

MEDICAL CASENOTES

Allergies:



1703751191

Dr Rajendra Raman
Victoria Hospital
Kirkcaldy
KY2 5AH
Tel: 01592 643355

NHS
Fife

Patient surname: Gratton		Date of arrival: 30/08/2025	Management type: Resus ☒ (A) (S)
Patient forename: Leon		Time of arrival: 08:57	Majors ☐
Patient address: 3 Makgill Row Cupar KY15 5SA		Date & time of incident: 30/08/2025 08:45	Minors ☐
DOB: 17/03/1975		Incident location: Home	Discharge/Ward destination & Time: A&E 6/1
Age: 50 Yrs		Incident type: Non-injurious cause	
Patient email:		Activity when injured:	Breach reason:
Landline: 01334 769473	Mobile: 07368479150	Specific location:	GP Address: Bank Street Medical Group, The Health Centre, Bank Street, Cupar, KY15 4JN Tel No: 01334 651201
Ethnicity: B Other British		Temporary alerts:	
Special requirements:		Source of attendance: 999 Emergency Services	School/Nursery address:
Accompanied:		Arrival mode: Ambulance (road)	Tel No:
1st Contact name:		Attendance category: New - unplanned	Named person/HV:
1st Contact address:		Annual A&E attendance No: 1	
L:			
M:			

Presenting complaint
Sepsis

STANDBY

Triage notes

Triage category.....

Observations

Temp	Pulse	BP	SpO2	RR	FEWS Score
	BM	Cap refill	Sup. O2	Weight/Kg	Pain score

Follow up clinic (please ✓)

C	[]	Knee	[]
Physiotherapy	[]	IAT	[]
Ophthalmology	[]	ENT	[]
Other (specify)	[]	OMFS	[]
		ECAS/DVT	[]

PVC Bundle audit.

Reason for insertion:	Aseptic technique Yes []
Colour Gauge:	Dressing date & Yes [] timed
	Skin cleansed Yes []
Site/number:	Inserted by:
Hand hygiene Yes []	



1703751191

Allergies:



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Leon Gratton

Once only prescription/treatments

Date	Time	Medicine/Treatment	Dose	Route	Prescribers signature	Treatment time	Administ by
30/8	11:21	Salbutamol	5mg	neb	[Signature]	1145	OD
30/8	11:21	Doxycycline	200mg	PO	[Signature]	1145	OD
30/8	11:21	Amoxicillin Carbamoxylan	1.2g	IV	[Signature]	1150	OD
30/8	15:30	Paracetamol	1g	oral	[Signature]	1550	LG

Take home medications

Date	Medicine	Dose	Route	Prescriber signature	Dispenser signature
	1000				
	1000				

Date	Fluid	Vol/ml	Duration of administration	Clinician signature	Time started	Completion time	Adminis by
	Additional Medicine	Dose			(00:00 hrs)		Added to chart



1703751191

Date & Time	MULTIDISCIPLINARY NOTES NAME MUST BE PRINTED AGAINST EACH ENTRY
	Med: Uzupine Fluoxetine Simvastatin One provide Metoprolol Aspirin Aripiprazole? Mefenamic acid
30/8/25 1330	Raman (E) Cons Seen on arrival at 0857hrs and at intervals since. Please see summary of initial assessment documented by med student overleaf - Thanks Laura. 3/7 headaches, fevers and progressive shortness of breath Looks + feels much better now after nebuliser, oxygen + antibiotics compared to on arrival Bilateral consolidation on CXR, good going inflammatory response → Treat for community-acquired pneumonia / early chest sepsis

J 24/73



1703751191

Date & Time	MULTIDISCIPLINARY NOTES NAME MUST BE PRINTED AGAINST EACH ENTRY
	RAURA RAN SCOT GEM STUDENT
	A/C - SOB + Fever (query sepsis?)
	A - open & protect, on 1L of oxygen.
	B - 24 RR 93% O2 sat, equal bilateral airway entry, left basal crackles, Dry cough, no no haemoptysis - Asthmatic, worsening SOB.
	C - 116 HR regular HSI + T + O. No chest pain, no palpitations, CRT 2 normal perfused peripheries.
	D - GCS 15, no GCS, neck stiffness
	Headache, no photophobia
	E - ASO 5 NT, no calf swelling, no vomiting, no diarrhoea, eczema widespread on body - Arms, hands, legs.
	Thursday 28/08 had foot pain from eczema & fever resolved by Friday morning then Friday night had fever & headaches & worsening SOB.
	prob: Schizophrenia, diabetes, T. Cholesterol for 10 years, eczema
	Medication: Metformin - 1g bid, oral, one capsule Simvastatin, Aripiprazole, Folic acid Methotrexate, Clozapine, epinephrine Sildenafil, Gabapentin, vitamin D, Desm. 500. Avenor, NKDA
	SKX: NOH Alcohol, with smoking, with recreational drug.

GRATTON
LEON

17-03-1975

CORE



1703751191

ton

re KY15 SSE

WD.

FEWS KEY

CONS.

0	1	2	3

FEWS ≥ 3 FOLLOW FEWS FLOWCHART

DATE	30-8-25					
FREQUENCY						
TIME	081314151617 005011121					
TEMP.	36.9					
BLOOD PRESSURE	A 139/89					
FEWS SCORE uses Systolic BP						
HEART RATE	138					
SpO2	97					
FiO2	0.21					
RESP. RATE	28					
NEURO.	Awake					
FEWS SCORE:	2 (5) 4 3 3					
BM:						
Signature/initials						

MS1377

EMERGENCY DEPARTMENT, VHK Care Rounds Check List

Date: 30/8/2025

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) **1hr 2hr 3hr 4hr**

Signed [Signature] Name L.M. Gregory Designation S/N
 Signed [Signature] Name W. Dwyer Designation SN
 Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:

Y=YES N=NO NA=NOT APPLICABLE NT=NO THANKS S=SLEEPING O=OVERCAPACITY I=INDEPENDENT

	Times												
			1150										
1.	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES inform nurse in charge of area	N	N										
2.	PAIN: ASSESS AND ADDRESS Is the patient distressed or in pain? If YES arrange analgesia as required	Y	N										
3.	SKIN INSPECTION -INDEPENDENT(I) patient reported as intact Pressure areas checked: Red (R) Discolored (D) Pressure Ulcer (PU) Intact (INT) Moisture (M)	INT	INT										
4.	KEEP MOVING - INDEPENDENT(I) Has the patient moved or walked? Position change (PC) Stick or Zimmer	Ind	I										
5.	ELIMINATION Does the patient need the toilet INDEPENDENT(I) Assistance (A) Incontinent of urine or faeces (IC)	Ind	I										
6.	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth (NBM) SWALLOW ASSESSMENT FORM COMPLETED if clinically needed Drink taken? Food, snack or supplement taken? IVI fluid balance chart where required	✓	NO + NF										
7.	PATIENT SAFETY CHECK Name band applied / Allergy band FEWS and Neuro Observations completed Elevated FEWS (>3) escalated as per protocol FALLS RISK identified Y/N Detail actions taken on documentation variance section	✓	Y										
8.	CHECK DRUG PRESCRIPTION Routine medication prescribed eg: PARKINSONS, DIABETES, EPILEPSY	✓	Y										
9.	COMMUNICATION with patient, NOK other services eg, GP, Care home, Police	✓	A										
	Care provider initials/ role	[Signature]	[Signature]										

Sheet

17-03-1975



1703751191

1.Think Delirium	2.Pain	3.Skin Inspection	4.Keep moving	5. Elimination
6.Food,Fluids,Nutrition	7.Patient safety/Falls risks check	8.Check drug prescription	9.Communication	

[illegible]

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

CCS INCIDENT No. **64012387486NNN**

Last Name **BEATTIE**

First Name **LEON**

Location **3 MAGGFL ROW SPRINGFIELD KY15 3SA**

Age **50**

Sex **M**

D of B **703175**

Date **30/08/15**

Time of Call **0827**

Time at Patient **0745**

Time Left **0816**

AMPDS Code

AMPDS Revised

Airway Clear ☒ Suction ☐ N/OPA ☐ ET ☐ LMA ☐ Successful? ☒ C-spine Injury ☒

Breathing ☒ Rate **F 28** BVM ☐ Ventilation ☐ Successful? ☒ Paralysis ☒ Fitting ☒

Pulse ☒ Rate **F N S** CPR ☐ IV/IO ☐ Fluids ☐ Successful? ☒ ECG **SINUS**

Despite the above unable to

Clear airway ☐ Detect breathing ☐ Detect pulse ☐ **A V P U**

Injury Site	Wound	#	Pain	Spilt	Dressed
Head					
Neck					
Chest					
Abdomen					
Back					
R/Arm					
R/Leg					
L/Arm					
L/Leg					

RTA ☐

Trapped ☐

Ejected ☐

M / cyclist ☐

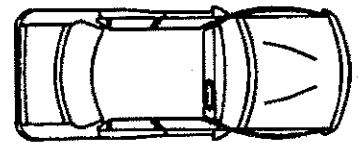
Cyclist ☐

Pedestrian ☐

>20 min. Extricate ☐

Temp. °C

PEFR % B. Sugar mmol



Allergies

Medication

Assisted by and Name -

Doctor ☒ Nurse ☒ Other ☒

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
0800	155	28	120/80	F S N	90	E 15	S 4	S 4
0805	148	28	120/80	F S N	93	E 15	S 4	S 4
			S Y S	D I A	F S N	E V M	S R	S R
			S Y S	D I A	F S N	E V M	S R	S R

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result	Rhythm
0810	PARA	100	GM	OR	+ 0					
0810	OR	100	GM	IN	+ 0					
					+ 0					
					+ 0					

Condition at hospital Pulse ☒ Breathing ☒ Conscious ☒ Time at Hospital **0820**

History and Additional Information

999 FOR 50YOM - HEADACHE/DIZZINESS, OA - PT IN BED - TEMP 39.8

UNWELL FOR 2+ DAYS. NAUSEA/DIZZY ON STANDING - OFF FOOD.

OWN PARACETAMOL @ 2100 (29/8/15). GREW C? SEPSIS - PMH ASTHMA

SCHIZOPHRENIA + EXCLMA. NEWS 11 - GIVEN PARACETAMOL @ 0810

CONVEYED TO VHK - PRE ALERT.

