reassess his intraabdominal collections. We have also arranged for weekly lab work.
3. Regarding follow-up from a Cardiology point of view from it had been previously instructed from to follow up with Dr. Bree in 3 months' time. Again, his INR goal is 2-3 and he has been given outpatient lab requisitions to follow this. If he requires titrating of his warfarin, copies have been sent to his family physician so that this can be adjusted if needed. There were also instructions from earlier in his stay that he is to follow up with Dr. Pearson from Hematology in 3 months' time and this note has also been copied to him.
4. CPAS Home Care has also been arranged to continue providing ongoing support and care for his percutaneous drain at home. His wife, Andrea, does have a nursing background and is fairly comfortable managing this herself, as well as some administration of the IV medications. However, Home Care and the Home IV program have both been arranged, in case extra support is required.
5. Regarding follow-up from a gastroenterology point of view regarding his common bile duct stricture, the procedure report from his ERCP March 25, 2022 is currently pending; however, we will leave any further followup at the discretion of Dr. Bedi or Dr. Haimanot to perform these procedures.

It was a pleasure to be involved in Richard's care. We wish him all the best going forward. Should he have any questions or concerns, especially regarding increasing pain, nausea, vomiting, fevers or any other concerns, he has been counselled to return to RUH as needed. He and his wife did not have any further questions at this time.

Dictated by: Kendell Mackenzie Pon, RESIDENT

_____
Dilip Gill, MD

This document has been dictated and may have been distributed before being read. Any corrections to this document must be made within thirty (30) days following the transcription date.

KMP/MODL
DD: 2022-Mar-30 00:34:11
DT: 2022-Mar-30 21:50:45
Job #: 58060574/58060574

cc: Dilip Gill, MD
Jillian Fraser, MD
Derek S Pearson, MD
Shaqil Peermohamed, MD
Teresa L Bree, MD

MD Admission Note-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 05-Dec-2021 23:27, Authored: 05-Dec-2021 23:27]- for Visit: 10521726, *Incomplete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

ASSESSMENT:
Service: ICU
Identification: 40M smoker post-cardiac arrest and ischemic bowel Sgx
History of Presenting Illness: Patient was admitted on December 2nd for a cardiac arrest and brought to the cath lab in the context of an acute MI. He has 1 DES put in his LAD at the time.

From the cardiac arrest standpoint, he had CPR done with bystander and achieved ROSC. He was shocked multiple times during ambulance transport has had no pulse and VT/VF signals. He initially received amiodarone boluses, narcan, epi (multiple). AT ER, first pulse check was PEA then ROSC. Defibrillated multiple times, CPR 30 seconds fur absent pulse and amiodarone infusion started and lidocain given. Intubtion was grade 1 at ER. Unclear how long he was CPR'ed for in the community. He was seen moving all 4 limbs when neuro status checked with decreased sedation in CCU.

He was anticoagulated until now with heparin initially then DAPT until OR.

He arrived in ICU intubated and sedated post-E1 laparotomy. Handover (brief) and OR note pertinent for necrotic colon (ascending, transverse and descending) with viable sigmoid, viable small bowel although patchy areas of possible duodenal ischemia v. staining. There was also evidence of areas of pancreatic necrosis. The surgery was a subtotal colectomy with VAC placement and open abdomen.
Past Medical History: Current smoker
Past Surgical History: Unknown
Review of Systems: Non contributory
Social History: Wife is next of kin, she has a nursing background. Occasional ROH, no drugs/IVDU. Works at U of S dairy.
Allergy Details: NKDA
Pre-Admission Medications: No active meds as per eHR.
Double vaccinated as seen in eHR (Pfizer)
Physical Exam: CNS: PEARL but constricted. RASS -3,-4. Propofol 30 Dilaudid infusion 1 mg/h
CV: HR 100-105 Sinus rhythm on monitor. Previously on amiodarone. Norepi 0.16, Dobutamine 2
RESP: PCV PEEP 10 RR 16 TV 500 FiO2 40%
GI: VAC in place, abdomen distended but not hard
GU: Concentrated urine in Foley
Heme-ID: No sign of overt bleeding.
Relevant Investigations: Recent blood ICU pending
Post-op TEG normal. 24% of Ticagrelor activity.
CXR pending

TTE 2-12-2021: EF 15% Grade 1 DD, regional wall abnormalities. RV normal in size, systolic function mod-sev reduced. No thrombus or effusion

MOST RESPONSIBLE DIAGONSIS:

Most Responsible Diagnosis: Immediate post-operative for E1 laparotomy

PROBLEM LIST:

Active Issues and Plan: 1. Immediate post-operative period: Subtotal colon resection.
- Likely pancreatic ischemia +- necrosis.
- Will keep RASS -4,-5
- CV support, fluid and r/a of heart function. May be uptitrating Dobutamine if cardiogenic seems to be culprit. Will resume amiodarone if Dobu increased.
- Keep on PSV for now as not planning extubation
- NPO strict and IV meds. R/A for TPN in morning
- Continue Tazocin for intra-abdominal SIRS

2. CV: Post-cardiac arrest and EF15%
- On Dobutamine 2 so far and increasing Norepi needs. Will follow up with SvcO2 and pending labs including lactates

3. Pancreatic ischemia +- necrosis. Ringer's PRN and pain control. NPO

Dean Ferguson PGY5 Respirology

Electronic Signatures:
Ferguson, Dean (Resident) (Signed 06-Dec-2021 06:28)
Authored: *Patient HSN, Physician Admission Note*

Last Updated: *06-Dec-2021 06:28 by Ferguson, Dean (Resident)*

[redacted]

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH Other ________

Patient Label

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: SCHOONBAERT, IAN
FAM: FRASER,JILLIAN

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

DATE: Dec 6,2021 **PLEASE CHECK**

TO: DR. KANTHAN SERV. NSS URGENT ☐

FROM: DR. Schoonbaert SERV. ICU ROUTINE ☐

CONSULTATION NOTIFIED ☐ DATE/TIME: ____________

NURSING UNIT & ROOM NO.: 5321-2

REQUEST:

TPN Assessment.

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☐ TRANSFER TO YOUR CARE

SIGNATURE: ____________

40 year old male admitted to RUH after being found down on sidewalk - cardiac arrest - CPR by bystander Dec 2. Upon tx pt taken to cath lab. Findings - clot distal LAD - stented & tx CCU. Dec 5 - pts abdomen became distended & ↑ lactate. CT - free air with evidence of bowel ischemia → OR - laparotomy, subtotal colectomy, abdominal washout & application of vac dressing. Plan to take back in 24-36 hours. Other findings - pancreatic ischemia +/- necrosis - viable sigmoid

PMHx: Smoking, tonsillectomy

Meds: Noted propofol, dobutamine, norepi

Labs Dec 6 - Na-136 K-5.5 Cl-103 CO_2-23 urea-12.5 creat-134 mg 1.10 PO_4-1.66

Anthros: 80kg (Dec 2 - ECG report) 182cm UBW ~ 80kg
IBW - 63-82.5kg - 100% UBW & IBW

Nutrition hx: enteral feeds - Promote until Dec 5 (1:1 with propofol)
UTO details prior to admission

Nut. dx: Altered GI fx related to bowel ischemia as evidenced by urgent lap & bowel resection with open abdomen.

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: ______

R'ments: 25-30 kcal/kg = 2000-2400 kcal
1.5-2 g pro/kg = 120-160 g pro/d.

DATE: Dec. 6, 2021. W. Larocque, RD for Dr. Kanthan

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

Plan ① Start central - 100 ml/hr = 2140 kcal 151 g pro,

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SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☒ RUH ☐ SCH ☐ SPH Other ________

Patient Label

SK UNKNOWN
RUH 1315031 V#10521726
FEHR, RICHARD NEIL
FEB-23-1981 40y IP M
ADM: DEC-2-2021
ECKSTEIN, JANINE

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

DATE: 06/12/21 PLEASE CHECK

TO: DR. Gill SERV. ACS URGENT ☐

FROM: DR. Eckstein SERV. ICU ROUTINE ☐

CONSULTATION NOTIFIED ☐ DATE/TIME: 05/12/21.

Ⓓ 527629.

NURSING UNIT & ROOM NO.: CCU-9.

REQUEST:

Ischemic Bowel.

SIGNATURE: ____________________

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pH / CO_2 / O_2
7.30/50/42/108

131 | 99 | (167)
(5.6) | 20 |

7.20 / 112 / 211

Lactate 3.9 (arterial)

HPI

40M found unresponsive/unconscious by bystander. CPR initiated. DEC 2.
→ RUH.
→ CPR
→ Cath Lab.
→ clot in distal LAD
→ EF 20-25%.

– Repeat echo EF 15%.
→ a kinetic septal, anteroseptal + inferior
– Last BM Dec 3rd.

PMHx
Ø

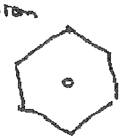
PSHx
Tonsillectomy

Meds
Ø

Allergies
Ø

Social Hx
Smoker pack/day
Lives in Saskatoon
Double vaccinated
MJ/vaping

O/E: Heparin. low dose nomogram
Dobutamine infusion
Amiodarone infusion
Distended.
Peritonitic



CTAP
⊕ free air
pneumatosis Ascending through transverse colon. SB dilated
Pancreatic tail infarct
Origin of Celiac artery could not be seen but downstream patent.
Air in iliac vein
Ø portal venous gas.
SVC flat, adrenal hyperenhancing.
I/P Ischemic bowel w perforation
① EI laparotomy + bowel resection.
Discussed w wife.

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: ______

DATE: Dec 5, 2021 20:38

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

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WHITE – PATIENT CHART YELLOW – CONSULTANT PINK - ATTENDING

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☑ RUH ☐ SCH ☐ SPH Other _____

Patient Label

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

DATE: Dec 14, 2021

PLEASE CHECK

TO: DR. Pearson SERV. Heme URGENT ☐

FROM: DR. Eshtaya SERV. ICU ROUTINE ☑

CONSULTATION NOTIFIED ☑ DATE/TIME: Dec 14, 2021

NURSING UNIT & ROOM NO.: RUH ICU 3321-2

REQUEST:

40 year old man w/ MI + cardiac arrest + subtotal colectomy + ileostomy w/ tinzaparin site erythema/blackening, HIT assay ⊕, assistance w/ mgt of HIT/skin necrosis

SIGNATURE: G. Robson R2 on behalf of Dr. Eshtaya

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TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: _____

DATE: _____

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

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Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ○

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

Patient Label
Richard Fehr.
540 228 788
Feb 23/81

DATE: Dec 15/21.

PLEASE CHECK

TO: DR. Pylypchuk SERV. Cardio URGENT ☐

FROM: DR. ______ SERV. ______ ROUTINE ☐

13.6 / 89 / 442 138 / 3.8 / 100 / 26 / 13.8 / 12 / 67

CRP 210 (Dec 14)

CONSULTATION NOTIFIED ☐ DATE/TIME: ______

NURSING UNIT & ROOM NO.: ______

VBG 7.47/40/36/29
BE 5

REQUEST:

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PMHx : ø
SHx : smoker cigs + THC.
Meds : ø at home.
ICU : Fondaparinux, atorva, ASA, metoprolol, metolazone, pantoloc, insulin, ticagrelor, meropenem, TPN

SIGNATURE: ______

Thank you!

40 M a/w OHCA Dec 2 rec'd CPR, shocked multiple times, unknown down time

Angio LAD → DES x1 prox LAD + asp. thrombectomy. Clot embolization distal LAD → left alone

2° HD instability. cooled + IABP. EF 15-20%. ø thrombus.

Dec 5: - ischemic bowel → subtotal colectomy
- pancreatic ischemia +/- necrosis

Dec 7: - relook laparatomy + removal VAC drsg + washout
- formation end-ileostomy
- abd wall closure.

O/E: 79 127/61

Chest clear. AE ↓ @ bases
HS Ⓝ flow murmur @ apex
Abdo distended. tender. guarding
necrotic area x 2 (HIT)
Ped Ed R > L, R cooler.
Arm Ed L > R.

A/P: - OHCA c̄ LADp as culprit → DES
- Cardiogenic shock / septic shock resolving
- ischemic Bowel c̄ subtotal colectomy + ileostomy
- pancreatic ischemia / necrosis
- necrotic skin 2° HIT

} continue ongoing management, can step down unit.

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIALS ______

DATE: Dec 15 16:05h.

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

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[signature] Rg

WHITE – PATIENT CHART YELLOW – CONSULTANT PINK - ATTENDING

Saskatoon Health Region

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Saskatoon, Saskatchewan

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Patient Label

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

DATE: Dec 17

PLEASE CHECK

TO: DR. MDhammad SERV. ID URGENT ☐

FROM: DR. Bree SERV. Cardio ROUTINE ☐

CONSULTATION NOTIFIED ☒ DATE/TIME: 10:55

NURSING UNIT & ROOM NO.: _____

REQUEST: Please see this 40 y. M c OHCA → LAD Compl ischemic bowel s had subtotal colectomy - on Meropenem, however developed Pneumosepsis now while on Meropenem. Pls advise on abx for Pneumosepsis. Thank you.

SIGNATURE: _____

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TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: _____

DATE: _____

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH Other ________

Patient Label

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

DATE: Dec 18, 2021 PLEASE CHECK

TO: DR. Gebhardt SERV. ICU URGENT ☐

FROM: DR. Bree SERV. Cardio ROUTINE ☐

CONSULTATION NOTIFIED ☐ DATE/TIME: ________

NURSING UNIT & ROOM NO.: ________

REQUEST: Please see re: suspected intraabdominal abscess.

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SIGNATURE: [signature]

40 yo M.

PMHx
anterior STEMI
revascularized DES
↳ EF ~20's
Ischemic gut – subtotal colectomy / end ileostomy
pancreatic ischemia.

Allergy
Heparin – HITT
?

see p(?)

HPI
see prev notes for details of admission on Cardio and issues including ↑ ostomy output ? conservatively
Surgery.
This AM ↑HR 130 → 150 over today
RR 30 → 60. febrile @ 39°.
Sys 120 → 100's.
Abdo pain worse today, NG placed to LCS.
Tube feed off 1450.
Total volume in 2.8 L.
U/O ↓ today
lactate ②.
CT → evolving pancreatic necrosis → maybe maturing into collection.

Plan
Admit
Broaden Abx. to mero / vanco.
A line
NE.
GSx consultation ongoing and IR drain to collection once mature
Ann(?) [signature]
for Dr Gebhardt

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: ______

DATE: ________

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

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5033

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH Other ________

Patient Label

NAME: ________
HSN: ________
D.O.B.: ________

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: GILL, DILIP
FAM: FRASER,JILLIAN

DATE: Feb 19, 2022

PLEASE CHECK

TO: DR. Gill Dilip SERV. ________ URGENT ☐

FROM: DR. ________ SERV. ________ ROUTINE ☐

CONSULTATION NOTIFIED ☐ DATE/TIME: ________

Fondaparinux 2.5 Dec 12-14
Fondaparinux Full dose Dec 14-20
" Prophylactic dose Feb 1-7

NURSING UNIT & ROOM NO.: ________

REQUEST:

INR subtherapeutic since Feb 12

Pre op anticoagulation — has PEG tube
⇒ Procedure: ERCP on Feb 22 c̄ sphincterotomy, stent

SIGNATURE: ________

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HIT assay ⊕ Dec 12
today: PLT 438 Hb 96
: INR 1.4
Bili 4⊕
ALT 76 AST 39
80 kg

RFC: anticoagulation peri op

40 y/o M c̄ long H stay. / recent Dx of [DVT on Dec 21, 2022 / HIT⊕] warfarin

HPI Initially had cardiac arrest (OHCA) / MI requiring ICU admission, and DES to LAD, course complicated c̄ [Ischemic bowel (hypotension) / Subtotal colectomy Dec 5]
Echo post MI → EF 10-15% → improved some.

40 y/o M c̄ | recent DES to LAD | HIT | DVT Dec 21

Pancreatic ischemia & necrosis
Dec 7 second laparotomy / washout formation end ileostomy and abdo wall closure
Intraabdominal inf VRE — on linezolide cipro/Flagyl
Dec 21 in fected hematoma, sigmoid stump leak (laparotomy washout / repair)
Perc drain Dec 19
last check Feb 4
ERCP Jan 31 ischemic long biliary stricture received sphincterotomy and biliary stent

(1) ? R/c anticoagulation / DAPT

(1) DAPT continue if possible (recent LAD DES Dec 21)

(2) A/C: ERCP Feb 22
INR subtherapeutic since Feb 12
INR 1.4 today / Spoke to Hematology:
⇒ Hold warfarin → start Fondaparinux 2.5 OD x 2 days then restart post op c̄ bridge to warfarin

Call GIM if any concerns.

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: ________

DATE: ________

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

Word Form #103922 07/15 Category: Consults

WHITE – PATIENT CHART YELLOW – CONSULTANT PINK - ATTENDING

MRI (P) - potentially tomorrow!

ECG QTc 448.

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH Other ________

INR 2.2.

ALT 114
AST 203.
ALP 1698
GGT 794
TBili 184

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

Patient Label

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: GILL, DILIP
FAM: FRASER, JILLIAN

DATE: Jan 26/22

PLEASE CHECK

TO: DR. Ubhi SERV. GIM URGENT ☐

FROM: DR. Gill SERV. ACS ROUTINE ☐

CONSULTATION NOTIFIED ☐ DATE/TIME: ________

109 / 318 / 390.

NH3 86. → 36.
BCx Jan 18 (-).

133, 99, 0.9
3.5, 21, 36
Mg 0.66 PO4 0.96.
Ca 1.98

NURSING UNIT & ROOM NO.: 5013

REQUEST: Please review re: Confusion, ?hepatic encephalopathy. Climbing bilirubin & transaminases, INR rising despite warfarin held. Worse Confusion. Complex admission: Cardiac arrest w/ Stent to LAD, ischemic colon, infected hematoma. On ACS for drains, infection/Abx & feeding. Thanks!
MRCP pending

SIGNATURE: M Russell

☐ CONSULTATION ONLY
☐ CONSULTATION THERAPY
☐ TRANSFER TO YOUR CARE

CT Abdo Jan 11.
Stable bilat pleural effusions.
Pancreatic tail necrosis.
Fluid gas collection in (L) paracolic gutter.
↑ mucosal enhancement of small bowel

Abdo U/S Jan 17.
GB debris/sludge, ø cholecystitis.
CBD @ ULN (6mm), mild intrahepatic bile duct dilation.

Hospital course Mom @ bedside.
Initially p/w as OHCA ū unknown downtime + received LAD DES x1, but complicated by distal embolization. Course complicated by ischemic bowel requiring subtotal colectomy + end ileostomy.
HIT, (L) DVT, intra abdo sepsis (VRE, bacteroides, parabacteroides)
Worsening confusion.
ū rising LE + bilirubin. INR up to 6.8 Jan 25, given Vit K 10'
LE pattern predominantly cholestatic.
Worsening confusion o/n, NH3 ↑, started on lactulose, NH3 normalized.
Warfarin held

	20	21	22	23	24	25	26.
INR 2.1	2.2	3.3	4.8	5.0	5.9	6.8	2.2.
warfarin 4	4	3	2	2	–	– ↑ VitK	2.

Minimal Ativan use, Gravol
Hallucinations - VH/AH only as pt falls asleep + closes eyes. Otherwise A+O x3 always. Poor sleep. Worse in x1wk.
since arrest but worse x1 wk
Poor appetite
wt ↓ x 1wk — NG
+ PO intake.
ø infectious sx.

Profile
1. CAD - p/w OHCA + unknown downtime. DES to prox LAD, clot embolized to distal LAD.

Meds
Metronidazole 500 q8h.
Cipro 400 q12h.
Plavix 75; ASA 81.
Linezolid 600 BID.
Atorva 80 HS.
Warfarin 2mg today.
Acetaminophen 975 Q6H.
Pantoprazole 40 OD.
Ramipril 2.5 OD.
Metoprolol 12.5 BID.
Gravol PRN
Dilaudid 0.5-1mg IV q2h PRN

A/P 40M complicated course in hospital following cardiac arrest now ↑ delirium in context of rising cholestatic liver enzymes, ↑ INR + ↑ NH3.
(1) Confusion: Only ū falling asleep ? Hypnagogic hallucinations - ø evidence of asterixis on exam but poor sleep could indicate ↓ grade HE. Low suspicion of infectious cause given afeb + (N) wbc. ~~Continue lactulose for now, though~~ given ø Δ ū lactulose, would d/c. D/C Ativan → trial ~~seroquel~~ for sleep. melatonin.
(2) ↑LE: ? intrahepatic cause (P) MRCP. Unlikely liver failure given (N) plt. ↑INR. ? also 2º2 fluctuating PO intake given good correction ū Vit K. Order fractionated bili + PBS to r/o hemolysis given 2unit PRBC required yesterday.

C. Yim R3

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: ________

DATE: Jan 26/2022

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

Word Form #103922 07/15 Category: Consults

WHITE – PATIENT CHART YELLOW – CONSULTANT PINK - ATTENDING

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH Other _____

Patient Label

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
LLIAMTN: KANTHAN (CHANDRAKANTHAN), SEL
FAM: FRASER,JILLIAN

PRACTITIONER STAFF AFFAIRS
CONSULTATION REQUEST

DATE: Feb 24/22

PLEASE CHECK

TO: DR. Stevenson SERV. NSS URGENT ☐

FROM: DR. Ogaick SERV. ACS ROUTINE ☐

CONSULTATION NOTIFIED . ☐ DATE/TIME: _____

NURSING UNIT & ROOM NO.: 5005-3

REQUEST:

NJ re-insertion

☐ CONSULTATION ONLY
☐ CONSULTATION THERAPY
☐ TRANSFER TO YOUR CARE

SIGNATURE: _____

Pt has been followed by NSS since Dec 6/21 (see NSS initial consult Dec 6/21). He has been on a combination of TPN + NJ enteral feeds but NJ removed for ERCP Feb 22/22.

Pt requires NJ re-insertion in IR.

Paxed

TRANSFER ACCEPTED? YES ☐ NO ☐ INITIAL: _____

DATE: Feb 24/22

Christine Salamy RD #10550

Salamy RD for Dr. Stevenson

CONSULTANT'S SIGNATURE/PRINT CONSULTANT'S NAME

Word Form #103922 07/15 Category: Consults

WHITE – PATIENT CHART YELLOW – CONSULTANT PINK - ATTENDING

MD Consultation Request-ID [Charted Location: RUH-5000 Unit 1-5005-03] [Date of Service: 11-Mar-2022 11:30, Authored: 11-Mar-2022 11:30]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

Health Issues:
ED HEALTH ISSUES:
Infection Cntrl:
VRE: Onset Date: 19-Dec-2021, Status: Active, Last Modified By: Matschke-Neufeld, Rhianna

Referring Physician:
CARE PROVIDERS:
Kanthan (Chandrakanthan), Selliah(Attending): Royal University Hospital, General Surgery Department, 103 Hospital Drive, Saskatoon, SASKATCHEWAN S7N 0W8, Business, 306 844-1082
Acute Care, Surgery(Consulting):
Unknown, Family(Family):

CONSULTING PHYSICIAN:

Consulting Physician:

• **Service**	ID

PATIENT CONTACT INFORMATION:

• **Patient Name**	FEHR, RICHARD NEIL
• **Address**	PO BOX 38028, SASKATOON, SASKATCHEWAN, S7N 1H2
• **Phone Type**	Home
• **Phone Number**	306 2297259
• **HSN**	SKUNKNOWN 10SK

Consultant Note:
CONSULTANT NOTE:
• **Consultant Note:** Asked to see patient regarding Candida albicans growth in drain.

From my previous consult:

40M admitted Dec 2 after presenting with out of hospital cardiac arrest secondary to ACS. Had DES to LAD at that time. Resultant ischemic bowel requiring E1 laparotomy. Subtotal colectomy with end-ileostomy and rectal stump. Evidence of necrotic colon as well as possible duodenal ischemia and pancreatic necrosis. Admitted to ICU post op Dec 5. Was started on Piptazo then.

Taken back to OR Dec 7 for second look. Remaining bowel health but edematous.

In ICU was pancultured which demonstrated E. cloacae in sputum. Was changed from Piptazo to Meropenem Dec 10. Started to notice around that time that he had what was described as bilateral abdominal hematomas. Areas of erythema with central blackening occuring at tinzaparin injection sites. Was changed to fondaparinux and HIIT assay ordered and positive.

Transferred to GenSx ward Dec 15. First mention of rash Dec 17 when noted to have a macular rash to his trunk and arms bilaterally as well as low grade temp. ID consulted at that time and suspected to have beta-lactam induced rash and changed to Cipro Metro Dec 17. Was having tachycardia and fever at that time. Dec 18 started to develop increasing abdo pain along with persistent fever. Had CT done Dec 17 that showed "collection near the pancreatic tail has

enlarged in size now measuring 7.2x 3.7 x 2.8 cm (AP x TV x CC); however there is no peripheral enhancement to suggest an organized abscess."

Was transferred back to ICU Dec 18 and was started on Piptazo plus vanco and caspofungin. Mentioned that he had rash in the ICU readmit note. Had IR guided drain insertion Dec 19 which grew VRE and bacteroides. Was started on Linezolid Dec 21 and vanco stopped. Had repeat CT done Dec 21 that showed "worsening peripancreatic and retroperitoneal fluid accumulation with probable fat necrosis and hemorrhagic pancreatitis. A large retroperitoneal collection is seen at the level of the sigmoid staples with fluid and gas bubbles present in the vicinity of the sigmoid colon staples. This is highly suspicious for anastomotic dehiscence. A gas forming organism can also form bubbles. This fluid is also mixed density suggesting it has hemorrhage within it. Generalized peritoneal fluid is now seen. Some of the new peritoneal fluid has gas bubbles and air-fluid levels within it in the left lower quadrant. This could be either from a gas-forming organism or from the bowel anastomotic dehiscence." Also noted to have thrombosis so was changed to argatroban.

Went to the OR that night for laparotomy. Had evacuation of infected hematoma, wash out, repair of sigmoid stump leak and repair of tear. Cultures collected at that time grew VRE and parabacteroides species (swab, not tissue). Caspofungin stopped Dec 25 and continued on Piptazo and Linezolid. Piptazo changed to Amoxiclav Dec 31 then stopped Jan 11. Linezolid stopped Jan 5.

Mid January started to develop delirium in the context of elevated liver enzymes and E. cloacae bacteremia. Was started on Cipro plus Metronidazole and Linezolid January 13. Linezolid stopped Feb 12. Cipro and Metro are ongoing.

Elevated LE were thought to be due to ischemic stricture in the CBD. Failed ERCP due to too much edema at the site. Therefore had a percutaneous biliary drain placed and had response in LE's and eventually had ERCP for stent placement and biliary drain removed. Had a CT Feb 12 which showed There has been improvement of the abscess collection in the left abdomen with presence of a pigtail catheter drain and intimate with suture line for the rectal stump and tail of pancreas which was necrotic.

For some reason, March 6 he had bacterial fungal cultures sent off of a long standing pigtail drain. I am not sure the reasoning. There was mention of patient having one episode of vomiting the day prior. No other documentation regarding reasoning. Cultures growing E. cloacae which was previously sensitive to Cipro and C. albicans (only on the fungal culture thus far). Looking at vitals at the time, no documentation of fever, increased tachycardia or hypotension.

Patient states feels well. States has 1 episode of vomiting every 5 days. No fevers, chills or sweats. Has some discomfort related to the NJ tube but no issues prior. No thrush.

On exam: Afebrile and vitals stable. Looks like has gained some weight as compared to when I last saw him. Formed stool in ostomy. L sided pigtail draining small amount purulent fluid. Pt states drainage has slowed down quite a bit. Abdomen soft and non tender. No oral thrush.

Labs:
ALP 260, AST, ALT, Bili N
CRP 14.8
CBC, Cr N.

Micro:
March 6 old JP site: Mod PMN, Abundant GNB, mod E. cloacae

March 6 old JP site fungal culture: C. albicans

Imp/Plan:
41M with complicated course as outlined above. ID asked to see regarding C. albicans from drain. Patient clinically well and not clear why drain culture was collected. Patient overall quite well and responding to current therapy. Very common to have yeast colonize catheters particularly in the context of broad spectrum antibiotic use. No evidence of disseminated infection. Will do blood cultures given on TPN to insure no invasive candidiasis.

Suggest:
1. Do not need to treat the candida growth in drain at present.
2. Blood cultures to insure no candidemia. If blood culture positive for yeast, start Caspofungin, get ECG to see what QTc is and call ID back.
3. FU susceptibilities of E. cloacae growth from pigtail drain. If it comes back Cipro R may need to change to TMPSMX. Could do Meropenem but pt previously had ?rash to Meropenem although not quite clear regarding details.
4. Repeat imaging of abdomen to assess size of abscess given last scan 4 weeks ago. If abscess resolved then abx can be stopped.

ID will not actively follow. Please call back if yeast grows in blood or if any further questions.

Electronic Signatures:
Henni, Amina (Sarah) (MD) (Signed 11-Mar-2022 12:10)
Authored: *Health Issues, Referring Physician, Consultant Note*

Last Updated: *11-Mar-2022 12:10 by Henni, Amina (Sarah) (MD)*

[Date of Service: 26-Jan-2022 00:00, Authored: 26-Jan-2022 00:00]Consultation [Charted Location: RUH-5000 Unit 1-5013-01]- for Visit: 10521726, [Signed by: Ubhi, Charanpreeti (MD) 26-Jan-2022 16:47]; [Entered by: Filed by, Interfaces (Other) 26-Jan-2022 16:44]; [Signed by: Yim, Carly (Resident) 26-Jan-2022 16:47] General, *Complete, Entered, Signed in Full, General*

MRN: 1315031
NAME: FEHR, RICHARD NEIL
DOB: 23-FEB-1981
VISIT ID: 10521726
HSN:
CONS PHYS: Charanpreeti Ubhi, MD
FAM PHYS: Jillian Fraser, MD
DATE SEEN: 26-Jan-2022
LOCATION: 50U1 IP ADM: 02-DEC-2021
Royal University Hospital
Consult

REASON FOR CONSULTATION: Confusion in the setting of increasing liver enzymes, bilirubin, and INR, query hepatic encephalopathy.

PATIENT PROFILE: Prior to this hospital admission, Mr. Fehr was previously healthy with no past medical history. He was admitted following an out-of-hospital cardiac arrest and subsequently received a drug-eluting stent to the LAD.

HISTORY OF PRESENTING COMPLAINT: Mr. Fehr was seen with his mother, Doreen, at bedside. Mr. Fehr initially presented with an out-of-hospital cardiac arrest with unknown down time and received several shocks. He eventually achieved ROSC and received an LAD drug-eluting stent, but this was complicated by distal LAD embolization. His course was subsequently complicated by ischemic bowel requiring a subtotal colectomy and end ileostomy. He also developed a postoperative left DVT on this admission and then subsequently HIT, for which he was started on argatroban and is now anticoagulated with warfarin. He, unfortunately, also developed intraabdominal sepsis that grew VRE, bacteroides, and parabacteroides. He endorses that he has had visual and auditory hallucinations since he woke up from his cardiac arrest. However, these hallucinations only occur once he closes his eyes and is about to fall asleep. These have been becoming worse and more frequent in the last week. He denies having any hallucinations while he is awake and his mother corroborates the same. He denies having any confusion while he has been awake. His mother also states that this is his baseline, and her only concern is the hallucinations that he experiences when he is about to fall asleep. Otherwise, he has not had any infectious symptoms and has not had any fevers or chills.

He states that in the last couple days, his appetite has gone down, and yesterday on January 25th, he had not kept anything down because he was vomiting. His nutrition is primarily through both a combination of NG and oral intake. Overnight, due to his hallucinations and his ammonia level being elevated, he received lactulose which allowed him to have some output through his ostomy. He has not had any further nausea or emesis. However, his hallucinations upon almost falling asleep have not subsided. He denies having any abdominal pain. He does occasionally require 1 mg of Ativan just prior to procedures, particularly this today when he went for a tube exchange to facilitate an upcoming MRCP. But overall, Richard prefers to not have any Ativan if possible.

CURRENT MEDICATIONS: IN HOSPITAL:
1. Metronidazole 500 mg q.8 h.
2. Ciprofloxacin 400 mg q.12 h.
3. Linezolid 600 mg b.i.d.
4. Aspirin 81 mg daily.
5. Plavix 75 mg daily.
6. Atorvastatin 80 mg at bedtime.
7. Pantoprazole 40 mg daily.
8. Ramipril 22.5 mg daily.
9. Metoprolol 12.5 mg b.i.d.
10. Gravol p.r.n., only requiring it once or twice a day, if at all.
11. Acetaminophen 975 mg q.6 h. p.r.n.
12. Dilaudid 0.5 to 1 mg IV q.2 h. p.r.n., which he requires quite frequently.

PHYSICAL EXAMINATION: Mr. Fehr's cardio respiratory examination was unremarkable. His abdominal exam was benign and his stoma appeared healthy and no evidence of purulence. There was no evidence of asterixis on examination, though the patient did appear jaundice. Mr. Fehr was alert and oriented x3 and was able to very confidently answer all orientation questions.

INVESTIGATIONS: The patient's hemoglobin was 109, but this was in the context of having received 2 units of packed red blood cells the day prior for a hemoglobin of 65. At present, it is unclear why the patient's hemoglobin dropped so drastically as there does not appear to be any overt bleeding. The patient's platelets were 318 and have been stable since being treated for HIT. The patient's electrolytes were unremarkable. His ammonia levels on January 25th overnight was 86 which came down to 36 on the day of consult the day after. His blood cultures were negative on January 18th. His liver enzymes were elevated predominantly in a cholestatic pattern with his ALP being 1698, GGT 7094, and total bilirubin 184. With regard to his INR, his INR began to rise on January 21st, at which time, it rose to 3.3. At this time, his warfarin dose was reduced from 4 mg to 3 mg and then on January 22nd, his INR rose to 4.8 at which time his warfarin dose was decreased to 2 mg. The INR continued to rise and peaked on January 25th at 6.8. However, his warfarin was only held on January 24th and January 25th. On January 25th, he received vitamin K following the peak INR of 6.8, and his INR decreased down to 2.2 following vitamin K administration.

His last CT abdomen on January 11th did not show any evidence of liver or gallbladder pathology. His abdominal ultrasound on January 17th did demonstrate some gallbladder debris and sludge, but no cholecystitis. His common bile duct was slightly dilated at the upper limit of normal of 6 mm and there was evidence of some mild intrahepatic bile duct dilatation.

ASSESSMENT AND PLAN: Mr. Fehr is a 40-year-old gentleman who has had a very complicated course in hospital following an out-of-hospital cardiac arrest, who is now presenting with hypnagogic hallucinations as well as increasing cholestatic liver enzymes, elevated INR.
1. Confusion: This is unlikely hepatic encephalopathy or delirium as his hallucinations only occur in the context of just falling asleep. These are more likely hypnagogic hallucinations. Furthermore, there is no evidence of asterixis on exam, which further points away from hepatic encephalopathy. While poor sleep cycle could indicate a low-grade hepatic encephalopathy, this suspicion is low, especially given the ammonia level dropped quite precipitously with very minimal doses of lactulose, no improvement of these hallucinations following lactulose. Furthermore, given that his platelets have remained stable and normal since being treated for HIT, hepatic encephalopathy is less likely. There is also a low suspicion for infectious cause given that he has been asymptomatic and with a normal white blood cell count. We would suggest using Ativan sparingly, which is already the case and a trial of melatonin to help him with sleep.
2. Elevated liver enzymes: This appears to be more likely a possible intrahepatic cause. Currently, he has an MRCP pending. Again, as with above, this is unlikely liver failure given that he has had a normal platelet count.

3. Elevated INR: This is likely secondary to fluctuating oral intake given that he has had a very good correction with vitamin K supplementation. However, given that he did have a precipitous hemoglobin drop with no overt bleed, we will order a hemolytic workup as well as a peripheral blood smear to rule out any hemolysis.

Thank you very much for involving us in the care of Mr. Richard Fehr. GIM will continue to follow this patient in hospital.

Dictated by: Carly Yim, RESIDENT

_____
Charanpreeti Ubhi, MD

This document has been dictated and may have been distributed before being read. Any corrections to this document must be made within thirty (30) days following the transcription date.

