34818

Advancing Quality
Hip / Knee Replacement Record

North Cumbria University Hospitals NHS
NHS Trust

Hospital number [ ][ ][ ][ ][ ][ ][ ] *One letter / number per box*
W 0 1 2 3 4 5

Date of birth [ ][ ] / [ ][ ] / [ ][ ][ ][ ]
D D M M Y Y Y Y

1. Date of admission [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Time of admission [ ][ ] : [ ][ ] *Please use 24 hour clock*

2. Date of discharge [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

Time of discharge [ ][ ] : [ ][ ] *Please use 24 hour clock*

Please place a X in the appropriate box(es) [X]

3. Is the patient part of a clinical trial? ☐ No ☐ Yes

4. Did the patient have an infection whilst in hospital, prior to anaesthetic? ☐ No ☐ Yes

5. Antibiotic allergy? ☐ No ☐ Yes If yes, specify: (please write clearly within the box, IN BLOCK CAPITALS)

6. Antibiotic received?

☐ Antiobiotic not received (admission through 48 hours postop)

☐ Antibiotic received only during hospital stay (admission through 48 hours postop)

☐ Antibiotic only within 24 hours prior to admission and not during hospital stay

☐ Antibiotic within 24 hours prior to admission and during hospital stay (through 48 hours postop)

7. Please list below any antibiotics given (first doses only)

Date given [ ][ ] / [ ][ ] / [ ][ ] *D D M M Y Y*

Time given *24 hour clock* [ ][ ] : [ ][ ] *H H M M*

Route OR ☐ IV ☐

☐ Co-Amoxiclav ☐ Vancomycin ☐ Flucloxacillin
☐ Teicoplanin ☐ Other, specify

(please write clearly within the box IN BLOCK CAPITALS)

☐ Co-Amoxiclav ☐ Vancomycin ☐ Flucloxacillin
☐ Teicoplanin ☐ Other, specify below

(please write clearly within the box IN BLOCK CAPITALS)

☐ Co-Amoxiclav ☐ Vancomycin ☐ Flucloxacillin
☐ Teicoplanin ☐ Other, specify below

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☐ Co-Amoxiclav ☐ Vancomycin ☐ Flucloxacillin
☐ Teicoplanin ☐ Other, specify below

(please write clearly within the box IN BLOCK CAPITALS)

Please turn over...

Please return completed forms to Clinical Audit Department, WCH

8. Was Vancomycin given for any of the reasons below:

- ☐ Beta-lactam (penicillin or cephalosporin) allergy
- ☐ Known prior colonisation with MRSA
- ☐ Patient high-risk due to acute inpatient stay within the last year
- ☐ Patient high-risk due to long term care setting within the last year, prior to admission
- ☐ Increased MRSA rate, either Trust wide or procedure-specific
- ☐ Chronic wound care or dialysis
- ☐ Continuous inpatient stay of more than 24 hours prior to the procedure
- ☐ Other reason
- ☐ Patient has undergone valve surgery

9. Were the Trust Antibiotic Prescribing Guidelines followed? ☐ No ☐ Yes ☐ Not known

10. Surgery start date

☐☐ / ☐☐ / ☐☐☐☐
D D M M Y Y Y Y

11. Surgery incision time

☐☐ : ☐☐ *Please use 24 hour clock*
H H M M

12. Spinal anaesthetic? ☐ No ☐ Yes

13. Surgery end time

☐☐ : ☐☐ *Please use 24 hour clock*
H H M M

14. Other surgery within +/- 3 days of joint surgery? ☐ No ☐ Yes

15. Did patient take warfarin during 7 days prior to admission? ☐ No ☐ Yes

16. Is there a documented risk of bleeding? ☐ No ☐ Yes

17. Did patient receive venous thromboembolism (VTE) prophylaxis? ☐ No ☐ Yes (If yes go to question 19)

18. Contraindication to venous thromboembolism (VTE) prophylaxis? ☐ No ☐ Yes

19. Details of venous thromboembolism (VTE) prophylaxis:

If crossed, answer →

	Commenced within 24 hours of the surgery incision time or surgery end time (i.e 24 hours before or after surgery)?
☐ Low dose unfractionated heparin	☐ Yes ☐ No
☐ Low molecular weight heparin i.e. Clexane	☐ Yes ☐ No
☐ Intermittent pneumatic compression devices i.e. Flotron	☐ Yes ☐ No
☐ Graduated compression stockings	☐ Yes ☐ No
☐ Factor Xa inhibitor	☐ Yes ☐ No
☐ Warfarin	☐ Yes ☐ No

20. Postoperative infection? ☐ No ☐ Yes Date of infection ☐☐ / ☐☐ / ☐☐☐☐
D D M M Y Y Y Y

Form completed by (print name):