Working assessment **SEPSIS** Diagnosis Code

Crew Name 1 **G. GREEN** Grade **L P C**

Crew Name 2 **A. FINLAYSON** Grade **L T C**

RADIOMETER ABL90 SERIES

ABL90 ED Resus I393-092R0328N0001

10:44

30/08/2025

PATIENT REPORT

Syringe - S 65uL short
probe

Sample #

3960

Identifications

Patient ID 1703751191
Operator Rachael Bradley
Patient last name Gratton
Patient first name Leon
Date of birth 17/03/1975
Sample type Venous
T 37.0 °C
FO₂(I) 21.0 %
Note

Blood gas values

↑ pH	7.469		[7.350 - 7.450]
↓ cH ⁺ _c	33.9	nmol/L	[35.0 - 45.0]
? pCO ₂		kPa	[- -]
↓ pO ₂	6.79	kPa	[10.0 - 14.0]
↓ sO ₂	89.3	%	[95.0 - 98.0]
↑ cLac	2.1	mmol/L	[1.0 - 2.1]
cCa ²⁺	1.17	mmol/L	[1.15 - 1.35]
↓ cK ⁺	3.3	mmol/L	[3.5 - 5.3]
cNa ⁺	142	mmol/L	[133 - 146]
ctHb	153	g/L	[120 - 175]
↑ FO ₂ Hb	88.1	%	[0.9 - 1.0]
FCOHb	0.8	%	[0.5 - 1.5]
FMetHb	0.5	%	[0.1 - 1.5]
↑ FHHb	10.6	%	[1.0 - 5.0]

Notes

↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)
pCO₂ 0210: Calibration error(s) present
pCO₂ 0211: Quality control error(s) present

Solution pack lot: RE-02

Sensor cassette run #:

Printed 10:45:15 30/08/2025

2562-217

GRATTON
LEON

17-03-1975



1703751191

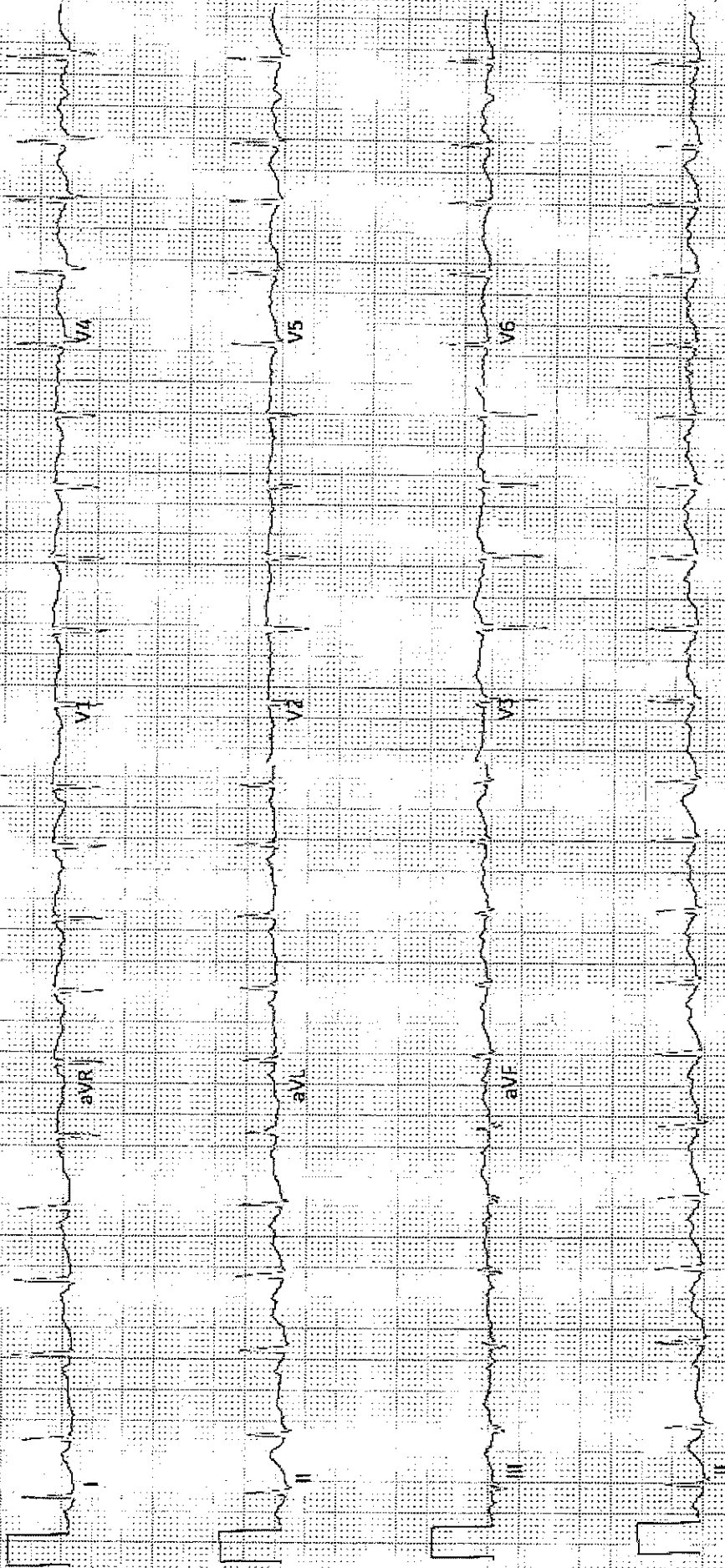
Victoria Hosp Kirkcaldy

Patient ID: 1703751191

Vital Signs™ 220 160 06
Ventric rate 127 bpm
PR interval 132 ms
QRS duration 82 ms
QT/QTc-Baz 312/453 ms
P-R-T axes 23 16 79

Ward Dept

Unconfirmed



V Emergency Department

KJ MacLaren
20413/1
Bank Street Medical Group
The Health Centre
Bank Street
Cupar
Cupar
KY15 4JN

Victoria Hospital
Hayfield Road
Kirkcaldy
KY2 5AH

Dear Doctor

Mr Leon Gratton
3 Makgill Row
Springfield
Cupar
KY15 5SA

CHI: 1703751191
ED Consultant: Dr Rajendra Raman

The above patient attended the V Emergency Department on 30/08/2025 at 08:57. I outline below some information regarding this attendance.

Present Complaint: Sepsis

Diagnosis:			
Description	Body Site	Laterality	Comments
ED diagnosis - Respiratory - Lobar pneumonia			

Investigation(s)/Treatment(s):

Medication(s):

Additional Notes (for GP):

Your patient has been admitted to hospital for further investigations/treatment. A final discharge letter will be issued from the admitting specialty team.

Senior Review:

Senior Review Comments:

Yours sincerely

Christopher Braid SN

**GRATTON, Leon J**BORN 17-Mar-1975 (50y) GENDER Male
CHI 1703751191

Immediate Discharge Letter

Last updated by Nicola CURRAN on 05-Sep-2025 17:51 (v. 22)

Patient Address	3 MAKGILL ROW	GP Name	KATHRYN MACLAREN
	SPRINGFIELD	GP Practice	Bank Street Medical Group
	CUPAR	Address	The Health Centre
	FIFE		Bank Street
	KY15 5SA		Cupar
			—
			KY15 4JN

Encounter Details

Encounter Id	I0000791968	Hospital	Victoria Hospital
Type	Inpatient	Ward	V Ward 53
Specialty	Respiratory Medicine	Consultant	Iain MURRAY
Discharge Date	—		

Admission Details

Date of Admission	31-Aug-2025 17:45	Discharge To	Home - Living Alone
Discharge Date	05-Sep-2025 13:00		

Clinical and Management Information

Primary reason for admission

Pneumonia

DIAGNOSIS

Secondary / Other Diagnoses

No problems selected

Presenting complaint

SOB + Cough

Operation / Procedures

Date of Operation/ Procedure

—

Operation Type

—

Operation/ Procedure detail

—

Responsible Consultant

—

Clinical summary

Dear Doctor,

Leon Gratton was admitted to VHK with 3/52 generally well with SOB + cough.

PMH: T2DM, Asthma, Schizophrenia, Anxiety, Eczema, Psoriasis, Obesity, Ex-smoker

Investigations: CXR - Rt basal consolidation

Issues: 1. Sepsis secondary to Pneumonia - started on IV Co-amox + Doxycycline. Pt completed 5/7 Doxy and was IVOSTed to oral Co-amox to complete 10/7 course total
Resp Specialist nurse saw patient, gave inhaler advice and completed spirometry testing. Pt is for repeat spirometry when chest settles to determine true results.
Methotrexate and Metformin were withheld on admission. They have now been resumed on discharge.

Medication changes: D/C to complete oral Co-amoxiclav

Follow-up: CXR in 6/52 to assess resolution
PFTs in 3/52

Many thanks for your ongoing care,
VHK Ward 53

Notes/ Follow Up for GP

—

Awaiting results

—

Explanation given to patient and/or their representative

—

Med 3 Fitness to Work Certificate

—

Care arrangements made

—

Allergies

Allergies

ADVERSE REACTION Filter Applied

NO KNOWN

Megan TEMPLE confirmed there are no known adverse reactions 04-Sep-2025 12:32

Medications

Medication History **16** **VERIFIED**

Last updated by Megan TEMPLE on
04-Sep-2025 12:31

Discharge **17** **VERIFIED**

Last updated by Daniel WATKINS on
05-Sep-2025 14:03

Encounter I0000791968 (TrakCare)
 Sources Used Community Pharmacy, Emergency Care Summary, Patient
 Details Medication history completed by A. Akoh (Trainee Pharmacist) but updated by M. Temple (Pharmacist)
 Verification Verified by Megan TEMPLE, 04-Sep-2025 12:31.

Encounter I0000791968 (TrakCare)
 Verification Verified by Erin SINCLAIR, 05-Sep-2025 14:34.

Aripiprazole 10mg tablets

ORAL 2 tablets once daily, via compliance aid

Aripiprazole 10mg tablets

ORAL 2 tablets once daily, via compliance aid **RX**

Supply 14

Script Details M

Betamethasone valerate 0.1% ointment

TOPICAL 1 application once daily for 1-2 weeks, then reduce to alternate days for 1-2 weeks, then reduce to twice weekly for 1-2 weeks, then stop (patient reports still applying once daily)

Betamethasone valerate 0.1% ointment

TOPICAL 1 application once daily for 1-2 weeks, then reduce to alternate days for 1-2 weeks, then reduce to twice weekly for 1-2 weeks, then stop (patient reports still applying once daily) **SUPPLY**

Supply Own at home

Clozapine 100mg tablets

ORAL 3 tablets once daily at night, via compliance aid (dispensed at QMH & collects from Weston Day Hospital)

Clozapine 100mg tablets

ORAL 3 tablets once daily at night, via compliance aid (dispensed at QMH & collects from Weston Day Hospital) **SUPPLY**

Supply Own at home, receives 4 weekly nomads separately to community nomad for clozapine from day hospital QMH.