CY/MODL
DD: 2022-Jan-26 15:58:47
DT: 2022-Jan-26 16:44:04
Job #: 425136/57198675

cc: Charanpreeti Ubhi, MD
Jillian Fraser, MD
Dilip Gill, MD

MD Consultation Request-ID [Charted Location: RUH-6000-Obs-6025-03] [Date of Service: 17-Dec-2021 13:39, Authored: 17-Dec-2021 13:39]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

Referring Physician:

REFERRING PHYSICIAN:

- **Reason for Referral** Query pneumosepsis

CARE PROVIDERS:

Bree, Teresa Lee(Attending): 402 Queen Street, Saskatoon, SASKATCHEWAN S7K 0M3, Business, 306 975-0600
Acute Care, Surgery(Consulting):
Fraser, Jillian(Family): City Centre Family Physicians, 200-3211 Preston Avenue South, Saskatoon, SASKATCHEWAN S7T 1C9, Business, 306 244-3016

CONSULTING PHYSICIAN:

Consulting Physician:

- **Service** ID
- **Consultant** Dr. Peermohamed

PATIENT CONTACT INFORMATION:

- **Patient Name** FEHR, RICHARD NEIL
- **Address** PO BOX 38028, SASKATOON, SASKATCHEWAN, S7N 1H2
- **Phone Type** Home
- **Phone Number** 306 2297259
- **HSN** SKUNKNOWN 10SK

Consultant Note:

CONSULTANT NOTE:

- **Date and Time of Consultant's Initial Assessment:** 17-Dec-2021 13:40
- **Consultant Note:** ID: 40 M admitted currently to cardiology after OHCA complicated by ischemic bowel and sepsis

Past medical history
- CAD (DES to LAD this admission)

Medications
- Metoprolol
- Fonda 7.5
- ASA
- Atorvastatin
- Pantoprazole
- Ticagrelor
- Meropenem 1 g q8h Dec 9 - present
- Tazo 3.375 Dec 6-9

Allergies/intolerances
- Heparin - positive anti-heparin antibodies (confirmation assay pending)

Social
~30 pack year smoker, no recent alcohol. Some marijuana, denies IVDU. No transfusions before 1990.

HPI
Patient was BIBEMS Dec 2 after an OHCA with bystander CPR for unknown time and had pulseless VT/VF on transport. Achieved ROSC in ER. Found to have 95% lesion in LAD. Coded several times in cath lab. Found to have ischemic bowel Dec 5 and underwent laparotomy Dec 5 and end-ileostomy Dec 7. Since then had been improving hemodynamically in ICU and transferred up to ward Dec 15.

Over past 2 days developed a non-pruritic erythematous rash over chest and spreading to abdomen and arms. Noticed chills/sweats yesterday. Denies new cough and hasn't been choking. Denies abdo pain. Passing BMs, perhaps more watery than usual through his ostomy and having it changed every several hours.

Physical
118/84 T 36.7 (Tmax 38.1 Dec 17 0620) 96% 4L NP
Abdo: Soft, nontender. 2 necrotic areas on abdomen corresponding to tinzaparin injection sites.
MSK: No sacral ulcer
CV: S1, S2 normal
Resp: non-specific upper airway sounds

Labs
WBC 16 plt 1152 Cr 73 INR 1.6
Eos 0.18

UA - negative nitrites, neg leuk esterase, 0-2 WBCs

Microbiology
Blood cultures
Dec 17 pending
Dec 10 NG
Dec 3 NG

Resp cx
Dec 10 - E cloacae, yeast
Dec 8 - E cloacae (sens to cipro)

Urine Cx
Dec 3 - NG

Imaging
CT A/P Dec 5 - pancreatic infarct, abdominal free air, pneumatosis intestinalis
CT A/P Dec 14 - more defined pancreatic lesion, colonic stump fluid vs abscess
CXR Dec 17 - possible retrocardiac opacity

I/P 40 M admitted post OHCA complicated by ischemic bowel with new fever and rash on meropenem.

1. Will test stool for C. diff due to high-output ostomy.
2. Developing foci in abdomen may be contributing to ongoing fevers, will suggest repeat CT next week to reassess possible abscess.
3. Will switch meropenem to ciprofloxacin IV for E cloacae and metronidazole for intra-abdominal organisms.

Drew Zhang R3

ID Attending (Dr. S. Peermohamed): Agree with above. In summary, this is a 40 year old man with cardiac arrest complicated by ischemic gut with suspected drug rash secondary to beta-lactams. Thus, we recommend switching to ciprofloxacin and metronidazole for coverage for hospital acquired pneumonia and possible early intra-abdominal infection. We will continue to follow. Thank you for involving us in the management of this patient.

Electronic Signatures:
Peermohamed, Shaqil (MD) (Signed 18-Dec-2021 05:53)
Authored: *Consultant Note*
Co-Signer: *Referring Physician, Consultant Note*
Zhang, Zhubo (Resident) (Signed 17-Dec-2021 14:46)
Authored: *Referring Physician, Consultant Note*

Last Updated: *18-Dec-2021 05:53 by Peermohamed, Shaqil (MD)*

[Date of Service: 05-Dec-2021 00:00, Authored: 05-Dec-2021 00:00]Consultation [Charted Location: RUH-ICU 3-3321-02]- for Visit: 10521726, [Signed by: Gill, Dilip (MD) 06-Dec-2021 08:19]; [Entered by: Filed by, Interfaces (Other) 06-Dec-2021 02:59]; [Signed by: Nocon, Christopher-Brian (Resident) 06-Dec-2021 08:19] General, *Complete, Entered, Signed in Full, General*

MRN: 1315031
NAME: FEHR, RICHARD NEIL
DOB: 23-FEB-1981
VISIT ID: 10521726
HSN:
CONS PHYS: Dilip Gill, MD
FAM PHYS: Jillian Fraser, MD
DATE SEEN: 05-Dec-2021
LOCATION: ICU3 IP ADM: 02-DEC-2021
Royal University Hospital
Consult

It is my pleasure to see Mr. Fehr here at the CCU unit together with his wife. He is a 40-year-old gentleman who you have requested for us and consulted us to see him because of concerning features and CT findings of ischemic bowel.

This 40-year-old gentleman was admitted to the hospital December 2nd after being found down and had bystander CPR. At that time, he was taken to the cath lab and had a clot in the distal LAD, for which he was stented. The EF is 20% to 25%. During his stay here in the hospital, it was noted that his abdomen was getting quite tender with an elevation of his lactate. For this reason, he was brought to the CT scanner to have his abdomen scanned. Then it was noted that he had free air as well as ischemic bowel.

He is currently on heparin and this has been brought on to more prophylactic levels, to try to minimize the effect of heparin at the moment considering that he will need surgery. He is off of pressors and currently on a dobutamine infusion. He is also not on propofol or any sedation. His last bowel movement was December 3, 2021.

PAST MEDICAL HISTORY: Other than the medical history noted above, he was otherwise healthy prior to this.

PAST SURGICAL HISTORY: He has had a tonsillectomy in the past. Otherwise, no abdominal surgery.

CURRENT MEDICATIONS: He does not take any regular medications other than the medication he is currently on.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: He smokes cigarettes, as well as marijuana. He is double vaccinated and lives in Saskatoon.

PHYSICAL EXAMINATION: Abdominal examination noted that his abdomen was quite distended and peritonitic to examination more so around the left lower and upper quadrants and midline as well. His heart rate when I saw him was 101 with a blood pressure of 132/64. He is afebrile and currently intubated on a

mechanical ventilator.

INVESTIGATIONS: Blood work done shows a white blood cell count of 7.2 with a hemoglobin of 112, platelets 211. Electrolytes show a sodium of 131, potassium 5.6, and creatinine of 167. Lactate is 3.9 (arterial).

A CT scan did show free air with pneumatosis of the ascending to transverse colon. Small bowel was dilated. Pancreatic tail infarct. Origin of celiac artery could not be seen, but downstream patent. Air in the iliac veins, but no portal venous gas. SVC is flat and there is hyperattenuation of the adrenals. All of this is reported verbally and was communicated to the team by the radiology resident on call. Official report is pending.

IMPRESSION: This 40-year-old gentleman who has been in CCU post cardiac arrest now has ischemic bowel and concern for perforation as well. Considering the fact that he is young, we did talk to his wife Andrea that we will need to take him for an emergency surgery. We will do a laparotomy and examine his bowel and resect the bowel that is ischemic. We did communicate to Andrea that this is a poor prognosis, but considering that he is young we will be aggressive with this management.

Thank you very much for involving us in his care. We will bring him to the operating room as soon as we are able to.

Dictated by: Brian Christopher Nocon, RESIDENT

_____
Dilip Gill, MD

This document has been dictated and may have been distributed before being read. Any corrections to this document must be made within thirty (30) days following the transcription date.

BN/MODL
DD: 2021-Dec-05 20:47:25
DT: 2021-Dec-06 02:59:43
Job #: 527629/56528545

cc: Dilip Gill, MD
Jillian Fraser, MD
Janine Sara Eckstein, MD

ED Disposition [Charted Location: JPCH-ERT-G504] [Date of Service: 02-Dec-2021 09:22, Authored: 02-Dec-2021 09:22]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

Triage Information:
Triage and Nursing Complaints:

Triage Complaint:

• **Complaint Category**	Cardiovascular [1]
• **Chief Complaint**	Cardiac Arrest (Non-Traumatic) [1]
• **Triage Complaint**	Cardiac arrest (non-traumatic) [1]
• **Comments/Interventions**	approx 40 yo male found uncx/unresp by bystander. CPR initiated. pt in with EMS; LUCAS in progress. multiple rounds ept/amio/cpr. pt direct to 504 on arrival[1]
• **CTAS Based on Chief Complaint**	1 [1]
• **CTAS Calculated Score**	1 [1]
• **CTAS Overridden Score**	1 [1]

ED VITAL SIGNS:
ED Triage Reassessment:
02-Dec-2021 08:22

Eye Opening	(E1) none
Verbal Response	(V1) none
Motor Response	(M1) none
GCS Score	3

TRANSFER TO INPATIENT:

• **Nursing Transfer Details**	Patient transferred to cath lab with physicians xs2, RT, and multiple nurses. De-fib, cardiac arrest medications and infusions taken with. Social work speaking with family.
• **Report Given**	face to face
• **Transfer Checklist**	hospital meds sent; patient belongings sent
• **Date and Time of Report**	02-Dec-2021 09:10
• **Date and Time of Transfer**	02-Dec-2021 09:10
• **Accompanied By**	RN physician RT
• **Mode of Transport**	stretcher
• **Equipment Accompanying Patient**	defib cardiac monitor airway bag RSI kit suction oxygen

Electronic Signatures:
Tuba, McKenzie (RN) (Signed 02-Dec-2021 09:26)
Authored: *Triage Information, Transfer*

Last Updated: *02-Dec-2021 09:26 by Tuba, McKenzie (RN)*

References:
1. Data Referenced From "ED Nurse Triage" 12/2/2021 8:22 AM

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ED MD Assessment [Charted Location: RUH-Coronary Care Unit-CCU-09] [Date of Service: 02-Dec-2021 09:10, Authored: 02-Dec-2021 09:10]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

Physician Documenation:

ASSESSMENT:

History: delayed note: patient was being resuscitated the entire time and is now in cath lab
HPI: patient brought in by EMS
found down on sidewalk unconscious
bystander cpr initiated
time of call was 0740
?ROSC, brought into back of ambulance and no longer had pulse, in VT/ VF, shocked multiple times
received amio 300mg and 150mg
narcan 0.4mg IV (pupils were never pin point)
epi multiple rounds
unable to intubate as clenched
Past Medical History: healthy
Past Surgical History: none
Medications: none
Allergies: no known drug allergies
Immunizations: up to date, double vax
Social History: smoker, occasional EtOH, no drugs (incl no IVDU), works at U of S dairy

Physical: A - being bagged, some blood around airway, trachea midline
B - air entry equal bilaterally, no subcutaneous emphysema, no chest wall tenderness, no bruising to chest wall aside form Lucas device area
C - heart sounds normal, extremities cool and mottled, abdomen soft and non-tender,
D - GCS 3, pupils but not reactive
E - no signs of trauma (never log rolled as CPR in progress for most of ED visit)

INITIAL IMPRESSION/PLAN:

Notes: Patient initiated ACLS protocol with CPR and epi
first pulse check was PEA
eventually obtained ROSC
VF/VT off on therefore defibrillated multiple times at 200 and 300 J
Amio started at 1mg/min infusion

Lines: had 1 AC IV, obtained second IV and then R tibial IO by ACP student under supervision of Dr. Bouchard

Other treatments:
Rocuronium 200mg to achieve intubation
initially some blood obscuring the CMAC, cleared and then had grade 1 view, size 8 ETT place by Dr. Bouchard (other ED physician) with RT
Initiated on propofol 20mcg/kg/min after paralytics given
sats difficult to obtain as patient shut down peripherally but read in the 80's then up to 90's
BP low so norepi initiated at 0.05mcg/kg/min and then increased to 0.07mcg/kg/min
ECG obtained and appeared wide with signif ST elevation in ant leads so cardio consulted
treated with calcium chloride and amp of sodium bicarb to treat any possible hyper K
labs in to draw, cardiac and tox workup ordered
Dr. Shavadia present almost immediately after called

planned to take to cath lab, echo showed ?ant wall down
few further episodes of VF, lidocaine added to treatments and more defibrillations
once requiring approx 30 seconds of CPR
OG placed and ASA and Ticagrelor given
Heparin in but did not have time to give bolus, sent with team to cath lab

patient taken to cath lab by team with Dr. Shavadia present
I spoke with patient's wife Andrea in family room with social work and on speaker phone, the patient's parents at the same time to inform them of his critical status, suspected diagnosis (ACS) and current management plan
Andrea accompanied by social worker to CCU wait room

DISCHARGE:

• **Final Diagnosis**	Cardiac arrest with ROSC, likely secondary to ACS, ?ant STEMI

PATIENT CONTACT INFORMATION:

• **Patient Name**	FEHR, RICHARD NEIL
• **Address**	PO BOX 38028, SASKATOON, SASKATCHEWAN, S7N 1H2
• **Phone Type**	Home
• **Phone Number**	306 2297259
• **HSN**	SKUNKNOWN 10SK

Electronic Signatures:
Ferguson, Janet (MD) (Signed 02-Dec-2021 09:37)
Authored: *Physician Documenation, Patient Contact Information*

Last Updated: *02-Dec-2021 09:37 by Ferguson, Janet (MD)*

****

ED Nurse Triage [Charted Location: JPCH-ERT-G504] [Date of Service: 02-Dec-2021 08:22, Authored: 02-Dec-2021 08:22]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

COVID-19 SCREENING:

• **TRIAGE ASSESSMENT FOR ISOLATING COVID-19 (and Other Respiratory Viruses)**	unable to screen - assumed positive

Triage:

• **Complaint Category**	Cardiovascular
• **Chief Complaint**	Cardiac Arrest (Non-Traumatic)
• **Triage Complaint**	Cardiac arrest (non-traumatic)
• **Comments/Interventions**	approx 40 yo male found uncx/unresp by bystander. CPR initiated. pt in with EMS; LUCAS in progress. multiple rounds ept/amio/cpr. pt direct to 504 on arrival

• **Isolation Required**	Droplet/Contact PLUS
• **Eye Opening**	(E1) none
• **Verbal Response**	(V1) none
• **Motor Response**	(M1) none
• **GCS Score**	3
• **First Order Modifier Summary**	Vital Signs deferred to bedside
• **Assessment Comment**	cpr in progress no vitals @ this time
• **CTAS Based on Chief Complaint**	1
• **CTAS Calculated Score**	1
• **CTAS Overridden Score**	1
• **Transport Service**	EMS - Saskatoon
• **Mode of Arrival**	stretcher
• **Directed To**	Bed
• **CTAS Recheck**	Reassessment Timer - Start

Electronic Signatures:
Turner, Lani D (RN) (Signed 02-Dec-2021 08:24)
Authored: *COVID Screening, Triage*

Last Updated: *02-Dec-2021 08:24 by Turner, Lani D (RN)*

Saskatchewan Health Authority

SK UNKNOWN
RUH 1315031 V#10521726
FEHR, RICHARD NEIL
Feb-23-1981 40y ER M
ADM: Dec-02-2021
FERGUSON, JANET

☐ RUH ☐ SCH ☐ SPH ☐ Other _____

EMERGENCY DEPARTMENT

SYSTEMIC PATIENT ASSESSMENT

Date: Dec. 2/21 Time of assessment: 0819

Presenting problem: Found down on college Dr. CPR in progress by bystander. pupils fixed + dilated. Had 4 rounds of epi and max dose of amio Vfib with shock x1 at 200 J.

Pertinent past medical history: _____

RESPIRATORY

Can the patient take a full, deep, relaxed breath: ☐ Yes – rate _____ S.O.B.: ☐ No ☐ Yes

Findings on exam: O_2 saturation _____ O_2 delivery method _____

Rhythm	Depth	Quality			Airway Adjuncts
☐ Regular	☐ Adequate	☐ Easy	☐ Stridorous	☐ Use of accessory muscles	☐ Oral airway
☐ Irregular	☐ Shallow	☐ Laboured	☐ Moist		☐ Nasal airway
☐ Paradoxical	☐ Deep	☐ Wheezing	☐ Cheyne Stoke	☐ Retractions	☐ ET tube – size _____
☐ Kussmaul	☐ Guarded	☐ Hyperventilating		☐ Cyanosis	☐ Tracheostomy

Cough: _____ Sputum: _____

Auscultation/Other findings/Action: _____

CARDIOVASCULAR

Are the radial pulses full, regular: ☐ Yes – rate _____ ☐ No

Other pulses/Findings: _____

Are the extremities warm, skin dry and well perfused? ☐ Yes ☐ No Findings: _____

☐ Edema – describe _____

☐ Chest pain – describe _____

Heart sounds/Other findings/Action: _____

CENTRAL NERVOUS SYSTEM

Is the patient alert and orientated to three spheres? ☐ Yes ☐ No ☐ See GCS

☐ Restless ☐ Irritable ☐ Lethargy ☐ Headache ☐ Dizziness ☐ Numbness

Describe/Other findings/Action: _____

SYSTEMIC PATIENT ASSESSMENT

GASTROINTESTINAL ☐ Not related to presenting problem

☐ Nausea ☐ Vomiting Describe _____

☐ Diarrhea ☐ Constipation Describe _____

☐ Dysphagia ☐ Appetite ☐ Last meal Describe _____

☐ Weight change – describe _____

☐ Pain – describe _____

Findings on exam, include bowel sounds: _____

_____

_____

_____

GENITOURINARY/REPRODUCTIVE ☐ Not related to presenting problem

☐ Urgency ☐ Frequency ☐ Hematuria ☐ Incontinence ☐ Distention ☐ Nocturia ☐ Indwelling catheter

LMP _____ **TPALG** ____/____/____/____/____ **EDC** _____ FHR _____

☐ Bleeding – describe _____

_____

☐ Pain – describe _____

Findings on exam: _____

_____

_____

_____

PSYCHOSOCIAL Is this patient managing independently at home: ☐ Yes ☐ No – describe _____

_____

Emotional status: _____

_____

MUSCULOSKELETAL/INTEGUMENTARY ☐ Not related to presenting problem

☐ Cramping ☐ Tingling ☐ Numbness ☐ CSM ☐ Bruising ☐ Petechiae ☐ Rash ☐ Sores

☐ Pain – describe _____

Findings on exam: _____

_____

_____

_____

EENT ☐ Not related to presenting problem

☐ Drainage ☐ Bleeding ☐ Foreign body ☐ Pain ☐ Laceration ☐ Tinnitus

Describe/Action: _____

_____

_____

Initial assessment completed by:

_____ _____ _____

Signature Status Initials

Saskatchewan Health Authority

SK UNKNOWN
RUH 1315031 V#10521726
FEHR, RICHARD NEIL
Feb-23-1981 40y ER M
ADM: Dec-02-2021
FERGUSON, JANET

☐ RUH ☐ SCH ☐ SPH ☐ Other _____

EMERGENCY DEPARTMENT

SYSTEMIC PATIENT ASSESSMENT

Date: Time:	0828	0832	0836	0840	0845		
Initial BGM Nurse ID	9.7						
Temperature							
Pulse	98	117	108	102	93		
Respiration	19	18	18	18	18		
Blood Pressure	109/54	111/73	106/67	74/52	129/82		
Oxygen Saturation					77%		
O_2 Delivery (M - Mask, ETT - Endotracheal tube, RA - Room air, NP - Nasal prongs, BVM - Bag valve mask)	ETT	ETT	ETT	ETT	ETT		
Output (C - Chest drainage, E - Emesis, NG - Nasal gastric, U - Urinary)							
Eyes Open (C - Closed by swelling) (4 - Spontaneously, 3 - To voice, 2 - To pain, 1 - Will not open)							
Best Verbal Response (ETT = ET Tube) (5 yrs - Adult: 5 - Oriented, 4 - Confused, 3 - Inappropriate words, 2 - Incomprehensible sounds, 1 - None; 2 - 5 yrs: 5 - Orientated, 4 - Inappropriate words, 3 - Cries or screams, 2 - Grunts, 1 - No response; Less than 24 months: 5 - Smiles, coos, 4 - Cries, 3 - Inappropriate crying, screaming, 2 - Grunts, 1 - No response)							
Best Motor Response (6 - Obeys commands, 5 - Localizes pain, 4 - Flexion withdrawal, 3 - Abnormal flexion (rigidity), 2 - Abnormal extension (rigidity), 1 - None)							
Glasgow Coma Scale							
Pupil Reaction (N - Normal, S - Sluggish, F - Fixed) Rt							
Lt							
Motor Power (3 - Strong, 2 - Moderate, 1 - Weak, 0 - Absent) Arms Rt							
Arms Lt							
Legs Rt							
Legs Lt							
Pain Scale (0-10) (0 - No pain, 10 - Worst pain)							
Sedation Scale (S - Normal sleep, easy to rouse; 3 - Somnolent, difficult to rouse, 2 - Frequently drowsy, easy to rouse, 1 - Sometimes drowsy, 0 - Alert)							

☐ Initiated ED Medication Administration Record (MAR)

Time	Needle Size & Site	Solution & Amount	Medication Added	Rate	Comments/Amount Absorbed	ID

Caregivers:

1. Dr. Janet Ferguson ✓ — Signature & Status — Initials
2. Dr. Nicole Bouchard — Signature & Status — Initials
3. _____ — Signature & Status — Initials

SYSTEMIC PATIENT ASSESSMENT

Time	Action/Progress Notes

☐ Continue on Progress Notes

Fehr, Richard 10521726

Saskatchewan Health Authority

DOCUMENTATION ALERT
THIS DOCUMENT WAS RECEIVED WITH
NO PATIENT ID, AND WAS FOUND
IN THE CURRENT CHART

☐ RUH ☐ SCH ☐ SPH ☐ Other _____

RESPIRATORY THERAPY
EMERGENCY DEPARTMENT RESPIRATORY ASSESSMENT

Date Dec 2/21 Time 845 Signature _____

Reason for assessment _____

CNS

RASS/GCS/AVPU 3. Temperature _____ °C

Medications _____

Other _____

CVS

HR 140 ABP/NIBP _____

Medications _____

Other _____

RESPIRATORY

RR _____ O_2 therapy/FiO_2 _____

SpO_2 _____ %

Auscultation _____

_____

Work of breathing _____

_____

☐ None ☐ Tripoding ☐ Nasal flaring

☐ Paradoxical respirations ☐ Forced expiration

☐ Pursed lip breathing ☐ Grunting

Accessory Muscles/Retractions _____

_____

☐ None ☐ Subcostal ☐ Intercostal

☐ Supraclavicular ☐ Suprasternal ☐ Substernal

☐ Scalene

NPA/OPA/ETT/LMA/Trach size 8 evac

Position 20 at teeth (adult)/lip (pediatrics)

Cuff pressure 30 cmH_2O

Cough _____

☐ Absent ☐ Productive ☐ Non-productive

☐ Weak ☐ Strong ☐ Hemoptysis ☐ Not observed

Sputum colour _____

Amount ☐ Scant ☐ Small ☐ Moderate ☐ Copious

Recommendations/Intervention/Plan

_____

_____

_____

Goals

SpO_2 _____ $ETCO_2$ _____ pH _____ PaO_2 _____

Time	Progress Notes
910	late entry: Pt found ↓ by RUH hospital, bystander CPR,
	brought in, intubated on 2nd attempt by ER Dr. Blood
	in mouth caused obstructed view. Spo2 unreadable
	ROSC obtained x 6, but keeps going into Vtach.
	Brought to cath lab. CPR done in cath lab. — AL
930	ABG done, PCO_2 69, PO_2 60's, TRR, ↑peep. ABG sent. — AL
945	Called as Pt Spo2 80's, bagged for ~20min
	+ sxn'd large pink frothy. Spo2 slow to
	recover to 94%. Cath lab procedure
	complete. Brought to CCU on T1. Econcern
	placed on servo vent. — AL

EMERGENCY DEPARTMENT RESPIRATORY ASSESSMENT

DOCUMENTATION ALERT
THIS DOCUMENT WAS RECEIVED WITH
NO PATIENT ID, AND WAS FOUND
IN THE CURRENT CHART

Date: Dec 2/21 **Equipment:** T1

Patient height: ________ cm **Patient weight:** ________ kg

Interface and size: ________

Mask port and exhalation setting: ________

Time	910	920	925				
Initial	NG	NG	NG				
Mode	A/V CMV	A/V CMV	A/V CMV				
Flow	10	—	—				
FiO_2	100	100	90				
Rise/Ramp	30	30	[illegible]				
RR Set	28	30	28				
RR Total	28	30	28				
Ti (sec)	0.85	0.80	0.80				
ETS%/E-Cycle	—	—	—				
Vt Set	450	500	500				
Vte	460	500	500				
MVe	13.0	14.8	13.6				
PC/PIP/IPAP	28	30	30				
PS	—	—	—				
PEEP/EPAP/CPAP	6	12	10				
Leak	—	—	—				
Trigger	2v	2v	2v				
Humidifier Temperature	HME	HME	HME				
FiO_2 Alarms	—	|	|				
High/Low Press	40/5	|	|				
High/Low MVe	20/3	|	|				
High/Low RR	40	|					
SpO_2	?	?	92				
$ETCO_2$	—	—	—				

Time							
Type							
pH							
pCO_2							
pO_2							
HCO_3							
BE							
SaO_2							
Lactate							
PaO_2/FiO_2							

Time	Progress Notes

Saskatchewan Health Authority

Patient Chart Flowsheets

MRN: 1138390 Visit: 10521726 Age: 40y (23-Feb-1981)	**FEHR, RICHARD NEIL** Gender: Male	Royal University Hospital Current Location: RUH-5000-Unit 4-5039-01

Flowsheet Name: ED Assessment and Care
[Charted Location: RUH-5000-Unit 4-5039-01]
[Authored By: Turner, Lani D]
[Authored Date/Time: Dec 2 2021 8:22AM] - for Visit: 10521726

ED Isolation	ED Isolation			Droplet/Contact PLUS

MRN: 1138390 Visit: 10521726 Age: 40y (23-Feb-1981)	**FEHR, RICHARD NEIL** Gender: Male	Royal University Hospital Current Location: RUH-5000-Unit 4-5039-01

Flowsheet Name: ED Triage Reassessment
[Charted Location: RUH-5000-Unit 4-5039-01]
[Authored By: Turner, Lani D]
[Authored Date/Time: Dec 2 2021 8:22AM] - for Visit: 10521726

Glasgow Coma Scale			Eye Opening	(E1) none
			Verbal Response	(V1) none
			Motor Response	(M1) none
			GCS Score	3
Triage Reassessment	Triage Reassessment		Comment	Reassessment Timer - Start

MRN: 1138390 Visit: 10521726 Age: 40y (23-Feb-1981)	**FEHR, RICHARD NEIL** Gender: Male	Royal University Hospital Current Location: RUH-5000-Unit 4-5039-01

Flowsheet Name: ED Vital Signs
[Charted Location: RUH-5000-Unit 4-5039-01]
[Authored By: Turner, Lani D]
[Authored Date/Time: Dec 2 2021 8:22AM] - for Visit: 10521726

CTAS Reassessment	CTAS Reassessment		Comment	Reassessment Timer - Start
Glasgow Coma Scale (GCS)			Eye Opening	(E1) none
			Verbal Response	(V1) none
			Motor Response	(M1) none
			GCS Score	3

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
RUH 1315031 V#10521726
FEHR, RICHARD NEIL
Feb-23-1961 40y ER M
ADM: Dec-02-2021
FERGUSON, JANET

NURSING
PROGRESS RECORD

DATE/TIME	REMARKS
0824	Pt intubated, LUCAS restarted.
0826	Pulse returned, LUCAS on hold.
0830	Pulse lost, Vfib arrest, shock.
	Pulse returned. ——
0838	Vfib arrest, shock at 200J and
	pulse returned. ——
0841	16G IO to @ hbiq. ——
0843	Cardio in to assess. ——
0845	Vfib arrest, shock for rosc
	Vfib again, shock for rosc. ——
0848	6Fr inserted. crushed ticagrelor
	and ASA in through same. ——
0851	Vfib arrest with shock. Compressions
	resumed. ——
0853	Epi given, PEA arrest afterward.
0855	ROSC achieved, bagging. ——

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other_____

NURSING
PROGRESS RECORD

DATE/TIME	REMARKS

1138390

MEDAVIE HEALTH SERVICES West

M.D. Ambulance Care
Patient Care Report
Service : (177)
Finalized: Yes

Run Number: M2112020058
Service Date : 2021-Dec-02
Patient 1 of 1
PCR Number : A29025

PATIENT

Provincial Health Card No	540228788
Patient Name	**FEHR, RICHARD**
Date of Birth	2/23/1981 (40 Years - Actual)
Address	BOX 38028 Saskatoon SK S7N 1H2
Telephone	306-229-7259

RESPONSIBLE PARTY

NOK Name	FEHR, ANDREA
Relationship	Spouse
Address	Saskatoon SK
Telephone	306-229-7529

COMPLAINTS

Chief (Primary)	Cardiac Arrest

Allergies

Crew Members

Vincent, Fearghus	1547011
Cameron, Teron	3514894

COMMENTS

Echo response for an unconscious unresponsive 40 year old male patient, cardiac arrest. According to bystander, patient was making his way home from work because he was feeling unwell. Patient collapsed and CPR was initiated. EMS arrived on scene and a pulse was confirmed at the Carotid. Patient was placed on a spine board, placed on stretcher and brought to unit. While in the unit and attempting to get a proper assessment and vitals on the patient, it was noted that patient was pulseless and apneic once again and CPR was initiated. Pads were placed as well as an OPA, 100MM was inserted with no difficulties and BVM was initiated with 15LPM O2.
PDO arrived shortly after and Lucas was applied.

PMHX-UNKNOWN
Medications-UNKNOWN

O/A-Patient found outside on the ground with CPR ongoing. It was determined that patient had a pulse and CPR was stopped. However once in the unit CPR was initiated.
A---Patent
B-Absent
C-Absent pulses
Skin-P/cool/dry
Head-Patient unconscious and unresponsive
Neck-NAD
Chest-no signs of trauma noted
Abd-NAD
Pelvis-Stable
Extremities-no trauma noted

-Patient found outside CPR in progress
-CPR stopped as carotid pulse was found
-Patient placed on spine board, moved to cot and brought to unit
-While in unit and attempting to obtain vitals and assessment, it was noted that patient was now unconscious and unresponsive and no pulses present and that was when CPR was initiated.
-Pads placed on patient
-100mm OPA was inserted and BVM was initiated with 15LPM of O2
-18G IV initiated to Right AC and 500ml N/S was infusing
-Rhythm check revealed V-Fib and Defibrillation at 360J initiated
-PDO arrived on scene and Lucas was applied
-Lucas in place.
-Bagging was ongoing by code 11 who had no difficulties
-PDO went to assess for difficult intubation, however patient was clenched
-Patient had spontaneous respirations at times.
-Pulse check revealed an organized rhythm on the monitor, however no pulses present
-CPR with Lucas ongoing
-Patient presented with a pulse, however brief and reverted back into V-fib

TOTAL SHOCKS AND MEDICATIONS
-10 Shocks administered
-EPI 1mg/10ml (0.1mg/ml) administered*5
-Narcan 2mg IVP
-Amiodarone 150mg

-Amiodarone 300mg

Patient transported Bravo to RUH and placed in 504

ABCD

Primary Survey	**Start time:** 12/2/2021 08:57:14 **Done by:** Teron Cameron **Airway:** Patent **Breathing:** Absent **Circulation:** Pulse Not Present **Disability:** Unresponsive **Priority Scene:** No Life Signs

VITAL SIGNS

Time	Heart Rate	Respiratory Rate	BP Systolic	BP Diastolic	MAP	SPO2	ETCO2	CO	Glucose	Temperature	Pain: Numeric	Pain: Wong-Baker FACES®	GCS	GCS-Q	Position	RASS	Done By
M-12/2/2021 07:54:33	157 BPM	Weak / Agonal;	U;						9.2 mmol/L - Off IV Cathlon;				E 1 V 1 M 1 3				TC
LP-12/2/2021 07:56:38	123 BPM																TC
LP-12/2/2021 07:58:11	279 BPM																TC
LP-12/2/2021 07:59:01	131 BPM																TC
LP-12/2/2021 08:02:20	157 BPM																TC
LP-12/2/2021 08:04:50	195 BPM																TC
LP-12/2/2021 08:05:38	128 BPM																TC
LP-12/2/2021 08:06:05	128 BPM																TC
LP-12/2/2021 08:06:40	106 BPM																TC
LP-12/2/2021 08:08:23	100 BPM	15 BPM					16 mmHg										TC
LP-12/2/2021 08:09:37	84 BPM																TC
LP-12/2/2021 08:10:06	57 BPM	25 BPM					19 mmHg										TC
LP-12/2/2021 08:11:57	103 BPM																TC
LP-12/2/2021 08:12:28	100 BPM	20 BPM					19 mmHg										TC
LP-12/2/2021 08:13:08	104 BPM	22 BPM					21 mmHg										TC
LP-12/2/2021 08:14:20	93 BPM																TC

LP- 12/2/2021 08:17:20	90 BPM	12 BPM					16 mmHg										TC
LP- 12/2/2021 08:19:16	81 BPM																TC

SCORES

Time	CTAS	Broselow Tape Category	Jump START Triage	% Burn	APGAR	Done By
M- 12/2/2021 07:48:41	1 - AP;					TC

ECG / MONITOR

Time	Leads	ECG Changes	ECG Type	Underlying Rhythm	Ectopy	Report	Comments	Done By
ECGInterp - 12/2/2021 07:53:47	Paddles;			Ventricular Fibrillation ;		Initial Rhythm		TC

HISTORY OF PRESENT ILLNESS

Symptoms	
	General: Unconscious; **Cardiovascular :** Cardiac Arrest;

Assess / Plan

Start Time	Stop Time	Section	Item	Description	Done By
12/2/2021 07:48:22		Exams	AVPU	**AVPU**: Unresponsive	Teron Cameron
12/2/2021 07:49:03		Exams	Pulse Status	**Site**: Right Carotid **Rate**: Normal **Rhythm**: Regular **Strength**: Strong	Fearghus Vincent
12/2/2021 07:53:47		Procedures	Attach / Monitor ECG	**Attach/ Monitor ECG**: Monitoring With Pads	Teron Cameron
12/2/2021 07:54:33		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 07:56:38		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 07:57:00		Procedures	Vascular Access	**Side**: Right **Site**: Antecubital **Type**: IV **Size**: 18 Gauge	Teron Cameron
12/2/2021 07:58:11		Procedures	Drug Therapy	**Defib Case ID**: 20211202075145004963950O **Drug Name**: Epinephrine 0.1mg/ml **Route**: Intravenous	Teron Cameron
12/2/2021 07:59:01		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:02:20		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:04:50		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:06:05		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Synchronized Cardioversion **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:06:40		Procedures	Drug Therapy	**Defib Case ID**: 20211202075145004963950O **Drug Name**: Amiodarone **Route**: Intravenous	Teron Cameron