Co-amoxiclav 500mg/125mg tablets **ADDED**

ORAL 1 tablet three times daily **RX**

Duration Fixed Period for 5 Day(s), starting on 03-Sep-2025 ending on 08-Sep-2025

Supply 7

Script Details started lunchtime 3/9, last dose to be given 8/9/25 AM dose as per kardex

Reconciliation History

05-Sep-2025 Added - Daniel WATKINS

Dermol 500 lotion (Dermal Laboratories Ltd) **BRAND RESTRICTED**

TOPICAL 1 application when required as a soap substitute **PRN**

Dermol 500 lotion (Dermal Laboratories Ltd) **BRAND RESTRICTED**

TOPICAL 1 application when required as a soap substitute **PRN** **SUPPLY**

Supply Own at home

Fluoxetine 20mg capsules

ORAL 3 capsules once daily, via compliance aid

Fluoxetine 20mg capsules

ORAL 3 capsules once daily, via compliance aid **RX**

Supply 21

Script Details M

Folic acid 5mg tablets

ORAL 1 tablet once daily except day of methotrexate (Tuesdays), outwith compliance aid

Generic Aveeno cream

TOPICAL 1 application when required for dry skin

PRN

Generic Epaderm cream **DEVICE**

TOPICAL 1 application twice daily

Liquid paraffin light 63.4% bath additive

DEVICE

TOPICAL 1 application twice weekly

Metformin 500mg tablets

ORAL 1 tablet once daily, via compliance aid

Methotrexate 2.5mg tablets

ORAL 4 tablets once a week on a Tuesday, outwith compliance aid

Omeprazole 20mg gastro-resistant capsules

ORAL 1 capsule once daily, via compliance aid

Paracetamol 500 mg Caplets

ORAL 1 - 2 tablets four times daily **PRN**, acute
Rx 01/07/25
Max 8 tablets per 24 hour(s)

Salbutamol 100micrograms/dose inhaler CFC free

INHALATION 2 puffs four times daily **PRN**,
Max 8 puffs per 24 hour(s)

Simvastatin 40mg tablets

ORAL 1 tablet once daily at night, via compliance aid

Soprobe 100micrograms/dose inhaler (Glenmark Pharmaceuticals Europe Ltd)

BRAND RESTRICTED

INHALATION 2 puffs twice daily

Folic acid 5mg tablets

SUPPLY

ORAL 1 tablet once daily except day of methotrexate (Tuesdays), outwith compliance aid

Supply Own at home

Generic Aveeno cream

SUPPLY

TOPICAL 1 application when required for dry skin

PRN

Supply Own at home

Generic Epaderm cream **DEVICE**

SUPPLY

TOPICAL 1 application twice daily

Supply Own at home

Liquid paraffin light 63.4% bath additive **DEVICE**

SUPPLY

TOPICAL 1 application twice weekly

Supply Own at home

Metformin 500mg tablets

RX

ORAL 1 tablet once daily, via compliance aid

Supply 7

Script Details M

Methotrexate 2.5mg tablets

SUPPLY

ORAL 4 tablets once a week on a Tuesday, outwith compliance aid

Supply Own at home

Omeprazole 20mg gastro-resistant capsules

RX

ORAL 1 capsule once daily, via compliance aid

Supply 7

Script Details M

Paracetamol 500 mg Caplets

SUPPLY

ORAL 1 - 2 tablets four times daily **PRN**, acute
Rx 01/07/25
Max 8 tablets per 24 hour(s)

Supply Patient Pack / TTO

Salbutamol 100micrograms/dose inhaler CFC free

SUPPLY

INHALATION 2 puffs four times daily **PRN**,
Max 8 puffs per 24 hour(s)

Supply Patient Pack / TTO

Simvastatin 40mg tablets

RX

ORAL 1 tablet once daily at night, via compliance aid

Supply 7

Script Details N

Soprobe 100micrograms/dose inhaler (Glenmark Pharmaceuticals Europe Ltd) **BRAND RESTRICTED**

SUPPLY

INHALATION 2 puffs twice daily

Supply Patient's Own Supply

Authorising Clinician
Daniel Watkins 05 Sep 2025 14:04
Prescriber Contact Number
29539

Pharmacy Verification Required
Yes

Patient's Length —
/Height

BMI

Patient's Weight —

Date

Community Pharmacy

Community Pharmacy Name
Rowlands Pharmacy - Cupar

Medicines Supply
Compliance Aid

Contact Number
01334 654755

Details

Note also receives separate NOMAD from QMH (collects from Weston Day Hospital) containing clozapine. unable to contact pharmacy on discharge, new nomad supplied from VHK disp 5/9/25 no reg med changes but unable to contact pharmacy for redelivery of community nomad for pt going home. L. Mcluckie ext. 26952

Mental Health template required
No

Nursing Information Required
No

Ward Discharge

Ward Comments
—

Pharmacy Comments

Professionally checked in VHK dispensary without access to medical notes or kardex. Patient supplied ONE WEEK NOMAD on discharge (E.Sinclair 05/09/2025 @14:35)

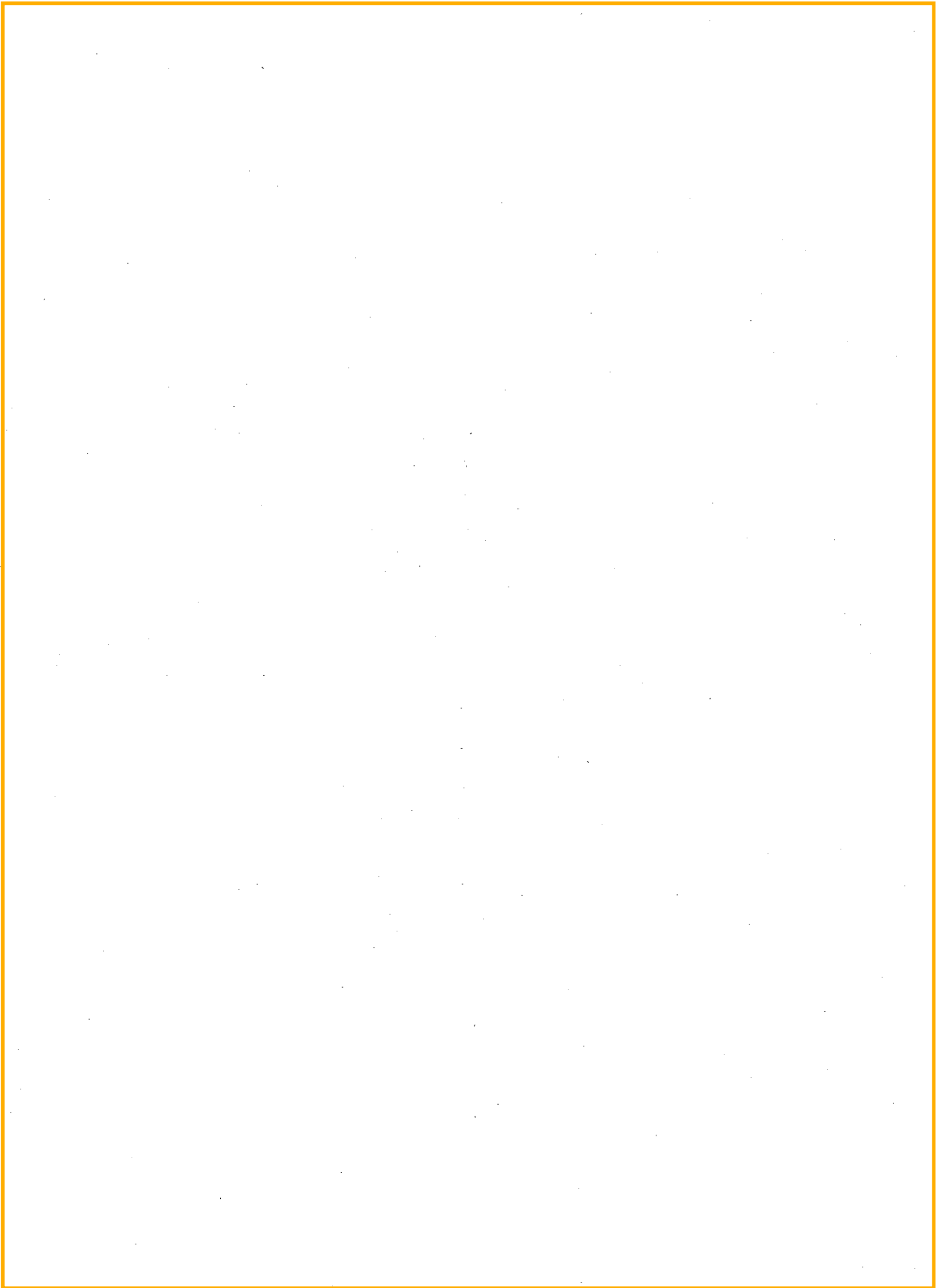
I confirm that medications issued for this patient discharge have been checked in accordance with the local policy and medication issued for discharge has been discussed with the patient and/or their representative.

I Confirm

Yes

Registered Healthcare Practitioner (e.g. Nurse)
Sarah Miller 05 Sep 2025 17:48

Secondary Registered Healthcare Practitioner
Nicola Curran 05 Sep 2025 17:51



Victoria Hospital
Hayfield Road
Kirkcaldy
Fife
KY2 5AH

Department of Respiratory
Tel: 01592 643355 21755
<http://www.nhsfife.scot.nhs.uk>



Dr KJ MacLaren
Bank Street Medical Group
The Health Centre
Bank Street
Cupar
KY15 4JN



CHI: 1703751191

Letter ID: 200203135

Date Typed: 06 November 2025

Dear Dr MacLaren

Leon Gratton, 3 Makgill Row, Springfield, Cupar, Fife, KY15 5SA

Date of Birth: 17/03/1975

Date of Admission: 31/08/2025

Date of Discharge: 05/09/2025

Diagnosis: Pneumonia
Medication: As per discharge letter
Follow up: Repeat chest x-ray

Please take the immediate discharge summary as an accurate representation of this gentleman's recent admission to the Victoria. I will be in touch with his chest x-ray results in due course.

18/11/25

His CXR shows resolution of his right lower zone consolidation: I will write to let him know.

Yours sincerely

Dr Iain Murray
Consultant in Respiratory Medicine

Authorised on 18/11/2025 12:31:42 by Iain Murray.

PATIENT CARE ASSESSMENT AND ADMISSION RECORD



PATIENT DATA: Patient label or write

PATIENT NAME:

GRATTON

17-03-1975

P. LEON

D:



1703751191

(50)

ADDRESS:

PHONE NUMBER:

GP PRACTICE:

Bank Street Medical Group

NEXT OF KIN

NAME:

George Martin

RELATIONSHIP:

Step-dad

ADDRESS:

TEL:

01316239928

Patient consent to inform

of admission:

☐ YES☐ NO

Next of kin informed:

☐ YES☐ NO

ALTERNATIVE CONTACT

NAME:

Anne Lumsden

RELATIONSHIP:

Richmond Fellowship
key worker

ADDRESS:

TEL:

07586310888

Patient consent to inform

of admission:

☐ YES☐ NO

Contact person informed:

☐ YES☐ NO

ETHNIC STATUS: (see ETHNIC STATUS KEY information, held at nurses' station)

FIRST LANGUAGE

☒ English☐ Other: (specify)Does this person require an interpreter? ☐ YES☒ NO If yes, specify:

ACUTE DIVISION

BED BUREAU MUST BE PHONED WITHIN 15 MINUTES OF PATIENT'S ADMISSION

BED BUREAU TEL: x29964

Tick when completed:



CONFIRM PATIENT DETAILS



BED BUREAU INFORMED



PATIENT NAME / FEWS ?

SIGNED:

DATE OF ARRIVAL:

30/6/25

TIME OF ARRIVAL:

2050

SOURCE OF REFERRAL:

GP

☒ ED

OTHER

ESTIMATED DISCHARGE DATE:

NAME OF ADMITTING CONSULTANT:

WARD CONSULTANT:

SPECIALTY:

FEWS on ADMISSION: (3)

If FEWS ≥ 3 , complete the

'SCOTTISH STRUCTURED RESPONSE'

Nurse in charge informed: ☐ YES ☐ NO

ePCS/eKIS reviewed (acute admissions wards only):

☐ YES ☐ NO ☐ N/A

Please provide an explanation in the Continuation Notes for points 1 to 7, utilising the 'SSR Sticker'

1. Screened for Sepsis
2. Appropriate care givers have met and discussed plan
3. Documentation of active problems, working diagnosis, management plan and review time
4. Patienttrack observation profiles / flags reviewed
5. Escalation ceiling recorded
6. Early referral to higher level of care considered and documented
7. DNACPR considered and completed if appropriate

Transfer Checklist					
Obs checked within last hour?	Y	N	Dentures?	Y	N
Medications packed?	Y	N	Glasses?	Y	N
Infection control issue?	Y	N	Hearing aid?	Y	N
Skin integrity assessed?	Y	N	Mobile/Charger?	Y	N
Falls risk?	Y	N	Clothing?	Y	N
Toilet bag?	Y	N	Footwear?	Y	N

SIGNATURES

SIGNATURES
This record is a **LEGAL DOCUMENT**. Your signature indicates that you have reviewed and updated the record, and it is a true reflection of the treatment and care given by you or delegated by you.
Whenever anyone writes in this record for the first time, they should fill in their details below:

[illegible]

ASSESSMENT

PRACTITIONERS NAME:

Kartik Ajith

DATE: 20/08/25

TIME COMMENCED: 21:42

JOB TITLE: FY2

LOCATION: AO 1

PRESENTING COMPLAINT

Shortness of Breath.

Cough.

Generally unwell

HISTORY OF PRESENTING COMPLAINT

50 yr old gentleman presenting with feeling generally unwell for 2-3 weeks with progressive shortness of breath and cough. For the past few days, he has also been feeling warm, heavy chills and sweating. He called the ambulance today and they found that he was pyrexia.

- No expectoration with cough.
- No chest pain present, Headache present
- No burning pain on micturition, no abdominal pain, no diarrhoea
- No painful swollen feet.

He was seen in A&E, and started on antibiotics for probable sepsis.

CHECKLIST

CVS	Chest Pain
	SOB
	PND/Orthopnoea
	Palpitations
	Ankle Swelling
RS	Claudication
	Cough
	Sputum
	Wheeze
	Haemoptysis
GI	Anorexia/Weight loss
	Abdominal Pain
	Nausea/Vomiting
	Dysphagia
	Heartburn
GUS	Diarrhoea
	Constipation
	PR Bleeding
	Dysuria
	Nocturia
CNS	Frequency/Urgency
	Haematuria
	Incontinence
	Last menstrual period
	Cervical smear
MS	Contraception
	Headache
	Dizziness
	Fits/Blackouts
	Memory Problems
	Visual Problems
	Hearing Problems
	Weakness
	Paraesthesia
	Joint pains
	Joint stiffness

PAST MEDICAL, SURGICAL, OBSTETRIC and ANAESTHETIC HISTORY

(tick box and give dates and details)

Cardiac Disease / Pacemaker		
Hypertension		
Diabetes		DM-II
Asthma / COPD		Asthma
Epilepsy		
Stroke Disease		
Thromboembolic Disease (DVT / PE)		
Cognitive Impairment		
Liver Disease		
Other (e.g. Mental Health)		Schizophrenia, Anxiety disorder, Eczema, Psoriasis
Malignancy / Chemotherapy		Cancer diagnosis: Previous treatment (date last treatment):

Surgical / Anaesthetic History:

Past Obstetric History:

Relevant Family History:

SOCIAL HISTORY

Smoking:	☐ Never	Ex-smoker since: 2020	Current: _____ /per day	Pack years:
Alcohol:	Units / week: 0	History of previous excess:		
Driving:	☐ Yes ☐ No			
Occupation:	Write	Retired:	☐ Yes ☒ No	

Usual level of activity (please circle):

Bedbound	Dependent for personal care	Requires minimal assistance with ADLs	Slowed: assistance with heavier household tasks	"Slowed-up" but not requiring assistance	No exercise beyond walking	Occasional exercise	Regular exercise
----------	-----------------------------	---------------------------------------	---	--	----------------------------	---------------------	------------------

MEDICINES RECONCILIATION

(You must complete below AND print ECS checklist)

Source of information

Must be at least 2 of the following:

Patient Consent for ECS

☐ YES ☐ NO

GP letter / Print out

☐ YES ☐ NO

Patient's Own Drugs / Compliance Aid

☒ YES ☐ NO

ECS

☒ YES ☐ NO

Nursing Home Chart

☐ YES ☐ NO

Patient / Carer / Relative

☒ YES ☐ NO

Repeat Prescription

☐ YES ☐ NO

Allergies: Drugs

NICPA

C: Continue

W: Withhold

A: Amend

St: Stop

(Tick appropriate box)

Compliance Aid ☒ YES ☐ NO

Community Pharmacy (please specify which Pharmacy):

Allergies: Other

Medicine Form and Strength	Dose	Route	Freq	C	W	A	St	Comments
Betamethasone Valerate	0.1%	ointment	local alternate days	/				
Paracetamol	500mg	PO	PRN (4 tablets)	/				500mg PRN - since he is pyrexia
Folic acid	5mg	PO	PO (except on MTC day)	/				
Methylprednisolone	2.5mg	PO	4 tablets once a week		/			Currently in sepsis - usually Tuesdays
Metformin	500mg	PO	OD		/			Currently high lactate
Omeprazole	20mg	PO	OD	/				
Simvastatin	40mg	PO	NOCTE	/				
Aspirin	30mg	PO	OD	/				
Fluoxetine	60mg	PO	OD	/				
Aureo Cream		local	PRN	/				
Synobac	100micrograms / pnt	INH	2 puffs BD	/				see EIDL on clinical portal for medication history
Salbutamol	100micrograms / pnt	INH	2 puffs PRN	/				
Clozapine	300mg	PO	OD (PRN)	/				
Epidural cream	large	local	BD	/				
Dilator		local	twice a week	/				
Dermol 500	Lothion	use as soap	substitute	/				
Fluoxetine	60mg	PO	OD	/				

Over the counter / illicit substances / Herbal remedies / Homeopathic drugs

Medicine reconciliation completed by:

Date: 30/08/15

Sign: [Signature]

Designation: FYC

Pharmacy Review

Comments:

Date: 4/9/15

Sign: [Signature]

Designation: Pharmacist

FOR ORTHOPAEDICS: SEE MEDICATION GUIDANCE, PAGE 8

INFORMATION ON 'PATIENTS ON ANTICOAGULATION': SEE PAGE 8

EXAMINATION

General Appearance:

unwell

Hydration Status:

euvolemic

Is this patient SEPTIC?

☒ YES ☐ NO

T°C: 36.6

S_pO₂: 93

FiO₂: 4L
NC

BP: 121/56

HR: 101

RR: 18

BM: -

FEWS
SCORE:

2

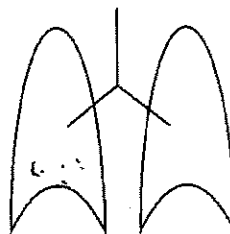
CARDIOVASCULAR

Pulse

JVP

Oedema no pedal edema.

RESPIRATORY



Rt basal and middle lung fields have
Creps.

ABDOMEN

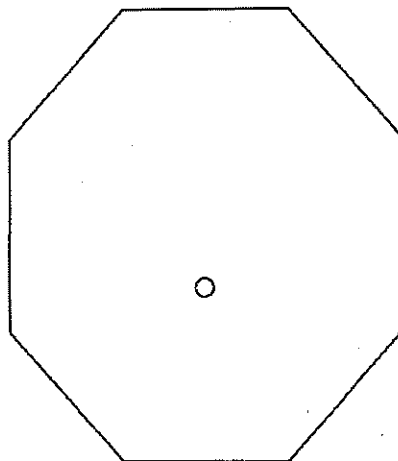
Mouth

Herniae

Genitalia

- Speculum Exam
- VE

PR / Anal Tone



soft non tender

CIRCULATION

Capillary Refill 1 second

Pedal pulses palpable

MUSCULOSKELETAL / SKIN

Describe (use diagrams where appropriate), joint examination

Multiple Scabs over arms and legs.
legs appear red, but not swollen & warm to touch.

BREASTS

PERIPHERAL LYMPH NODES

INVASIVE DEVICES (eg Hickman line, catheter, pacemaker)

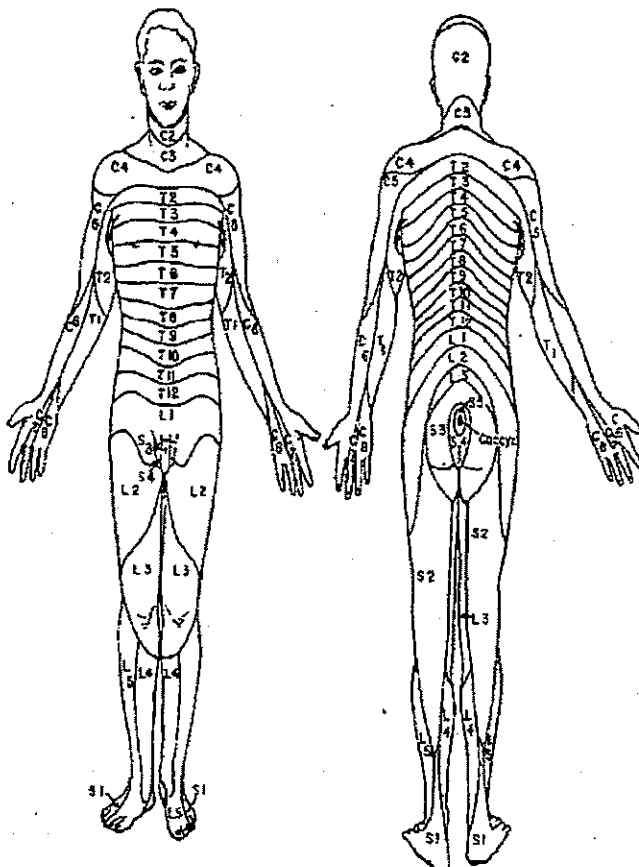
EXAMINATION

NEUROLOGY: Full neurological assessment is not required on all patients. However, general assessment of Tone, Reflexes, Power and Sensation should be documented to exclude acute neurology and as a baseline to assess any subsequent neurological decline. Full assessment is required in all patients admitted with spinal trauma or back pain.