				Amount: 150 mg	
12/2/2021 08:08:23		Procedures	Drug Therapy	**Defib Case ID**: 20211202075145004963950O **Drug Name**: Naloxone **Route**: Intravenous **Amount**: 2 mg	Teron Cameron
12/2/2021 08:09:37		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:10:06		Procedures	Drug Therapy	**Defib Case ID**: 20211202075145004963950O **Drug Name**: Epinephrine 0.1mg/ml **Route**: Intravenous	Teron Cameron
12/2/2021 08:11:57		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:12:28		Procedures	Drug Therapy	**Defib Case ID**: 20211202075145004963950O **Drug Name**: Amiodarone **Route**: Intravenous **Amount**: 150 mg	Teron Cameron
12/2/2021 08:13:08		Procedures	Drug Therapy	**Drug Name**: Epinephrine 0.1mg/ml **Route**: Intravenous	Teron Cameron
12/2/2021 08:13:08		Procedures	Other	Incomplete LIFEPAK: Generic	Teron Cameron
12/2/2021 08:14:20		Procedures	Electrical Therapy	**Defib Case ID**: 20211202075145004963950O **Type**: Defibrillation **Pads Applied**: Yes	Teron Cameron
12/2/2021 08:17:20		Procedures	Drug Therapy	Incomplete LIFEPAK medication not found Epinephrine	Teron Cameron
12/2/2021 08:19:16		Procedures	Electrical Therapy	Incomplete LIFEPAK: Shock 10, 300 J	Teron Cameron
12/2/2021 08:39:58		Procedures	Drug Therapy	**Drug Name**: Amiodarone **Route**: Intravenous **Amount**: 150 mg	Teron Cameron
12/2/2021 09:25:39		Procedures	Oxygen Therapy	**Type**: Other: BVM **Rate**: 15 L/min	Teron Cameron
12/2/2021 09:25:45		Procedures	IV Fluid	**Type**: Normal Saline **Fluid Bolus (ml)**: 500 **Total volume infused (ml)**: 500	Teron Cameron
12/2/2021 09:25:50		Procedures	Suctioning	**Type**: Oropharyngeal **Contents**: Blood	Teron Cameron
12/2/2021 09:25:51		Procedures	CPR Start	**Type**: Pit Crew CPR	Teron Cameron

Times

Incident Date / Time:	12/2/2021 07:40:38
Unit Dispatched	12/2/2021 07:40:47
Enroute	12/2/2021 07:40:56
Unit Cancelled	
Arrive Scene	12/2/2021 07:48:22
Arrive Patient	12/2/2021 07:48:41
Depart Scene	12/2/2021 08:10:58
Arrive Destination	12/2/2021 08:16:47
Care Transfer	12/2/2021 08:52:25
Available	12/2/2021 09:58:36

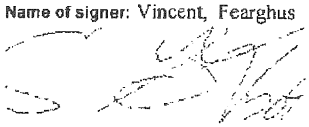
PPE Used

Eye Protection Gloves Mask-N95 Mask-Surgical (Non-Fitted) Gown Eye Protection Gloves Mask-N95 Mask-Surgical (Non-Fitted) Gown

SIGNATURE

Attendant 2

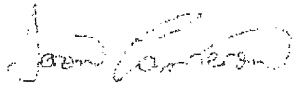
Name of signer: Vincent, Fearghus



PCR : A29025
2021-Dec-02

FEHR, RICHARD
HSN :
DOB : 2/23/1981

Attendant 1
Name of signer: Cameron, Teron



ATTACHED WAVEFORMS

Initial Rhythm

PCR : A29025
2021-Dec-02

FEHR, RICHARD
HSN :
DOB : 2/23/1981

Saskatchewan Health Authority

SK UNKNOWN
RUH 1315031 V#10521726
FEHR, RICHARD NEIL
Feb-23-1981 40y ER M
ADM: Dec-02-2021
FERGUSON, JANET

☐ RUH ☐ SCH ☐ SPH ☐ Other _____

ADULT/PEDIATRIC

CODE BLUE RECORD

Page 1 of 2

☒ Adult ☐ Pediatric Weight: _____

Date: Dec. 2/21 Time: 0819 Location: _____

Diagnosis: _____

Events preceding: found down on college, bystander CPR in progress

Reason for initiation: ☑ Pulseless ☑ Apneic Witnessed: ☐ Yes ☐ No

Code Blue called at: _____ hours Arrival of Code Blue Team: _____ hours

AIRWAY/VENTILATION ☐ Spontaneous ☑ Absent ☐ Ineffective ☐ Assisted

O_2 therapy: ☐ NP ☐ Mask ☐ NRB ☑ BVM at 100% O_2 at 15 L/min

RR _____ min SpO_2 _____ %

Air entry _____

Intubated at 0823 hours ☑ ETT insitu ☐ Trach insitu

ETT size _____ mm ☐ Cuffed ☐ Uncuffed

Person intubating Dr. Bouchard Depth lip _____ cm

$ETCO_2$ device: ☐ No ☑ Capnography ☐ Colorimetric 32

Blood gas collected at _____ hours

Anesthesia/RRT signature _____

CIRCULATION Rate _____ min BP _____ mmHg cuff art

Cap refill _____ seconds

Femoral: ☐ Palpable ☐ Weak ☐ Absent

Cardiac compression started ongoing hours

Feedback device used: ☐ Yes ☐ No

Rhythm: ☐ Sinus rhythm ☐ Bradycardia ☐ V-fib ☑ PEA ☐ V-tach ☐ Asystole ☐ SVT ☐ Other Lucas on

Vascular Access:

IV site #18 (R) AC Gauge 18 Time EMS

IV site (R) FA Gauge 18 Time 0834

IO site (R) tib Gauge 15 Time 0841

MEDICATIONS GIVEN

EPINEPHrine

Time	Dose	Route
0853	1mg	IV

atropine

Time	Dose	Route

amiodarone

Time	Dose	Route

Other Medication

Time	Medication	Dose	Route

FLUID BOLUS

Solution	Volume	Time

DEFIBRILLATION/SYNC CARDIOVERSION

Rhythm	Joules	Time	Post Tx Rhythm
vfib	200	0830	wide complex sinus
vfib	200	0838	
vfib	200	0845	
vfib	200	0845	
vfib	200	0851	
vfib	300	0852	

INFUSION STARTED

Drug	Dose/Rate	Time
PPF	20mcg/kg/min	0830
amiodarone	1mg/kg/min	0836
Norepi	0.3mcg/kg/min	0840

EXTERNAL PACING Time _____

Rate _____/min Output _____ (MA)

CODE BLUE RECORD

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021 IP
FEHR, RICHARD NEIL
FEB-23-1981 40y V#10521726 M
ATN: KANTHAN (CHANDRAKANTHAN), SE
FAM: FRASER,JILLIAN

ADDITIONAL INFORMATION RELATED TO CODE BLUE EVENTS

* See Nurse's Notes for additional information

INITIAL ECG RHYTHM PEA arrest.

Paste rhythm strip here

FINAL ECG RHYTHM

Paste rhythm strip here

PATIENT OUTCOME

❑ Successful Transferred to _____ Time _____ hours

Vital signs: Time _____ HR _____ BP _____ mmHg SaO_2 _____ % $ETCO_2$ _____

LOC _____ Temp. _____ °C

❑ Unsuccessful Time expired _____ hours

Family notified by SW @ 0840 at _____ hours

Name _____ Relationship _____

Attending Dr. _____ Notified at _____

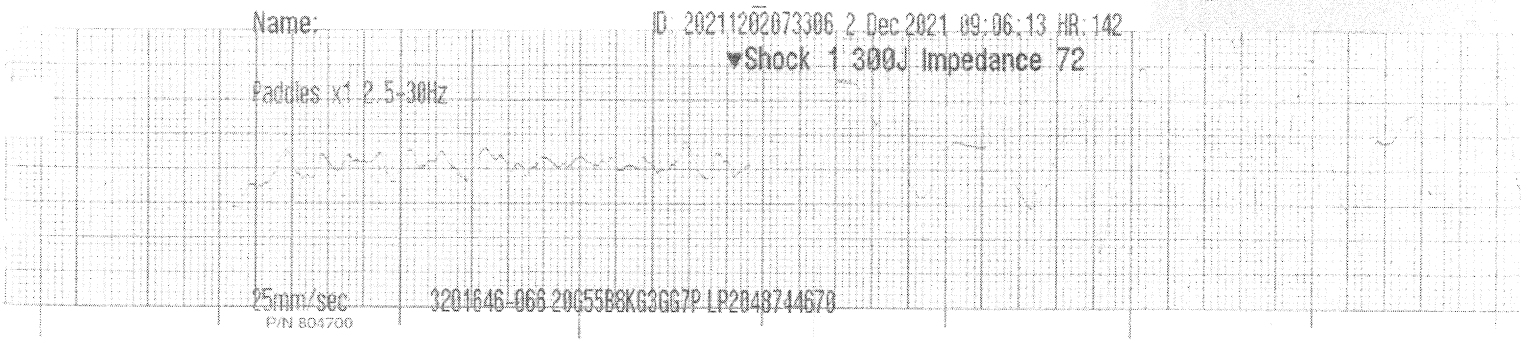
Recorder printed name _____ **Recorder signature** _____

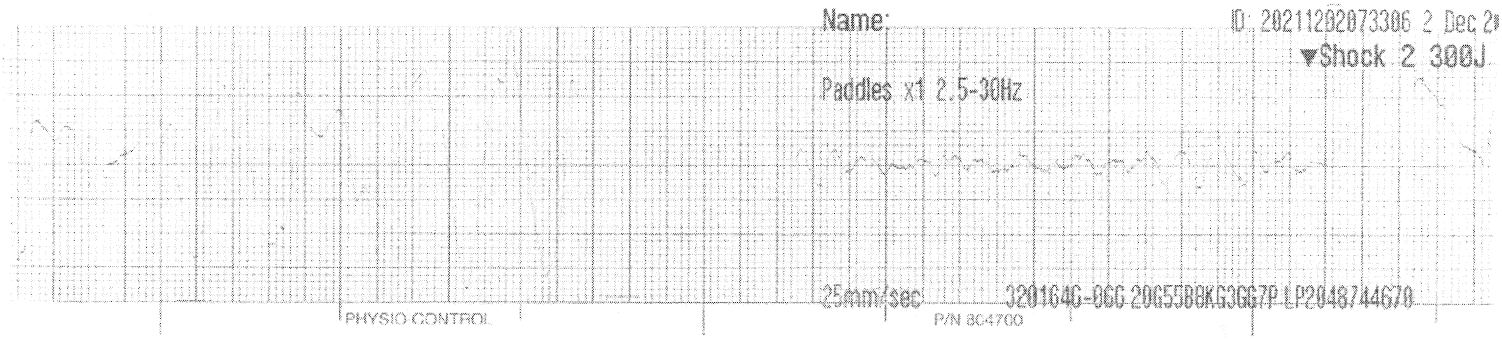
Physician printed name _____ **Physician signature** _____

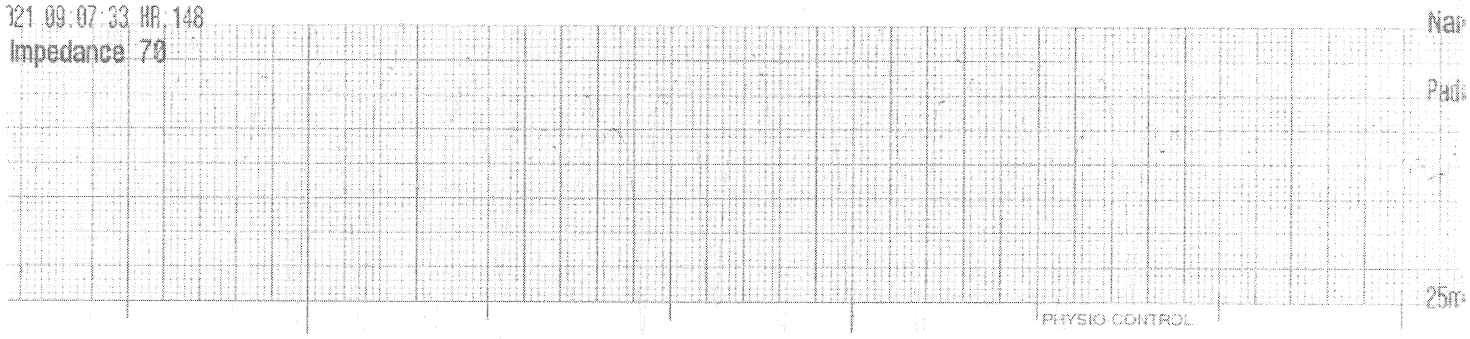
Code Blue RN printed name _____ **Code Blue RN signature** _____

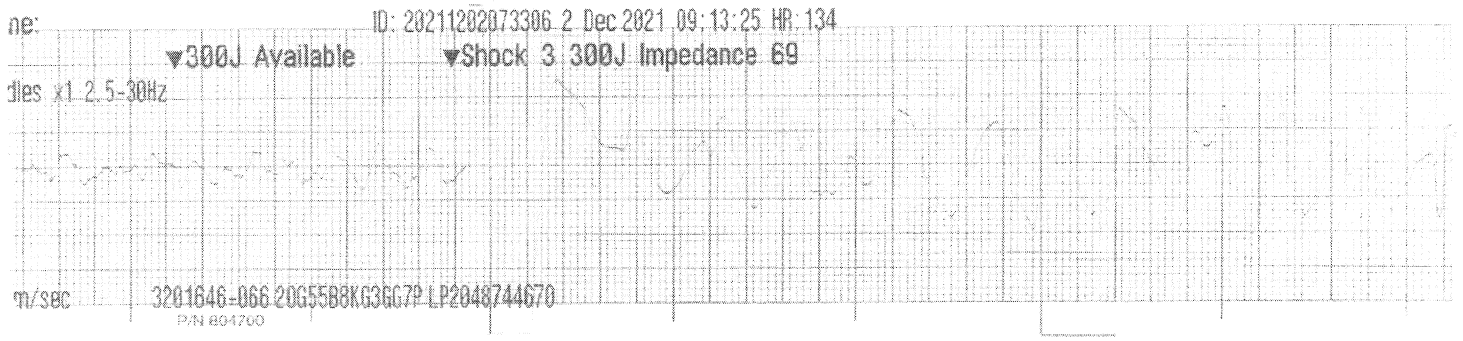
Code Blue RN printed name _____ **Code Blue RN signature** _____

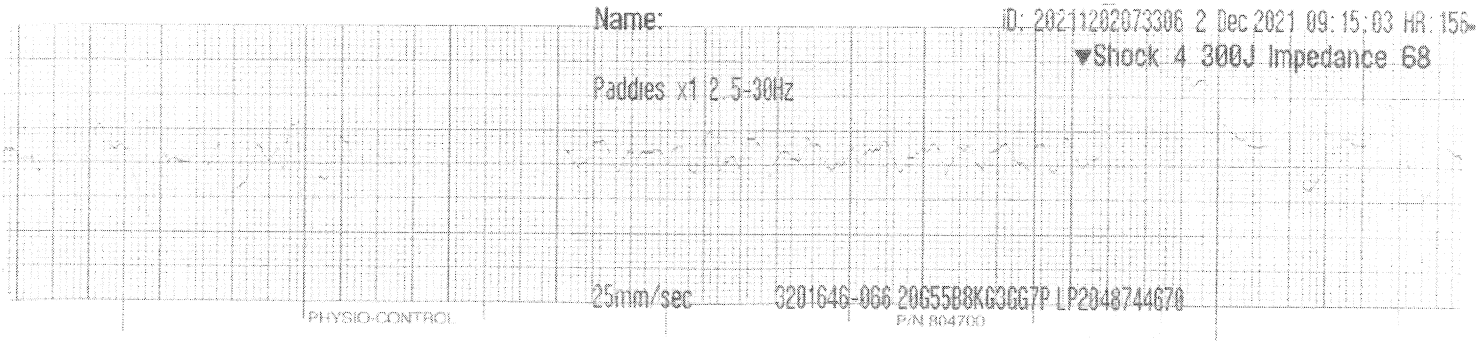
SK UNKNOWN
MRN: RUH 1315031
FEHR, RICHARD NEIL
DOB: FEB-23-1981



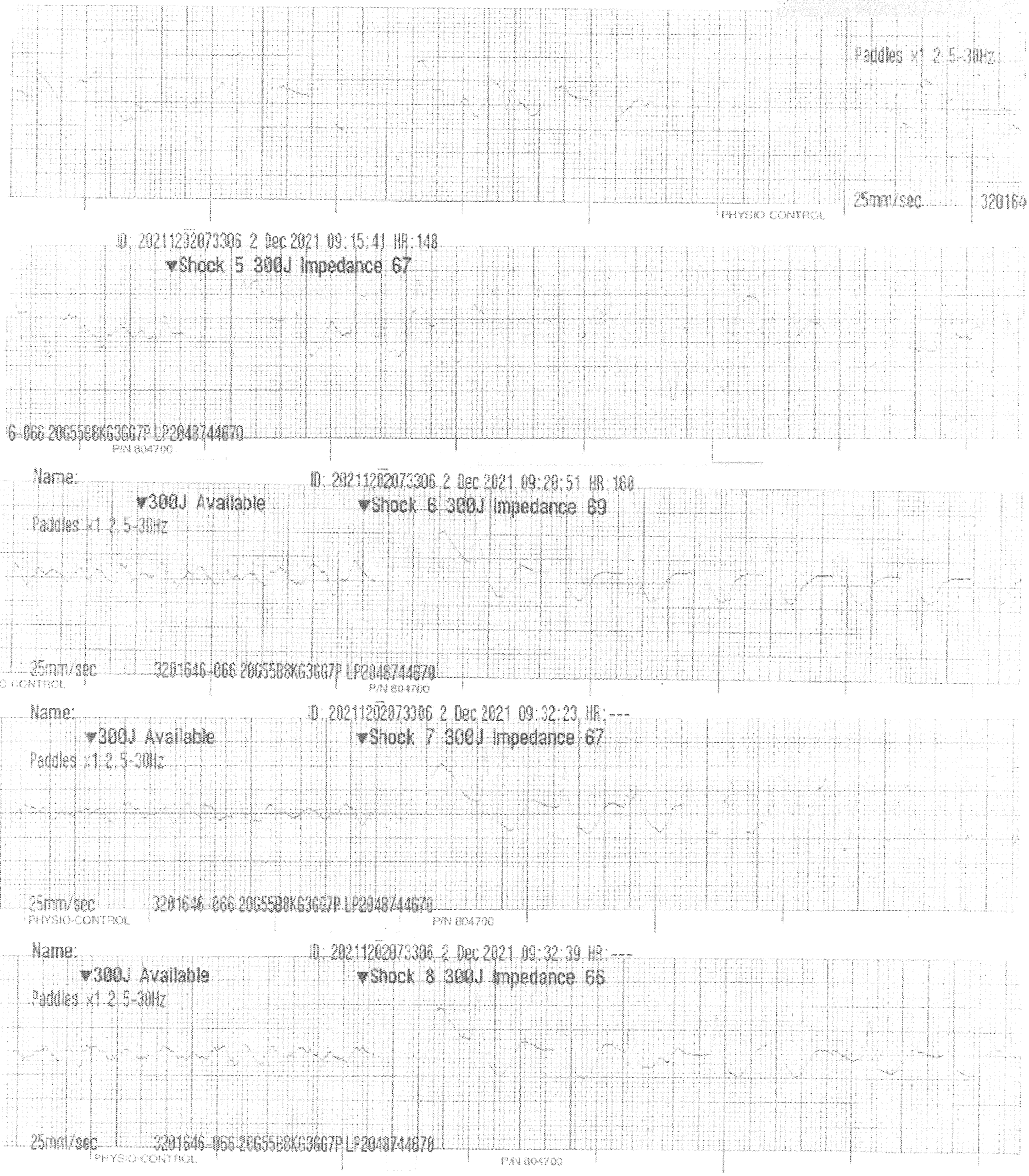








SK UNKNOWN
MRN: RUH 1315031
FEHR, RICHARD NEIL
DOB: FEB-23-1981



MD Progress Note-Brief-ID [Charted Location: RUH-5000-Unit 4-5039-01] [Date of Service: 25-Mar-2022 16:50, Authored: 25-Mar-2022 16:50]- for Visit: 10521726, *Incomplete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ID
Progress Note: 41M post cardiac arrest and ischemic bowel, with ongoing intraabdo collections. ID consulted for recurrent fever March 21.

Remains clinically well. On Mero/Dapto, tolerating. PICC cultures E> colcae (now pulled). Peripheral blood cultures (March 21) negative. Repeat from March 23 pending.

Will leave on Mero/Dapto for now. We understand that he is likely going home next week. Potential we can still tailor cultures, will await final blood cultures. Likely will need home IV none the less.

Please phone ID prior to discharge to confirm discharge antibiotic plan. There will be no inpatient ID coverage next week, therefore will need to phone for advice.

Electronic Signatures:
Jackson, Meghan (Resident) (Signed 25-Mar-2022 16:54)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *25-Mar-2022 16:54 by Jackson, Meghan (Resident)*

****

MD Progress Note-Brief-ID [Charted Location: RUH-5000-Unit 4-5039-01] [Date of Service: 23-Mar-2022 12:56, Authored: 23-Mar-2022 12:56]- for Visit: 10521726, *Incomplete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ID
Progress Note: 41M post cardiac arrest and ischemic bowel, with ongoing intraabdo collections. ID consulted for recurrent fever March 21.

Clinically well. Afebrile since March 21. On Mero/Dapto, no rash developed with Mero. PICC cultures positive for gram neg bacilli (March 22), with peripheral cultures from March 21 not yet reported. Have asked for repeat peripherals today to r/o systemic infection (hopefully just contaminated line). PICC has already been d/c'd by primary team.

Keep on Mero/Dapto for now, and will follow-up on final cultures. As previous, intraabdo collections improving based on last CT.

Electronic Signatures:
Jackson, Meghan (Resident) (Signed 23-Mar-2022 13:00)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *23-Mar-2022 13:00 by Jackson, Meghan (Resident)*

****

Pharmacist Note-Medication Management... [Charted Location: RUH-5000-Unit 4-5039-01] [Date of Service: 22-Mar-2022 10:59, Authored: 22-Mar-2022 10:59]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

CHART TEXT:
- **Pharmacy progress note** — Daptomycin/Atorvastatin Drug Interaction

Body Metrics:
INFORMATION:
- **Pharmacy Service** — ID Pharmacist

Type of Document:
PHARMACY SERVICE PROVIDED:
- **Type** — Medication Management

Plan/Recommendation:
CHART TEXT:
- **Issue 1**

41 yo male with IAI, spiked temp Mar 21, changed to meropenem and daptomycin as drain cultures Mar 6 show resistant E cloacae and VRE. Patient also on atorvastatin 80 mg po daily, which was initiated in December when patient presented with ACS.
Drug interaction between daptomycin and atovastatin exists - increased risk of rhabdomyolysis. Usual recommendation would be to hold statin while on daptomycin therapy. However, given patient presented with ACS in December, will opt to continue atorvastatin and monitor CK more closely.

- **Suggestion/Plan**

1. Increase CK monitoring to twice weekly. If CK increases, hold atorvastatin.

- **Pharmacist Contact Information (Phone, Pager, etc.)** — Danielle Shmyr, BSP (Ph: 2975)

Electronic Signatures:
Shmyr, Danielle (Pharmacist) (Signed 22-Mar-2022 11:06)
Authored: *CHART SECTION, Body Metrics, Type of Document, Plan/Recommendation*

Last Updated: *22-Mar-2022 11:06 by Shmyr, Danielle (Pharmacist)*

****

MD Progress Note-Daily-ID [Charted Location: RUH-5000-Unit 4-5039-01] [Date of Service: 22-Mar-2022 10:06, Authored: 22-Mar-2022 10:06]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:

- **Service:** ID
- **Historical Information/Hospital Course:** ID: 41M with prolonged hospital stay post cardiac arrest, complicated by ischemic bowel and intraabdominal sepsis.

See previous ID consult from March 11, for full details. In summary, admitted to hospital Dec 2/21 post cardiac arrest. Has 1x stent to LAD. Complicated by hypoperfused/ichemic gut, therefore to OR Dec 5 for colectomy. Repeat washout and end ileostomy creation Dec 7. Had stay in ICU 2' intra-abdo sepsis Dec 18, on broad coverage antibx as previous and source control with IR drain (thought to be a sigmoid stump leak). Course also complicated by biliary stricture requiring ERCP and stent Feb 22, but no evidence of cholangitis. Now on ward convalescing.

Called back today as patient febrile O/N with N/V and tachycardia. Not hypotense, and feels well this AM. Working on increasing PO intake. Repeat CTAP yesterday shows pancreatic tail collection to be improving along with the extension towards mid-line. Perc drain drains ~50ml/day.

March 6 drain culture grew candida (not treated), E. Cloacae (resistant to Cipro) and E. Faecium. Blood cultures from March 11 negative.

WBC's elevated today with neutrophilia, mild increase in Cr. Otherwise, cholestatic enzymes trending down. Remains tachy 90-100's, SBP 90-100 (typical for him). Afebrile this AM. Picc and Perc drain site look well. No abdo tenderness, no murmurs heard.

Suggestions:
-Ensure blood cultures from PICC sent (only peripherals sent yesterday). With prolonged antibiotics, risk of line infection (or now fungal involvement)
-D/C Cipro/Flagyl, start Mero based on previous resistances of E. cloacae. Add Dapto to cover E. faecium. Notes potential previous rash with Mero, but not clear at the time. Will watch closely. Will also need weekly CBC, lytes, CRP, CK for sure while on Dapto. Seemingly improving from intra-abdo perspective based on imaging, but chance there is a set back as antibiotics were not appropriate for the past week.
- We will follow-up with the above cultures and tailor/comment about ongoing management needs after.

ID Attending (Dr. S. Peermohamed): Agree with above. This is a certainly a challenging situation given the isolation of multi-drug resistant bacteria. Agree to expand coverage to meropenem and daptomycin given the isolation of Enterobacter cloacae complex and VRE, obtain blood cultures from his PICC line, and monitor clinical response. He will need a

prolonged course of antimicrobials, ongoing source control and drainage, and serial imaging to guide duration of therapy. Please monitor bloodwork including CK levels twice weekly given risk of rhabdomyolysis with daptomycin, and monitor for rash and eosinophilia given possible prior drug reaction with meropenem. No prior history of anaphylaxis with carbapenems so will monitor closely. Thank you for involving us in the management of this patient. We will continue to follow.

Electronic Signatures:
Jackson, Meghan (Resident) (Signed 22-Mar-2022 10:42)
Authored: *Patient HSN, Physician Daily Progress Note*
Peermohamed, Shaqil (MD) (Signed 22-Mar-2022 11:03)
Authored: *Physician Daily Progress Note*

Last Updated: *22-Mar-2022 11:03 by Peermohamed, Shaqil (MD)*

[Date of Service: 03-Feb-2022 00:00, Authored: 03-Feb-2022 00:00]Inpatient Progress Note [Charted Location: RUH-5000 Unit 1-5005-03]- for Visit: 10521726, [Signed by: Pirani, Fatima (MD) 05-Feb-2022 07:49]; [Entered by: Filed by, Interfaces (Other) 04-Feb-2022 16:57]; [Signed by: Tsybina, Polly (Resident) 05-Feb-2022 07:49] General, *Complete, Entered, Signed in Full, General*

MRN: 1315031
NAME: FEHR, RICHARD NEIL
DOB: 23-FEB-1981
VISIT ID: 10521726
HSN:
CONS PHYS: Fatima Pirani, MD
FAM PHYS: Jillian Fraser, MD
DATE SEEN: 03-Feb-2022
LOCATION: 50U1 IP ADM: 02-DEC-2021
Royal University Hospital
Inpatient Progress Note

IDENTIFICATION: Mr. Fehr is a pleasant 40-year-old man who has been initially admitted to hospital after an out-of-hospital cardiac arrest. The General Internal Medicine service has been following him for increased liver enzymes, delirium, antiplatelet therapy management, and anticoagulation management. This will serve as a sign-off note.

COURSE IN HOSPITAL: The GIM team has been following Mr. fair for increased liver enzymes following MRCP. This has been progressive over the course of about 2 weeks, going since January 10. MRCP done on January 28 revealed that there was a stricture, likely ischemic stricture in the CBD. Subsequent to this, ERCP was arranged; however, this failed as reportedly there was too much edema at the site and the gastroenterology team was not able to do the ERCP or deploy a stent. Following this, General Surgery arranged for percutaneous biliary drain, which was successful. Essentially, at this point, the management was given by General Surgery, and we will leave it in their capable hands. The liver enzymes began to degrees quite quickly after the bilirubin drain was inserted, which was reassuring. In the gastroenterology note from ERCP, the gastroenterologist recommended trying to repeat ERCP in about 2 weeks, once the local edema has decreased, and we will leave this to the to the General Surgery team to arrange.

In terms of antiplatelet management, we spoke with Cardiology, and this patient had this patient had an occlusion in his LAD and use a drug-eluting stent just in December of 2021, and notably, his presentation with this particular pathology was quite dramatic with out of hospital cardiac arrest, his dual antiplatelet therapy in the form of Plavix and aspirin should be continued for minimum of 1 year from the stent placement. Specifically, the dual antiplatelet therapy should be continued for the first 3 months after stent placement, even when invasive procedures are planned. Of course, a specific procedure being planned needs to be considered. Specifically, we have advised doing ERCP as well as percutaneous drain. The dual antiplatelet therapy is to be continued, as these procedures were done fairly recently, and the stent was quite fresh. If there are further questions regarding potential interruption of antiplatelets, please feel free to call us back.

Otherwise, this patient has also had a DVT. This occurred on December 21, 2021. This was in the context of a diagnosis of heparin-induced thrombocytopenia, which was made some 2 weeks prior to the DVT. To that end, patient is currently on warfarin. The patient will need a minimum of 3 months of warfarin in total to treat the DVT, and after that, he is to follow up with Hematology regarding further management of anticoagulation. We have liaised

with Hematology during this admission, and Dr. _____ suggested fondaparinux at a prophylactic dose when warfarin needs to be interrupted. Therefore, again if further invasive procedures are planned where interruption of warfarin is needed, please do not hesitate to call us back. At this point, we have left the patient on warfarin, which was restarted after the percutaneous drain was placed. Once the INR reaches 2, fondaparinux can be stopped.

We thank you very much for involving us in the patient's care. Please do not hesitate to contact us if you have any further questions.

Dictated by: Polly Tsybina, RESIDENT

_____
Fatima Pirani, MD

This document has been dictated and may have been distributed before being read. Any corrections to this document must be made within thirty (30) days following the transcription date.

PT/MODL
DD: 2022-Feb-04 16:00:22
DT: 2022-Feb-04 16:57:48
Job #: 461388/57329199

cc: Fatima Pirani, MD
Jillian Fraser, MD

Pharmacist Note-Medication Management... [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 18-Jan-2022 14:43, Authored: 18-Jan-2022 14:43]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

CHART TEXT:

• **Pharmacy progress note**	Haloperidol QTc interaction and options for antiemetic

Type of Document:
PHARMACY SERVICE PROVIDED:

• **Type**	Medication Management
• **Reason for Intervention**	drug interaction

Plan/Recommendation:
COMMUNICATION:

• **Pharmacist Suggestion/Plan Discussed With**	General surgery resident (paged pharmacy for consult)

CHART TEXT:

• **Issue 1**

Patient receiving low dose haloperidol IV to manage nausea/vomiting. Haloperidol has the following drug interactions:
-increased risk of QT prolongation with ciprofloxacin
-increased risk of serotonin syndrome/neuroleptic malignant syndrome with linezolid

• **Rationale 1**

Risk of experiencing QT prolongation and serotonin syndrome will increase if dose is increased and if medication is used frequently to manage nausea. ECG today, QTc = 439. Patient has experienced significant QT prolongation in the past (QTc has been 520).

• **Issue 2**

In discussion with resident re: options for nausea management was asked about risks associated with adding erythromycin as a prokinetic.

• **Rationale 2**

Erythromycin has the following interactions:
-atorvastatin: may increase serum concentration of atorvastatin
-clopidogrel: may diminish antiplatelet effects of clopidogrel
-ciprofloxacin: increased risk of QT prolongation
-haloperidol: increased risk of QT prolongation

• **Suggestion/Plan**

As discussed, may continue using haloperidol for now as patient did benefit from first doses. Recommend closely monitoring QTc and serum electrolytes (ie. potassium) and discontinuing use if QTc rises significantly (suggest using caution if QTc 470, discontinue if QTc rises to 480 or greater). Replace electrolytes as needed to maintain optimal cardiac function. Monitor for signs of serotonin syndrome and/or neuroleptic malignant syndrome while using with linezolid (eg. mental status changes, autonomic instability, neuromuscular hyperactivity, muscle rigidity, hyperthermia)

Regarding erythromycin, may consider trial if haloperidol no longer providing benefit. Would not suggest starting trial if haloperidol discontinued due to QT prolongation. If proceed with erythromycin trial, suggest daily ECGs and discontinue use if no benefit after 2 days or QTc rises to 480 or greater. Monitor liver function as jaundice and hepatic impairment have been reported with use (more likely with prolonged therapy).

- **Pharmacist Contact Information (Phone, Pager, etc.)** Pager # 12582

Electronic Signatures:
Rosen, Jennifer (Pharmacist) (Signed 18-Jan-2022 15:55)
Authored: *CHART SECTION, Type of Document, Plan/Recommendation*

Last Updated: *18-Jan-2022 15:55 by Rosen, Jennifer (Pharmacist)*

****

Pharmacist Note-Medication Management... [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 14-Jan-2022 10:13, Authored: 14-Jan-2022 10:13]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

CHART TEXT:
- **Pharmacy progress note** Ciprofloxacin + Qtc

Type of Document:
PHARMACY SERVICE PROVIDED:
- **Type** Medication Management
- **Reason for Intervention** investigation

Plan/Recommendation:
CHART TEXT:
- **Issue 1**

Ciprofloxacin can increase Qtc. Original ECG Jan 11 Qtc=520 - prolonged. Repeat ECG Jan 13th prior to starting Ciprofloxacin Qtc 435 - within normal range. Repeat ECG Jan 14th after starting Ciprofloxacin was 433 - no increase since starting Cirpofloxacin.

- **Rationale 1**

Ciprofloxacin has not shown to affect Qtc currently on initiation.

- **Suggestion/Plan**

Suggest

Repeat ECG periodically while on Ciprofloxacin and had prolonged Qtc in past.
Ensure electrolytes are replaced and maintained in normal range while on Ciprofloxacin.
Avoid additional Qtc prolonging medication in addition to Ciprofloxacin.

- **Pharmacist Contact Information (Phone, Pager, etc.)** Amanda Tisdale pg 12582

Electronic Signatures:

Tisdale, Amanda (Pharmacist) (Signed 14-Jan-2022 10:21)
Authored: *CHART SECTION, Type of Document, Plan/Recommendation*

Last Updated: *14-Jan-2022 10:21 by Tisdale, Amanda (Pharmacist)*

****

Pharmacist Note-Medication Management... [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 14-Jan-2022 08:29, Authored: 14-Jan-2022 08:29]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

CHART TEXT:

- **Pharmacy progress note** — Linezolid + Metoclopramide Interaction

Type of Document:
PHARMACY SERVICE PROVIDED:

- **Type** — Medication Management
- **Reason for Intervention** — drug interaction

Plan/Recommendation:
CHART TEXT:

- **Issue 1**

Metoclopramide has significant interaction with linezolid.

- **Rationale 1**

As per Lexi - interaction risk X. Avoid combination. Linezolid is a weak MAOI. Combination with metoclopramide can result in increased blood pressure and concurrent use is not recomended.

- **Suggestion/Plan**

Safest antinauseant although not ideal due to interactions, linezolid and metoclopramide and ciprofloxacin and ondansetron is dimenhydrinate.

- **Pharmacist Contact Information (Phone, Pager, etc.)** — Amanda Tisdale pg 12582

Electronic Signatures:
Tisdale, Amanda (Pharmacist) (Signed 14-Jan-2022 08:36)
Authored: *CHART SECTION, Type of Document, Plan/Recommendation*

Last Updated: *14-Jan-2022 08:36 by Tisdale, Amanda (Pharmacist)*

****

Pharmacist Note-Medication Management... [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 13-Jan-2022 13:31, Authored: 13-Jan-2022 13:31]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

CHART TEXT:

- **Pharmacy progress note** — Antibiotics and Issues

Type of Document:

PHARMACY SERVICE PROVIDED:

- **Type** — Medication Management
- **Reason for Intervention** — adverse reaction, drug interaction

LAB INFORMATION:

Microbiology:

11-Jan-2022 08:00, Blood Culture.