GCS	EYE	VERBAL	MOTOR	CRANIAL NERVES
	OPENING	RESPONSE	RESPONSE	
	Spontaneous =4	Orientated =5	Obeys =6	II
	To command =3	Confused =4	Localises pain =5	III, IV, VI
	To pain =2	Random =3	Withdraws =4	V
	None=1	Incomprehensible sounds = 2	Flexes to pain =3	VII
		None =1	Extends to pain=2	VIII
			None =1	IX, X
				XI
				XII
	TOTAL ___/15			

TONE	tick	normal	flaccid	spasticity	clonus	REFLEXES Mark: -- = absent - = reduced + = normal ++ = brisk	Please tick		right	left
	Right UL						Biceps	C6		
	Left UL						Triceps	C7		
	Right LL						Knee	L3,L4		
	Left LL						Ankle	S1, S2		
							Plantar response			
POWER	Please tick			right	left	Please tick		right	left	
	Shoulder abduct	C5				Hip flexion	L2, 3			
	Elbow flex	C5, 6				Knee ext	L3, 4			
	Wrist ext	C6, 7				Foot dorsal	L4, 5			
	Elbow ext	C7, 8				EHL	L5			
	Grip	C7, 8				Knee flex	L5, S1			
	Finger abduction ~	T1				Foot plant flex	S1, S2			

SENSATION mark areas reduced and absent sensation



ABBREVIATED NEUROLOGICAL ASSESSMENT
(comment on PTRS in all limbs)

Normal tone and power in all limbs.

VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT

Medical patient expected to be mobilising as normal within 2 days		Proceed to VTE risk actions
Medical patient with reduced mobility for ≥ 2 days OR Surgical patient	✓	Assess thrombosis and bleeding risk factors

Thrombosis risk factors.

ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ Mobility reduced for >2 days
- ☐ Age >60
- ☐ Dehydration
- ☒ Obesity BMI >30 kg/m²
- ☒ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
- ☐ Active cancer or cancer treatment
- ☐ Thrombophilia
- ☐ Personal history or first degree relative with history of VTE
- ☐ Use of hormone replacement therapy or oestrogen containing contraceptive
- ☐ Pregnancy or $<6/52$ post-partum

- ☐ Acute surgical admission with inflammatory or intra-abdominal condition
- ☐ Surgery with significant reduction in mobility
- ☐ Critical care admission
- ☐ Knee or hip replacement
- ☐ Hip fracture
- ☐ Total anaesthetic+ surgical time >90 mins
- ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60 mins
- ☐ Varicose veins with phlebitis

Bleeding risk factors.

Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia ($<75 \times 10^9/L$)
- ☐ Uncontrolled hypertension ($>230/120$ mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

INFORMATION PROVIDED TO PATIENT	LMWH	ANTIEMBOISM STOCKINGS
Provide if admission is anticipated ☒ YES ☐ NO	☐ YES ☐ NO ☐ Contraindicated If NO Bleeding Risk, prescribe Dalteparin 5000 units daily (2500 units if <46 kg. No dose change in renal failure). ☒ Dalteparin prescribed	Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH. Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema ☐ YES ☒ NO ☐ Contraindicated
Name: <u>Kanika Ajith</u> Sign: <u>Kanika</u>	Date: <u>01/01/21</u> Time: <u>00:00</u>	

MEDICATION GUIDANCE: PATIENTS ON ANTICOAGULATION

INR is only necessary in patients on Warfarin or those with known or suspected liver disease. If INR >1.5 check with surgeon if they wish to proceed with surgery. For a spinal anaesthetic, the INR must be less than 1.5.

Warfarin must be reversed immediately to prevent delay to surgery.

Refer to guidance on intranet:

- Management of anticoagulation during surgery
- Emergency reversal of warfarin
- NOAC – advice on emergency situations (or discuss with haematology on call)

MEDICATION GUIDANCE: ORTHOPAEDICS

Omit ACE-INHIBITORS (perindopril, lisinopril, losartan, candesartan, telmisartan, olmesartan) and omit DIURETICS (furosemide, bumetanide, bendroflumethiazide) if patient is:

- Dehydrated, Low BP, Septic
- pre-op, and 24 hours post op in hip fracture

NSAIDs:

- Do not prescribe, D/W senior if indicated

ANALGESIA PROTOCOL: ORTHOPAEDICS (for patients aged ≥ 70 who have sustained a fragility fracture)

WARD PRESCRIBING: All patients should be prescribed the following:

- Regular Paracetamol 1g four times daily orally
 - Reduce the dose to 500mg four times daily if patient weighs <50 kg
- Oxycodone Immediate Release liquid 2mg three times daily orally OR 1mg subcutaneously if unable to take orally
- Oxycodone Immediate Release liquid 2mg orally OR 1mg subcutaneously, hourly as required (PRN)
- Cyclizine 50mg orally or intramuscularly six to eight hourly PRN (maximum 150mg in 24 hours)

NSAIDs, Nefopam, Tramadol, Codeine and Dihydrocodeine should NOT be started as NEW prescriptions.

- IF A PATIENT HAS KNOWN SENSITIVITIES TO ANY OF THE ABOVE MEDICATIONS OR HAS A MEDICAL CONTRA-INDICATION, DO NOT PRESCRIBE IT AND PLEASE SEEK SENIOR ADVICE ON ANALGESIC CHOICE.

DIFFERENTIAL DIAGNOSIS AND PROBLEM LIST

- Sepsis
- Pneumonia

MANAGEMENT PLAN (REMEMBER: FEWS of 3 or more = Scottish Structured Response)

Sepsis 6 protocol.

- Antibiotics $\Rightarrow$ IV Co-amoxiclav + PO Doxycycline
- IV fluids $\Rightarrow$ Plasma-lyte
- O₂ $\Rightarrow$ via nasal cannula
- Bloods sent
- Lactate $\Rightarrow$ elevated
- Urine output $\Rightarrow$ monitor

FLUIDS / FASTING Allow clear fluids until 2 hrs pre op. Allow normal diet until 6 hrs pre op.

Anticipated op time: ____ am / ____ pm

Fast for theatre: ☐ YES ☐ NO

Clear fluids until: _____

Fasting from: _____

Clerking Practitioner Sign off	Tick Box
Completed: VTE risk assessment	☒
Prescribed Dalteparin if indicated	☒
Completed: medicines reconciliation and kardex written	☒
Clerking complete	☒

Name: Kerthik Ajith Signature: *Kerthik* Job Title: FY2 Date: 30/08 Time: 22:22

RESULTS

XR	CT	MRI	USS	ECG	ABG VBG
Rt basal consolidation.				Sine tachycardia	FiO2 pH 7.47 BE HCO3 pCO2 pO2

Blood Results (previous results in shaded area)

Date	30/08			Date	30/08			Date	30/08		
WCC	25.5			Na	140			Alb	32		
Neut	22.05			K	3.6			Protein			
Lymph	0.75			Urea	4.5			Alk Phos	87		
Hb	147			Creat	81			GGT			
MCV				eGFR	76			ALT	18		
PLT	226			HCO3	19			Bilirubin	14		
Ddimer				Cor Ca ²⁺				Amylase			
PT				Phos				CRP	37.9		
APTT				Mg				Serum HCG			
INR				TSH				Adm Trop			
B12				Glucose				12h Trop			
Folate				Lactate	2.1			CK			

CONSULTANT (REGISTRAR) WARD ROUND

Consultant Name: DELICATA

50 M Schizophrenia, anxiety
disorder, 120M, eczema, dizziness

Abv 50+ comp.

Few 2

147 147
wll 24.5

Hr 103

BP 99/56

Mr 226

U+E 10

CRP 37.9

Extr 7.1

LFT 10

CXR - DLZ

IMPRESSION (to be completed by Consultant / Registrar only)

Abv 50+

consolidation

1 Pneumonia w consolidation - p
10A18

DLZ

ELU - 10
tissue

CONSULTANT SIGN OFF (to be completed by Consultant only)

PLAN:

1 10A18

2 10 fluids

3 BL, 10

4 Sputum culture 10

5 Lactate 10

6 ABG, please for next
target (no pO2 result on
initial ABG). D²
(Rebed)

Analgesia considered	☐ YES	☐ NO	Med rec complete	☐ YES	
CXR seen	☐ YES	☐ NO	Remove unwanted PVCs	☐ YES	
ECG seen	☐ YES	☐ NO	AWI required	☐ YES	☐ N/A
Bloods seen	☐ YES	☐ NO	Oxygen prescribed	☐ YES	☐ N/A
VTE Risk assessment	☐ YES		Target saturations	Other	>94% 88% - 92%
Dalteparin prescribed	☐ YES	☐ N/A	IV fluid prescription considered	Yes	☐ N/A

Resuscitation and Escalation status Discussed with patient / family / POA: ☐ Family phoned, but not contactable
☐ Yes ☐ To be discussed (state time of discussion:) ☐ No

☒ For CPR	☐ Not for CPR	DNACPR form completed ☐ YES ☐ NO	<48 hour stay	Specialty RET / GEN Med
☒ ICU	☐ MH DU	☐ Ward level care		

Escalation Plan: Full

Consultant Name: DELICATA Sign: Date: 31/08/18 Time: 9:35am

FRAILTY SCREENING TOOL

Would this person benefit from Comprehensive Geriatric Assessment? If answered "Yes" to any of the following questions please refer to the Integrated Assessment Team

Practitioner Signature.....*K. Jones*.....