- **Blood Culture.**

Collected: 11/01/22 08:00 Received : 11/01/22 09:04
Source: Blood - venipuncture
Site:
Blood Culture PRELIM 12/01/22 15:47
ORGANISM 01 Enterobacter cloacae complex
(Growth in both aerobic and anaerobic bottles)
.
Resistance to cephalosporins, extended-spectrum penicillins and beta-lactam/beta-lactamase inhibitor combinations MAY develop during therapy with these agents. For serious infections, these agents should be avoided. Please contact the Microbiologist-on-call, via RUH Switchboard, if further consultation is required.
.
This organism is intrinsically resistant to cefazolin.

11-Jan-2022 08:30, Wound Culture

- **Wound Culture**

Collected: 11/01/22 08:30 Received : 11/01/22 09:03
Source: Drainage
Site: chest tube peritoneal
Gram Stain FINAL 11/01/22 13:31
Abundant polymorphonuclear white blood cells
Few squamous epithelial cells
Abundant mixed flora including:
Abundant gram negative bacilli
Abundant gram positive bacilli
Few gram positive cocci
Wound Culture PRELIM 13/01/22 10:54
Commensal flora (moderate)
ORGANISM 01 Enterobacter cloacae complex
(moderate)
.
Resistance to cephalosporins, extended-spectrum penicillins and beta-lactam/beta-lactamase inhibitor combinations MAY develop during therapy with these agents. For serious infections, these agents should be avoided. Please contact the Microbiologist-on-call, via RUH Switchboard, if further consultation is required.
.
This organism is intrinsically resistant to cefazolin.

ORGANISM	ORG# 01		
ANTIMICROBIAL	MIC	INT	DAILY COST
Amoxicillin/Clav	>=32	R	PO $$
Ampicillin		R	IV $$
			PO $
Cefixime	>=4	R	PO $$
Ceftriaxone		R	IV $$$
Ciprofloxacin	0.25	S	IV $$$$
			PO $
Ertapenem	2	R	IV $$$$
Gentamicin	<=1	S	IV $$
Piperacillin/tazobactam	>=128	R	IV $$$$
Trimethoprim/Sulfa	<=20	S	IV $$$$
			PO $

$=<$2 $$=$2-$10 $$$=$11-$40 $$$$=$41-$90 $$$$$>$90

S=Susceptible SDD=Susceptible Dose Dependent NS=Non-susceptible
R=Resistant MIC values in mcg/mL
SYN-S: susceptible result indicates synergy is likely with a susceptible penicillin or a susceptible glycopeptide.
SYN-R: resistant result indicates synergy is NOT likely.

• **Wound Culture**
Collected: 11/01/22 08:30 Received : 11/01/22 09:04
Source: Jackson Pratt drainage
Site: abdominal
Gram Stain FINAL 11/01/22 13:34
Abundant polymorphonuclear white blood cells
Scant squamous epithelial cells
Abundant mixed flora including:
Abundant gram negative bacilli
Few gram positive bacilli
Scant gram positive cocci
Wound Culture PRELIM 13/01/22 10:59
ORGANISM 01 Enterobacter cloacae complex (moderate)
Organisms from this specimen appear identical to organisms isolated from another specimen.
See Micro. order V3111367 collected on 11/01/2022.
ORGANISM 02 Enterococcus faecium - (Group D) (few)
Organisms from this specimen appear identical to organisms isolated from another specimen.
See Micro. order V3111367 collected on 11/01/2022.

General Laboratory:

13-Jan-2022 10:57, PT + PTT

• **INR** ↑ 3.3 [0.8 - 1.2]
IMPORTANT: The Na Citrate ("blue top") sample tubes required for coagulation testing are in short supply world-wide for the foreseeable future. As applicable, appropriately selected patients should be prescribed a DOAC instead of warfarin, to minimize dependence on coagulation testing for anticoagulant management.
Recommended Ranges for Therapeutic Oral Anticoagulant

INDICATION	INR
Mechanical Prosthetic Heart Valves	2.5-3.5
Recurrent Systemic Embolization	2.5-3.5
Most Other Indications	2.0-3.0

Plan/Recommendation:

CHART TEXT:

• **Issue 1**
Patient started on Ciprofloxacin & Metronidazole.
• **Rationale 1**
Both Ciprofloxacin and Metronidazole can increase INR. Regular monitoring and dose adjustment is required. During therapy and when stopped.

• **Issue 2**
Ciprofloxacin can prolong Qtc. ECG Jan 11 Qtc=520.
• **Rationale 2**
ECG baseline Jan 11. Qtc=520.
• **Issue 3**
Linezolid if started has no interaction with current medications

• **Suggestion/Plan**
Warfarin interaction - will continue daily INR + warfarin dosing. INR=3.2 Jan 13. Reduce dose to 2mg today. Assess further dosing as per daily INR.

Qtc - repeat ECG today and Jan 14th for new baseline + Ciprofloxacin effect on Qtc. Will also stop ondansetron to ensure receiving no other Qtc prolonging medication. Reassess Jan 14th.

Linezolid if started is safe with current medications.
• **Pharmacist Contact Information (Phone, Pager, etc.)** Amanda Tisdale pager 12582

Electronic Signatures:
Tisdale, Amanda (Pharmacist) (Signed 13-Jan-2022 13:46)
Authored: *CHART SECTION, Type of Document, Plan/Recommendation*

Last Updated: *13-Jan-2022 13:46 by Tisdale, Amanda (Pharmacist)*

****

MD Progress Note-Brief-ID [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 07-Jan-2022 12:02, Authored: 07-Jan-2022 12:02]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ID
Progress Note: 40M with complications post cardiac arrest and resultant ischemic bowel and pancreatic necrosis. Developed infected hematoma/collections that have since been source controlled Dec 21. Cultures grew VRE (Dapto and Linezolid S) as well as bacteroides and parabactereoides species.

Had been on piptazo Dec 18-31 then Amoxiclav Dec 31-pres and Linezolid Dec 21-Jan 5.

Was having some increased abdominal pain a couple days ago but this has been improving. CT scan showed amorphous collections without discernable wall.

Plan:
Has been stable off Linezolid. Would monitor for few more days then suggest stopping Amoxiclav. Collections don't have wall or rim enhancement to suggest abscess. If deterioration off antibiotics then suggest IR guided aspirate of same.

Will sign off but please call back if any questions or concerns.

Electronic Signatures:
Henni, Amina (Sarah) (MD) (Signed 07-Jan-2022 12:06)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *07-Jan-2022 12:06 by Henni, Amina (Sarah) (MD)*

****

MD Progress Note-Brief-ID [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 06-Jan-2022 11:10, Authored: 06-Jan-2022 11:10]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ID
Progress Note: 40M with complications post cardiac arrest and resultant ischemic bowel and pancreatic necrosis. Developed infected hematoma/collections that have since been source controlled Dec 21.

Doing well on Antibiotics step down to PO Amoxiclav. Following complaints of abdominal discomfort, trial to stop linezolid was recommended yesterday (Jan 5). Abdominal discomfort improved, was able to pass gas and ambulate today.

Labs
WBC- 7.40 Plt - 344
Urea- 5.9,Cr- 39; eGFR - 142

CT abd/pelvis still show considerable fluid in the upper abd, redistribution of collections, some sub hepatic collections.

Imp:
40M with complications of cardiac arrest. No fever /chills, doing well on step down antibiotics coverage. CT shows some redistributed fluid collection but no sign of worsening infection. Very much improved with attempts at ambulating today.
Plan:
Continue Amoxiclav
Monitor for signs of worsening infection -Vitals, WBC

Electronic Signatures:
Onaemo, Vivian (Resident) (Signed 06-Jan-2022 16:56)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *06-Jan-2022 16:56 by Onaemo, Vivian (Resident)*

****

MD Progress Note-Brief-ID [Charted Location: RUH-5000 Unit 1-5005-02] [Date of Service: 05-Jan-2022 09:46, Authored: 05-Jan-2022 09:46]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ID
Progress Note: 40M with complications post cardiac arrest and resultant ischemic bowel and pancreatic necrosis. Developed infected hematoma/collections that have since been source controlled Dec 21. Growth of VRE, bacteroides and parabacteroides species (was on Mero and then Piptazo in time before/during aspirate/OR).

Had been stepped down to PO Amoxiclav last week and continued Linezolid. Has done relatively well. With increase in diet has noticed some increased abdominal bloating/cramping. No fevers or chills. Some liquid output in ileostomy but not clear if this is a change. No nausea or vomiting.

Plan:
Trial stop of Linezolid
Continue Amoxiclav

Electronic Signatures:
Henni, Amina (Sarah) (MD) (Signed 05-Jan-2022 09:50)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *05-Jan-2022 09:50 by Henni, Amina (Sarah) (MD)*

****

MD Progress Note-Brief-ID [Charted Location: RUH-5000-Obs-5021-03] [Date of Service: 31-Dec-2021 13:02, Authored: 31-Dec-2021 13:02]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ID
Progress Note: Continues to clinically improve. Currently on Piptazo plus Linezolid.

Plan:
Will change Piptazo to amoxiclav and continue Linezolid
Monitor CBC for any signs of bone marrow suppression.

Electronic Signatures:
Henni, Amina (Sarah) (MD) (Signed 31-Dec-2021 13:03)

Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *31-Dec-2021 13:03 by Henni, Amina (Sarah) (MD)*

****

MD Progress Note-Brief-ID [Charted Location: RUH-5000-Obs-5021-03] [Date of Service: 28-Dec-2021 16:22, Authored: 28-Dec-2021 16:22]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: 540228788 10SK

PROGRESS NOTE:
Service: ID
Progress Note: 40M admitted Dec 2 after presenting with out of hospital cardiac arrest secondary to ACS. Had DES to LAD at that time. Resultant ischemic bowel requiring E1 laparotomy. Subtotal colectomy with endileostomy and rectal stump. Evidence of necrotic colon as well as possible duodenal ischemia and pancreatic necrosis. Admitted to ICU post op Dec 5. Was started on Piptazo then.

Taken back to OR Dec 7 for second look. Remaining bowel health but edematous.

In ICU was pancultured which demonstrated E. cloacae in sputum. Was changed from Piptazo to Meropenem Dec 10. Started to notice around that time that he had what was described as bilateral abdominal hematomas. Areas of erythema with central blackening occuring at tinzaparin injection sites. Was changed to fondaparinux and HIIT assay ordered and positive.

Transferred to GenSx ward Dec 15. First mention of rash Dec 17 when noted to have a macular rash to his trunk and arms bilaterally as well as low grade temp. ID consulted at that time and suspected to have beta-lactam induced rash and changed to Cipro Metro Dec 17. Was having tachycardia and fever at that time. Dec 18 started to develop increasing abdo pain along with persistent fever. Had CT done Dec 17 that showed "collection near the pancreatic tail has enlarged in size now measuring 7.2x 3.7 x 2.8 cm (AP x TV x CC); however there is no peripheral enhancement to suggest an organized abscess."

Was transferred back to ICU Dec 18 and was started on Piptazo plus vanco and caspofungin. Mentioned that he had rash in the ICU readmit note. Had IR guided drain insertion Dec 19 which grew VRE and bacteroides. Was started on Linezolid Dec 21 and vanco stopped. Had repeat CT done Dec 21 that showed "worsening peripancreatic and retroperitoneal fluid accumulation with probable fat necrosis and hemorrhagic pancreatitis. A large retroperitoneal collection is seen at the level of the sigmoid staples with fluid and gas bubbles present in the vicinity of the sigmoid colon staples. This is highly suspicious for anastomotic dehiscence. A gas forming organism can also form bubbles. This fluid is also mixed
density suggesting it has hemorrhage within it. Generalized peritoneal fluid is now seen. Some of the new peritoneal fluid has gas bubbles and air-fluid levels within it in the left lower quadrant. This could be either from a gas-forming organism or from the bowel anastomotic dehiscence." Also noted to have thrombosis so was changed to argatroban.

Went to the OR that night for laparotomy. Had evacuation of infected hematoma, wash out, repair of sigmoid stump leak and repair of tear. Cultures collected at that time grew VRE and parabacteroides species (swab, not tissue). Caspofungin stopped Dec 25 and continued on Piptazo and Linezolid.

Since transferred out to the ward and doing fairly well. Still some ongoing tachycardia but rest of vitals stable. He denies any abdominal pain. Had VAC changed and wound has some sang ooze related to his anticoagulation but no surrounding erythema on exam.

WBC normal. CRP Dec 27 100 from >300.

Imp/Plan
40M with complications post cardiac arrest and resultant ischemic bowel and pancreatic necrosis. Developed infected hematoma/collections that have since been source controlled Dec 21. Cultures grew VRE (Dapto and Linezolid S) as well as bacteroides and parabactereoides species. He has been on piptazo since Dec 18 and Linezolid since Dec 21 and doing well.

Generally can stop abx for intra-abdominal sepsis 48-72hours post source control. Given protracted course will continue for now. Will need to continue monitoring CBC as Linezolid can cause myelosuppression but usually not till around 2 weeks. Eventually will plan to titrate antibiotics off. Discussed with patient and mother who is at bedside and both agreeable and happy with plan.

Electronic Signatures:
Henni, Amina (Sarah) (MD) (Signed 28-Dec-2021 17:21)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *28-Dec-2021 17:21 by Henni, Amina (Sarah) (MD)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-5000-Obs-5021-03] [Date of Service: 25-Dec-2021 11:13, Authored: 25-Dec-2021 11:13]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E) requiring dobutamine, ischemic bowel received subtotal colectomy with end ileostomy on Dec 6, and evacuation of hematoma on Dec 22, HIT on fondaparinux (currently held), and deep femoral vein DVT on Lt side with no PE.

  He has persistent tachycardia, febrile episodes consistent with spesis, went to OR again

overnight (Dec 22) for evacuation of infected hematoma and repair of sigmoid stump leakage. Multiple drains put in. Drain culture grew VRE sensitive to daptomycine, VRE. He has been switched to linezolid + pip tazo + caspofungin for intraabdominal sepsis since Dec 21.

Rounds this am:
CNS: GCS 15/15, RASS 0 CAM -.
Resp: SV on RA 92%
CV: Sometimes HTN, MAP adequate HR 120, SR. Metoprolol
GI: TPN at 90, NPO with NG
GU: FB +1.2L/24h, 3.4L cumulative
Heme/ID: Afebrile. On linezolid, pip-tazo, caspofungen, agatroban for AC, ASA
Art line
Drainage
1. Perc drain 75
2. L-flank 100
3. JP nothing

Meds:
Argatroban
lanso
Tazo jan 7, linezolid jan 7, caspo last day,
Plavix
TPN
Metoprolol 12.5
Dilaudid schedule + PRN

- **Active Issues and Plan:** 1. Intraabdominal sepsis
Sepsis improving, surgery is happy with current progress and ok with start trickle feed
continue with linezolid + pip taz + caspofungin

2. CAD
Previously only on ASA, will restart plavix
off dobutamine infusion now
restart on metoprolol 12.5mg BID
echo shows much improved LV function with normal EF, mild pulm HTN

3. DVT
argotogan and PCD for VTE

4. Respiratory
Extubated, on RA

5. ICU Care
Feeds: TPN, start trickle feed promote 20mL/h
Analgesia: dilaudid 0.5-1 q1h prn + acetaminophen
Sedation: none
Thromboprophylaxis: PCDs, agotraban infusion for DVT
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID
Glycemic Control: Humulin R Low Dose Correction

Rounds plan:
1. discontinue dose limit to agatroban

2. Sticker to ward

Dean Ferguson PGY5 Respirology

RN concerns about escalating dose of agatroban with decreasing aPTT, spoke with hematology on call Dr. Kodab, maximum dose 10mcg/kg/min, recommending continuing with normogram if therapeutic anticoagulation to be achieved. I ordered repeat CBC and monitor drain output to ensure patient no having hemorrhage overnight.

Electronic Signatures:
Ferguson, Dean (Resident) (Signed 26-Dec-2021 01:27)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *26-Dec-2021 01:27 by Ferguson, Dean (Resident)*

****

MD Progress Note-Daily [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 24-Dec-2021 11:28, Authored: 24-Dec-2021 11:28]- for Visit: 10521726, *Complete, Appended Only, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:

- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E) requiring dobutamine, ischemic bowel received subtotal colectomy with end ileostomy on Dec 6, and evacuation of hematoma on Dec 22, HIT on fondaparinux (currently held), and deep femoral vein DVT on Lt side with no PE.

  He has persistent tachycardia, febrile episodes consistent with spesis, went to OR again overnight (Dec 22) for evacuation of infected hematoma and repair of sigmoid stump leakage. Multiple drains put in. Drain culture grew VRE sensitive to daptomycine, VRE. He has been switched to linezolid + pip tazo + caspofungin for intraabdominal sepsis since Dec 21.

  Rounds this am:
  CNS: GCS 15/15, RASS 0
  Resp: SV on RA 92%
  CV: MAP adequate HR 120, SR. Metoprolol
  GI: TPN at 90, NPO with NG
  GU: FB +1.2L/24h, 3.4L cumulative
  Heme/ID: linezolid, pip-tazo, caspofungen, agatroban for AC, ASA
- **Active Issues and Plan:** 1. Intraabdominal sepsis
  Sepsis improving, surgery is happy with current progress and ok with start trickle feed continue with linezolid + pip taz + caspofungin

2. CAD
Previously only on ASA, will restart plavix
off dobutamine infusion now
restart on metoprolol 12.5mg BID
echo shows much improved LV function with normal EF, mild pulm HTN

3. DVT
argotogan and PCD for VTE

4. Respiratory
Extubated, on RA

5. ICU Care
Feeds: TPN, start trickle feed promote 20mL/h
Analgesia: dilaudid 0.5-1 q1h prn + acetaminophen
Sedation: none
Thromboprophylaxis: PCDs, agotraban infusion for DVT
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID
Glycemic Control: Humulin R Low Dose Correction

Rounds plan:
1. Feed: disucssed with surgery, happy with progress from surgical perspective, can start trickle feed. start on promote 20/h keep same rate.
2. discontinue dose limit to agatroban
3. restart on plavix
4. restart on metoprolol 12.5mg BID

Electronic Signatures for Addendum Section:
Wu, Nan (Resident) (Signed Addendum 25-Dec-2021 01:03)

RN concerns about escalating dose of agatroban with decreasing aPTT, spoke with hematology on call Dr. Kodab, maximum dose 10mcg/kg/min, recommending continuing with normogram if therapeutic anticoagulation to be achieved. I ordered repeat CBC and monitor drain output to ensure patient no having hemorrhage overnight.

Electronic Signatures:
Wu, Nan (Resident) (Signed 24-Dec-2021 19:31)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *25-Dec-2021 01:03 by Wu, Nan (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 23-Dec-2021 07:56, Authored: 23-Dec-2021 07:56]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:

HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:

- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E) requiring dobutamine, ischemic bowel received subtotal colectomy with end ileostomy on Dec 6, and evacuation of hematoma on Dec 22, HIT on fondaparinux (currently held), and deep femoral vein DVT on Lt side with no PE.

  He has persistent tachycardia, febrile episodes consistent with spesis, went to OR again overnight (Dec 22) for evacuation of infected hematoma and repair of sigmoid stump leakage. Multiple drains put in.

  Today one of drain culture grew VRE, resistent to ampicillin. Other sensitivity pending. He has been switched to linezolid + pip tazo + caspofungin for intraabdominal sepsis since Dec 21.

  CT chest/abdo also shows non-occlusive clots from Rt common femoral vein to IVC. no PE.

  Rounds:
  CNS: CAM negative, PEARL T max 37.9 AM, 39.1 overnight. Propofol off x 30 minutes.
  CV:
  Resp: Strong cough, PS 12/8 O/N now 8/8 0.30 RR 30-40.
  GI: on TPN, multiple chest/abdo drains, overnight drains:
  - chest tube 500/24
  - LUQ JP irrigated 10 cc/h
  - Perc 75/24h sang
  - L-malacot 50/24h; old sang
  - LLQ ?
  - midline JP 10 O/N serosang
  - rectal tube ?
  - vac ?
  - NG to suction

  GU: U/O 40-250 ml/h. +700/24h, +2L cummulative
  Heme/ID: + VRE, resistent to amicillin, Abx switched to linezolid + pip tazo + caspofungin, febrile overnight
- **Active Issues and Plan:** 1. Intraabdominal sepsis
  - likely from leaky rectal stump and Enterococcus resistant to vanco
  - discussed with surgery, will continue monitoring drain output
  - Spoke with microbiology to add extended sensiivity to VRE (including daptomycin)
  - continue with linezolid + pip taz + caspofungin

  2. CAD
  - only on ASA right now, plavix held since OR
  - Continue dobutamine infusion @ 2.5mcg/kg/min
  - yesterdays echo shows much improved LV function with normal EF, mild pulm HTN
  - argotogan started yesterday, still a HGB drop from yesterday (87-79)
  -No Plavix today, will reassess tomorrow

  3. DVT
  CT abdo confirms Rt deep femoral vein DVT, no PE
  - spoke with gen surg, ok with restarting anticoag from surgical perspective
  - spoke with hematology, agree with agatroban infusion

- PCD for VTE ppx
- started on agatroban infusion yesterday, small Hgb, some oozing from drains however no evidence of overt abdominal bleeding today

4. Respiratory
- intubated post op, PS 17/8, RR 38, FiO2 0.35
- Extubate today to high flow

5. ICU Care
Feeds: TPN, NPO with NG on suction
Analgesia: Dilaudid PRN + acetaminophen
Sedation: ppf infusion off, will D/C when extubated
Thromboprophylaxis: PCDs, agotraban infusion for DVT
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID
Glycemic Control: Humulin R Low Dose Correction

Rounds plan:
1. Extubation
2. Plavix tomorrow if Hb stable
3. D/C ET tube and if heart tolerates, D/C dobutamine
4. Await sensitivities of E. Faecium in drain culture

Angela Hodgson R2 Anesthesia

Electronic Signatures:
Ferguson, Dean (Resident) (Signed 23-Dec-2021 10:39)
Authored: *Physician Daily Progress Note*
Hodgson, Angela Jean (Resident) (Signed 23-Dec-2021 14:56)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *23-Dec-2021 14:56 by Hodgson, Angela Jean (Resident)*

****

MD Progress Note-Daily [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 22-Dec-2021 09:39, Authored: 22-Dec-2021 09:39]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E) requiring dobutamine, ischemic bowel received subtotal colectomy with end ileostomy on Dec 6, and evacuation of hematoma on Dec 22, HIT on fondaparinux (currently held), and deep femoral vein DVT on Lt side with no PE.

He has persistent tachycardia, febrile episodes consistent with spesis, went to OR again overnight (Dec 22) for evacuation of infected hematoma and repair of sigmoid stump leakage. Multiple drains put in.

Today one of drain culture grew VRE, resistent to ampicillin. Other sensitivity pending. He has been switched to linezolid + pip tazo + caspofungin for intraabdominal sepsis since Dec 21.

CT chest/abdo also shows non-occlusive clots from Rt common femoral vein to IVC. no PE.

Rounds:
CNS: RASS -2, sedation with PPF 50 and dilaudid prn
CV: MAP 80s, stable, HR 120 sinus tachy. On dobutamine 2.5
RESP: PS 17/8 RR 38, 0.35
GI: on TPN, multiple chest/abdo drains, overnight drains:
- chest tube 20
- LUQ JP 60
- Perc 15
- L malacot 130
- LLQ none
- midline JP 110
- rectal tube none
- vac 50
- NG 100 since OR

GU: U/O > 100/h
Heme/ID: + VRE, resistent to amicillin, Abx switched to linezolid + pip tazo + caspofungin, febrile overnight

- **Active Issues and Plan:** 1. Intraabdominal sepsis
- likely from leaky rectal stump and Enterococcus resistant to vanco
- discussed with surgery, will continue monitoring drain output
- Spoke with microbiology to add extended sensiivity to VRE (including daptomycin)
- continue with linezolid + pip taz + caspofungen

2. CAD
- only on ASA right now, plavix held since OR
- Continue dobutamine infusion @ 2.5mcg/kg/min
- Echo today
- Competing need for AC with DVT, and DAPT for DES, will continue hold plavix and start anticoag, continue with ASA

3. DVT
CT abdo confirms Rt deep femoral vein DVT, no PE
- spoke with gen surg, ok with restarting anticoag from surgical perspective
- spoke with hematology, agree with agatroban infusion
- PCD for VTE ppx
- started on agatroban infusion

4. Respiratory
- intubated post op, PS 17/8, RR 38, FiO2 0.35
- wean down sedation and check for cuff leak today, possibly extubate tomorrow

5. ICU Care
Feeds: TPN, NPO with NG on suction

Analgesia: Dilaudid PRN + acetaminophen
Sedation: ppf infusion
Thromboprophylaxis: PCDs, agotraban infusion for DVT
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID
Glycemic Control: Humulin R Low Dose Correction

Rounds plan:
- start agotraban, hold plavix
- request for VRE sensitivity
- Echo today
- possibly wean down on sedation and vent support

Electronic Signatures:
Wu, Nan (Resident) (Signed 22-Dec-2021 14:22)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *22-Dec-2021 14:22 by Wu, Nan (Resident)*

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MD Progress Note-Daily [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 21-Dec-2021 08:40, Authored: 21-Dec-2021 08:40]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E), ischemic bowel (subtotal colectomy with end ileostomy), and HIT on fondaparinux

PMHx:
Smoker

Called on Dec 18 by cardiology (Dr. Bree) for ongoing tachypnea, soft hemodynamics and tachycardia. CT abdomen found enlarging collection near pancreatic tail, ascites both of which have nil to suggest abscess at this time, R>L atelectasis and small pleural effusion.

Clinically, tachy 130, tachypneic >30 RR, febrile, SBP 100, sats 95% on NP. Looks unwell. Eschar to abdomen from subcut heparin. Ostomy pink, but output lower, lower UO. Bedside echo showed VTI 8-10 and E/e of 10, with A lines bilaterally. Macular rash on (torso from B lactams).

See previous admission note to ICU for more details.

Rounds HL:

CNS - stable,
CV - sBP well over 120, stable. HR 130 sinus tachy
RESP 2.5 Lpm SpO2 94%
NG on suction. Staples look good. Pig tail draining sang.
+450/24h, -64 total ICU. 30 cc/h overnight
38.8 Fever last night, R-IJ, received

- **Active Issues and Plan:** · Active Issues and Plan:

1) Shock
- Combination of cardiogenic shock post-arrest + distributive for query intra-abdo sepsis
- Briefly on norepinephrine, currently on dobutamine 2.5mcg/kg/min IV infusion
- Central venous saturation in 59.8%, down from 69
-Lactate 2.0 today up from 1.2

Plan:
1. Continue dobutamine infusion @ 2.5mcg/kg/min
2. Conyinue ASA, hold ticagrelor, will start Plavix instead of Ticagrelor
3. Hold fondaparinux, will not start agatroban at this time
4. PCDs for VTE proph

2) Abdominal collection
- General surgery following to bedside
- Peritoneal signs night of Dec 18
- Aware of pancreatic tail collection and abscess brewing. Regardless, not wishing to open via OR
- On Piperacillin-Tazobactam + Vancomycin + Caspofungin
- Would be high risk operation, option of last resort
Plan:
1. Drain culture grew Enterococcus, sensitivities not back yet, however could add VRE coverage until speciation because of no improvement
2. Re-image abdo 48-72 hours after last CT

3) Respiratory failure
- SpO2 96% on 2LNP. overall oxygen requirements are not increasing
- Remains tachypneic in 30's-40s
- Not requiring escalation to non-invasive ventilation nor intubation at this time
Plan:
1. Continue antimicrobials as above

4) Heme
- Hgb 64 this am, transfused 1 unit PRBC
-repeat ABG later today

5. Pain
-Oral dilaudid prn for pain

6. Replace calcium

4) ICU Care
Feeds: Restarting TPN
Analgesia: Dilaudid 0.5-1mg IV q3hrs PRN + acetaminophen 325-650mg PO q4hrs PRN (max 4g/day)

Sedation: None
Thromboprophylaxis: PCDs, fondaparinux on hold
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID
Glycemic Control: Humulin R Low Dose Correction
SBT: N/A

Rounds plan:
1. pRBC and control labs 2 h after +- re-transfuse
2. Switch Vanco to Linezolid pending E. faecium sensitivity
3. Add Dilaudid to PO tomorrow
4. D/C norepi
5. Repeat TTE
6. CTPE and CT abdo

Electronic Signatures:
Hodgson, Angela Jean (Resident) (Signed 21-Dec-2021 12:43)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *21-Dec-2021 12:43 by Hodgson, Angela Jean (Resident)*

Pharmacist Note-Medication Management... [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 20-Dec-2021 14:26, Authored: 20-Dec-2021 14:26]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

Type of Document:
PHARMACY SERVICE PROVIDED:

- **Type** Medication Management
- **Reason for Intervention** drug interaction

Plan/Recommendation:
CHART TEXT:

- **Issue 1**

40 yo male admitted 18 days prior for cardiovascular event and subsequent intrabdominal ischemia following resuscitation, further complicated by development of HITT with dermal necrosis at site of tinzaparin subcutaneous injections. Previously on DAPT ASA + ticagrelor with DES at LAD, however experienced bleeding event, ticagrelor stopped in favour of clopidogrel (holding anticoagulant therapy at present). Also initiated on fluconazole for broad coverage of intrabdominal organisms on setting of pancreatitis (not a surgical candidate at present).

Fluconazole is a strong CYP 2C19 and 3A4 inhibitor; clopidogrel is metabolized from pro-drug to active form via both enzymes. Combination of two will reliable reduce or inhibit efficacy of clopidogrel.

- **Rationale 1**

DAPT is preferred in context of recent DES, however ticagrelor is less preferred given recent bleeding event.

- **Suggestion/Plan**

Select caspofungin as antifungal alternative to fluconazole.

- **Pharmacist Contact Information (Phone, Pager, etc.)** Vocera 0202

Electronic Signatures:
Berry, Cynthia (Pharmacist) (Signed 20-Dec-2021 14:36)
Authored: *Type of Document, Plan/Recommendation*

Last Updated: *20-Dec-2021 14:36 by Berry, Cynthia (Pharmacist)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 20-Dec-2021 09:30, Authored: 20-Dec-2021 09:30]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:

- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E), ischemic bowel (subtotal colectomy with end ileostomy), and HIT on fondaparinux

PMHx:
Smoker

Called on Dec 18 by cardiology (Dr. Bree) for ongoing tachypnea, soft hemodynamics and tachycardia. CT abdomen found enlarging collection near pancreatic tail, ascites both of which have nil to suggest abscess at this time, R>L atelectasis and small pleural effusion.

Clinically, tachy 130, tachypneic >30 RR, febrile, SBP 100, sats 95% on NP. Looks unwell. Eschar to abdomen from subcut heparin. Ostomy pink, but output lower, lower UO. Bedside echo showed VTI 8-10 and E/e of 10, with A lines bilaterally. Macular rash on (torso from B lactams).

See previous admission note to ICU for more details.

Rounds highlights:
CNS RASS 0 GCS 15
CV - Sinus tach SpO2 95%+, dobutamine 2.5; norepi. ASA, other held
RESP - RR 30's, weak non prod. cough. Stable on 2L via NP
GI - NG tube. L-flank drain 270
GU - Urine 70-100 cc/h. -644/24, -500 since ICU
Heme-ID; afebrile, R-IJ, R-art line. Tazocin. fluconazole.

- **Active Issues and Plan:** 1) Shock
  - Combination of cardiogenic shock post-arrest + distributive for query intra-abdo sepsis
  - Briefly on norepinephrine, currently on dobutamine 2mcg/kg/min IV infusion
  - Central venous saturation in 60s

  Plan:
  1. Continue dobutamine infusion @ 2.5mcg/kg/min
  2. Continue ASA, hold ticagrelor, will start Plavix instead of Ticagrelor
  3. Hold fondaparinux, will not start agatroban at this time
  4. PCDs for VTE proph

  2) Abdominal collection
  - General surgery following to bedside
  - Peritoneal signs night of Dec 18
  - Aware of pancreatic tail collection and abscess brewing. Regardless, not wishing to open via OR
  - On Piperacillin-Tazobactam + Vancomycin + Caspofungin
  - Would be high risk operation, option of last resort

  Plan:
  1. Continue current antibiotic regime
  2. Likely reimage in 48 hours

  3) Respiratory failure
  - SpO2 96% on 2LNP. overall oxygen requirements are not increasing
  - Remains tachypneic, however improved from yesterday

- Not requiring escalation to non-invasive ventilation nor intubation at this time
Plan:
1. Continue antimicrobials as above

4) ICU Care
Feeds: Restarting TPN
Analgesia: Dilaudid 0.5-1mg IV q3hrs PRN + acetaminophen 325-650mg PO q4hrs PRN (max 4g/day)
Sedation: None
Thromboprophylaxis: PCDs, fondaparinux on hold
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID
Glycemic Control: Humulin R Low Dose Correction
SBT: N/A

Rounds plan:
1. Repeat CT abdo in 48-72h
2. Not for surgery now as inflammatory abdomen and risk of perforation
3. TPN to restart
4. Restart plavix, hold prophylaxis, d/c fondaparinux
5. ABG/VBG SpcvO2 4 PM
6. Pending drain culture

Angela Hodgson R2 anesthesia

Electronic Signatures:
Ferguson, Dean (Resident) (Signed 20-Dec-2021 09:46)
Authored: *Patient HSN, Physician Daily Progress Note*
Hodgson, Angela Jean (Resident) (Signed 20-Dec-2021 15:16)
Authored: *Physician Daily Progress Note*

Last Updated: *20-Dec-2021 15:16 by Hodgson, Angela Jean (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 19-Dec-2021 08:38, Authored: 19-Dec-2021 08:38]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman with out of hospital cardiac arrest on December 2 with DES to LAD, complicated by cardiogenic shock (SCAI E), ischemic

bowel (subtotal colectomy with end ileostomy), and HIT on fondaparinux

PMHx:
Smoker

Called on Dec 18 by cardiology (Dr. Bree) for ongoing tachypnea, soft hemodynamics and tachycardia. CT abdomen found enlarging collection near pancreatic tail, ascites both of which have nil to suggest abscess at this time, R>L atelectasis and small pleural effusion.

Clinically, tachy 150, tachypneic >40 RR, febrile, SBP 100, sats 95% on NP. Looks unwell. Eschar to abdomen from subcut heparin. Ostomy pink, but output lower, lower UO. Bedside echo showed VTI 8-10 and E/e of 10, with A lines bilaterally. Macular rash on (torso from B lactams).

See previous admission note to ICU for more details.

- **Active Issues and Plan:** 1) Shock
- Combination of cardiogenic shock post-arrest + distributive for query intra-abdo sepsis
- Briefly on norepinephrine, currently on dobutamine 2mcg/kg/min IV infusion
- May need volume, elected to use albumin and RL
- Central venous saturation in 60s

Plan:
1. Continue dobutamine infusion @ 2.5mcg/kg/min
2. Continue ASA, hold ticagrelor
3. Hold fondaparinux, will not start agatroban at this time
4. PCDs for VTE proph

2) Abdominal collection
- General surgery following to bedside
- Peritoneal signs night of Dec 18
- Aware of pancreatic tail collection and abscess brewing. Regardless, not wishing to open via OR
- On Piperacillin-Tazobactam + Vancomycin + Caspofungin
- Would be high risk operation, option of last resort

Plan:
1. General surgery reassessed this am, suggest drain sample lipase
2. Continue antimicrobials, switch caspofungin to fluconazole 400mg IV daily

3) Respiratory failure
- SpO2 96% on 3LNP
- Tachypnea could be due to poor oxygen delivery and increased oxygen consumption from brewing sepsis
- Not requiring escalation to non-invasive ventilation nor intubation at this time

Plan:
1. Continue antimicrobials as above

4) ICU Care
Feeds: For r/a this afternoon
Analgesia: Dilaudid 0.5-1mg IV q3hrs PRN + acetaminophen 325-650mg PO q4hrs PRN (max 4g/day)
Sedation: None
Thromboprophylaxis: PCDs, fondaparinux on hold
Head Position: At 30 degrees
Ulcer Prophylaxis: Pantoprazole 40mg IV BID

Glycemic Control: Humulin R Low Dose Correction
SBT: N/A

-- Garrett Robson R2

Electronic Signatures:
Robson, Garrett (Resident) (Signed 19-Dec-2021 12:33)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *19-Dec-2021 12:33 by Robson, Garrett (Resident)*

****

MD Progress Note-Brief-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 18-Dec-2021 19:43, Authored: 18-Dec-2021 19:43]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PROGRESS NOTE:
Service: ICU
Related to: attending note
Progress Note: 40 OHCA Dec 2 with DES to LAD, complicated by cardiogenic shock (SCAI E) complicated by ischemic bowel (subtotal colectomy edn ileostomy), HIT on fondaparinux

Called tonight by cardiology Dr Bree for ongoing tachypnea, soft hemodynamics and tachycardia. CT abdomen found enlarging collection near pancreatic tail, ascites both of which have nil to suggest abscess at this time, R>L atelectasis and small pleff.

Clinically, tachy 150, tachypneic >40 RR, febrile, SBP 100, sats 95% on NP. Looks unwell. Eschar to abdomen from subcut heparin. Ostomy pink, but output lower, lower UO. Bedside echo showed VTI 8-10 and E/e of 10, with A lines bilaterally. Macular rash on (torso from B lactams)

PLAN:
1. Shock: start noradrenaline and dobutamine. May need volume; elected to use albumin and RL. SvO2 and lactate to be assessed
2. Respiratory failure: SpO2 96% on NP. Tachypnea could be due to poor oxygen delivery and increased oxygen consumption from brewing sepsis.
3. Infection: abx changed to cipro/flagyl by ID for B lactam rash. Consulted with Dr Shumilak who suggested tazocin and vanco. Cdiff negative.
4. Abdominal collection: called GSx to bedside. No peritoneal signs...yet. Aware of pancreatic tail collection and abscess brewing. Regardless, not wishing to open via OR. Broad spectrum antibiotcs at this time.
5. No feeds at this time
6. Prophylaxis with fondaparinus full dose.

Electronic Signatures:

Gebhardt, Colin Robert (MD) (Signed 18-Dec-2021 19:54)
Authored: *Patient HSN, Physician Brief Progress Note*

Last Updated: *18-Dec-2021 19:54 by Gebhardt, Colin Robert (MD)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 15-Dec-2021 07:54, Authored: 15-Dec-2021 07:54]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman admitted to ICU post cardiac arrest/MI/DES to LAD with ischemic bowel.

PMHx:
Smoker

This patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual ROSC. Down time was minimal. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU. Currently he has an end ileostomy and a rectal stump.

Round highlights:
- **Active Issues and Plan:** 1) Shock
- Initially likely Cardiogenic that has been mixed with distributive shock secondary to bowel ischemia/necrosis
- ECHO post MI showed EF of 10-15%
- Patient had been on dobutamine, now off for 4 days
- Bedside cardiac ultrasound showed improved contractility
- Dec 10, lactate normal, LVOT VTI = 19.5
- CXR Dec 12 - improved bibasilar atelectasis and pleural fluid
- Patient is out of shock now and holding MAP without pressors

Plan:
1. Cont. to monitor MAP, cardio/CCU to follow when out of ICU

2) Heparin-induced skin necrosis

- Second site appeared over past weekend, approx. 7 cm diameter
- Areas of erythema with central blackening that have extended to border
- Occurring at site of tinzaparin injections, wonder about LMWH-induced skin necrosis
- Hematology seen Dec 12 - Ordered HIT assay, Tinzaparin stopped, Fondaparinux started
- Plts now improving 77-- 289
- HIT assay POSITIVE on Dec 12
- Discussed with Dr. Pearson - erythema represents thrombosis, need therapeutic level anticoagulation

Plan:
1. Increase Fondaparinux to 7.5mg SC daily

3) Ischemic bowel
- Likely secondary to hypotension, not felt to be clot
- Abdomen is now closed with ++edematous bowel; lactate today remains normal; good U/O, abdomen feels firm but not tense
- Diuresis to reduce bowel ischemia; may have over-diuresed
- General Surgery following
- Good ileostomy output

Plan:
- Sticker to Sgx.

4) MI
- Patient has received DES post anterior MI
- OK to use gut for meds therefore patient on DAPT with asa + ticagrelor + Atorvastatin 80mg PO HS today

Plan:
1. Continue ASA + Ticagrelor + atorvastatin
2. D/c telemetry

5) AKI
- Due to intrarenal/hypoperfusion
- Creatinine peaked and normalized

Plan:
1. Cont. to monitor urine output and creatinine

6) Ischemic pancreas
- Pancreatic bed showing signs of insufficiency on second operation

Plan:
1. CT Abdomen as per Gen Surg

7) ICU care
Feeds - TPN
Analgesia - d/c dilaudid infusion; Add dilaudid prn
Thromboprophylaxis - Therapeutic Fondaparinux + compression stockings
GI prophylaxis - Yes
Transfer to Gen Surg ward today

Rounds plan:

Dean Ferguson PGY5 Respirology in ICU

Electronic Signatures:
Ferguson, Dean (Resident) (Signed 15-Dec-2021 08:00)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *15-Dec-2021 08:00 by Ferguson, Dean (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 14-Dec-2021 07:58, Authored: 14-Dec-2021 07:58]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman admitted to ICU post cardiac arrest/MI/DES to LAD with ischemic bowel.

PMHx:
Smoker

HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU. Currently he has an end ileostomy and a rectal stump.

Round highlights:
Suspect high normal CO2 related to increased dead space
- **Active Issues and Plan:** 1) Shock

- Initially likely Cardiogenic that has been mixed with distributive shock secondary to bowel ischemia/necrosis
- ECHO post MI showed EF of 10-15%
- Patient had been on dobutamine, now off for 4 days
- Bedside cardiac ultrasound show improved contractility
- Dec 10, lactate normal, LVOT VTI = 19.5
- CXR Dec 12 - improved bibasilar atelectasis and pleural fluid
- Patient is out of shock now and holding MAP without pressors

Plan:
1. Cont. to monitor MAP

2) Heparin-induced skin necrosis
- Second site appeared over past weekend, approx. 7 cm diameter

- Areas of erythema with central blackening that have extended to border
- Occurring at site of tinzaparin injections, wonder about LMWH-induced skin necrosis
- Platelets not thrombocytopenic on Dec 12
- Hematology seen Dec 12 - Ordered HIT assay, Tinzaparin stopped, Fondaparinux started
- Plts now improving 77-- 289
- HIT assay POSITIVE on Dec 12
- Discussed with Dr. Pearson - erythema represents thrombosis, need therapeutic level anticoagulation

Plan:
1. Increase Fondaparinux to 7.5mg SC daily

3) Ischemic bowel
- Likely secondary to hypotension, not felt to be clot
- Abdomen is now closed with ++edematous bowel; lactate today remains normal; good U/O, abdomen feels firm but not tense
- Diuresis to reduce bowel ischemia; may have over-diuresed
- General Surgery following
- Good ileostomy output

Plan:
- Cont. to monitor for signs of abdominal compartment syndrome

4) MI
- Patient has received DES post anterior MI
- OK to use gut for meds therefore patient on DAPT with asa + ticagrelor + Atorvastatin 80mg PO HS today

Plan:
1. Continue ASA + Ticagrelor + atorvastatin
2. D/c telemetry

5) AKI
- Due to intrarenal/hypoperfusion
- Creatinine peaked and normalized
- Ringer's Lactate @ 50mL/hr IV infusion

Plan:
1. Cont. to monitor urine output and creatinine
2. D/c metolazone

6) Ischemic pancreas
- Pancreatic bed showing signs of insufficiency on second operation

Plan:
1. CT Abdomen as per Gen Surg

7) ICU care
Feeds - TPN
Analgesia - d/c dilaudid infusion; Add dilaudid prn
Sedation - None
Thromboprophylaxis - Fondaparinux + compression stockings
GI prophylaxis - Yes
Glucose Control - No Concern
SBT - Did well with SBT today and extubated
Transfer to Gen Surg ward tomorrow

-- Garrett Robson R2

Electronic Signatures:
Robson, Garrett (Resident) (Signed 14-Dec-2021 15:15)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *14-Dec-2021 15:15 by Robson, Garrett (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 13-Dec-2021 09:10, Authored: 13-Dec-2021 09:10]- for Visit: 10521726, *Incomplete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman admitted to ICU post cardiac arrest/MI/DES to LAD with ischemic bowel.

PMHx:
Smoker

HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU. Currently he has an end ileostomy and a rectal stump

Rounds highlights
Neuro: GCS 11/11
Resp: PS 1-/14 fio2 30%
GI: Staples look good, JP in situ
GU: FB -1557/24 hours

- **Active Issues and Plan:** 1) Shock
- Initially likely Cardiogenic that has been mixed with distributive shock secondary to bowel ischemia/necrosis
- ECHO post MI showed EF of 10-15%
- Patient has been on dobutamine, now off for 3 days
- Bedside cardiac ultrasound show improved contractility
- Dec 10, lactate normal, LVOT VTI = 19.5

- Cxray Dec 12 - improved bibasilar atelectasis and pleural fluid
Plan:
Patient is out of shock now and holding MAP without pressors. Monitor

2) Bilateral abdominal hematomas
- Second site appeared over past 24hrs, approx. 7 cm diameter
- Areas of erythema with central blackening that have extended to border
- Occuring at site of tinzaparin injections, wonder about LMWH-induced skin necrosis
- Platelets not thrombocytopenic on Dec 12
- Hematology seen Dec 12 - Ordered HIIT assay to be done today, Tinza stopped, Fondaparinux started
- plts now improving 77-- 289
Plan:
1. continue Hold tinzaparin
2. Continue Fondaparinux 2.5mg SC daily for VTE proph as per heme
3. Compression stockings as well for VTE proph
4. Await Hiit assay results

3) Ischemic bowel
- Likely secondary to hypotension, not felt to be clot
- Abdomen is now closed with ++edematous bowel; lactate today remains normal; good U/O, abdomen feels firm but not tense
- Diuresis to reduce bowel ischemia; may have over-diuresed
- General Surgery following
Plan:
- Cont. to monitor for signs of abdominal compartment syndrome

4) MI
- patient has received DES post anterior MI
- OK to use gut for meds therefore patient on DAPT with asa + ticagrelor + Atorvastatin 80mg PO HS today
Plan:
1. Continue ASA + Ticagrelor + atorvastatin

5) AKI
- Due to intrarenal/hypoperfusion
- Creatinine peaked and normalized
- Trial of albumin and Lasix on Dec 10
- Ringer's Lactate @ 50mL/hr IV infusion
- scr improving now 75
Plan:
1. Cont. to monitor urine output and creatinine

6) Ischemic pancreas
- Pancreatic bed showing signs of insufficiency on second operation
Plan:
1. May need repeat CT abdomen early this week to reassess

7) ICU care
Feeds - TPN
Analgesia - d/c dilaudid infusion; Add dilaudid prn
Sedation - Propofol 20mcg/kg/min IV infusion
Thromboprophylaxis - Fondaparinux + compression stockings

GI prophylaxis - Yes
Glucose Control - No Concern
SBT - Did well with SBT today and extubated

PGY2 Im Jake Towriss

Electronic Signatures:
Ferguson, Dean (Resident) (Signed 13-Dec-2021 12:06)
Authored: *Physician Daily Progress Note*
Towriss, Jacob Lewis (Resident) (Signed 13-Dec-2021 16:00)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *13-Dec-2021 16:00 by Towriss, Jacob Lewis (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 12-Dec-2021 20:45, Authored: 12-Dec-2021 20:45]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman admitted to ICU post cardiac arrest/MI/DES to LAD with ischemic bowel.

PMHx:
Smoker

HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU. Currently he has an end ileostomy and a rectal stump

- **Active Issues and Plan:** 1) Shock
  - Initially likely Cardiogenic that has been mixed with distributive shock secondary to bowel ischemia/necrosis
  - ECHO post MI showed EF of 10-15%
  - Patient has been on dobutamine, now off for 2 days
  - Bedside cardiac ultrasound show improved contractility

- Dec 10, lactate normal, LVOT VTI = 19.5
Plan:
1. Chest X-ray to reassess for pleural effusions and prolonged ventilation

2) Bilateral abdominal hematomas
- Second site appeared over past 24hrs, approx. 7 cm diameter
- Areas of erythema with central blackening that have extended to border
- Occuring at site of tinzaparin injections, wonder about LMWH-induced skin necrosis
- Platelets not thrombocytopenic on Dec 12
Plan:
1. Hold tinzaparin
2. Start Fondaparinux 2.5mg SC daily for VTE proph
3. Compression stockings as well for VTE proph
4. Hematology consult

3) Ischemic bowel
- Likely secondary to hypotension, not felt to be clot
- Abdomen is now closed with ++edematous bowel; lactate today remains normal; good U/O, abdomen feels firm but not tense
- Diuresis to reduce bowel ischemia; may have over-diuresed
- General Surgery following
Plan:
- Cont. to monitor for signs of abdominal compartment syndrome

4) MI
- patient has received DES post anterior MI
- OK to use gut for meds therefore patient on DAPT with asa + ticagrelor
Plan:
1. Restart Atorvastatin 80mg PO HS today

5) AKI
- Due to intrarenal/hypoperfusion
- Creatinine peaked and normalized
- Trial of albumin and Lasix on Dec 10
- Ringer's Lactate @ 50mL/hr IV infusion
Plan:
1. Cont. to monitor urine output and creatinine

6) Ischemic pancreas
- Pancreatic bed showing signs of insufficiency on second operation
Plan:
1. May need repeat CT abdomen early this week to reassess

7) ICU care
Feeds - TPN
Analgesia - dilaudid +/- ketamine
Sedation - Propofol 20mcg/kg/min IV infusion
Thromboprophylaxis - Fondaparinux + compression stockings
GI prophylaxis - Yes
Glucose Control - No Concern
SBT - on PS/CPAP FiO2 30% 14/10, wean to PSV 5/5

-- Garrett Robson R2

Electronic Signatures:
Robson, Garrett (Resident) (Signed 12-Dec-2021 21:00)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *12-Dec-2021 21:00 by Robson, Garrett (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 10-Dec-2021 08:42, Authored: 10-Dec-2021 08:42]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** ID: 40 year old male admitted to ICU post arrest/MI/stent with ischemic bowel.

  PMHx: smoker

  HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU. Currently he has an end ileostomy and a rectal stump
- **Active Issues and Plan:** 1) Shock which is likely a mixture of cardiogenic and distributive shock
  Cardiogenic shock
  -echo post MI showed EF of 10-15%; patient has been on dobutamine; bedside echoes show improved contractility; no scvo2 today, lactate normal, LVOT VTI = 19.5
  -plan to continue dobutamine until after extubation; once there is no more PPV then turn off dobutamine and assess how hemodynamics respond to reduced afterload reduction and decreased contractility; consider another followup echo once the dobutamine is off to assess heart function
  Distributive shock - due to bacterial translocation or systemic inflammatory state from dead bowel
  -blood cultures have not grown anything; sputum culture has grown E.Cloacae; pip tazo changed to meropenem given saskatoon area antibiogram. Would treat for a total of 10 days.
  -lactate is normal, ScvO2 is good, kidney function is good; organs are perfused.
  -norepi and vasopressin are now off; will target slightly lower MAP/SBP; afterload reduction to

aid LV; however must watch out for poor gut perfusion, trend lactate and serial exams.

2) Ischemic bowel
-likely secondary to hypotension, not felt to be clot.
-abdomen is now closed with ++edematous bowel; lactate today remains normal; good U/O, 100-150 per hour; abdomen feels firm but not tense
-diuresis to reduce bowel ischemia; may have overdiuresed - decreased vti, rising Cr/urea, ?hypotension; consider albumin
-decreasing sedation to wake up
-general surgery following regarding stoma site

3) MI
-patient has received DES post anterior MI; OK to use gut for meds therefore patient on dapt with asa+ticagrelor

4) post arrest
-patient has had a VT/VF arrest and received bystander CPR and had ROSC; as per the history downtime was minimal and patient was seen moving all four limbs afterwards; patient is able to open eyes and move all four limbs while being sedated; no changes today

5) AKI
-AKI due to intrarenal/hypoperfusion; Cr peaked and normalized; planned for -1 to -1.5L overnight however may have overdiuresed due to rising cr/bun; will attempt albumin/ +/-lasix to achieve balance today

6) Ischemic pancreas
-pancreatic bed was not healthy looking during his second look; this was not touched on Dec 7 and will be monitored. May need serial re-imaging in 1-2 weeks.

7) ICU care
-feeds - TPN
-analgesia - dilaudid +/- ketamine for analgesia/sedation if required
-sedation - propofol, dilaudid +/- ketamine
-Thromboprophylaxis - LMWH
-GI prophylaxis - yes
-Sugars - OK
-SBT - not yet

Electronic Signatures:
Liu, Shui (Resident) (Signed 10-Dec-2021 16:34)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *10-Dec-2021 16:34 by Liu, Shui (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 09-Dec-2021 15:38, Authored: 09-Dec-2021 15:38]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:

- **Service:** ICU
- **Historical Information/Hospital Course:** ID: 40 year old male admitted to ICU post arrest/MI/stent with ischemic bowel.

PMHx: smoker

HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU.

Current issues are the stoma site looks dusky.

- **Active Issues and Plan:** 40M with recent STEMI, VT storm requiring PCI to LAD and bowel resection for ischemic gut. Pt also with ischemic pancreatic bed. Patient is status post resection with endoileostomy with a rectal stump.

1) Shock which is likely a mixture of cardiogenic and distributive shock
Cardiogenic shock
-echo post MI showed EF of 10-15%; patient has been on dobutamine; bedside echoes show improved contractility; LVOT VTI is 22 cm today; SCVO2 = 85% today; lactate remains normal
-plan to continue dobutamine until after extubation; once there is no more PPV then turn off dobutamine and assess how hemodynamics respond to reduced afterload reduction and decreased contractility; consider another followup echo once the dobutamine is off to assess heart function
Distributive shock - due to bacterial translocation or systemic inflammatory state from dead bowel
-blood cultures have not grown anything; sputum culture has grown E.Cloacae; pip tazo changed to meropenem given saskatoon area antibiogram. Would treat for a total of 10 days.
-lactate is normal, ScvO2 is good, kidney function is good; organs are perfused.
-norepi and vasopressin are now off; will target slightly lower MAP/SBP; afterload reduction to aid LV; however must watch out for poor gut perfusion, trend lactate and serial exams.

2) Ischemic bowel
-likely secondary to hypotension, not felt to be clot.
-abdomen is now closed with ++edematous bowel; lactate today remains normal; good U/O, 100-150 per hour; abdomen feels firm but not tense.
-stoma looks somewhat dusky; gen surge is aware and following
-plan to keep asleep today as bowel is still likely edematous; focus on diuresis - PRN lasix for balance of -1 to -1.5 L
-if looking well, plan to decrease sedation tomorrow; otherwise keep synchronous to vent today but does not need RASS of -5.

-general surgery following regarding stoma site.

3) MI
-patient has received DES post anterior MI; Gen Surg note today says they are OK with using gut for medications therefore we will DC eptifibatide and start DAPT with ASA and ticagrelor to prevent in stent thrombosis.

4) post arrest
-patient has had a VT/VF arrest and received bystander CPR and had ROSC; as per the history downtime was minimal and patient was seen moving all four limbs afterwards; patient is able to open eyes and move all four limbs while being sedated; no changes today.

5) AKI
-the patient did have rise in Cr after arrest which may be due to renal hypoperfusion and ATN from shock; Cr has peaked and is returning to normal; patient had U/O 100-150 per hour overnight and made himself negative; plan for negative balance of -1 to -1.5 L with PRN lasix to achieve.

6) Ischemic pancreas
-pancreatic bed was not healthy looking during his second look; this was not touched on Dec 7 and will be monitored. May need serial re-imaging in 1-2 weeks.

7) ICU care
-feeds - TPN
-analgesia - dilaudid +/- ketamine for analgesia/sedation if required
-sedation - propofol, dilaudid +/- ketamine
-Thromboprophylaxis - OK for DVT proph with LMWH
-GI prophylaxis - yes
-Sugars - OK
-SBT - not yet

Note ammended, agree with above.
Ian Schoonbaert, MD, FRCPC
Critical Care Medicine

Electronic Signatures:
Liu, Shui (Resident) (Signed 09-Dec-2021 16:04)
Authored: *Patient HSN, Physician Daily Progress Note*
Schoonbaert, Ian (MD) (Signed 09-Dec-2021 21:19)
Authored: *Physician Daily Progress Note*

Last Updated: *09-Dec-2021 21:19 by Schoonbaert, Ian (MD)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 08-Dec-2021 15:11, Authored: 08-Dec-2021 15:11]- for Visit: 10521726, *Complete, Entered, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:

- **Service:** ICU
- **Historical Information/Hospital Course:** ID: this is a 40 year old male who is admitted to the ICU with shock

PMHx: smoker

HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instability and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with an open abdomen. A second look done on Dec 7 showed that the remaining bowel was healthy but ++ edematous; abdomen was closed and patient was returned to the ICU

- **Active Issues and Plan:** 1) Shock which is likely a mixture of cardiogenic and distributive shock
Cardiogenic shock
-echo post MI showed EF of 10-15%; patient has been on dobutamine; bedside echoes show improved contractility; LVOT VTI is 21 cm today; SCVO2 = 68% today; lactate remains normal
-plan to continue dobutamine until after extubation; once there is no more PPV then turn off dobutamine and assess how hemodynamics respond to reduced afterload reduction and decreased contractility; consider another followup echo once the dobutamine is off to assess heart function
Distributive shock - due to bacterial translocation or systemic inflammatory state from dead bowel
-cultures have not grown anything; patient remains on piptazo; source control has been achieved
-lactate is normal, SCVO2 is good, kidney function is good; organs are perfused adequately
-norepi requirements have been reduced significantly overnight; from 0.22 to < 0.1 now, vaso 0.04
-Plan today would be to turn off vasopressin; may improve bowel perfusion as well

2) Ischemic bowel
-abdomen is now closed with ++edematous bowel; lactate today remains normal
-stoma looks somewhat dusky; gen surge is aware and following
-given signifcant edema and closed abdomen, we anticipate abdominal pressures to be high; will monitor for rising lactate, poor urine output, and have low threshold to check bladder pressures if patient appears sicker
-plan to keep asleep for today as increased abdominal pressures likely pushes on chest resulting in discomfort and air hunger if the patient were awake and trying to breathe on spontaneous mode; will reduce sedation to rass -2 to -3 and target ventilator synchrony
-must balance afterload; higher perfusion pressures may be required to perfuse bowel given edema and high venous pressures; however lower afterload would be required for improved heart function

3) MI

-patient has received DES post anterior MI; current this is being protected with eptifibatide as the patient was previously on a strict NPO by GSX
-gen surge note today says they are OK with using gut for medications therefore we will DC eptifibatide and start DAPT with ASA and plavix to prevent in stent thrombosis

4) post arrest
-patient has had a VT/VF arrest and received bystander CPR and had ROSC; as per the history downtime was minimal and patient was seen moving all four limbs afterwards; patient is able to open eyes and move all four limbs while being sedated which is positive; will not attempt other significant interventions now; next step is to wake up and examine which can be done when abdomen permits.

5) AKI
-the patient did have rise in Cr after arrest which may be due to renal hypoperfusion and ATN from shock; Cr has peaked and is returning to normal; patient is making good urine however was 1500 ml positive in the last 24 hours; given ++ edematous bowel will plan to make the patient neutral to +500 ml with lasix to achieve

6) Ischemic pancreas
-pancreatic bed was not healthy looking during his second look; this was not touched on Dec 7 and will be monitored.

7) ICU care
-feeds - TPN
-analgesia - dilaudid +/- ketamine for analgesia/sedation if required
-sedation - propofol, dilaudid +/- ketamine
-Thromboprophylaxis - OK for DVT proph with LMWH
-GI prophylaxis - yes
-Sugars - OK
-SBT - not yet

Electronic Signatures:
Liu, Shui (Resident) (Signed 08-Dec-2021 15:30)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *08-Dec-2021 15:30 by Liu, Shui (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 07-Dec-2021 15:59, Authored: 07-Dec-2021 15:59]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU

- **Historical Information/Hospital Course:** ID: this is a 40 year old male who is admitted to the ICU with shock

  PMHx: smoker

  HPI: this patient presented to hospital as an out of hospital cardiac arrest. He had bystander CPR and in hospital resuscitation with VT/VF storm and there was eventual rosc. Down time was minimal from my understanding. He was moving all four limbs after the arrest however he was sedated soon after this. He was taken to the cath lab given his history and it was found he had an anterior MI; he had a clot retrieved and a drug eluting stent placed and was sent to CCU post procedure. From my understanding he developed more hemodynamic instablity and a rising lactate and so his abdomen was scanned showing ischemic bowel. He was taken to the OR for emergency laparotomy and ended up getting a subtotal colectomy. He was transferred to the ICU postop with abdomen open with plans for a second look and closure after 24-48 hours.
- **Active Issues and Plan:** 1) shock - secondary to likely a combination of cardiogenic shock and distributive shock (primarily distributive) due to sepsis.
  sepsis - presumed with intraabdominal source given ischemic gut, bacterial translocation. Cultures are pending. Patient is on tazocin for coverage. MAP is maintained at 65 on norepi 0.21 vaso 0.04. SCVO2 = 70's. Lactate has been downtrending since operation. Doing OK from this perspective although will still require a second look and removal of more dead gut if there is any and closure.
  Cardiogenic - patient is on dobutamine 2. SCVO2 = 70's. LVOT VTI on bedside cardiac ultrasound = 19.8 cm. Previous TTE done shows EF 10-15%; on norepi and dobutamine the EF appears better today; globally qualitatively it looks moderately reduced, definitely not 10%. Patient is still at risk of hemodynamic instability post abdominal closure due to edematous bowel and raised intraabdominal pressure, as well as possible hemodynamic instability from 3rd spacing into the bowel; will treat with crystalloids as there is no advantage of albumin in this situation

  2) MI - post MI the patient was revascularized. Unable to use oral antiplatelets therefore the patient was on integrilin (eptifibatide); this has been off in preparation for a repeat operation; the patient is at high risk for in stent thrombosis given fresh stent and inflammatory state; IST would result in significantly worse outcome than surgical bleeding therefore plan would be to restart integrilin asap when the patient returns from OR.

  3) Cardiac arrest - patient was seen moving all 4's after ROSC which is reassuring but neurologic status has been a backburner issue as the patient cannot be assessed at this time due to the need to repair the abdomen first; After abdomen is closed and patient is stable on antiplatelets, will lighten the sedation to see what the patient does.

  4) AKI - mild ATN vs prerenal insult from poor perfusion and low flow state; Cr has now normalized and we will continue to follow

  5) Ischemic pancreas - reported on CT abdomen from time of admission; will continue to monitor for this at this time

  6) Feeds - TPN
  Analgesia - dilaudid infusion
  Sedation - propofol
  Thromboproph - PCDs +/- integrilin, will start chemical DVT proph later
  Ulcer - on
  Glycemic - OK

SBT - not time yet.

Electronic Signatures:
Liu, Shui (Resident) (Signed 07-Dec-2021 16:41)
Authored: *Patient HSN, Physician Daily Progress Note*

Last Updated: *07-Dec-2021 16:41 by Liu, Shui (Resident)*

****

MD Progress Note-Daily-ICU [Charted Location: RUH-ICU 3-3321-02] [Date of Service: 06-Dec-2021 07:43, Authored: 06-Dec-2021 07:43]- for Visit: 10521726, *Complete, Revised, Signed in Full, General*

PATIENT HSN:
HSN: SKUNKNOWN 10SK

PHYSICIAN DAILY PROGRESS NOTE:
- **Service:** ICU
- **Historical Information/Hospital Course:** 40 year old gentleman post-cardiac arrest and ischemic bowel requiring subtotal colectomy

History of Presenting Illness: Patient was admitted on December 2nd for a cardiac arrest and brought to the cath lab in the context of an acute MI. He has 1 DES put in his LAD at the time. From the cardiac arrest standpoint, he had CPR done with bystander and achieved ROSC. He was shocked multiple times during ambulance transport has had no pulse and VT/VF signals. He initially received amiodarone boluses, narcan, epi (multiple). AT ER, first pulse check was PEA then ROSC. Defibrillated multiple times, CPR 30 seconds fur absent pulse and amiodarone infusion started and lidocain given. Intubation was grade 1 at ER. Unclear how long he was CPR'ed for in the community. He was seen moving all 4 limbs when neuro status checked with decreased sedation in CCU.

He was anticoagulated until now with heparin initially then DAPT until OR.

He arrived in ICU intubated and sedated post-E1 laparotomy. Handover and OR note pertinent for necrotic colon (ascending, transverse and descending) with viable sigmoid, viable small bowel although patchy areas of possible duodenal ischemia v. staining. There was also evidence of areas of pancreatic necrosis. The surgery was a subtotal colectomy with VAC placement and open abdomen.

Past Medical History: Current smoker

Pre-Admission Medications: None

Social History: Wife is next of kin, she has a nursing background. Occasional ROH, no drugs/IVDU. Works at U of S dairy.

Allergy Details: NKDA

TTE 2-12-2021: EF 15% Grade 1 DD, regional wall abnormalities. RV normal in size, systolic function mod-sev reduced. No thrombus or effusion

- **Active Issues and Plan:** 40M with recent history of Cardiac Arrest with a short downtime due to an LAD lesion that required DES, his stay has been complicated by ischemic bowel and he is POD#1 from a total colectomy left in discontinuity.

1) Post-Operative/GI:
- Subtotal colectomy
- Likely pancreatic ischemia +/- necrosis
- Made NPO strict and IV meds
- On Piperacillin-Tazobactam for intra-abdominal SIRS
- Given Ringer's boluses PRN

Plan:
1. Start TPN
2. Will need to back to OR in 48 hours for reanastomosis.

2) CVS:
- Post-cardiac arrest and EF 15%
- Post recent DAPT
- On Dobutamine 2mcg/kg/min IV infusion.
- Lactate 3.7 on Dec 6 (Prev. 3.8 also on Dec 6)
- Amiodarone on hold.
- ScvO2 of >70%.

Plan:
1. Cont. dobutamine
2. Integrelin IV (unable to use PO meds due to GI).

3) Distributive Shock:
- Post of from extensive surgery for ischemic bowel.
- On Piperacillin/Tazobactam.
- No micro yet.

Plan:
1. Fluids as above.
2. NE for distributive component.
3. Vasopressin added.

4) Post arrest hypoxic brain injury?
- Unfortunately will need to keep sedated for open abdo, was moving all four extremities prior to OR.

Plan:
1. Target RASS -5
2. Propofol infusion.
3. HM infusion.

5) AKI:
- Creatinine 134 on Dec 6, AKI
- Suspect pre-renal secondary to poor perfusion related to cardiac arrest
- Creatinine peak 184, trending down since

Plan:
1. Cont. Ringer's Lactate IV boluses keeping in mind that his LV function is very poor.
2. Trend creatinine and urine output.

6) Ischemic pancreatitis:
- Not sure if this was due to poor perfusion or to embolic phenomenon, same goes for the abdominal injury.
- Will need to monitor LFTs/lipase.
Plan:
1. Daily LFTs/lipase.

6) Heparin 5000 units SubQ BID for VTE proph
Lansoprazole 30mg PO/OG daily for GI proph
Mobilize as able
Feeds: Start TPN today

-- Garrett Robson R2

Modifications made to above note.

Ian Schoonbaert, MD, FRCPC
Critical Care Medicine.

Electronic Signatures:
Robson, Garrett (Resident) (Signed 06-Dec-2021 07:55)
Authored: *Patient HSN, Physician Daily Progress Note*
Schoonbaert, Ian (MD) (Signed 06-Dec-2021 15:05)
Authored: *Physician Daily Progress Note*

Last Updated: *06-Dec-2021 15:05 by Schoonbaert, Ian (MD)*

[Date of Service: 05-Dec-2021 00:00, Authored: 05-Dec-2021 00:00]Inpatient Progress Note [Charted Location: RUH-Coronary Care Unit-CCU-09]- for Visit: 10521726, [Entered by: Filed by, Interfaces (Other) 05-Dec-2021 21:19]; [Signed by: Gill, Dilip (MD) 05-Dec-2021 21:23] General, *Complete, Entered, Signed in Full, General*

MRN: 1315031
NAME: FEHR, RICHARD NEIL
DOB: 23-FEB-1981
VISIT ID: 10521726
HSN:
CONS PHYS: Dilip Gill, MD
FAM PHYS: Jillian Fraser, MD
DATE SEEN: 05-Dec-2021
LOCATION: CCU1 IP ADM: 02-DEC-2021
Royal University Hospital
Inpatient Progress Note

We were called to assess Richard Fehr, who is a 40-year-old gentleman, currently admitted to the CCU at Royal University Hospital.

Please see my resident's full dictation regarding consultation details.

This note is for his RUH chart as I carried out a family meeting with Richard's wife, Andrea.

I explained that we were called within the past hour regarding CT findings as noted in our consultation. In brief, he was found unresponsive by bystanders and CPR was initiated and he was brought in to the Royal University Hospital on December 2, 2021. He was resuscitated and taken to the cath lab for management. Currently, he is intubated in the CCU and I was told that he was being weaned off his propofol and did seem to have abdominal distention and tenderness to the abdomen, which ultimately led to a CT scan. This was also in the setting of a rising lactate on arterial blood gas.

Preliminary CT report does report extensive pneumatosis throughout the ascending, transverse and proximal descending colon. There is the appearance of extraluminal air outside of the colon in the region of the splenic flexure. Furthermore, there does appear to be an infarct involving the pancreas as well as report of gas within the systemic vascular circulation. The IVC appears collapsed and he does have imaging suggestive of shock.

I had the opportunity to discuss this with Andrea. I informed her that given the findings and clinical situation, he will require an emergent laparotomy and management. I explained that given the circumstances that the prognosis is currently dire and he will likely require extensive bowel resection. Given his instability, this may require a damage control laparotomy and a future second-look depending on his clinical status over the next 24 to 48 hours. I explained that he may require a stoma as part of his definitive operation, but he may be taken back to the CCU with an open abdomen with plans for a second look.

We also briefly discussed the possibility of extensive ischemic bowel throughout the small bowel as well which may require extensive small bowel resection, which could ultimately lead to significant morbidity as well as mortality. Nevertheless, she was agreeable to an emergent E1 laparotomy and management as we saw see fit and I explained that we will do our best.

We have mobilized the OR team and they are currently preparing at the theatre and we will expedite his laparotomy in the coming minutes.

Consent was obtained from his wife, Andrea, in the presence of the CCU care team and my resident, Dr. Brian Nocon.

_____
Dilip Gill, MD

This document has been dictated and may have been distributed before being read. Any corrections to this document must be made within thirty (30) days following the transcription date.

DG/MODL
DD: 2021-Dec-05 20:53:39
DT: 2021-Dec-05 21:19:20
Job #: 56528576/56528576

cc: Dilip Gill, MD
Jillian Fraser, MD
Janine Sara Eckstein, MD

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other______

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y ER V#10521726 M
ATN: FERGUSON, JANET
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 02/21	Echo
RA CRCS	Complete
	Cardio.
Dec 2/21.	
1700.	(40) M resuscitated out of hospital VF/VT arrest -
	unknown down time
	EMS / fire notes pending.
	In ER - recurrent VF/VT - multiple shocks + CPR
	ROSC - ECG: extensive anterolateral STEMI
	In cath lab - multiple VF - epi x [illegible] on the table -
	CPR + shocks -
	Once we had ROSC - IABP - coronary angiogram
	confirmed 100% occluded pLAD -
	4.0 x 38 Xience DES.
	No illicit drug use, smoker ?

Dyslipidemia ? / HTN ?