Date: *30/8* Time: *2110*

1. Has the patient been admitted from a nursing or residential home?	☐ YES ☒ NO
2. Does the patient have NEW functional decline?	☐ YES ☒ NO
3. Dementia diagnosis or are there any concerns about memory/cognition?	☐ YES ☒ NO
4. Is the patient acutely confused, more confused than usual or more sleepy/drowsy than usual?	☐ YES ☒ NO
5. Has the patient fallen in the past 3 months or is a fall the reason for admission?	☐ YES ☒ NO
6. Does the patient attempt to walk alone although unsteady or unsafe?	☐ YES ☒ NO
7. Does the patient or their relatives have fear or anxiety re falling?	☐ YES ☒ NO

If YES to Question 3, 4 or 5: Complete 4AT below. THINK DELIRIUM
Initiate FALLS PATHWAY if FALLS and COGNITIVE questions positive

FALLS PATHWAY initiated ☐ YES ☒ NO

4AT		SCORE
1	Alertness: This includes patients who may be markedly drowsy (eg difficult to rouse &/ or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. Ask patient to state their name and address to assist rating • Normal (fully alert, but not agitated throughout assessment) • Mild sleepiness for 10 secs after waking, then normal • Clearly abnormal	0 0 4
2	AMT 4: Age, DOB, place name and current year AMT score= /4 • No mistakes • 1 mistake • 2 or more mistakes/untestable	0 1 2
3	Attention: Ask the patient: "Please tell me the months of the year backwards starting at December" You can assist with 1 prompt of "What is the month before Dec?" • Achieves 7 or more • Starts but score <7 months/refuses to start • Untestable (cannot start because unwell, drowsy, inattentive)	0 1 2
4	Acute change or fluctuating course: Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg paranoia, hallucinations arising over last 2 weeks and evident in last 24 hours) • No • Yes	0 4
4AT score 4 or above: possible delirium+/- cognitive impairment: THINK DELIRIUM - initiate TIME BUNDLE 1-3: possible cognitive impairment 0: delirium or severe cognitive impairment unlikely (but delirium still possible if question 4 information incomplete)		Total score:

NURSING ASSESSMENT – INITIAL ASSESSMENT ON ADMISSION

Belongings (tick)	With patient	☒ With family	In safe	Bagged	Labelled
Own medication	☐ YES	☒ NO			
Name band	☒ YES	☐ NO			
Patient fasted	☐ YES	☒ NO	Food time:	Fluid time:	See also page 9
Relatives with patient	☐ YES	☒ NO	☐ Informed		

Home circumstances:	☒ Lives alone	Lives with:
Living Arrangements:	☐ Own Home	☐ Sheltered
Care Package:	☐ Yes	☒ No
Family Support:	Details: <u>Richmond Fellowship - Company</u>	

CAPACITY AND CONSENT			
Mental State	Orientated ☒ YES ☐ NO	Confused ☐ YES ☒ NO	Distressed ☐ YES ☒ NO
Unconscious (GCS $\leq$ 9) ☐ YES			
Consider if the patient has capacity to consent. If the patient's ability to consent is in doubt refer to medical staff to assess and then complete the following:			
Is there a concern that the patient is at risk?			
1. Are they unable to safeguard their own wellbeing, property rights or other interests?	☐ YES	☒ NO	
2. Are they at risk of harm?	☐ YES	☒ NO	
3. Are they affected by disability, mental disorder, illness, physical or mental infirmity which makes them more vulnerable to harm than adults not affected in this way	☐ YES	☒ NO	
If the patient meets all 3 points, follow NHS Five Adult Protection and Support process			
Does patient require supervision / special observation?	☐ YES	☒ NO	Refer to Supervision Policy
Consider need for Violence and Aggression Risk Assessment			
Adults With Incapacity (AWI) form completed	☐ YES	☐ NO	☐ N/A
Discussed with and signed by family / carer	☐ YES	☐ NO	☐ N/A
Date treatment plan in place?	☐ YES	☐ NO	☐ N/A
Is Welfare Power of Attorney held?	☐ YES	☐ NO	☐ N/A
Has copy been requested?	☐ YES	☐ NO	☐ N/A
Does the patient consent to us sharing information with:			
Other Health Professionals	☐ YES ☐ NO	Family	☐ YES ☐ NO
Carers	☐ YES ☐ NO		
Specify:			

SPIRITUAL CARE & PSYCHOLOGICAL SUPPORT			
Does the patient want you to contact their spiritual or religious leader?	☐ YES ☐ NO	Name:	
		Phone:	
		Date:	
Does the family / carer want support from Spiritual Care Team (Chaplain)?	☐ YES ☐ NO		
Reason for referral (please circle):	Patient support	Family Support	Religious care (faith group?)
Refer to Spiritual Care Team:	☐ YES ☐ NO	Date:	Time:

NURSING ASSESSMENT – INITIAL ASSESSMENT ON ADMISSION

PAIN ASSESSMENT ON A SCALE OF 0 – 10 WHERE '0' = NO PAIN & '10' = WORST IMAGINABLE OR FACE LEGS ACTIVITY CRYING AND CONSOLABILITY (F.L.A.C.C. SCORE 0 - 10)

Does the patient have pain? ☐ YES ☒ NO If 'Yes' initiate pain assessment chart

SWALLOWING

Does patient have any risk factors that would affect their ability to swallow? (e.g. previous or suspected stroke) ☐ YES ☒ NO Follow 'Compromised Swallow Assessment Flow chart' or 'Stroke Swallow Assessment' if stroke suspected

Swallow Screen Checklist completed? ☐ YES ☒ NO If Nil By Mouth ensure essential medicines and hydration are prescribed via an appropriate route

ORAL HEALTH (IF YES TO ANY OF THE FOLLOWING IMPLEMENT THE ORAL HYGIENE TOOL)

Does the patient have dentures? Full Partial ☒ No Tongue coated? ☐ YES ☒ NO

Are there any issues with oral health? ☐ YES ☒ NO Lips dry and cracked? ☐ YES ☒ NO

PRESSURE ULCER RISK ASSESSMENT (PURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If the answer is **NO** to any assessments, commence SSKIN bundle

Remember

- People who are overweight may not be well nourished
- Please sign after each check

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SSKIN BUNDLE COMMENCED	SIGNATURE/ PRINT
30/8/25	2110	Y	Y	Y	N	N	K5

Name: Kim Gilt Signature: [Signature] Date: 30/8 Time complete: 2110

FALLS (see 'Falls History' Page 12)

Please score through any part of the following that is not used

URINALYSIS

Glucose	Bilirubin	Ketones	SG	Blood	PH	Protein	Urobilinogen	Nitrates	Leuco-cytes	Date	Initials

MSU – Culture and Sensitivity

Chlamydia (P.C.R.)

What was the date of the patient's Last Menstrual Period?

Ask the patient if there is any possibility that they may be pregnant

Pregnancy Status on Admission (Female patients over 12 years) – please tick box

Pregnant Not Pregnant Don't know Not applicable

A pregnancy test must be carried out if the patient is uncertain/states that they are pregnant.

Ask the patient for verbal consent for a urine pregnancy test

Pregnancy test results	Negative	Positive
------------------------	----------	----------

DATE **TIME** **PROGRESS / CONTINUATION / EVALUATION OF CARE**

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

Admission Record ☐ Nursing Assessment ☐

Bloods ☐

ECG ☐

Swabs - POC ☐ LFT ☐

Track Online Assessments Frailty ☐ +/- 4AT ☐ CPE ☐ & MRSA screening ☐

Nutrition profile ☐ MUST ☐ PVC ☐

30/8/25 2110 (S) 50 year old man admitted via A+E due to Sepsis
(R) PMH noted. Lives alone NO POC - Richmond fellowship for company
(A) FEWS (3) Alert and orientated Independent with ADLs. Normal diet and fluids BM = 7.1 Reports skin fully intact - not seen.
(2) Awaiting medical review. — K. Jones

(A) FEWS 3 RECOGNITION/ESCALATION 1 sticker per episode per 24 hours		ESCALATE NOW IF CLINICAL CONCERN Date: 30/8/25 Time: 2110 FEWS (3)	
Nurse in charge informed Patient track observation profiles/flags reviewed		PRINT NAME/SIGNATURE: K. Jones, K. Jones	
(B) FEWS 2-4 (or 3 for more than 1 hour) RESPONSE/INTERVENTION		ESCALATE NOW (SEE FEWS ESCALATION CHART)	
1. Responsible nurse and clinician to review patient & complete sticker (within 1hr) ☐ 2. Possibly due to infection? Y ☐ (Complete Septis 6 form) N ☐ 3. Appropriate escalation if ongoing deterioration - tick one only a) For ICU ☐ b) For HDU ☐ c) For ward based care ☐ 4. Resuscitation status: for CPR ☐ DNACPR ☐ (Complete DNACPR form) 5. DOCUMENT MANAGEMENT PLAN IN NOTES BELOW STICKER PRINT NAME/SIGNATURE: _____			
IF NO IMPROVEMENT, OR FEWS 7 OR ABOVE - CALL FOR HELP IF FEWS 7 OR ABOVE AND NO IMPROVEMENT AFTER 1 HOUR WITH NO DECISION MADE TO LIMIT ESCALATION - MANDATORY CONSULTANT CONTACT NOW IF FEWS ≥ 5 OVERNIGHT - Inform team consultant in morning Discuss all plans with patient and family as soon as able & document ☐			

DATE

TIME

PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

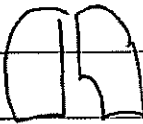
31/8/25 0610 Settled throughout the night. FEWS
now stable. BM stable. O2 via NC ongoing.
IV fluids continue. IV CO-amox given
as prescribed. Clozapine given through
the night from emergency drug cupboard.
Datix submitted as per protocol. Remains
independent. Not keen on catheter -
using bottles to pass urine - fluid balance
NO complaints of pain. ——— KATON

31/8/25 1130, pt, has been settled. Reverses on
O2 - Canula TISSARD through Re-
Canulated, IV fluids he started,
Blood culchost taken & R-Blocks,
Washed with a Baren. Didn't want
to wash pelvis area. SKIN very dry
Deland Check - on SKIN, ab's stable
Drinking more fluids (Juree) - ALLC.

31/8/25 1420 Dr Delicata had requested ABG.
Went to do it - pt refused investigation.
A. BANHO WYNA, PHU

31/8/25 1450 pt handed over to WD 53. - ALLC

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.		
		PRESSURE ULCER RISK ASSESSMENT STICKER FILE IN NURSING NOTES Date: 31/8/25 Time: 1700 Skin inspection within 6 hours of admission to Respiratory Pain completed within 6 hours of admission to Respiratory SSKIN bundle initiated Frequency of skin bundle Pressure damage present Pressure Ulcer identified on admission: GRADE Appropriate pressure relieving equipment Datix completed WEB Number Referral to Tissue Viability/Podiatry Known to community district nurses/podiatry YES/NO YES/NO YES/NO/N/A 2° 3° 4° N/A YES/NO/N/A YES/NO/N/A YES/NO/N/A YES/NO/N/A YES/NO/N/A
		(S) + (B) as per chart. (A) FOWS (1); alert and orientated at time of assessment. Not on respiratory distress on 4L O2 via NC. ePVC insert. IV fluids resumed at 100ml/hr. DD/NF. Continent - uses bottle. Skin dry and scaling. Nil pressure sore noted. (Hx Eczema/Psoriasis). Axi with ADLS and with O2 cylinder at the moment; Independent with mobility (needs encouragement) (2) Encourage ↑ fluid intake; encourage self care. monitor ePVC. Cont. with W Abx; wean O2 as able.
31/8/25	2050	Leon's key worker Graeme Humsden called for an update on him. He has kindly left his mobile number if medical staff need any further information. Graeme Humsden Richmond Fellowship key worker 07536310888 12 SN