Form #103651 10/2013

PROGRESS NOTES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y ER V#10521726 M
ATN: FERGUSON, JANET
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	Over last 2hrs,
	BP ↓ MAP ~ 50 — [illegible]
	↑ doses of levophed.
	Lines fine – no hematoma
	Abdomen – soft.
	Chest – equal bilat breath sounds.
	Hb ~180
	No clear cause for ↓BP — [illegible] — sedation — vasoplegia — ? hypovolemia
	Bedside echo – CVP ~7.
	severe LV systolic dysfn. was in pulm edema
	EF ~ 20-25% in CCU → [illegible]
	on [illegible] [illegible] ~2L now.
	We have [illegible] volume –
	– will consider dob ± vasopressin
	Albumin 25% 1 bottle.
	[illegible]
	[illegible]

Form#103651 10/2013

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y ER V#10521726 M
ATN: FERGUSON, JANET
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec-3 0750	CCU
	40 M cardiac arrest, VFib/VT, numerous shocks, epi, amio, lidocaine, IABP - 2 DES to 100% LAD occlusion
Ck 10,000	Currently on levo 0.18, propofol 50, fentanyl 50, heparin, amio
141/106	
42/14	PRVC VT 550, rate 20, PEEP 10, FiO2 35%.
My 1.16	pH 7.42/pCO2 32/pO2 78/bicarb 20/lactate 2.1
Cr 125 (117)	Runs of vtach
	ecg → deep q-waves V1-V4 ST STE V2-V5
	qtc 548 msec
	Echo → LVEF 15% akinetic, septal, anteroseptal, anterior, mid lateral; mod to severely reduced RV systolic function, ↓ valve gdn, ↓ thrombus
	CCS 3. T 36.0 HR 85, BP 95/55 on 100% RA
	A+P
	1) We will continue 36°C until ~1900. Amio infusion to prevent vtach. LOS 4.0
	My 1.0

PROGRESS NOTES

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	② Continue ASA, DAPT, heparin
	③ Wean off propofol + ventilation as tolerated. tomorrow.
	④ Numerous (R) sided rib # will start scheduled tylenol / Hrly
	⑤ Will attempt out of bed today (chronic?)
	⑥ Neuroprognostication difficult at this time. Once stable, will consider neuroimaging.
	⑦ Rewarm to 37°C.

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

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ATN: FERGUSON, JANET
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 4/21	CCU
08:30	40 y/o male c OHA 2° to STEMI
	Prolonged multiple arrests, prox LAD
	culprit. PAD #3.
	Issues
	① Neuro – Sedated GCS 3. Will try
	and wake up once IABP out today.
	this afternoon. Finished cooling protocol.
	② Cardiac – EF 15% on last echo.
	Somewhat better on [illegible]. Off [illegible]
	levo now but on dob 7 [illegible]. BP ok.
	Weaned IABP now – 2:1 [illegible],
	will remove [illegible] in 4 hrs.
	③ Resp – PSV on 25% FiO2
	[illegible]
	④ Renal – 28-42 – UO 30-50 ml/hr.
	[illegible]
	⑤ HF – will need [illegible]
	[illegible]

[signature]

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PROGRESS NOTES

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FEB-23-1981 40y ER V#10521726 M
ATN: FERGUSON, JANET
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	CCU Weekend Rounds
Dec 5	40 y/o M cardiac arrest, VF/VT, numerous
0840	shocks, epi, amio, lidocaine, IABP. (outside yesterday) One DES
	to 100% LAD occlusion.
CVP 6-10	Currently on dob 2, amio, RL 150
+5.5L/24hr urine 30-50	PS CPAP 10/10 FiO2 25%.
	Propofol 30, fentanyl 80
132 / 100	
(3.7) / 20	Meds: dilaudid 2mg q4h, tylenol 975mg QID,
	heparin, ASA 81 OD, ticagrelor 90mg PO BID,
Cr 184↑ (172)	atorvastatin 80mg OD, pantoprazole 40mg IV
Mg 0.94	
	HR100, BP 87/52, SpO_2 93%, T37.1.
(7.2)	CVS, S1, S2, ... Ø murmur
112/211	Resp - GAEB, Ø sig crackles or wheezes
	Ø peripheral edema
7.33/40/104/20	
	A+P
	① Neuro. GCS 3. Sedated on propofol.
	Will wean sedation today + consider
	precedex. Frequent neuro checks.

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Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

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ATN: FERGUSON, JANET
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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	(2) Cardio - EF 15%. On heparin, ASA, ticagrelor. Will consider discontinuing amio given normal sinus rhythm + hypotension. Continue dobutamine. RL 500 cc bolus.
	(3) Resp - CPAP 10/10 FiO2 25%.
	(4) Renal - Cr 184, steadily increasing. K 5.7. Fluid bolus + shift K+.
	(5) GI. [illegible]
	Maxeran 10g IV q12h
	monitor [illegible].

Department of Medical Imaging
Procedure: CT Brain + CT P/U A/P
Date: 05/12/21 Initials: amp
Procedure Completed: ✓

Form #103651 10/2013

PROGRESS NOTES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y ER V#10521726 M
ATN: FERGUSON, JANET
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
05/12/21	OR Note - SB & Sigmoid in discontinuity.
	SubTotal colectomy + Abthera vac placement
	Dr. Gill.
	Assists: Deste James, Brian Nolan & Simon Adams
	General Anesthetic Dr. Xia
	EBL minimal.
	Findings. Dead & necrotic Colon (ascending, transverse & descending)
	Viable SB.
	Patchy areas of SB & possible duodenal ischemia (vs staining)
	Viable Sigmoid colon.
	Dispo To PACU. then ICU.
Dec. 6, 2021	ACS
	• POD 1 STC + Abthera.
	• Tmax 36.8 Map min of 60. 1+V FiO_2 0.4 Resp 40.
	• Dobutamine 2 levo 0.28 propofol 45
	• Ng 550. Vol 800 0 in rectal tube
	• Plan for takeback tomorrow

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

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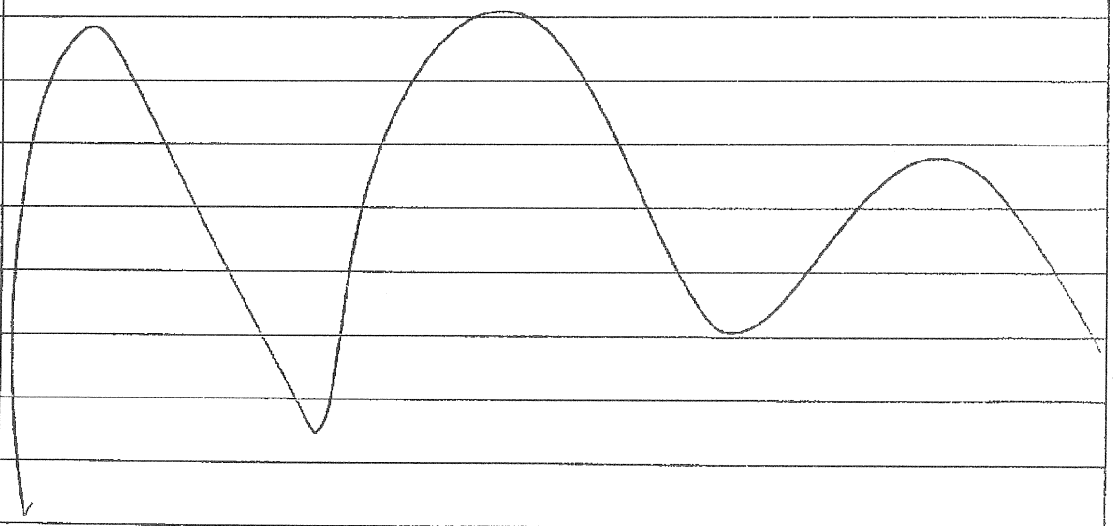
SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec. 7, 2021	ACS
0800.	• P/F_{O_2} STC + Alethera
	• Tmax 37.8. MAPs >65 HV S_{O_2} 0.35 PeepIO.
	• Dobutamine 2mcg/kg/min Levo @ 0.23. Vaso @ 0.04
	• UOp: 725 Rectal tube present. Vol 1023. U/O adequate
	• Weight up 5kg. Diffusely edematous. Abdomen destended. Non-reactive to touch.
	• Anticoag on hold
	• SAP: Plan for take-back today.
	L. Thiessen, RN



PROGRESS NOTES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ ~~Signature/Title~~ (Please include for each entry)	~~Initial Plans - Progress Notes~~
	OR NOTE
7 Dec 2021	PreopDx: ischemic bowel
16:00	Post opDx: same
	Procedure: Relook laparotomy, removal Abthera,
	Washout, end ileostomy;
	Surgeon: Dr GILL,
	Assist: S. Adams, I. WEBE (RS)
	Anesth: Dr Taylor, GA.
	EBL: ~100 cc
	Ø complications.
	Ø Specimen
	Drains: (1) JP #10 in RUQ (Superior)
	(2) JP #10 in Subcut space (inferior)
	Dispo: To ICU intubated, on pressors.

Saskatoon Health Region

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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 8, 2021	ACS
0830	• PODS 3/1 STC / washout, end ileo, closure
	• Levo 0.08 Dobutamine 2 Vaso 0.04 propofol 45
	• Tmax 38.1 Maps generally >70 I+V FiO2 0.3 Peep+10
	• JP1 100 (serosang) JP2 40 (sang) Ng: 1000 Rectal tube 5. Ileo: (min) 10. U/O adequate.
	• Abx: Tazocin
	• Nutrition: TPN
	Rousable today as compared to yesterday
	↑ stoma dusky sang. Abdo softer.
	↳ will follow + aware (gen sx)
	[signature] CCM
Dec. 9, 2021	ACS
0810	• PODS 4/2 STC / washout, end ileo, closure.
	• Tmax 37.8 MAPs gen. >65. I+V FiO2 0.4 Peep+10. HR ~110.
	• Dobutamine @ 2. Off levo + vaso. Propofol at 50
	• JP1 80. - serous JP2 35. / sang Ng: 900. Rectal tube 15. Ileo: 65 (sang tinged w gas or stool) U/O adequate
	• Abx: Tazocin
	• Nutrition: TPN
	• Anticoag: DAPT w/ ticagrel + ASA81, tinza proph.
	• Stoma still dusky but not retracted or grossly ischemic.
	• No new concerns or suggests.
	[signature] L. Toessen R4

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PROGRESS NOTES

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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ ~~Signature/Title~~ (Please include for each entry)	~~Initial Plans – Progress Notes~~
Dec 10 21	ACS
07:53	POD 5/3 SI c/washout end ileo, closure
	tmax 38.8
	ø levo ø vaso dob 2 propofol 50
	intubated FiO_2 0.35 PEEP 14
	JP 1 105 serous
	JP 2 10 sang - finger.
	NG 1100
	ileo - 75 sweat, small volume gas this AM
	u/o adequate
	on mero, tazo stopped
	Abdo: mildly distended, mod firm, ø tender, incision clean
	ø surgical concerns or suggestions
	Bahman Kamenco CCF

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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
DEC. 10/21 947. Leanne SW - Sillers	SW received page to speak to Pt's spouse, Andrea. Spouse was having an emotional time so for today. SW spent time w/ Andrea at bedside and provided support. SW to do cross over to ICU SW as this writer was covering for the morning SW to follow S Sillers BSW, RSW #12793

PROGRESS NOTES

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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans - Progress Notes
Dec 11/21	ACS on-call
0030	- called to assess (R) abdominal wall
	rash / lesion
	- appeared around 1700 - grew over 1hr
	& progressively got darker.
	- has ∅ inc in size since ~ 1800
	O/ hemodynamically stable, febrile in day.
	HR 120, BP - 157/85 ∅ pressors.
	ileo = 200 U/O = >100cc /hr.
	7.98 lactate = 1.3
	72 / 79
	- plts ↓ from 130 earlier today
	- Hgb stable (70-80s).
	∅ subcut emphysema ∅ fluctuance.
	pt. grimace to deep palpation ∅ skin breakdown.
	palp. femoral pulses.
	lesion on (R) LQ abdo wall ∅ extending posterior
	A&P/ will r/a in 1hr.
	likely hematoma.
	Monitor for hemodynamic instability;
	- will r/a lesion if declines
	[signature] Spafford (R2)

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Saskatoon Health Region

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Saskatoon, Saskatchewan

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Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 11/21 0200	ARS - on-call - rla abdominal lesion - unchanged from previous - vitals unchanged. plan: will rla in AM unless changes Spathod 022
Dec 11/21 0815	ARS 105, 147/74, RS 14/14 FiO_2 30% ϕpressors Stoma = 300/24hrs JP 1 = 40 JP 2 = 10 UO 7100/hr. NGT = 650 hematoma unchanged from overnight Stoma pink/healthy. abd soft ϕdistended AES/ CCM Spathod 022

PROGRESS NOTES

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Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ECKSTEIN, JANINE
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans - Progress Notes
Dec. 12, 2021	ACS
0750	POD5 7/5 STC / end ileo, closure.
	· Tmax 38.8°C. Vpressors/inotropes. MAP ≥ 65. Tachy @ 100-130.
	I+V Spont FiO2 0.3 16/10
	· JP1 65 serous JP2 15 serosang Ileo 375. OG 350 U/O adequate.
	· Abx: Meropenem
	· Anticoag/DVT proph: ticagrelor, ASA 81, tinza
	· Nutrition: TPN, NPO.
	· Bilateral hematomas on lower abdomen. Right has single bulla. Skin
	otherwise unremarkable. Incision clean & dry, Ø signs of infxn.
	Stoma pink & healthy
	· A/P. No gen SX concerns. ? drug for enteral feeds - will discuss
	L. Th[illegible] RN

Saskatoon Health Region

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Saskatoon, Saskatchewan

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PROGRESS NOTES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec. 13, 2021	ACS
0800	PODs 8/6 STC / end ileo, closure
	• Tmax 38.4° MAPs >65 Ø pressors or sedation. I+V spont. FiO2 0.3 14/10.
	• Ileo: 725. Enteral feeds @ 20/hr. U/O adequate
	• Abx: meropenem
	• Tinzaparin held re: ?HIT - on fondaparinux, ticagrelor, ASA81.
	• Bilateral hematomas now have central area of dark, necrotic appearing skin. Ø expansion. Moderate distension but Ø tenderness.
	• Pt able to nod to questions. Denies pain or nausea.
	• Ø GenSx concerns. Advance feeds as tolerated. [signature] L. Thiessen RN.
Dec 14, 2021	ACS
0800	PODs 9/7 STC / end ileo, closure.
	extubated, CN 0.35. Tmax 38.3. Ø pressors/inotropes MAPs ≥65.
	• Ileo: 825. Enteral feeds @ 50. U/O adequate.
	• Abx: meropenem
	• Incision clean + dry. Abdomen soft. Necrotic skin patches enlarged.
	• No GenSx concerns. [signature] L. Thiessen RN.

PROGRESS NOTES

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Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec. 14/2021	Pt seen to mobilize, agreed to same,
Physio	spouse present t/o session. On CN c̄
Reg #11433	35% → SpO_2 initially low 90s. Mod Ax2 to
1200	sit c̄ (L) edge of bed. Pt + weak x4
	extremeties. While seated pt able to
	perform B/L knee ext 3-/5 w/ ↓AROM. UEs
	weaker than LEs. Pt has downward gaze
	able to correct head/neck position w/
	cueing. Tolerated ~5-6 mins. Able to
	perform DB + hold → cough Ks + weak. SpO_2
	↑ high 90s post-angle. Will f/u — [illegible signature]
	Department of Medical Imaging Procedure: CT Ab/Pel Date: Dec 14/21 Procedure Completed ✓

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Saskatoon Health Region

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ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	ACS Senior.
14 Dec 2021	CT reviewed. No abscess or organized
16:15	intra abdominal fluid collections.
	L: Colon RLC PNA.
	1. (CM & [redacted]
	ACS
15/12/21	POD #10/8. STC/closure.
	Ø pressors. Tube feeds @ 90cc.
	Mentating. well.
	CN 35%
	Ileostomy 1500 cc
	Abdo soft. minimally tender.
	A/P Advance diet as tolerated
	Keep staples for now.

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PROGRESS NOTES

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FEB-23-1981 40y IP V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec. 15/2021	Pt seen to mobilize, more alert today
[illegible] Physio	than previous session. Max Ax2 LAY → SIT
[illegible] #11433	@ (L) side of bed. Once positioned, able to sit
1015	self-supported for (+) short intervals. In
	sitting, B/L 3/5 knee ext, AROM (L) > (R).
	B/L 3/5 shoulder + elbow flexion w/
	↓AROM. Able to cough on command w/
	upper airway 'rattle'. Max Ax1 sit → stand
	@ bedside. SpO_2 high 90s T/O session. In
	general, strength + alertness improved
	from yesterday ——— [signature]
Dec. 15, 2021	Heme Clerk
11:50 ID:	40 yo M w/ recent Ant. MI & STC/end ileo, POD #10.
S:	pt feeling tired, but denied SOB, CP, palpitations, abdominal
	pain, fever/chills or lower limb pain.
16.4 / 89 / ? (N) MCV O/E:	T: 37.1 BP: 120/75 HR: 110 O_2 Sat: 97% on 35% cold neb
[illegible]:	Bilateral lower limb non-pitting edema, R>L ø
	worse since yesterday. ø erythema or tenderness.
158 / 100 / 13.8 / 3.8 / 26 / 67 A/P:	(1) HIT
	- Pt on Fonda currently. Plt improved yesterday ø
	new plt count today as lab error.
	- Heme will follow. Nafisa [illegible] CC4

Saskatoon Health Region

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FEB-23-1981 40y IP V#10521726 M
ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 15/21 - 1515	SLP in for f/u - per nursing staff RR improved slightly
SLP-Sadia #1541	26-30 as opposed to 40+ yesterday. Pt. has been
	taking ice chips and tolerating well. Today, pt.
	stated too tired to work w SLP - try again
	tomorrow. Pt has NGT for feeding. Will f/u tomorrow.
	SLP (S reg. sk Sadia #1541
Dec 16/21	UCS
0830	40M POD 11/9 subtotal colectomy/closure
	Per RN, ↓ delirium overnight, required haldol this
	AM & eating d/t aspiration risk, on NG feeds.
	Tmax 37.4 HR 128 120/74 96% 4L NP
	Abdo soft, mildly distended. Wound CDI. Ost 1650 @ NP.
	A/P: Will suggest rx for Pstoma output
	∅ contraindication to reg diet when ok w SLP
Dec 16/21 - 1015	SLP in for f/u. However per nursing staff pt. + agitated &
SLP- Sadia #1541	sedated @ moment, cannot be assessed. Pt's RR has also
	been + elevated ∴ not appropriate for swallow As. Will
	f/u later
	SLP (S reg. Sadia #1541

PROGRESS NOTES

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ATN: ESHTAYA, EHAB
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ ~~Signature/Title~~ (Please include for each entry)	Initial Plans – Progress Notes
Dec 16.	Cardio notes.
	40 M OHCA c LAD PCI/DES x 1. Prolonged
	resuscitation VT/VF multiple shocks/Epi.
	complicated ② ischemic bowel → subtotal
	colectomy + pancreatic isch/necrotic.
	② HIT → abd wall skin necrosis x2
	③ Pneumonia.
	O/E: GCS 15/15, confusion occasionally.
	chest clear anteriorly.
	CVS (N) HS. ØJVD.
	Abdo stoma intact; 2 patch of skin
	necrosis unΔ'd, soft, tender lower abd.
	c vol. guard/ ø rebound.
	Bilateral arm/legs edema +++.
	A/P.
①	CAD - stable, will titrate up cardiac meds.
②	Post op Day 11/9 - will start to feed when
	he can tolerates as per ACS & await SLP
	reassmt today.
	Wound looks good.
	ACS following.
③	necrotic skin from HIT - wound care RN following.

SASKATOON HEALTH REGION
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SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1961 40y IP V#10521726 M
ATN: PYLYPCHUK, STEPHEN
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	(4) Pneumonia – on Meropenem.
	(5) Cognitive – post arrest, still some confusion. Haldol prn.
Lubriderm RS	(6) Rash this am – new, non itchy.
	will observe, unlikely from Meropenem (has been on it for few days).

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PROGRESS NOTES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: PYLYPCHUK, STEPHEN
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans - Progress Notes

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

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PROGRESS NOTES

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Dec 16/21	Ostomy + Wound Dept
@ 1100	Consult received. Pt assessed. See consult
	note. Ileostomy care plan provided + wound
	care protocol. Will follow up as needed
	D. Palen RN NSWOC
Dec 16/21 11:10	Dietitian: A/ Wanderer recd per ICU RD. Pt currently NPO per
Hannah Dedonker, RD	SLP recommendation – pt prev running Promote @ 90ml/hr s
#12195	minimal flushes, though pt pulled NG this am while ++
	agitated. NG to be replaced today per team. Labs Dec 16/21
	WNL for nutr-related markers except K 3.3↓, Urea 13.0↑. Ø
	wt today – most recent wt per chart Dec 12/21 of 87.6 kg. Per
	pt wife, UBW of ~77kg, feels he has lost ++ wt while in ICU. Est
	wt today ~78kg per writer, will await measured wt. Noted
	new ileostomy – output ~1650ml Dec 15/21 per fluid balance
	sheet – noted loperamide 2mg TID ordered today re ileo
	output. Noted stapled sx incision & bilat hematomas
	to abdo per wound care – pt Ø on multivit at this time. D/Inadequate
	pro-E intake related to NPO status & Ø EN as evidenced by
	lack of NG & EN therapy. 1/1. Team to place NG. 2. EN order
	set placed on chart for Promote @ 90ml/hr continuous

Cont'd →

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	Cont'd → infusion, provides 2160 kcal (28 kcal/kg), 136g protein (1.7 g/kg) & 1807 mL free H_2O + 120 mL flushes q3h for total H_2O provision of 2767 mL H_2O (~35 mL/kg) not including medication flushes. 3. Initiate multivit liquid 15 mL OD via NG. 4. Initiate TENS labwork. RD will cont to follow re: EN, ?po/SLP suggests, GI tx, wt, labs, disposition course. [signature], RD
Dec 6, 2021	Heme Clerk
ID:	40 yo M ̄w recent STEMI ̄c STC/end ileo POD #11.
164 / 89 / 331 S:	Pt confused as per wife. ∅ SOB, CP, increased LL swelling/redness/ pain. ~~[illegible]~~
O/E:	T · 37' BP. 146/75 HR. 116 O_2 sat 98% on 4L N.P.
A+P:	① HIT
	- Pt currently on Fonda. until begins eating/drinking well, then transition to ~~[illegible]~~ likely Warfarin for 3 months.
	- Wound care managing skin lesions over R/LLQ.
	- Plt recovered. 331 today. Nafisa Akhter CC4

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 16, 21 - 1530	SLP in for f/u in PM - Pt more alert, awake, wife
SLP Sadia #1541	present. Pt. continues to have shallow breaths c̄
	30 + for RR. SLP explained to pt. & wife the
	relationship btw good breath support &
	swallowing. They were encouraged to suck on
	ice chips & toothettes instead of drinking water
	from a straw just yet. Pt has NGT back
	in and is getting fed. Ø further change to
	diet - continue NPO. Will f/u as appropriate.
	[signature] SLP (in reg. SL lic #1541 —
Dec 16/21 13:40	Pt agreeable to physio c̄ spouse, Andrea
Physio/OT	present. Mod @X2 supine → sit, MOBT
Jody Cannon #12704	+ use of rail. Pt moved legs over
Ciara. #12482	edge of bed c̄ cueing + hand support. Once up, able to
	sit c̄ close supervision. Pt also able to
	move hips forward to edge of bed
	c̄ supervision + cueing. Stood at 2ww c̄
	min @X2. ↓ Postural control; stood <15sec;
	Pt fatigued: @x2 to return to bed. Total lift to
	w/c daily. Physio to progress as able. — cont'd

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Time/Date/Printed ~~Name/~~ Signature/Title (Please include for each entry)	~~Initial Plans - Progress Notes~~
Dec 16/21	cont'd: writer to complete formal Ax
~~Physio~~	~~upon return on Monday~~
127 Jody Corman	[illegible]
Dec 17/21	ACS Rounds w/ Residents
08:14	S - febrile intermittently - septic work up (P).
	-truncal + arm rash bilaterally.
pH=7.45 pCO2=35 INR=1.6	Patient able to interact + respond. Ø pain.
lactate (N)	O ileo: ~~1075~~ 2L / day foley = 1700
	R tmax 38.1, HR 140-145, BP125/84, RR52, 4L 93%
	Abdo: soft Ø peritonitic
	Rash: lacey, erythematous, blanching. bilat arms, chest, abdo, min to legs. will leave to discretion of medicine.
	A/P (1) Febrile - Septic w/up (P). on meropenem. ? pneumosepsis
	Pt was also spiking fevers in ICU. Patient had recent CT abdo 3d ago - likely Ø yield in repeating imaging. There was evidence of consolidation at that time in the lungs. Belma Kamencic CCA
	(2) Ileo - high output while on
	immodium 2mg PO TID.
	Will ↑ (suggest) to 4mg PO TID.
	Suggestions for replacement fluids left;
	however, will leave to discretion of medicine
	team because of cardiac issues.
	(3) Rash - ? drug reaction.
	(4) Feeding - SLP Ø able to assess b/c of high RR.

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Belma Kamencic
CCA.

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec. 17, 2021	Heme Clerk
10:16 ID	40 yo M w̄ recent ~~STE~~MI s̄ STC/end ileo
S:	Pt developed blanchable erythematous petechia-like rash over abdo, chest, shoulders & arms yesterday. Non-itchy. Also has had a Temp of 38.¹ this AM. He denied any ~~S/S~~ Sx of GI ~~or~~ bleeding, lower limb edema/pain, abdominal pain, ↑ in SOB, chest pain, palpitations. He does endorse ↑ ileo output.
5.34 / 92 / 1152 (442) ⓗ MCV 88	
137 / 101 / 11.6 / 8.6; 3.8 / 24 / 72	
O/E:	T. 38.¹ → 36.⁷ BP. 125/84 HR. 145 RR 52 O₂ sat. 93% on 4L NP
aPTT 28; INR 1.6 ↑; pH 7.45 ↑; pCO2 38 ↓; Lactate Ⓝ 1.7; Bicarb 26 Ⓐ	Pt not in acute respiratory distress. There's ~~non~~ blanchable, non-pruritic, erythematous petechiae like rash over abdo, chest, shoulders & arms. Abdo - firm but non-tender, ∅ guarding or peritonic. CVD - ↑HR, reg ⒶS₁, S₂, ∅ murmurs. Resp - clear breathe sounds bilaterally. ∅ swelling, pain or erytheme over lower limbs.
A+P:	① HIT
	- Pt on Fonda, will be placed on Warfarin when eating/drink for 3 months.
	② Thrombocytosis likely ~~related~~ to reactive to ? pneumosepsis ?
	- Pt spiking fever, new rash, ↑RR : On meropenem s̄ septic w/up Ⓟ. CXR → ? retrocardiac LL opacity.
	- will discuss w/ team about further thrombocytosis w/up if needed.
	Nafisa [signature] CC4

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 17, 2021	SW met c pt's spouse + provided emotional support.
10:30	Bruce Rushinko BSW RSW SK
	10538
Dec 17	Cardio notes.
	(1) OHCA/CAD.
	- stable.
	(2) Post op D 12/10
	- ileostomy output ↑↑↑ 2L/d despite Imodium
	- ACS following → ↑ Imodium + ↑ rplcmt fld.
	- ∅ peritonitis on exam.
	(3) Febrile, tachypneic, tachycardic → ? Sepsis.
	↑ plat count → acute phase reactant likely to sepsis.
	CXR ↑ LLL behind cardiac shadow.
	? Pneumonia developed in the setting of Meropenem
	Coverage → ID consult to advise of Abx.
	(4) Rash → drug reaction/allergy vs sepsis.
	(5) HIT/necrotic skin.
	- skin unod.
	- on Fondaparinux; Heme following + advice ∅ Δ.
	(6) Cognitive → GCS 15/15 + less confusion.

→

Heath. Ellis

PROGRESS NOTES

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
(7)	Nutrition status.
	High volume PT intake in setting of severe
	LV systolic fx (EF ~ 15-25%) → would
Lukianton RS.	prefer to concentrate Promote to ↓ fld intake.
Dec 17/21 13:55	Dietitian: A/ Writer paged re H_2O provision in context of severe LV
Hannah Derbowka RD #12185	dysfx. Pt currently receiving Promote @ 90ml/h c̄ 120ml flushes
	q3h. Pt reports tolerating feed well per wife. Noted ileo output of
	~2250ml Dec 16/21 per fluid balance sheet. Urine output same
	day ~1775ml. Ø new wt. Labs Dec 17/21 Na 137, K 3.8, Urea 11.6,
	Creat 72, Phos 1.01, Mg 0.87. Noted Gen Sx suggest for 4mg
	loperamide TID (? from 2mg) c̄ 1:1 replacement of losses exceeding
	500ml/shift: 2/3 1/3 + 20 KCl. Spoke c̄ Cardio fellow re plan
	as pt fluid status will require careful monitoring to balance
	risk of dehydration.
	D/ Excessive fluid provision related to current EN regime as evidenced
	by current provision of 35ml free H_2O per kg.
	I/ 1. New EN order set – Vital Peptide 1.5 @ 20 ml/h c̄ 80ml
	flushes ~~q3h~~ q4h – provides 2520 kcal (32 kcal/kg), 117g protein (1.5g/kg) c̄ ~~1945ml (24.9ml/kg)~~ 1783ml (22.3ml/kg)
	Δ to warmed flushes (30ml SW q4h) if pt on IVF.
	ME/ Will cont to follow as evidenced goals re: ~~EN~~, ?po/SLP, GI
	fx, wt, labs, dispo. [signature] RD

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ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 17, 21 - 1515	SLP in for f/u - Pt. bedside. Nursg staff stated pt's
SLP-Sadia #1541	breathing was worse this AM but seems to have
	improved slightly. Pt also developed a rash possibly
	d/t med. allergies which is being dealt c. SLP
	encouraged pt. + staff to continue to take ice chips
	when sitting upright. Pt. may be ready for
	swallow Ax after the weekend. Will f/u as
	appropriate. SLP cosig. Sadia #1541
Dec 17/21	pt seen. agreeable to mobilize.
Physio	RR ↑ but SpO2 93-96% 3L per nursing
Tera# 12837	supine → sit through (A) sidelye c
1450.	mod (A) x1. Initially required (A) c
	balance 2° post lean. bll UE shaking
—	sit → stand c 2nd c mod (A) x2.
	pt able to wt shift + march.
	TF to Broda c step around TF (A) x2.
—	Repositioned in chair c min (A) x2 2° post
	lean + sliding tol well.
	Remained in Broda. Sling in place.
	Recommend up to chair c TL.
	Will request w/c PT review x1.
	Tera Shuler BScPT

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ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans = Progress Notes
Dec 17, 2021 Staff	40 y.o. ♂ c OOHCA → AWMI → VT/VF storm
	PCI to LAD (prox) (SV-CAD)
	LVEF 15%. Dec 2.
	• developed cardiogenic shock → emergent subtotal colectomy → end ileostomy / rectal stump
	• pancreatitis resolved high output
	• HITT → skin necrosis → Δ to fondaparinux
	• AKI
	• pneumonia on meropenem (+ rash) → Δ to cipro + metronidazole

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ATN: BREE, TERESA L
FAM: FRASER, JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 18/21	CCU overnight
0700	ID: 40yo M OHCA → VT/VF storm → PCI to LAD
	Developed ischemic bowel → colectomy, end ileostomy
	Called to assess RE: Climbing tachycardia (135)
17/15	& resp rate (42). ↑ increased O2 req 3L overnight
9L ↑ 35S	↓ pain, ↓ significant WOB, ↓ fever or cough
	↓ positional dyspnea
132/61 70	O/E: HR 129 BP 122/82 SpO2 95% on 3L RR (42)
4.1 ↓22 10.8	CV: (W)SS, ↓ E/Ks or murmurs
	Resp: air entry, lungs clear.
	Abdo: Soft, ↓ tender. Multiple Scars.
	A/P: (1) Concern for worsening/ progressive Sepsis.
	? Pneumonia vs intra-abdominal Source
	on Ciprol Flagyl for broad coverage of
	- Gentle IV fluids ~~500cc over 4h~~ 250 Replace GI losses prn. If responsive, further fluid resus.
	- Repeat VBG. Formal CXR this am.
	- ? repeat CT MRussell RN

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FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 18/21	ACS
0735	40M POD 13/11 laparotomy/closure
	Tmax 37.8 HR 129 (max 134) 124/82 RR 42 95% 3L NP
	Now on cipro/Flagyl - ?rash d/t mero. Ost 2740cc
	↑ HR + ↑ RR overnight - assessed U/O 1300cc
	as ?sepsis overnight - known pneumonia vs abdo
	source. On tube feeds @ 70.
	Denies abdo pain this am. Stoma remains
	↑ output.
	Abdo soft, mildly distended, wound intact + healthy,
	Ø tender. Stoma healthy.
	A/P: Continue current ~~[illegible]~~ imodium dose today. Low
	suspicion of abdo source of sepsis - exam benign, Ø pain
	[signature], R2
Dec 18, 2021	No chest pain or dyspnea.
@ 0920	No abdominal pain - high ostomy output persists.
	Temp. 37.2°
	(L) hemithorax bronchial breath sounds
	Abd soft [illegible] BS's ✓ Ø tenderness or rebound
	Plan: Fluid balance ~ -5L. → Add codeine to ↓ ostomy
	output. NG feeds concentrated. Consider loperamide.
	↑ fluid replacement. - watch lytes. Mg. / No evidence CHF.

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PROGRESS NOTES

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Dec 18/21	OT Note: Provide Roho cushion. Pt. up
Deirdre 12231	to Broda chair c̄ cushion, Nursing
(weekend OT)	paged. Roho cushion regulated. Pt
	reports same more comfortable. Pt leaning
	on Broda. OT to follow [signature]
18/12/21	Gen x On Call
1400	called re: abdo pain, ↑T
	T 38.7 HR 128 141/83 RR 16 97% 4L NP
	Patient reports some nausea, abd pain & bloating/distention
	Stoma has outputs (recently emptied)
	O/E: abdo S/mild distended/ ⊖ peritonitic - unchanged from
	A/P: hold tube feeds AM exam
	Await CT A/P as per MRP
	Consider chest CT? (known pneumonia) [signature]

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ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	Department of Medical Imaging Procedure: CT chest abdo pelvis Date: Dec 18, 2021 Initials: DG/GG Procedure Completed: ✓
Dec 18, 21 1600	Called by nursing c̄ changing clinical status — febrile 38.7°C, resp rate 40-50, ↑HR 150-160 WBC 23.1? nauseous, abdominal distension + mild discomfort [illegible]. No ostomy drainage x 3hrs. (previously high output) CT chest/abd/pelvis - no free air. - verbal rad report - no acute change of abdominal collection. peripancreatic fluid unchanged + nonenhancing.
	Lactate 1.4, INR 1.5
	I spoke c̄ general surg. resident on call - she recommends Δ of NG feeding to large bore NG for suction. Request for transfer to surgery for management of post-op abdomen declined.
	I remain very concerned about the constellation of clinical signs that suggest more than a post-op ileus — will change NG + reassess. Surgery has agreed to review again tonight.

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[redacted]

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 18, 21	↑ Temp 39.4°C
1730	↑ HR/RR
18/12/21	ACS
20:41	pt became sicker today c̄ high fever
	& high WBC. Abdo was mild tender
	But BS OK CT showed small
	not-completely-liquinized necrosis. ? further
	necrotic bowel found.
	D/w ICU, considering anti-fungal
	A/B; may try get IR involved
	for possible perc-drain; Surgery
	will be a big challenge; due to
	poor cardiac function, pt may not
	do well c̄ surgery.
	Will re-assess closely

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FAM: FRASER, JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 9/21 2:16	Interventional Radiology
	Limited U/S done; peripancreatic collection extending to (L) UQ and perisplenic region seen but difficult to access. Limited sonographic window & shadowing from internal air & contents.
	4 Fr Oneaty catheter used to access collection under U/S. Contrast injection showed irregular collection.
	12 Fr Ezdius drain then placed after serial over the wire dilation.
	10 cc dark / sanguinous fluid aspirated for microbiology. ∅ immediate complications.
	Otani

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ATN: SHUMILAK, GEOFFREY
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 19/21	ACS
0830	40 M POD 14/12 laparotomy/closure
	ICU concerned re: ?firmness to abdo overnight.
	IR drain inserted yesterday - draining Drain 250cc
	old sang fluid. 1 unit RBC's last night. Off levo. Dob 2.
	Ostomy 750 overnight. NG 700 - Ø bloody.
	Abdo - staples intact, slight bruising, moderate
	distention, ?tenderness LUQ w/ mvol guarding. Ø Diffuse
	DRE - old blood present. peritonitis. Remainder of abdomen Ø tender.
	A/P: Send perc drain for lipase
	Would be very challenging time to operate given
	time from previous ORS (+r inflammation) + current
	cardiac function. Ø Obvious anatomic indication
	for OR. Will review w/ staff
19/12/21	ACS
1000	pt stable both when last night
	UOP OK Ø fever
	Perc drain done on (L) Abd.
	old bloody fluid
	Abdo still mild distended & tender

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FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	~~Initial Plans – Progress Notes~~
	Bowel sound lowish
	Legs chest OK
	D/w ICU
	Consider medical mx at
	this time
	If bleeding persists, may
	consider CTA & angio as
	needed.
	Will f/u closely
	[signature]
Dec 20, 2021	ACS
0835	40M POD 15/13 laparotomy /closure
	NG 200+250=450 on Tazo/Vanco
	Drain 75+195 = 270
	Ostomy 50
	o/e Abdo distended, tender to L lower abdo.
	A/P: ① CCM
	② Review abdo imaging
	[signature]
	Daniel Hui, R1

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FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
20-Dec-2021 13⁷⁰	Home - HIT (Abstr), on Fonda, ticagrelor. - plt 5 to 924 - ✗ po intake yet. ⇒ CCM. Reasons for Δ to warfarin when condition improved. K Shaw
20Dec2021 SLP#126560 Jocelyn 1441	Follow-up: Chart reviewed, in to see pt. Pt returned to ICU over weekend. Pt reportedly asking for ice chips. Not yet appropriate for PO intake given issues with gut function- TPN to be initiated. Trialed ice chips with pt, spouse present. Pt and spouse at times suctioning ~~ice~~ water after ice melts, however, sometimes swallowing. Pt grateful for ice chips to moisten oral cavity. Additionally, pt's spouse performing regular oral care. – cont

PROGRESS NOTES

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans—Progress Notes
20Dec2021	cont - Pt currently appropriate
SLP #121656	for ice chips for hydration/comfort.
Jocelyn	Will continue to follow re:
14:45	appropriateness for oral intake.
	Jocelyn MScSLP
Dec20/21 15:00hrs.	
Eline, RD	NSS Dietitian: Pt t/f back to ICU Dec 18/21 c̄
#10542	shock - cardiogenic / intra-abdo sepsis. CT A/P ⇒ pancreatic
	tail collection. Abdo firm + distended. Ileo O/P: 50ml/24hrs.
	NG to LCS: O/P 450ml 24hrs. Pt prev receiving EN wa
	wh-held Dec 10/21. Plan: restart TPN, continue
	NG to LCS per ICU team. Further charting on Nutrition
	support flow sheet under clinical data.
	RD/NSS to follow. ——— Eline Kelly RD.
JC	

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Saskatoon Health Region

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Saskatoon, Saskatchewan

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PROGRESS NOTES

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	ACS POD #16/14 · Subtotal colectomy.
21/12/21	Ileo: 200. perc 60.
	Ø pressors.
	⊕ dobutamine
	⊕ distended but soft.
	~~↓ tenderness.~~
	Staples insitu. midline clean. Ø signs infx.
	A/P CCM.
	[signature]
Dec. 22/21	OR Note
00:44	Pre-op Dx: Intra-abdominal sepsis
	Post-op Dx: Infected hematoma
	Sigmoid stump leak.
	Procedure: Laparotomy, evacuation of infected
	hematoma, washout, repair of sigmoid
	stump leak, repair of serosal tear.
	Surgeon: Dr. Y. Luo / Noron / D. James
	Anesthesia: Dr. Smith / GA
	Findings: ① Infected Hematoma LUQ → evacuated
	② Serosal tear → over sewed.
	③ sigmoid stump leak → oversewed w/ fat patch
	Ø enteric content.

[signature] B. Noron [illegible]

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PROGRESS NOTES

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ATN: BREE, TERESA L
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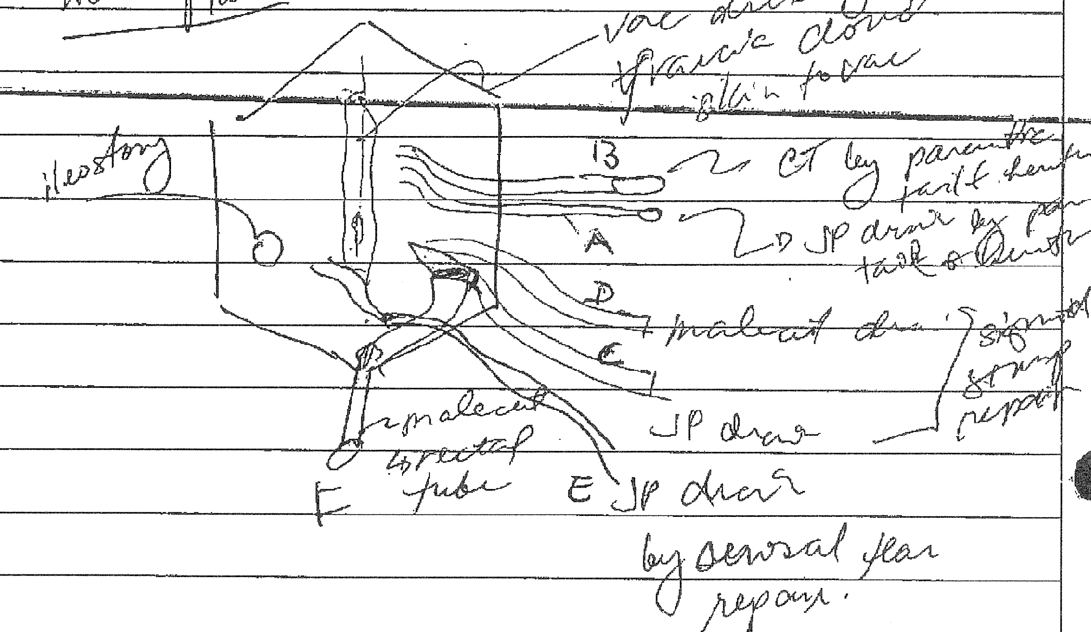
Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	Drain placement.
	
22/12/21	ACS POD#17/15/1
	Chest tube 20 — Febrile 38.1 — Linezolid/Pip Tazo/Caspo
	LUQ JP 60 — ⊕ VRE.
	perc 15cc
	Ⓡ malecot. 130 — NG 100 since OR
	LLQ ∅ — Dobutamine 2.5.
	midline JP 110. — ∅ pressors.
	rectal tube ∅.
	vac 50.
	A/P CCM. (signature)
	∅ feeds until ileo output improves

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec. 22/21 1053	Echo Completed
	M.McWhirter ORCS
	ACS haematoma
23/12/21	POD 2 ex lap + evacuation of infected
8:45	Drains Ⓐ chest irrigation Ⓑ CT 520 SS
	Ⓒ 155 SS Ⓓ 60 SS
	Ⓔ 10 SS Ⓕ 90 SS
	NG 595 ileo 300 enteric
	On propofol 25 , dexmedetomidine 2.5
	Intubated 8/12 @ 30% FiO2
	Plan: Continue current ICU mgmt
	M. Alt[illegible] R2
24/12/21	ACS
	POD #3 Exp lap + evac infected hematoma.
	Drains: all old sans
	perc 40 chest tube 500cc
	rectal 65 ileo 475.
	∅ pressors.
	extubated
	SCM [signature]

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PROGRESS NOTES

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ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	Gen Sx
Dec 26/2021	POD# 4 laparoty, evacuation of hematoma
	Ø [illegible], [illegible] on 2LNP
	LUQ perc = 135 CT (LUQ drain) ~ 805cc
	LLQ [illegible] = minimal SPUP = Ø
	Ileo = 925 [illegible] looks good
	Ø enteric output.
	I/P cem.
	[signature] PGY
Dec 26/21 9:10	ACS. POD #5 20/12/21 ex lap hematoma evac.
	ANSS 2L, HR 84.
	Foley 1425, JP (LUQ) 55, JP 45 JP Ø, chest tube 550 Ø
	ileo 350. perc, mallinck Ø.
	A/P: CF diet.
	[signature] SR1

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ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
DEC/27/21 9:27	ACS Rounds
	POD #6 ex lap hematoma evac; VRE-pos.
S/	Feeling better. ∅ much ambulation. ∅ sign. compl. N/V.
O/	→ Vitals: Stable as per pt (Afebrile, Tachypnea @ 30, Tachycardia @ 117, BP normal.)
	↳ Abdo: soft
24h:	↳ Urine: 4600; JP A: 80 (→ sang); Chest tube B: 145 (→ serosang); Perc C: 215;
	JP C: 100 (→ sang); Malecot D: ∅ (→ serosang); JP E: ∅ (→ sang); Rectal malecot: 100 (→ serosang)
	Ileo: 425. NG-minimal ↳ serosang.
I/P	→ POD#6
	↳ NG - d/c
	↳ Δ to CF; will consider further diet Δ later
	↳ CCM
	MOB (R1)

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PROGRESS NOTES

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ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans — Progress Notes
Dec 27/21	Pt refused to mobilize with her
Physio	today. States pain +
Courtney	fatigue limiting. Review
12588	of incentive spirometer +
	LE ROM exs. Physio
	to follow up thursday
	for mobility Ax.
	Courtney [illegible] MPT
28/12/21	ACS
725	POD 7
	DVTp: argatroban + clopidogrel + ASA
	AB: linezolid (VRE +) + piptaz
	Diet: CF
	S – stable
	→ stable from prior
	O → Vitals → 98% (2L); HR 118 – stable from prior; Afebrile, BP N
	→ Abdo → soft, drains ~~in-situ~~ – Ø concerns w. same.
	Foley: 500; Ileo: 850; JP A – 100; Chest tube B: 10; Perc: 100; JP C – 105.
	Mallecot D – Ø; Rectal: 150
	I/P – Stable
	→ wound care – vac replacement ~~today~~ consider today; consider removing another
	→ ~~will~~ ~~consider~~ call hsma later today r/e oral option in argatroban

MOS (R1)

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SK UNKNOWN
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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
DEC. 28/2021	PT MET W [illegible], AGREEABLE TO MOBILIZE.
PT/GW	TOLERATED SBA TO DANGLE @ Ⓡ SIDE
[illegible] #11422,	OF BED. Ax1 SIT → STAND + SIDE-STEP
1155	TO Ⓡ w/ 4 2WW. SBA TO LAY BACK
	IN BED. TOLERATED WELL. WILL F/U
	[signature]
28 Dec 21	Midline abd wound VAC dressing
1436	changed –
Ostomy & Wound	Wound measured ≈ 21cm x 2-4.5cm
	x 2cm - 3.5cm
	Wound bed: blue sutures visible.
	Periwound skin: intact
	Drainage: moderate serous.
	Mepitel one applied to wound bed
	Silver granufoam x 1 piece applied
	Setting remains 125mmHg.
	Plan to review Thursday —
	[signature]

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PROGRESS NOTES

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ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/title (Please include for each entry)	Initial Plans - Progress Notes
28 Dec 21	(R) & (L) lateral abd wounds
1439	reviewed.
Ostomy & wound	(R) wound measured 12.5 cm x
	6.5 cm wound bed 50% pink
	50% yellow non viable tissue
	Drainage scant serous.
	(L) wound measured 6.8 cm x 3.5 cm
	Wound bed: 30% pink 70% brown.
	Scant serous drainage.
	Suggest Adaptic c mepilex border
	switch to dry dress once
	necrotic tissue off —
	Ileostomy appliance changed
	Stoma measured 1¼" moderate profile
	Mucocutaneous junction c peristomal
	skin intact.
	Function: liquid green stool.
	Convatec one piece appliance
	applied with eskin 360°.
	Plan to change with vac
	change — [signature]

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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: WALL, ALASTAIR
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 28/2021	40y ♂ with HTN / SKin cancer.
	pmr Cardiac arrest / PCI with DES LAD with
	ischemic basal injury.
	on Argatroban + DAP
	in anticipation of hospital discharge
	would syst Transit To warfarin
	overlap of 5 days or longer will be needed
	To Transition
	- probably with Warfarin + Clopidogrel if
	Cardiology agreeable.
	ii) Pt interim willingness on Argatroban + DAP.
	H+P

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PROGRESS NOTES

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FEB-23-1981 40y IP V#10521726 M
ATN: WALL, ALASTAIR
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ ~~Signature/Title~~ (Please include for each entry)	Initial Plans – Progress Notes
Dec 29, 2021	ACS
0750	40M POD 8 laparotomy, evac hematoma
	Foley 4400 Chest tube 85
	Renal 85 ⓓ perc 110
	JP A 40 Ileo 600
	JP C 60 VAC scant
	S/ Doing well. ↓ N+V. Pain well controlled. Good appetite.
	O/ AVSS. Drains in situ, outputs above
	A+P/ ① Progress to full fluids
	② TFI = TPN + meds
	Daniel Hwy, R1
Dec. 29/2021	PT SEEN TO MOBILIZE, RECEIVED TO SESSION. SBA
1445/10	LAY → SIT @ ⓡ EDGE OF BED, A×1 SIT → STAND
Room # 11425	+ STEP-AROUND PT TO CHAIR, SAT UP FOR ~15 MINS.
1405	A×1 TO PT BACK TO BED. ABLE TO GET FROM
	SIT → LAY SBA. TOLERATED WELL, WILL F/U
	AS ABLE — [illegible]

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FEB-23-1981 40y IP V#10521726 M
ATN: WALL, ALASTAIR
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 29/21	Dietician TPN at goal rate. Pt tolerated clear fluids yesterday → advancing to full fluids today. Labs reviewed - unremarkable I: 1) Will continue c TPN at goal rate until pt demonstrates tolerance to solids Salamerd
Dec 29/21 1530 SLP-Allie pg 12e56	SLP Checked in on pt re oral intake + safety as last time ax'd was Dec 20/21, and was recommended ice chips only due to gut concerns and starting TPN. Team started clear fluids on Dec 27 and upgraded to full fluids today. Wife + nsg report no safety concerns c oral intake. Will monitor pt re swallow safety and once pt is cleared for solids SLP can re-ax. AJacobi MA CCC SLP

PROGRESS NOTES

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ATN: WALL, ALASTAIR
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans—Progress Notes
Dec 30, 2021	ACS
0745	Doing well, tolerated FF diet, starting
	to mobilize, pain well controlled
	O/E: VSS, ILNP
	abdo: soft, non distended, nontender
	-ileo, 400 CT: 15
	LLQ 25 Jpr: 125
	A/P: ① D/C JP
	② D/C CT
	③ D/C [illegible] [signature]
Dec 30/2021	Hem.
1:15	40 y O with ACS + HIT
	Transition To Warfarin – Target INR: 2–3
	of Argatroban
	[illegible] will follow
	H [signature]

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FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
30 Dec 21	Midline abd wound vac dressing changed
1347	Wound size: 21cm x 1cm proximal end
Ostomy & WOM	and 3cm distal end.
	Depth: 0.8cm proximal end
	1.5 - 2cm mid aspect
	3.0cm distal end
	Sutures visible - wound bed
	Drainage: moderate serosang.
	Contact layer: mepitel one
	Silver granufoam x 1 applied to
	wound bed
	Setting unchanged.
	Plan: review Monday — [signature] WWSOC
	Ileostomy appliance changed -
	One piece applied with ear -
	360° — [signature] WWSOC

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PROGRESS NOTES

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FEB-23-1981 40y IP V#10521726 M
ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Dec 31, 2021	ACS
0750	Doing well, tolerated FF diet. ØN/V.
	pain controlled. mobilizing.
	O/E: HR 114-123, RR 18, O_2 96% RA, BP 125/78, afebrile
	ileo: 525 perc: 200 CT: scant
	abdo:
	A/P: ① D/C CT
	② D/C abx
	③ DAT
	[signature] (R5)
	(K. [illegible])
2021 Dec 31 1305	ID
	See SCM
	[signature] Henri

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FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 1, 2022	ACS
0755	Doing well, tolerating DAT, ∅ N/V, mobilizing [illegible]
	O/E: AVSS, RA, afebrile
	ileo: 375 perc drain: 65 - old sang
	A/P: ① ↑ pain control
	② [illegible] perc drain
	[signature] (R2)
Jan 7, 2022	ACS
0615	Doing okay, passing some BRBPR overnight, ∅ N/V,
	tolerating diet, pain manageable
	O/E: VSS, HR ↑'d (relatively unchanged)
	perc: 75 - old sang ost: 240 UHC: scant
	abdo soft, ∅ distended
	A/P: ① monitor Hgb
	② continue DAT / wean + pH as able.
	[signature] (R2)
Jan 3, 2021 CPAS 0945	Will continue to follow pts' progress & assist as needed — [signature]

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PROGRESS NOTES

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ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	ACS
Jan 3, 2022	Ileostomy 1475, Perc (sang) 55, Hollister 85
0700	Doing better than yesterday. Less ~~some discomfort yesterday~~ after taking IV Dilaudid. IV Dilaudid controlling pain well
	O/ HR 124, other vital signs stable
	Abdo soft
	A+P/ ① Monitor Hgb, no transfusion at this time
	- sang drainage from perc → source of bleed?
	② Wean TPN as tolerated
	Daniel Hui, RN
Jan 3/22	Ostomy + Wound Dept
1450	NPWT changed to midline incision. 80:1 pink, 20:1 yellow slough. Sutures visible. Maratron peri wound. Adaptic as interface Silver granufoam x 3 pieces Ileostomy appliance changed. Plan to see Thursday
	DPalen RN NSWOC

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 3/22	Hematology
	40 ♂ with HIT/skin necrosis. On argatroban → warfarin + DAPT.
	Post-cardiac arrest, PCI with DES LAD: ischemic brain injury.
	Hb 83 → 75. Hemodynamically stable.
	Sang drainage from perc drain.
	Transfusing 2u pRBC currently
	INR 3.0 uncorrected today. On warfarin 7mg.
	Plts ✓.
	I/P: Ongoing transition from argatroban → warfarin
	Gradual ↑ warfarin to avoid >> supratherapeutic INR.
	↑ risk bleeding on therapeutic AIC + DAPT. ~ source control
	if possible if bleeding worsens.
	CHart
4/01/22	ACS
	POD # 30/28/14.
	On TPN
	AUSS HR 128.
	Mobilizing. Tolerating DAT.
	ØN ØU.
	Ileostomy healthy BOS.
	Vac 30 Sang
	PVC 60
	-Dr.

PROGRESS NOTES

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ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan. 4/21 Physio - [illegible] #12364 1200	Pt agreeable to dangle - pt waiting for wound care to change dressing. SBA roll, [illegible] (R) on EOB x 15 minutes. Sit [illegible] SBA. Plan to see tomorrow to walk if appropriate. [signature]
Jan 4/22 @ 1430	Ostomy: Wound Dept. - Nurse called re: sang exudate from abd VAC; VAC removed and small area of bleeding active from distal end of wound. Dr. in to assess and cauterize. Periwound intact, wound measures 21 cm x 1.5 cm x 1 cm at proximal end and 21 cm x 4 cm x 2 cm at distal end. Wound bed 100% pink, sutures visible. Adaptic used as interface c̄ 4 pieces silver granufoam placed with trac pad offset. Pt tol well with IV analgesic. Ileo appliance changed d/t proximity. Stoma 1½, pink, mod profile, mucocutaneous junction and peristomal skin intact. One piece applied. See Friday [signature] RN NSWOC

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 4/22 17:00	Hematology
	Hb stable. Small active bleed identified in vac wound → cauterized.
	Jan 1 / Jan 2 / Jan 3 / Jan 4
	INR 2.5 → 2.6 → 3.0 → 5.7.
	Warfarin 5mg → 7mg → 7mg
	Need to overlap warfarin with INR >4 and argatroban infusion x 48h.
	↓ warfarin to 6mg today.
	[signature]
5/1/21	ACS POD #31/29/15.
	Perc 15. Pt inadvertently got 7mg yesterday
	Hollister 50 will defer to heme for dosing of warfarin
	~~ileostomy 285~~
	vac scant.
	INR 4.5 (5.7).
	S/. ⊕ crampy Abdo pain. ØN ØV. "gassy"
	O/A AVSS HR 115. Abdo soft nontender non distended
	midline Ø s/s ooze.
	A/P ↑mob. Transfuse 1 unit PRBC.
	CCM.
	[signature]
Jan 05/22	Heme Clerk
1445	40 yo ♂ w/ HIT/skin necrosis. Post cardiac arrest PCI w/ DES→LAD
	On argatroban → warfarin + DAPT ischemic bowel injury
7.94 / (82) / 338.	INR 4.5 today, warfarin @ 6mg yesterday + DAPT (clopidogrel + ASA)
	A/P: ① AC → stopped argatroban, warfarin 6mg today
	repeat CBC this aft.
	Michelle Bravant CEH

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PROGRESS NOTES

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FEB-23-1981 40y IP V#10521726 M
ATN: WALL, ALASTAIR
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please Include for each entry)	Initial Plans – Progress Notes
	CT Abd/Pelvis
	Jan 5/22
	Completed
Jan 05/22	Heme clerk Addendum
1700.	② ↓ Hgb → ? from bleed from vac yesterday.
	→ monitor
	Michelle Baudot CCY
Jan 6, 2022	ACS
0645	POD # 3 21 30/16
	Ileo 175, L pere 35, Hollister 50
	Voe x cont, Foley 425-0
	S/ Was having more pain yesterday, that was more difficult to control. Passing gas
	O/ HR 134, other vitals stable
	Abdomen non-distended
	A+P/ CCM
	Monitor Hgb
	Daniel Heu, RN

Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: BREE, TERESA L
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 6, 2022 0934hrs	Dietitian
	TPN (cycled infusion) at goal rate. Pt on solids (GI surgery/ostomy diet). Calorie count (Jan 4) = 421 kcal (20% estimated req't) + 22g protein (18% req't). Labs reviewed - unremarkable.
	I: 1) Will continue TPN at current rate until po intake improves. (Balance PD)
Jan 06/22 1020	Heme Clerk
	40 yo ♂ w/ HIT/skin necrosis
ϕ bleeding ϕ Δ since stopping argatroban.	- discontinued argatroban yesterday.
	- on warfarin 6mg, INR 3.4 (3.4 @ 1920 Jan 05/22)
	$O_{//}$: 36.9°c, 20 RR 94% RA (125) 136/77
	7.4 / 92 | 344 INR 3.4 ← 3.4 ← 4.5 (on argatroban)
	A/P: ① anticoagulation → continue warfarin + DAPT, monitor INR
	② ↓ hgb → stable. Heme will continue to follow
	Will discuss w/ staff target INR + warfarin dosing.
	target INR 2-3 Michelle Brabant CCN
	warfarin @ 6mg po today, reassess tomorrow.

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 6/22 Physio- Rachel #12364 1100	Pt's hgb stable today and ø tests. Agreeable to mobilize. (I) lie→sit c̄ HOB↑ and rail. (I) sitting on ECB. Mild dizziness ↓ c̄ time up. Sit→stand SBA c̄ 2WW Walked ~25m c̄ 2WW min (A) x1 c̄ IV pole. Sit→lie (I) c̄ HOB↑ and rail. Pt tol walk well. Advised to have long rest and try 2nd walk in late afternoon/evening, distance as tolerated. Will f/u tomorrow. [signature] MPT
Jan 6/2022 11:30 Lauren (SW) #12829	Writer met w̄ pt. + pt.s wife at bedside. Pt. report feeling better today than yesterday. SW will continue to follow + check in for emotional support. [signature] (RSW 1BSW)

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ATN: SOTHILINGAM, NIROSHAN
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 7, 2022	ACS
0630	POD# 33/31/17
	Foley 2900 L perc 20. VAC scant
	Ileo 1000 Hollister 170
	s/ Argatroban ~~might~~ discontinued 2d ago
	Target INR 2-3 as per heme.
	↓ nausea with the Dilaudid SR
	Mobilizing. On clear fluids right now
	o/ Abdo soft, NTND
	HR 126, other vitals stable
	A+P/ 1) Increase Dilaudid SR to 6mg BID
	2) Will discuss potential for getting PICC with rads (patient anticoagulated on warfarin)
	Daniel Hui, RN

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 07/22	Heme Clerk
11:00	40 yo ♂ HIT/skin necrosis.
	- D/C argatroban 2 days ago.
8.75 / 90 / 304	- Ø bleeding, Ø change.
	O/: 37.2°C, 20RR, 96% RA, (118), 120/76
	INR 3.5 warfarin 6mg yesterday
	A/P: ① AC → target INR 2-3
	→ decrease warfarin dose to 5.5mg over the weekend.
	② anemia → hgb 90, stable.
	③ PICC → please discuss w/ Dr. Hart prior to (Heme staff)
	insertion.
	Michelle Brabant CC4.
Jan. 7/22	VAC dsg change to abd wound. Reapplied Adaptic
Ostomy/wound	x1 layer + 2x Silver foam - Reduced pressure to
1240	75mmHg to minimize risk of bleeding. Wound
	21x4 cm c̄ 2 cm depth & 90% pink c̄ visible
	sutures in base of distal portion of wound. Pt
	managed well c̄ IV analgesic. Next dsg change Tues.
	Ileostomy 1½" red [illegible] c̄ sm amt peristomal
	rash treated c̄ Marathon. 1 piece pouch placed +
	thick brown output noted. —— [illegible]

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FAM: FRASER,JILLIAN

PROGRESS NOTES

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Jan 7/22 Physio - Rachel #12364 1542	Pt agreeable to mobilize. (I) rolling (L), lie→sit c̄ rail and HOB ↑. (A) to organize lines and don house coat and slippers. Sit→stand SBA c̄ 2WW. Walked ~20m c̄ 2WW min(A) x1 mostly for IV pole. Some tightness in (L) calf. Sit→lie (I) c̄ rail and HOB ↑. Tol walk well overall. Pt recommended to go for OD→BID walks c̄ staff over w/e. Will f/u after w/e [signature]
Jan 8 2021 0700	ACS 40M POD #34/32/18 Foley: 2925 Ileo: 525 Vac: 25 Vac: 25 Hollister: 5 37.0 HR 119 118/74 RR22 95% RA Intense rib pain ≠ SOB o/n. Abdominal binder helped relieve pain. A&P / 1. Rib pain controlled c̄ binder & pain meds 2. Pt eating well - Continue current mgmt [signature]

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Time/Date/Printed Name/ ~~Signature/Title~~ (Please include for each entry)	Initial Plans – Progress Notes
	ACS
09/01/22	POD # 35/33/19.
	Tleo 300 Foley 3900
	vac 50
	~~perc~~ 0
	Holister 310. OID hematoma
	AUSS AGB eating half to 3/4 trax.
	Mobilizing well.
	A/P D/C Foley
	ACS
10/01/22	POD # 31/34/20
	Ileostomy 700 cc
	Holster 145 Perc 25.
	Vac Scant
	Emesis x1 Mobilized well yesterday.
	Foley out Pain well controlled. voiding x4.
	A/P CCM

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 10/22 13:20 Victoria PTA	Pt rec'd sleeping in bed, fairly easy to rouse. Pt declined amb c writer @ this time - stated he went c ~~her~~ wife V.B. this A.M. (Nurse confirmed same), + he will go again c her later, but right now he wanted to nap. Will continue. ——— V. Barron PTA
11/01/22	ACS POD #37/35/21 ileostomy 575 650 Pers 10 Hourly 5. Afebrile. Avss Hr 120. ~~mobilized well.~~ Tolerated 1/2 → 3/4 of tray. Drinking ensure 1-2 x per day ⊕ gas. Main pain is associated w/ribs ~~#s~~ A/P CCM. ? stop TPN - D
	CT ChAP Jan 11/22 Completed

Hgb 95

[redacted]

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Jan 11/22	Dstomy + Wound Dept.
@ 1340	NPWT changed to midline dehiscence. Wound improving. Visible sutures @ base. 90 cc pink. Adaptic as interface. Incisional to proximal incision. 1 piece of silver granufoam to distal opening. Settings @ 75 mmHg Continuous. Ileostomy appliance changed. Stoma pink, healthy, mod profile. One piece esteem applied. Plan to change Friday.
	[redacted] RN NSWOC
	ACS
Jan 12, 2022	POD # 38/36/22
	Ileo 350, Hollister 5, L perc ø, VAC ø
	s/BCx positive yesterday, CVL removed. Feels much better today. ~~Bld yesterd~~ Still having some pain in the ribs. On Pip-Tazo
	o/ HR 105, T 37°, other vitals stable
	Abdo soft, non-distended. Remains tender
	A+P/ 1) CCM
	Daniel Hui, R4

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 12/22	Dietitian
	Infected CVL removed ∴ TPN changed to peripheral PN yesterday. Labs reviewed – unremarkable.
	I: 1) Cyclic PPN to continue: (1600mL/d x 14hrs and 800mL/d x 2hrs, to provide 1700kcal + 72g protein.)
	~~will~~ 2) Will restart calorie counts to assess adequacy of po intake.
	Dalanor RD
Jan 13, 2022	ACS
0650	POD # 39137/23 purulent purulent
	Ileo 300, Lt perc 20, Upper Hollister 80, lower Hollister 20
	S/ Tolerated some FFs + solids last night. Sat up in chair yesterday.
	O/ AVSS, HR 111
	Abdo Soft, NTND
	A&P/ 1) CCM, continue to try to wean PN
	Daniel Hui, RN

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Jan 13/22 0930hrs	Dietitian
	Cyclic PPN continues (1800 - 1000hrs), off from 1000 - 1800hrs. Pt on solids (GI surgery/ostomy diet) and reports improving po intake; consumed ~½ breakfast tray this am. Also, gets Ensure (choc) and his mother brings him hearty soup every day. Nutr dx: Altered GI fxn resolved. I: 1) Recommend discontinue PPN after current bag is done. Balance RD
	ACS
Jan 13, 2022 13:35	Discussed patient with ID. Wound culture grew Enterobacter cloacae, resistant to Pip-Tazo (current abx therapy)
	ID recommends PO Cipro, Flagyl, Linezolid.
	In discussion with pharmacy, no drug interactions of current meds with linezolid, but cipro + flagyl expected to ↑INR
	substantially. Also recommend ECG given recent ECG
	with QTc = 520. Plan: 1) Change abx therapy
	2) ECG now, repeat tomorrow AM
	3) D/C ondansetron
	4) ↓ warfarin dose

Daniel Hui, RN

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	~~Initial Plans~~ ~~Progress Notes~~
Jan 13/22 Physio-Rachel #12364 1510	Pt eager and agreeable to mobilize. Provided c 4WW to trial. (I) lie→sit→stand→to 4WW. Walked ~100m (I) c 4WW. Tolerated very well. Recommended to walk (I) c 4WW when IV pole disconnected. Goal to ↑ to (I) ø walker and trial stairs. Mobility c wife and self encouraged. RJ Fraser
14/1/22	ACS Ileo 355ml, Holist 150ml, urine 1100 Prolonged admission S/ vomited meal last night. O/ HR 108, AUSS. Vomited during exam A&P/ (I) Adjust pain meds. Add maxeran E Taylor CC3

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Jan. 14/22	Midline NPWT changed. Wound progressing
1200	Sutures remain visible in base of
Ostomy/Wound	distal wound but granulation tissue
	is ↑'ing. No issues with bleeding.
	Reapplied NPWT with adaptic
	interface. Settings unchanged. Ileo –
	no concerns. Reapplied 1-piece
	appliance. Plan to change both on
	Tuesday ———— J Motsalla RN
	NSWOC
Jan 15/22	ACS
0700	40 yo ♂ prolonged hosp stay c̄
	cardiac arrest → colectomy → infected
	hematoma
	uneventful ileo: 350 PERC: 25 hall: 45
	emesis x1 last night → not tolerating
	some po abx or other large pills
	abdo not distended soft stoma healthy
	plan: try liquid form of abx
	A. Kudryk [illegible]

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 16/22	ACS
0705	Prolonged stay c total col. + end ileo,
	infected hematoma.
	Afebrile VSS
	pt [illegible]. N [illegible]/[illegible] [illegible],
	tol. PO linezolid.
	∅ other concerns.
	Plan: CCM
	[signature]
	A. [illegible]
Jan 17/22	ACS
0730	1D 40 yo M prolonged hosp stay with OHCA?
	total colectomy + end ileo, → infected hematoma
	S/ Pain ongoing. N+V. Lightheaded w/ ambulatory
	O/ Afebrile VSS. On IL yesterday
	output ~~day 250 Night ccm~~
	Vac-Scant Ileo 175 PERC 175 hollister 1 10 hollister 2 Scant
	Abdo soft, ⊖ tender
	A/P: CCM. Repeat liver enzymes. Review anti-emetics
	after rounds. Increase po tactivity. ? liver US later
	[signature] M[illegible]

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	~~Department of Medical Imaging~~
	Ultrasound done liver/GB
	Date Jan 17/22 Initials TW/DM
17 Jan / 22	SW referral received re: check in requ-
# 12829	
SW - Alexa	ested by pt. spouse Andrea. Pt. w RN
~ 15:30	at the bedside. SW and pt. spouse left
	the unit to speak in confidence.
	Emotional support provided to pt.
	spouse. She feels that she would bene
	fit from consistent check ins. Plan: SW
	following. Will provide emotional support
	to pt. and pt. family, as caseload
	allows. Alissa Zinicky
	BSW RSW(SK)

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	~~Initial Plans - Progress Notes~~
	ACS - Cipro/Flagyl/Linezolid
Jan 18, 2022	40M post cardiac arrest, colectomy, evacuation hematoma
0635	S/ feeling well. N/V improved with Haldol. Tolerating some
	soup.
	O/ VAC 0, Hollister 0, ~~Colostomy~~ Ileostomy 50, L perc 40
	AVSS, on 1L NP
	A+P/ 1) Repeat BCx. If negative, consider PICC
Jan 18, 22 - 1120	SLP in for f/u - spoke c̄ nursing staff who stated
SLP Sadia #12722	pt. is on TPN & takes FF diet by choice d/t
	stomach issues. Staff aware notified to reconsult
	SLP when pt. ready to try more solids. ∅ Δ
	to diet. Will f/u as appropriate.
	[signature] SLP as reg. Sk Lic #1541
	(SADIA MANSOOR)
Jan. 18/22	Pt agreeable to mob. (I) ↑, e→sit→stand
Physio. Rachel	into 4WW. Walked ~ 60m (I) c̄ 4WW.
#VL369 1400	Left sitting on EOB c̄ nurse for vac
	to be checked. Will continue to
	follow to ↑ endurance and ↑ to
	(I) swallow. [signature] MPT

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Jan 18, 2022	flu- writer asked to flu as pt had
NSSRD 1336hrs	acute rise in LFT's. Likely multifactoral
Wendie Larocque	but PPN may be contributing and is NO
#10052.	longer Warranted. Pt's Nutrition status
	is poor but not unexpected given his coorse
	Pt has multiple bottles of ensure at bedside
	unopened. We discussed the importance of
	Nutrition and patient agreeable to supplemental
	enteral feeding via small bore NG tube.
	Ostomy/Wound care to see this afternoon
	thus patient requested tube be placed
	tomorrow. Once tube is placed I will
	provide enteral orders — @laroqueRD
Jan 16, 2022	Writer met w pt. + pt's sp. at bedside.
Lauren (SW)	Pt. sleeping; however, writer discussed support needs
#12829	w pt. sp. Writer provided emotional support to
14:53	pt.s sp. SW will continue to follow +
	provide support as needed. Amy (RSW/BSW)

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan. 18/22	Midline abd NPWT changed. Slowly
1605	improving, no concerns, reapplied in same
Ostomy/Wound	fashion settings unchanged. Ileo appliance
	changed – no concerns – 1 piece reapplied.
	Bilat Rt + Lt quadrant dsgs changed. RLQ –
	healed + left OTA. LLQ – Small area of
	necrosis left to autolytically debride →
	reapplied adaptic + mep. borders + reapplied
	mep borders to old drain sites. Plan to
	change all on Friday — J Matsalla RN
	NSWOC
14/1/22	ACS
700	ABx: cipro + Flagyl DVTp: warfarin
	Diet: as per NSS note – will place feeds NG
	↳ ↓PO intake today
	– mobilizing c PT [illegible]
	wound ostomy following for [illegible] wound
	stoma – 425 vac – [illegible] perc – 55
	Patient reports nausea improving, tolerated CF [illegible]
	discussed diet,
	ASIP: trial FF today
	If not [illegible] – NG [illegible] [illegible]

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Jan 19, 2022	f/u - tolerating full fluids with order provided
NSS RD 0955hrs	to advance to DAT. In v/o patients course
Wendie Lavoque	thus far and current calorie/protein
#10052.	requirements I strongly recommend insertion
	of small bore NG for supplemental nutrition.
	and patient agreeable to same. D/ inadequate
	protein-energy needs persist I/ ① Nocturnal
	feeds Vital Peptide 1.5 - 75ml/hr. 1900-0200hrs
	to provide: 1350Kcal, 61g pro 684 ml free water,
	flushes 100ml q4h ③ d/c PPN ④ cal count
	⑤ wt check ⑥ multivit/multimineral - 1 tab
	po daily M/E labs, Wt, GI fx, clinical course
	W. Lavoque, RD
Jan. 19/22	Pt agreeable to mobilize. Ⓘ lie→sit→stand. Walked
Physio- Rachel	~100m c̄ 4WW Ⓘ. 1 seated break on walker.
#12364 1120	Tol well. Left sitting on EOB c̄ wife and CCA
	for weight. Will continue to see weekdays.
	[signature] MPT

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Time/Date/Printed Name/ ~~Signature/Title~~ (Please include for each entry)	Initial Plans – Progress Notes
Jan 20, 2022	ACS
0645	Post-cardiac arrest, Ischemic colon Cipro
	S1 ØN/V. Had soups. Having appetite for solids Flagyl Linezolid
	01 L perc 65, Colostomy 150 VAC ~~1200~~ Ø
	AUSS
	AnP/ ~~Plan to insert NG today for NG feeds~~
	Trial of diet progression. Hold off on NG for now
	Daniel Hui, R1
Jan 20/22 1415hrs	Dietitian
	Pt + wife concerned that NG tube for enteral feeds not yet inserted. Pt reports poor po intake so far today + wants tube inserted. Contacted ACS team + spoke c Dr. Hui; requested team to come to ward after surgical case + insert tube. Supplemental tube feeds to start this evening – enteral nutrition order set in Chart from Jan 19/22. Balamohan RD

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Jan. 20/22	Pt reports going for am and afternoon
Physio Rachel	walk c̄ wife c̄ 4ww. Tol well. Encouraged
#12364 1440	Walking to BR during day. Pt to continue
	c̄ BID walks and w/ing BR in daytime.
	Physio will f/u Monday. [signature] PT
Jan 21/22	ACS
0709	Post-cardiac arrest, ischemic colon
	S/ Had NG inserted last night. Vomited At 65mL/h.
	Colostomy bag filled up ×3 over night.
	Wound care nurse coming today. Nauseous
	overnight.
	O/ Intake: NG - 2727
	Output: VAC - scant ~~[struck]~~ colostomy - 350 (L) perc - 150
	AVSS.
	A&P/ 1. Consult dietician Re: NG feed rate
	2. Changed dilauded [scribbled out] PRN. [signature], CCS

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan. 21/22	Midline abd NPWT change. Wound healing
1600	slowly, no concerns. Reapplied in same
Ostomy/Wound	fashion. Settings unchanged. RUQ ileo
	appliance changed. Stoma healthy. Peristomal
	skin sl. dermatitis – marathon applied.
	1 piece appliance applied. Plan to change
	all Thus ———— J Matsolla RN NSWOC
	ACS
Jan 22, 2022	Post-cardiac-arrest, ischemic colon
0645	Had nausea/vomiting in evening yesterday. Feeling ok today
	o/ ~~Colostomy~~ Ileostomy ~~350~~ 220 L perc ~~150~~ 75 VAC scant
	INR 4.8
	A+P/ 1) 2mg warfarin today
	2) Tube feed rate ↓ yesterday
	[signature]
	Daniel [illegible] R1

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SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other_____

SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: OGAICK, MAURICE
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan. 22/22	Surg on call
13:41	Ψ pagers regarding ongoing nausea with emesis x 2, ↑ abdominal pain, & anxiety.
	• S. Patient feeling about the same as this morning but seems to have not tolerated ↓ Dilaudid IR 0.5-1 mg from q2h to q3h. Pain has settled 2/10 from 10/10 over epigastrium following IV Dilaudid.
	• O. Stable. Jaundice/scleral icterus, nursing thinks ↑. Abdomen soft, non-distended, and tender to palpation over epigastrium. Stoma working well passing gas & stool.
	• A/P. ① Δ Dilaudid IR back to q2h.
	② Haldol 0.5 mg IV x 1.
	③ ativan 1 mg PO x 1.
	④ Reviews with team.
	Dr Templeton R1.