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.		
01/09/25	09:10	NR <u>MURRAY</u>
		(50) Admitted 30/08/25
		<u>Issues</u>
		1. Pneumonia with sepsis
		on oral doxycycline + IV co-amoxiclav
		since 30/08 evening
		CXR - @ lower zone consolidation
		BG: T2DM, asthma, schizophrenia, anxiety
		FEMS = 2
		T: 35.6 HR: 85 BP: 120/72 RR: 18 Sat: 91% NC.
		Blood cultures - awaiting results
		Bloods (30/08) -
		WCC: 24.5 Neut: 22 CRP: 37.9 Ure - (N)
		ABG: 7.47 ↑ pCO ₂ N pO ₂ 6.8 ↓ lactate 2.1 ↑
		LDH (31/08) - Haemolysed
		BM: 14.4: yesterday eve
		Pt lying in bed. Alert & chatty.
		Cough - prod green sputum.
		Sharp CP when deep breath - improving.
		Bets SOB on waking, wheezy & Inhalers help.
		Stopped smoking 10 yrs ago, smoked 20/ day.
		 ↓ Air entry No wheeze No crackles

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE															
Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.																	
01/09/25	09:10	Plan 1. Bloods for inflammatory markers L If improved IV → oral switch 2. ABG L ? chronic CO₂ retainers & ↓ O₂ 3. CXR 6/52 after discharge 4. Will need Spiro + 1- further PFTs in due course ↳ RNS Spiro pre D/C Please 5. RNS RV pre D/C/Inhaler Tech Murray CONS 21084 MURRAY															
1/9/25	11:22	Pharmacy Review Med Hx Completed Is per ECS. As per lose clinic letter from 25.2.25, Pt takes Methotrexate on 2 Tuesday. Phoned CHMS Klho confirmed current Clozapine dose as 300mg On FTY Pharmacist Absent															
01/09/25	14:00	Bloods Review <table border="0"> <tr> <td>Hb: 127 (147)</td><td>WCC 20.2 (24.5)</td><td>Na 139</td></tr> <tr> <td>MCV: 97</td><td>Neut 16.94 (22)</td><td>K 4.0</td></tr> <tr> <td>RBC: 4.05 ↓</td><td>CRP 1584 (37.9)</td><td>α 39</td></tr> <tr> <td>HCT: 0.39 ↓</td><td></td><td>eGFR > 60</td></tr> <tr> <td>Plt: 195</td><td></td><td>Bicarb 25.9</td></tr> </table> (N)	Hb: 127 (147)	WCC 20.2 (24.5)	Na 139	MCV: 97	Neut 16.94 (22)	K 4.0	RBC: 4.05 ↓	CRP 1584 (37.9)	α 39	HCT: 0.39 ↓		eGFR > 60	Plt: 195		Bicarb 25.9
Hb: 127 (147)	WCC 20.2 (24.5)	Na 139															
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RBC: 4.05 ↓	CRP 1584 (37.9)	α 39															
HCT: 0.39 ↓		eGFR > 60															
Plt: 195		Bicarb 25.9															

PROGRESS / CONTINUATION
EVALUATION OF CARE

Patient name: LEON
CHI: GRATTON
1703751191
or attach addressograph

DATE TIME

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

2/9/25 02¹⁰ Repeat FBC taken @ 21⁰⁰ - Hb ↑
from 127 to 131. WBC ↓ from 20 to
17.7, for day team review. ? rpt bloods
pt getting increasingly anxious about
repeated venepuncture due to needle
phobia. Settled night, bedtime med,
including clonazepam taken. IV ab^x
given. pt sleeping good spells. Dr
wound to 3rd. pt requesting drink
and snacks and shower etc -
agreed to take this in morning
- AS

02/09/25 09:40 Daily Review Dr Chitkala + L. Drawbridge

(SO) Admitted 30/08/25

Issues

① Pneumonia with sepsis

↳ on oral doxy + IV co-Amox since 30/08 eve

Awaiting cultures

Bloods 01/09 eve Today's bloods not yet back

Hb 131 (127) Normal

WCC 17.7 (20)

FEWS = 2

Neut 13.7 (16.9)

T: 36.6 HR: 83 BP: 90/56

RR: 19 Sat: 93% NC

DATE TIME PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

02/09/25 09:40 Review continued

O/E - patient sleeping. sounds like sleep apnoea.

Plan

1. Cont abx.
2. Check bloods today - switch to oral abx
If CRP trend ↓
3. Wear Oz as appropriate maintaining SpO₂ > 92%.
4. Refer to derm for skin
5. Start discharge planning
6. Call resp nurses for PFTs + spiro before discharge

LDrausbridge (FY1)

3/9/25 00⁰⁰ pt has only 2 x clozapine 100mg Tablets left in box. Insufficient for tomorrow 12⁰⁰ dose. None ordered - unable to find Clozapine reporting option on datix - can this be clarified by pharmacy please - B.W.

02⁴⁵ Settled night. P^t slept good spells, ate full supper, indep to toilet - removing n/c and indep w. skin care for dry/irritated limbs w. new creams. Temp stable. Apyrexial slight wet cough noted @ time

PROGRESS / CONTINUATION EVALUATION OF CARE

GRATTON
PLEON name:

17-03-1975



1703751191

DATE TIME

or attach addressograph

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

but able to expectorate. Will try to
further wean O₂ to below 2L
in morning - ~~SN~~.

3/9/25 08:30 Respiratory Assoc - Lemmons (x 24237/200910)
- Spirometry + whealer review/technique
at request of Dr Murray - RMD - Asthma - ~~exp~~
exacerbated 2020. (N) on Beclomethasone 100mcg
2pfs BD + Salbutamol ¹⁰⁰ 2pfs PRN.
RNS will come back later + perform
spirometry + then review wheelers
SpO₂s 93% on H₂NC - (C) to wean off O₂
- target SpO₂s > 94%
PFTs will need to be organised with
Respiratory function lab and would need
to be carried out post d/c once chest settled.

(811110) (RNS)

03/09/25 12:00 Daily Review Dr. Chilala + L. Drawbridge

(SO) Admitted 30/08/25

Issues

(i) Pneumonia with sepsis

L on PO Doxy + IV Co-Amox since 30/08 eve

Derm - nursing team report pt has OP appt

Resp nurses - RNS later will do spirometry + riv inhalers

Plan to wean O₂ aim > 94% sat

DATE TIME PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

03/09/25

Bloods 02/09

WCC - 14.8 (13.7) Inflamm markers still raised

Neut - 11.0 (13.7) but improving + down-trending

CRP 91 (158)

FENS=1

T:36.0 HR:83 BP:114/78 RR:18 Sats: 90% on NC

PE sat in chair. Appears better + brighter.

Breathless^{ness} improving, mobilising to toilet independently.

Still bringing up some sputum. No concerns.

Some minor (12) sided chest pain.

Plan

① IV → oral Co-Amox due to blood results

② Stop Doxycycline - S/E complete

③ Bloods tomorrow - FBC, CRP, VEs

④ Continue to wear O₂ - on 1L currently.

LDrawbridge (Fv1)

PROGRESS / CONTINUATION EVALUATION OF CARE

GRATTON
LEON ^{PHR}

17-03-1975



1703751191

DATE TIME

or attach addressograph.

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

3/9/75 1150 Resp Nurse Specialist - (Simmons) ^{20090/} (24237)

Spirometry

for 2.77 (62% Predicted)

for 3.31 (58% Predicted)

ratio 0.84

PEAR 361 (56% Predicted)

Dr. Dr. Arayo - B disregard Spirometry results as patient currently in with a CAP therefore results may not be accurate - for PFTS once chest settles to determine true results.

Education given 1/2 inhaler technique & given aerochamber.

© to wear oxygen as SpO₂ abn

LONGMIST (RMS)

20-30

patient is suppose to be taken Clozapine 300 mg at 22:00. But Clozapine 200 mg left. Informed doctor on the ward. patient needs to be done once the box get finished. As I am not aware about proper indication of datix, informed charge nurse. Nicky staff name will be informing tomorrow to pharmacist for a datix.

ob
chfn

DATE TIME PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

22.30 S/N Maria has ordered Clozapine. Therefore, I have administered medication to the patient. DCN and change nurse aware.

JB
8/9/25

4/9/25 Sp^{o2} 93% on RA
Pulse 95
on going ear

A. Evans
RVS 28562

04/09/25 Daily Review - Dr Chitkala + L. Drawbridge

50 Admitted 30/08/25

Issues ① Pneumonia with sepsis

L completed PO Doxy course

L IVOST 03/09 on PO Co-Amoxiclav

L weaning O₂

Bloods - requested for today, will chase

FEWS = 1

Sats: 92% on NC T: 36.1 HR: 90 BP: 132/83 RR: 18

Nursing document 93% RA

- RNS RLY - Spirometry completed - for repeat when chest settles to determine ^{true} results
- Clozapine - DATIX

PROGRESS / CONTINUATION EVALUATION OF CARE

GRATTON name:
LEON

17-03-1975



1703751191

or attach addressograph

DATE TIME

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

04/09/25

Daily Review cont.

Blood: HCO_3^- - 24.2 @, CAP ↓ 29.6 @ 91.5, 158, HtEs → @

WBC ↓ 12.8 (sent 8.86) @ 14.8 (sent 11.0)

Blood culture → negative

of stroke

16' lying in bed on O_2 - 2C

felt slightly breathless after taking shower.

Alard.

RK. NSA in distress.

check - 1/2 in lower zones

Plan.

① keep in

② continue O_2 weaning.

③ Discharge planning.

hmgf

04/09/25 1210 Pharmacy

① NO need to OATIX cizapine - supply was on ward and given to patient.

② please review dalteparin & paracetamol doses. Patient 124 kg. ↑ dalteparin to 7500 units OD. Also scope to ↑ paracetamol if needed

③ metformin & MTX currently held whilst unwell

DATE TIME PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

04/09/25 12:10 Pharmacy Cont.

④ Olanzapine Rx unsigned - please sign

⑤ please note use of constipation [clonidine -
consider prescribing prn ^{reg+} laxatives.

Especially as now on ^{normal}
prn morphine

pharmacist
#28038

5-9-25 0030 Independent with all ADLs

Eating and drinking well

Prescribed 1L O₂ however not using this
and sat 95% ASCOB

05/09/25 9:20h

with Dr. Chulala mit.

Revised.

350 admitted for CAP - B19 DM/Asympt / Schizophrenia/
Anxiety.

~ 5/6 of Abx now

~ Inflammatory markers ↓

~ CRP - ↓

FSAB - 1-2

~ still on O₂ on/off.

5/ ac. stable.

is not currently needing O₂ but says he feels breathless
when the walking to shower / toilet.

~ But generally feeling much better

Plan:

① keep.

② Discharge planning.

③ Monitor saturations + weaning off O₂.

④ continue abx

PROGRESS / CONTINUATION EVALUATION OF CARE

GRATTON
LEON

17-03-1975



1703751191

DATE TIME

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

Wk. continued

Plan - continued

⑤ kept bed

⑥ On discharge follow up review + CXR (9P?)