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Jan 23/22	~~ACS~~ Surgery on call
0706	Post cardiac arrest, ischemic colon!
	Colostomy - 50 mL (L) perc - 60 mL ~~drainage 250 mL~~
	S: N/V ++ last night. Abdo pain ++. NG rate 60 → 40 →
	tube feeds currently held.
	O: AVSS.
	A/P: 1. Consider NJ tube.
	Gina Choi, CC3
Jan 24/22	ACS
0709	Post cardiac arrest, ischemic colon
	Vac Ø Colostomy 125mL (L) perc Ø NG Ø
INR 5.9	S/ Nausea + emesis x1 overnight. Ongoing pain
Bili 142	
	O/ AVSS. Abdo soft, mild distension
	A/P ① Hold Warfarin today
	② MRCP scheduled, ? obstruction w/ climbing Bili

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FAM: FRASER,JILLIAN

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Jan 24/22.	Cal counts as follows: Jan 20 - 390Kcal 20g pro
NSS RD 0914hr	Jan 21 - 765Kcal, 39g pro Jan 22 - 106 Kcal
Wendo Larocque	11g pro. Noted regular gravol provision
#10052	on MAR but No other antiemetics.
	NJ reasonable option but requires
63.6kg	insertion in radiology or endoscopy.
	It would have to be removed for
	MRI therefor verifying date for MRI
	would be ideal. I will speak with
	NSS physician re: availability for
	NJ insertion ——— W Larocque, RD
Jan 25/22	ACS
0645	Post cardiac arrest, ischemic colon
	Vac scant L Perc 30 (↳ feculent) Colostomy 100 per self
	S/ N/V improved with lower tube rate.
	O/ AVSS, HR 110
	Abdo soft.
	A/P/ ① Will touch base with MRI regarding scan
	[signature] Daniel Klein, RI

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 24/22	Pt agreeable to mobilize. (I) lie→sit→stand
Physio - Rachel	into 4WW. Walked c 4WW x 80m SBA for
#12364 1100	IV pole. Tol well. Left sitting on 4WW in
	room. Tolerated walk well. Pt and
	wife can walk c 4WW c lines
	together. Will have physio check
	in later in week [signature]
Jan. 25/22	Plan was to change NPWT + ileo
1445	appliance but pt for MRCP today
Ostomy/Wound	or tomorrow ∴ NPWT not changed.
	NPWT has silver granufoam ∴ will need
	to be removed for MRCP. Remove +
	apply mepilex border post-op for test.
	Will review plan tomorrow
	JMcBallaRN NSWOC

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FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 25/22	 Description: 12F ReSolve® 25 cm /0.038" (0.97 mm) Locking Drainage Catheter RLC-12-038MS 10108844500098 57
	Radiology
Jan 25/22. 1600.	Δ tube in MRI Comp. Resolve 12Fr & complete full input to follow. DW Stemler
Jan 26/22 0213	ACS on call (late note) Pts labs back: Ammonia 81o (↑), INR 4.1 (6.8) ALP 1458 (1393), ALT 95 (99), AST 170 (155), GGT 6836 (733) Bili 139 (142) Hgb 103 (165) Plan → start lactulose for ↑ Ammonia ? hepatic encephalopathy EMcEvenPA

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 26/22	ACS
07:15	Post cardiac arrest + ischemic colon
INR 2.2	S/ Pain improved. ⊕flatus Nausea improving
~~Hb 103~~	+ vomit x1
Ammonia 88 → 36	O/ L Perc 140mL Vac ⊖ ileo: 300mL
Hb ~~103~~	Abdo: SNT ~~afebrile~~ VSI (N)
65 → 103 → 109	A/P/ (1) Awaiting MRCP - PERC tube switched.
Perc ▷ yesterday	Re-fax MRCP req.
to MRI compatible	(2) ? HE- Ammonia 88, given lactulose last night. Call GIM today.
	Continue lactulose MMacmillan
Jan 26/22	Pt still awaiting ~~MRI~~ erosion MRCP – abd
1530	VAC not changed. No drainage + is
OStomy/Wound	intact. Will r/a tomorrow. Ileo
	appliance changed. No concerns.
	JMatsallaRN NSHoc

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 27/22	ACS
07:00	Post cardiac arrest + ischemia colon
	S: Pain improved. Pt still confused/delirious.
	O: Vac ~~O~~ Ileo 900 L perc 90
	Afebrile VS (N).
	Abdo: SNT, Afebrile
	A/P: (1) Awaiting MRCP for ? obstruction. Scheduled for today.
	GIM assessed for delirium ? HE, hemodysis labs ordered. They think unlikely acute liver failure.
	M Ahmed MD 2
	ACS

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	GIM R3
Jan 27/2022 1105	ID/I 40M w complicated stay post cardiac arrest.
	GIM following for delirium + ↑LE.
A/P	(1) Delirium: D/C deliriogenic Rx, Seroquel. Unlikely HE but will continue lactulose for now.
	(2) ↑LE: ongoing ↑, most likely ? intrahepatic obstruction — direct bili predominant, ø evidence of hemolysis. MRCP would be helpful. Given (N) pH + correction of INR w VH K, unlikely liver failure.
	C. Yim R3

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	ACS
Jan 28, 2022	Post cardiac arrest + ischemic colon
0715	VAC ∅ Ileo 45, L pere 75 NG ∅
	S/∅ Pain. Had poor sleep last night.
	Tolerated tube feeds w/o vomit N/V
	∅ AVSS, HR WNL
	A+P/ 1) MRCP today
	Daniel Hui, RD
01/28/22	Checked in re: pt mobility. Pt. is still
PT 11:25	confused but has been mobilizing (I) c cane walker.
Jan #10512	No concerns regarding mobility from PT perspective.
	Upheld Unit St
	J. O'Leary MPT

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	RUH MEDICAL IMAGING MRI EXAMINATION JAN 27 2022 PROCEDURE COMPLETE
Jan. 28/22 1500 Ostomy/Wound	Abd wound progressing – measuring 4.5 x 1.5 x 0.5cm + wound bed 100% red (some sag clot present). Proximal wound closed + left out of VAC. Adaptic applied as interface & silver granufoam. Settings unchanged. Next Tues will F/a + most likely DC VAC. Heo appliance changed – no concerns. 1 piece reapplied. — JMatsalla RN WOCN

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Jan 28/22	GIM
	40 y.o. M, long hospital stay after out of hospital cardiac arrest, complicated by bowel ischemia.
	GIM follow up for delirium and ↑ liver Enzymes.
	Issues:
	① Delirium → most likely 2° to prolonged illness → will continue ↓ conservative measures, continue monitoring → Seroquel prn
	② ↑ Liver Enzymes → MRCP done, stricture revealed;

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	→ Dr Bedi aware, ERCP
	planned for Tuesday
	Kelly Tybie
	RN
Jan 28/22 @1100	Introduced self to pt and pt wife for emotional
Social Work Jessa Pillipow	support. Spoke to pt wife for ~20mins
#10364	about pt and his recovery — Jessa Pillipow RSW
Jan 29/22	
0705	ACS
INR 3.9	160550 Prc 100
	S/ worsening delirium ++confused & hallucinating overnight
	had Seroquel ∅ improvement. Trying to leave
	O/ Afebrile VSS
	Vac intacted. Abdo soft
	A/P: ① ERCP for tuesday. Needs INR <1.5
	② Gim to r/a re anticoagulation.
	③ ? Increase Seroquel vs other prns for delirium/agitation

M. Rowell R2

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FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 29/22	GIM
	ID: 40 y.o. M, long hospital admission, initially presented w out of hospital cardiac arrest. Please see our dictated consult for details.
	Issues:
	(1) ↑ cholestatic liver Enz's
	→ stricture on MRCP
	→ ERCP sched'd for Tuesday
	(2) Med management in context of pending ERCP
	→ spoke w Cardio, plan to continue DAPT throughout ERCP
	→ Spoke w Haem: No Bridging necessary for warfarin; we will give LTK if necessary on →

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	Monday.
	→ Overall, difficult patient as pt @ high risk of clot due to recent PVT in Dec./22, however also has recent cardiac drug eluting stent
	(3) Delirium
	→ Suggested further sedation if needed → Most likely 2° to medical illness → Other wup ⊖ so far; will check TSH.
	Kelly Rysavy PGY1

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01/30/22	ACS
6:57	Outs: Ileo = 375 Vac = Ø
9.33 ALP = 238	Perc = 50
98 | 244 ALT = 129	ABX – cipro/flagyl
AST = 257	anticoag – warfarin [illegible], 2-3 INR goal, ASA/clopidogrel
GGT = 923	for antiplatelet meds
Bili = 172	S: dizzy/vertigo, upper abdo pain, worsening delirium
Ca = 2.09	
P = 0.73	O: patient on floor, confused, AVSS
Mg = 0.64	
134 / 100 / 0.7 / 6.6	A/P: 1. ERCP for tuesday, continue DAPT, Ø
3.5 / 22 / 44	warfarin bridging, vit K PRN
INR = 3.9	2. Haldol for delirium as per GIM, trial
	↑ dose, consider consulting again
	3. Hold warfarin today INR = 3.9
	4. Correct Mg & P
	Damien [illegible] CC3
10:30	ACS addendum
	Δ ERCP to Monday, GIM to reassess
	anticoagulation today
	- Obs [signature]

- GI recommended FFP if INR not at target this evening

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Jan 30/22	GIM
@1300.	ERCP moved up to tomorrow - likely AM.
	INR still ↑ @ 3.9 (Ø Δ; held since
	Friday the 28th)
	I spoke to Dr. Moodly c̄ hematology.
	Suggest reversal c̄ 5 mg IV vit K
	(b/c 10mg will likely make it difficult
* he will	post-ERCP to get back to therapeutic
need bridging	dose + options for A/C limited given hx HIT),
post ERCP	Will order 2 units FFP to be given
until warfarin	in am if INR is still < 1.5 prior to
therapeutic ✓	procedure - can be hung before leaving -
	Dr. Nizzi (c̄ GI) aware & agreeable
	to plan. She will pass this along to
	colleague who will be performing procedure.
	Delirium → cont. PRN Haldol. Calm/sleeping
	likely medical based on prolonged F.Pieri
	hospital stay + multiple medical issues. [signature]

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	ACS
Jan 31, 2022	Post-cardiac arrest, ischemic colon,
0745	S/ Had some agitation with delirium over the weekend. Improved
	today.
	O/ Ileo 350, PERC 75, VAC scant
	HR 121, other vitals stable
	A/P/ 1) For ERCP today with GI for stricture
	seen on MRCP.
	2) Needs AC restart once ERCP complete,
	will need bridging
	Daniel Hui, RD
31/1/22	ERCP
	See dictated report &
	Xray pictures.
	Suggest repeat ~ 1-2/52
	when swelling is decreased
	in duodenum

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0621.

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb1/22	ACS
0730	Post cardiac arrest, ischemic colon, CBD Stricture
	S/ Sleeping quietly
	O/ Abdo US (N)
	A/P. (1) PERC drain req'd
	(2) Anticoag- Continue to hold for perc.
	GIM following
	[signature] R2
~~Jan~~ Feb1/2022	GIM R3
1007	40M w prolonged + complicated stay post cardiac arrest.
	GIM following for delirium
	INR 1.4. (P) perc drain as ERCP unsuccessful
	2°/2 swelling in duodenum.
(1)	Delirium: d/w w pt + wife, much improved.
	Ø further hallucinations. Received Ativan x2
2°/2 prolonged stay & underlying medical issues.	Jan 30 for agitation - ~~sugges~~ recommend against
	Benzos as this will cause worsening delirium
	Haldol or Seroquel preferred.
(2)	perc drain scheduled Feb 3 as IR would like
	warfarin held x5 days. Will need fonda instead.
	[signature] GIM R3

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Feb 1/22 1127hrs	Dietitian
	Pt has been NPO ~~ABD~~ + on x 1 wk for various procedures. Generally, only able to take supper + then NPO again at midnight. Today, pt is NPO for IR-guided perc drain. Pt had NG in for nocturnal feeds but pt was delerious + pulled it out on Jan 30. On regular diet (when not NPO) but pt is malnourished. Discussed situation w pt + wife - he is agreeable to have NG reinserted + nocturnal feeds to restart to supplement po intake. TPN is not indicated as LFTs remain ++elevated
	I: 1) Reinsert small-bore NG
	2) Restart Vital Peptide 1.5 at 75mL/hr x 12hrs at night to provide 60g protein + 1350 Kcal to supplement po intake. Salam RD

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	~~Initial Plans — Progress Notes~~
Feb 1/22 1215 Ostomy/Wound	Discontinued abd NPWT. Distal opening 3.5 x 1.0 x 0.5cm. Wound bed 100% granulation tissue. Periwound healthy. Applied Hydrofera Blue classic & covered c mepilex borde. Suggest orders left. Ileo appliance changed. Reapplied 1-piece c hole cut eccentric to accomodate midline incision. Will review as able + continue ileo teaching when pt closer to discharge. —— JMatsalaRN NSWOC
Feb 1/22 @ 1415 Social Work Jessa #10364	SW support provided to pt wife Andrea, she expressed desire to have more frequent updates from nurses on pt timeline/plan, as time allows. —— Jessa Pillsfan #10364.

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Feb 1/22 Physio-Rachel #12364 1500	Pt agreeable to mobilize. Lie→sit (I) c HOB ↑. (I) sit→stand into 4WW c height of bed ↑. Walked ~ 200m c 4WW : 1 seated break on 4WW. Pt tol walk well. Happy to have VAC off. Will continue to mobilize as able c 4WW pm.
Feb 2/22	ACS
0810	Post cardiac Arrest, ischemic colon, CBD stricture
	Foley = 1750 VAC = Ø PERC = 125 ileo = scant
	S: patient ~~guar~~ has no new concerns. Awaiting drain.
	Ø
	O: INR = 1.4 Hgb = 82, AVSS, patient appears jaundiced
	A/P: 1) Drain (P)
	2) Will resume tube feeds + Anti-coags post drain insert
	Rishi Thakker
	Rishi Thakker CCS

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 2, 2022	IR Staff
	- PTBD GFr.
	- Inter / Ext.
	- Comp.
	[signature]
	[illegible] MD

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Feb 2/22	GIM
	40 y.o. M, admitted in out of hospital cardiac arrest, long hospital admission, see scm notes for details.
	Issues:
	① ↑ cholest Liver Enz's
	→ ERCP failed; too much edema
	→ pt received perc drain, doing well
	→ Rhology: 2 Ischemic Stricture
	Plan: monitor Liver enzymes, repeat ERCP @ a later date
	② DAPT
	will suggest restart as soon as possible

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
	(3) Anticoagulation
	will suggest proph. fonda
	and warfarin in view
	of DVT + HIT on this
	Admission.
	[signature]

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Feb3/22	ACS
0650	40yo M post cardiac arrest, ischemic colon,
Ileo 150	ischemic CBD stricture w/ obstructive jaundice
(L) Perc 210	S: Biliary drain placed yesterday.
(R) Perc 375	Feeling tired. no pain. Confusion clearing
Clear bile	O: Afebrile VS(N)
Bili 132 (220)	Abdo: Soft, ⊖ tender
	A/P: ① Restart Antiplatelets + A/C. GIM following
	② Start tube feeds
	[signature]
	GIM R3
Feb3/2022.	40M post cardiac arrest w complicated admit
	GIM following for delirium + A/C
	LE, Tbili downtrending post perc drain.
①	· Currently bridged w fonda → warfarin ↑INR today
	Back on DAPT.
②	Delirium: Improving.
	LY/IM R3 [signature]

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SK UNKNOWN
MRN: RUH 1315031
Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 3/22	Dietitian
	Pt tolerated NG nocturnal feeds of
	Vital Peptide 1.5 at 30ml/hr last night
	(goal is 75) Wife reports ↑ appetite
	yesterday but minimal po intake today
	2° to pain from perc. drain.
	I: i) Continue c̄ supplemental nocturnal
	feeds, advance to goal as tolerated.
	Will monitor po intake. [signature]
Feb4/22	
0720	ACS
	40M post arrest, ischemic bowel, ischemic
R perc 450	CBD stricture.
(bile)	S/ Pain @ drain site. Otherwise doing well.
L perc 300	
Ileo 700	O/ Afebrile. VS (N)
	A/P/ (1) Continue current management.
	(2) Anticoag - GIM orders written & signed off.
	[signature]

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Saskatoon Health Region

SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

☐ RUH ☐ SCH ☐ SPH ☐ Other______

PROGRESS NOTES

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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
5/2/22	ACS
730	U/O 1200 ,66 11@d
	(L) pec 200
	(R) (biliary) 575 - bilious
	AVSS
	No new concerns from patient or nursing
	Would like to d/c surgical drain in AM
	O/E: jaundice abdo flat, wound w/ healed
	A/P: AM INR pending
	CCM
	[signature]
6/2/22	ACS
0824	Prolonged admission
	S/ ∅ new concerns
	O/ AVSS HR 116
9.6 / 81 / 351	I/O: 1150 cc R drain 1000 L drain 200
133 / 101 / 2 ; 4.1 / 23 / 46	A/P: CCM
Bili 89	[signature]
INR 1.9	EMcEwen

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PROGRESS NOTES

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FEB-23-1981 40y IP V#10521726 M
ATN: LUO, YIGANG
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Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial, Plans – Progress Notes
Feb 7/22	ACS
0749	Prolonged admission.
	Ostomy = 850 (L) perc = ccs (R) Bili drain = 500
	Abx: Cipro + Flagyl + linezolid
	S: Ø New concerns.
	O: Abdo - soft Ø distended, Ø tender.
	A/P: F/u Hyb today
	[illegible] CCS
Feb 7/22 Physio-Rachel #123641345	Pt reluctant but agreeable to mobilize. Needed a pep talk. Lie→sit min (A) x1 c HOBT. (I) sitting on EOB. Sit→stand into 4WW Min (A) x1. Walked ~5m c 4WW in room. Legs heavy today. Left in bedside chair c wife present. Recommend (A) x2 back to bed c 4WW. Will provide ex's for bed as well. R Wong

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 8/22	ACS
0730	Prolonged admission – Cardiac arrest, ischemic
	bowel, ischemic CBD
Ileo 400	S/ Pain w/ tube feeds. Slow down rate
(L) perc 225	
(R) perc 900	O/ Afebrile, VSS (N)
	Abdo: SNT.
	A/P/ (1) cem
	[illegible] RN
Feb 8/22	Pt agreeable to bed exercises. Same
Physio-Rachel #12364 1608	completed c̄ pt. Pt's strength has
	↓ over last week. Feb 1 → walking
	(I) ~200m c̄ 4WW c̄ seated breaks.
	Legs 2/5 strength this week. Pt to
	work on bed exercises BID. Should
	get up to chair BID. (A) x2 c̄
	walker. Will continue to see to
	↑ strength and endurance and ↑
	to (I) c̄ walker again [illegible]

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PROGRESS NOTES

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ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 9/22	ACS
0820	40M complex stay - OHCA, ischemic bowel,
~~Ileo 170~~	ischemic CBD stricture post stent.
LPRC [illegible] 50	S/ Ø concerns today
[illegible]	
Biliary drain 560	O/ Afebrile. VS Ⓝ
	A/P/ CCM
	Plan to return to answer questions from
	wife/Mom later today
	[signature]
Feb 9/22	Dietitian
	Pt is not tolerating nocturnal NG feeds of Vital Peptide 1.5 - goal is 75ml/hr x
	12hrs but runs at 30-40ml/hr at pt's
	request. Nausea/vomiting/abd. pain
	remain issues. Notified of plans to insert
	a NJ tube later today. Minimal po intake
	~~[illegible]~~ at this time.
	I: 1) Recommend continuous feeds via
	NJ - Peptamen 1.5 at 40ml/hr (=1440kcal and 65g protein). [signature] RD

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PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 9/22	Pt reports doing some bed exercises. Agreeable
Physio - Rachel #12364 1400	to dangle. Lie→sit mod Ⓐx1. Ⓘ sitting
	on EOB. Sit→stand min-mod Ⓐx1 c̄ height
	of bed ↑. Sidestep up bed min Ⓐx1.
	3 more sit→stands c̄ 4WW min Ⓐx1.
	Tol well. Sit→lie Ⓐx1 at legs.
	Hopeful that pt's mobility and strength
	will improve c̄ more nutrition. Will
	continue to progress as able. R. Fraser
	R Fritz[illegible]
Feb 10/22	ACS
	40M OH(A) ischemic bowel → ischemic CBD stricture
Ileo 25	w/ stenting.
Biliary 80	S:/ NJ tube occluded & could not be flushed
Ⓛ perc 25	No other concerns
	O:/ HR 118 otherwise VS Ⓝ, Afebrile
	A/P:/ ① cont - try to adjust NJ tube later today
	N Burrell

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PROGRESS NOTES

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ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 10/22 Physio-Rachel ~~[illegible]~~	Pt agreeable to physio. Reports tried bed exercises on own. Min Ⓐx1 to roll to Ⓛ. Lie→sit min Ⓐx1 ~~[illegible]~~ HOB↑ and rail. SBA dangling. Sit→stand into 4WW 2 reps min Ⓐx1. Marched on spot and side stepped. Sit→lie min Ⓐx1 at legs. Pt tol well. Will hopefully be able to ↑ strength c̄ more nutrition. Will continue to follow. [signature]
Feb 11/22 0805	ACS
	40m OHCA → Ischemic bowel → CBD Stricture → Stent
	S/ Hallucinations worsening again
Ileo: 50	⊘ Vomiting yesterday
Lt Perc 605	O/ Afebrile VS Ⓝ
Rt Biliary 250	Abdo: Soft, ⊘ tender, ⊘ distended
	A/P: ① Fluro to adjust kinked NJ
	② CCM
	[signature]

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SK UNKNOWN
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Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: KANTHAN (CHANDRAKANTHAN), SELLIAH
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 11, 2022	NJ placed Feb 9. However tube not working - ?
NSS RD 1200hrs	Kinked ? pulled back. Fluoroscopy to adjust
Medic however	today 1500hrs. Unfortunately due to
#10052	various reasons - intolerance to NG feeds,
	poor PO intake, alternating periods of NPO
	abdominal discomfort - cumulative calorie
	and protein deficit has been significant.
	If NJ feeds able to resume please refer
	to enteral order set Feb 9th. Considering
	duration of inadequate nutrition supplemental
	patient with parenteral nutrition is warranted
	although LFT's are high (CBD stricture) the
	risk of parenteral nutrition provision is
	less than that of continued inadequate nutrition
	TPN dosing / additions have been adjusted
	to prevent hepatic dysfunction. Will continue
	to follow / monitor labs, LFTs, tolerance to EN
	——— D. Hemsequee, RD ———

PROGRESS NOTES

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FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 11/22	ACS staff:
	NJ pending IR interventions
	~~(+) frustration, but explained~~
	will happen in a.m. as per
	Dr. Je [illegible].
	Will start TPN c̄ TFI = 150cc
	[signature]
	ACS
Hb (37)	Complicated stay OHCA ≥ Ischemic colon; Ischemic CBD ≥ stent
Frequent lab	S: No concerns. no pain, bleeding
errors will	Awaiting NJ adjustment
re draw	O: Afebrile. VS (N)
	Abdo - Soft, ø distended. Wounds dry
	A/P: ① Continue current management
	② NJ today for feeds
	③ Started TPN
	④ Abx - Rlo cipro + flagyl today but ID to r/a
	next week
	M. [signature]

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ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 12/2022 1450	IR Staff.
	NJ tube insertion original one kinked distally exchange over ~~stiff~~ glide
	injection of contrast shows appropriate position & function
	A (READY FOR IMMEDIATE USE) PLEASE FLUSH WELL @ completion.
	J. HELDT MD

PROGRESS NOTES

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FEHR, RICHARD NEIL
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ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 13/2022	ACS
08:15	Complicated stay OHCA → ischemic colon → ischemic CBD → stent
	Ileo = 200mL, Perc = 35mL, Bili drain = 40mL, Foley = 2650mL
	S: NJ in yesterday, Ø Pain, Ø N/V
	O: AVSS, Afebrile, 96% on RA, Abdomen soft Ø distended Ø fever
	A/P: ① warfarin dose ordered
	② TFI adjusted
	Michael Anderson CC3 [signature]
10/2/22	ACS
820	Prolonged hospital stay
	DVTp: warfarin +ASA + plavix ABx: cipro+flagyl (finished off)
	As per nursing: vomiting overnight, rectal discharge
	Diet: NJ feeds + DA-1
	I/O 4550
	ileo 350 PTC
	perc 40 RUQ ~~[illegible]~~ -5
	S/ multiple episodes vomiting O/N ~~[illegible]~~ up
	O/ AVSS . Abdo soft NT
	AP/ Review imaging [illegible] [signature]
	CT abdo pelvis

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ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb14/22	Dietitian
	Stress central TPN restarted to on Feb11
	to supplement EN/po intake. NJ feeds
	are now tolerated at 40ml/hr (initial goal);
	n/v improved but not resolved.
	I: 1) will continue c current nutrition
	care plan (TPN and NJ feeds) [signature]
Feb 14/22	Pt agreeable to mobilize to stretcher
Physio-Rachel	for CT. Rolling to (R)(I) c rail. Lie-sit
#123664 1130	(I) c rail. (I) sitting EOB. Min (A)x1 sit-stand into 4WW. ~5 steps c 4WW
	to stretcher min (A)x1. Better quality
	steps than last week. Sit-lie (I)/
	some self (A) at legs. Pt moving
	better than last week. Will f/u
	tomorrow to trial walk. RW [signature]
	DEPARTMENT OF MEDICAL IMAGING
	PROCEDURE CT A+P
	DATE Feb 14/22
	PROCEDURE COMPLETED [initials]

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PROGRESS NOTES

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ATN: LUO, YIGANG
FAM: FRASER,JILLIAN

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans - Progress Notes
Feb14/22 @1530	Provided emotional support to pt wife. SW to
SW Jessa #10364	follow up w/ pt tomorrow at bedside for
	same. ——— [signature] RSW
Feb. 14/22	Bedside RN requested writer to reassess
1600	abd incision. Wound has almost completely
Ostomy/Wound	closed, not requiring hydrofera blue classic
	anymore. Mepilex border to be applied.
	Will f/u re: stoma teaching when pt
	closer to discharge. ——— J Matsalla RN
	NSWOC
Feb. 14/2022	IR Staff
1637	- Flush drain (PTBD) daily
	w/ 10 cc of sterile saline.
	- drain not plugged
	- Stopcock Ø working,
	changed & new bag attached
	[signature]
	J ZHENG MD

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SK UNKNOWN
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Admit Date: DEC-2-2021
FEHR, RICHARD NEIL
FEB-23-1981 40y IP V#10521726 M
ATN: HARRIMAN, SUZANNE
FAM: UNKNOWN,FAMILY

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
02/15/22	ACS
7:00	complicated stay OOCAS, ischemic colon, CBD stent
	ileo → 250 perc → 50 Bili 0-850
	∅ concerns O/N. tolerating feeds, ambulatory
	O/E - AVSS Abdo soft NT
	A/P - CCM
	FO r/a hernia
	[signature]
Feb ~~14~~ 15/22 error KW 1345 Physio- Rachel #12364	Pt agreeable to mobilize. Since getting NJ and
	TPN nutrition ↑ in strength and energy.
	(I) roll to (R) and lie → sit c̄ HOB↑ and rail.
	(I) sitting EOB. Sit → stand into 4WW c̄
	height of bed ↑. Walked ~30m c̄ 4WW
	SBA c̄ w/c follow. Equal step length.
	Mild ↓ eccentric control c̄ swing phase.
	Pt mildly SOBOE. SpO2 = 97% RA, HR = 117bpm.
	Pt left in w/c c̄ wife to go for
	walk off ward c̄ RN's consent.
	Will see OD for walk / gym.
	[signature]

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FEB-23-1981 40y IP V#10521726 M
ATN: HARRIMAN, SUZANNE
FAM: UNKNOWN,FAMILY

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb 15/22 1430	SW providing ongoing ~~s~~ emotional
Social Work	support to pt + wife. Ø outstanding
Jessa #10364	concerns at this time, SW will continue
	following. ———— [signature] RSW
Feb 15/22	Dietitian
	NJ feeds of Peptamen 1.5 infusing at 40ml/hr
	+ TPN at 50ml/hr supplementing EN.
	Pt tries to eat small amts - tolerates
	at brkfst + lunch but reports emesis after
	supper. NJ feeds + TPN are meeting
	nutritional reqts. ~~Discussed~~ emesis Pt is
	feeling good today; able to mobilize c̄
	PT. Discussed ↑ NJ feed rate c̄ pt.
	I: 1) Increase Peptamen 1.5 to 45ml/hr
	- pt agreeable to same. 2) Continue c̄
	same TPN. [signature] RD ————

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14/2/22	ACS
839	L perc - 4Q
	R perc (biliary) - Q5Q
	Stoma - 25g
	ABx: cipro + Flagyl Diet: DAT + TPN + NJ feed
	DVTp: warfarin
	↳ ↑ dose today as INR 1.3
	HR 105 AVSS RA
	Patient tolerated 3 meals yesterday
	mobilizing yesterday, plans to go out now
	today
	A/P: FU Dr Larki today
	→ Birthday next wednesday
	RYAN
Feb 16/22 Physio-Rachel #12364 1140	Agreeable and eager to mobilize. (I) lie → sit → stand c 4WW. (I) c 4WW to transport chair. In gym sit → stand and walked ~40m total c 4WW c 1 seated break SBA. TF onto scifit bike. Scifit level 1 x 3 minutes. Tol well. Left c spouse to go outside. Will see in gym tomorrow. [signature]

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ATN: HARRIMAN, SUZANNE
FAM: UNKNOWN,FAMILY

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
02/17/22	ACS
	Report of some pus from PCC drain O/N
	~~Doing well, eating. Vomit x1 after dinner~~
	AVSS Cal 495 Perc 35 1275 - Bili
	~~Abdo soft NT~~
	P: Boost nutrition + Strength
	[signature]
02/18/22	ACS
	3 episodes vomiting O/N ∅ PT → too much pain++
	c Perc - 315 Panc 30 ~~Bili~~ - 1175
	AVSS
	Abdo soft NT
	AP: consider CT (? pain)
	Buscopan [signature]

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FAM: FRASER,JILLIAN

PROGRESS NOTES

Time/Date/Printed Name/ Signature/Title (Please include for each entry)	Initial Plans – Progress Notes
Feb. 18/22.	→ Pt brought down to physio gym. Completed
13:15	6 min on scifit bike @ level 1. Tolerated
Kendra-physio	well, will continue to follow
	K Robertson PTA
Feb 19/22	ACS
7:40	S: feeling better, pain [illegible] gone, N/V x?
	O: AVSS
	[illegible] 175 [illegible] 100 [illegible] 500.
	[illegible]
	AP: Repeat procedure on Tue ~~[illegible]~~ ~~[illegible]~~
	~~[illegible]~~ then D/C.
Feb 19	[illegible]
~~[illegible]~~	GIM
INR 1.4	Re Pre op anticoagulation
on Warfarin	① Pt on DAPT for recent DES stent Cardiac arrest
	② PT on Warfarin for DVT 2/12 ago, today INR 1.4
	Pt for ~~[illegible]~~ OR for recanalization of → [illegible]
	Pt has HIT ⇒ plan to give Fondaparinux on
	Feb 19 and 20 and Hold it on Feb 21 (procedure on
[signature]	Feb 22) - ~~[illegible]~~ Also Hold Warfarin until
	Post procedure (need to be bridged POST OR)

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