[Signature]

05/03/75

W. Sunday

10:21

Pts 96% on deep breathers.

well, a/c and soon to go home.

①

② Can 6/52

③ PFTs 3/12.

④ Total 5 days out of bed

⑤ Rest to MUX next week

⑥ Dr. Tooby

[Signature]

NURSING ASSESSMENT AND PATIENT CARE PLAN RECORD



PATIENT DATA: Patient label or write

PATIENT NAME:

PATII GRATTON
LEON

17-03-1975

DATI



1703751191

PREFERS TO BE CALLED:

ADMISSION / TRANSFER INFORMATION

Date of admission: 30/8/25

Time of admission: 2050

Ward admitted to: AWU

Consultant: _____

Ward transferred to: 53

Date of transfer: _____

Time of transfer: _____

Consultant: _____

Ward transferred to: _____

Date of transfer: _____

Time of transfer: _____

Consultant: _____

Ward transferred to: _____

Date of transfer: _____

Time of transfer: _____

Consultant: _____

Date of Actual Discharge: _____

COMPLETION OF ASSESSMENTS

PATIENT CARE ASSESSMENT AND ADMISSION RECORD:

- ☐ Frailty Screening and Assessment
- ☐ Infection Control
- ☐ Capacity and Consent

Initial assessments:

- ☐ Pain
- ☐ Swallowing
- ☐ Oral Health
- ☐ Pressure Ulcers
- ☐ Falls

NURSING ASSESSMENT AND PATIENT CARE PLAN RECORD:

- ☐ Pressure Ulcers (*within 6 hours of admission or transfer to ward*)
- ☐ Handling Risk Assessment (*within 6 hours of admission*)
- ☐ MUST (*within 24 hours of admission*)
- ☐ Nursing Assessment
- ☐ Daily Care Plans

The information within this document is **CONFIDENTIAL** and may only be viewed and shared with the permission of the named patient.

This record is a legal document. Your signature indicates that you have reviewed and updated it, and it is a true reflection of the care given by you or delegated by you.

[illegible]

On Patienttrack: ☐ YES ☐ NO

Use daily if the person is **not** at risk

Sign after each check

REMEMBER – PEOPLE CHANGE, RISKS CHANGE

MOBILITY: Mobile without equipment / assistance OR able to mobilise with aid of Zimmer, or other walking aid
CONTINENCE: Continent
NUTRITION: Appears well nourished and able to eat and drink (people who are over-weight may not be well nourished)
SKIN: Skin condition good with no pressure damage or excoriation. **Record any identified skin integrity concerns on Pressure Ulcer Record (including diagram) on reverse of page**

Record your answer in the grid below Y = Yes or N = No

- If the answer is YES to all statements, use this chart daily
- If the answer is NO to any statement, implement SSKIN Care Bundle and continue to use this chart daily
- If the answer to at least one statement is NO, but you feel, within your clinical judgment, that the patient is not 'at risk', record the reasons for not commencing the SSKIN bundle at foot of page
- If you are unsure, default to SSKIN care bundle

[illegible]

Date	Time	Why SSKIN Care Bundle not implemented	Signature
1/9/25	0745	Independant	Rhe

CLIENT HANDLING RISK ASSESSMENT

On Patienttrack:

☐ YES

☐ NO

A. CLIENT DETAILS AND ASSESSMENT

Date					Diagnosis:
Weight Kg					
Height Mt.					Operation:
BMI					Date of Surgery:

EQUIPMENT USED BY THE CLIENT PRIOR TO ADMISSION AND ASSISTANCE (0, 1, 2)

TYPE	✓ ()	INITIAL	TYPE	✓ ()	INITIAL	TYPE	✓ ()	INITIAL
Zimmer			Crutches			Wheelchair		
Gutter Zimmer			Sticks			Hoist		
Rollator Zimmer			Gutter Crutch			Other:		

LEVEL OF MOBILITY FROM ADMISSION	✓	DATE	INITIAL	✓	DATE	INITIAL	✓	DATE	INITIAL	✓	DATE	INITIAL
Weight bearing	✓	30/8	lt									
Non weight bearing												
Partial weight bearing												
Variable weight bearing												
Not to be mobilised												
History of Falls	☐ YES ☒ NO											
Falls Risk Score												

ASSESSMENT	STATE	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL
Comprehension: Sight, Hearing, Speech	No issues	30/8	lt						
Behaviour: Unpredictable, Confused, Walking about Aggressive, Apprehensive, Delirium									
Ability: Balance, Movement, Weakness, Sensation	Indep								
Pain: Location	ni								
Skin lesions or Sores: Location	ni								
Attachments: Infusion, Catheter, PEG, Drains, Monitors	ni								
Other: Medication	As charted								
Culture or Religion (specify):									

OUTCOME / AIMS for PATIENT:

Date: _____

Date: _____

Aim @ manageable

Action Plan discussed with client and carer

☐ YES

☐ NO

Date:

30/8

Signature:

lt

B. HANDLING ACTION PLAN

TASK No. 1 Toileting		Task No. 2 Bathing	
Number of staff required:		Number of staff required:	
Mechanical Hoist	Type:	Mechanical Hoist	Type:
Sling Type	Sling size:	Sling Type	Sling size:
Other Equipment <i>Indep</i>		Other Equipment <i>Indep</i>	
Handling Instructions		Handling Instructions	
Signature: <i>[Signature]</i>	Date: <i>30/8</i>	Signature: <i>[Signature]</i>	Date: <i>30/8</i>

TASK No.		Task No.	
Number of staff required:		Number of staff required:	
Mechanical Hoist	Type:	Mechanical Hoist	Type:
Sling Type	Sling size:	Sling Type	Sling size:
Other Equipment		Other Equipment	
Handling Instructions		Handling Instructions	
Signature:	Date:	Signature:	Date:

TASK No.		Task No.	
Number of staff required:		Number of staff required:	
Mechanical Hoist	Type:	Mechanical Hoist	Type:
Sling Type	Sling size:	Sling Type	Sling size:
Other Equipment		Other Equipment	
Handling Instructions		Handling Instructions	
Signature:	Date:	Signature:	Date:

NURSING ASSESSMENT

ASSESSMENT	
Communication	Do you have any loss of sight ☒ hearing loss ☐ <i>leading</i> Do you use glasses / contact lenses ☒ hearing aids ☐ Do you have any problems / difficulty in understanding conversation ☐ YES ☒ NO Are there ways we can help with communication? Is referral to SALT required? ☐ YES ☐ NO Referral made to SALT (date): ____ / ____ / ____ or No Issues / Risk ☐
Pain	Are you in any pain? ☐ YES ☒ NO Where is the pain? _____ Severity of pain: mild ☐ moderate ☐ severe ☐ New pain ☐ Long term pain ☐ How long: hours ☐ days ☐ weeks ☐ months ☐ Regular Analgesia ☐ YES ☐ NO Pain assessment tool utilised ☐ YES ☐ NO Pain score: _____ or No Issues / Risk ☐
Respiratory	Do you have any difficulty with your breathing? ☐ YES ☒ NO Do you use inhalers? ☐ YES ☒ NO Domiciliary Oxygen? ☐ YES ☒ NO Do you smoke? ☐ YES ☐ NO Would you like to stop smoking ☐ YES ☐ NO Patient appears dyspnoeic ☐ YES ☐ NO At risk of deterioration (increasing FEWS) ☐ YES ☐ NO Referral to respiratory physio required? ☐ YES ☐ NO Referral made to respiratory physio (date): ____ / ____ / ____ Referral to Smoking Cessation service (SCS) required? ☐ YES ☐ NO Referral made to SCS (date): ____ / ____ / ____ or No Issues / Risk ☒
Falls	Falls Pathway initiated (see Patient Care Assessment and Admission Record) ☐ YES ☒ NO
Swallowing	Please note if stroke is suspected follow NHS Five Stroke Swallow Screening Protocol Have you had any difficulties with swallowing: food ☐ liquids ☐ Is patient coughing or choking on oral intake ☐ YES ☐ NO Is patient alert enough to manage oral intake? ☐ YES ☐ NO Utilise 'Flowchart/care plan for patients with compromised swallow' ☐ YES ☐ NO or No Issues / Risk ☐
Hydration / Fluid Management	Do you require any assistance with drinking? ☐ YES ☒ NO Do you use any special equipment? ☐ YES ☒ NO Do you feel thirsty? ☐ YES ☐ NO Nil by mouth? ☐ YES ☐ NO Does patient require intravenous fluids? ☐ YES ☐ NO Fluid management chart in use? ☐ YES ☐ NO Peripheral cannula in situ? ☐ YES ☐ NO Peripheral vascular catheter (PVC) Insertion and Maintenance Care Plan required? ☐ YES ☒ NO or No Issues / Risk ☐
Oral Hygiene	Do you have a sore mouth? ☐ YES ☒ NO Do you have dentures? ☐ YES ☒ NO What do you usually use to clean your teeth? _____ Initiate oral hygiene care plan? ☐ YES ☒ NO or No Issues / Risk ☐

ASSESSMENT

Elimination

Are you having any problems with: urinary incontinence ☐ urgency ☐ bowel incontinence ☐
 Does patient have a urinary catheter in situ? ☐ YES ☐ NO
 Catheter Associated UTI (CAUTI) Insertion and Maintenance Care Plan required? ☐ YES ☐ NO
 Do you require assistance to go to the toilet? ☐ YES ☐ NO
 Do you have a stoma? ☐ YES ☐ NO
 Do you suffer from constipation? ☐ YES ☐ NO new problem ☐ long standing problem ☐
 When did you last have a bowel motion? _____
 How do you usually manage your constipation? _____

or No Issues / Risk ☐

Personal Hygiene

Do you usually need help or use special equipment to:

Bathe ☐ YES ☐ NO

Shower ☐ YES ☐ NO

Dress ☐ YES ☐ NO

What help is given / equipment used: _____

When you are in hospital, would you prefer to have a bath ☐ shower ☐ neither ☐

Referral to OT required? ☐ YES ☐ NO

Referral made to OT (date): ____ / ____ / ____

or No Issues / Risk ☐

Wound Care

Do you currently have a wound / broken skin ☐ YES ☐ NO

Dressing in situ? ☐ YES ☐ NO

Wound post surgery? ☐ YES ☐ NO

Admitted with Pressure Ulcer? ☐ YES ☐ NO

Referral to Specialist Service required? ☐ YES ☐ NO

Referral made to Specialist Service (specify: _____) (date): ____ / ____ / ____

or No Issues / Risk ☐

Emotional well-being

Do you feel emotionally well? ☐ YES ☐ NO

Is there anything that we can offer to help support you? ☐ YES ☐ NO

Patient appears distressed / agitated / depressed ☐ YES ☐ NO

or No Issues / Risk ☐

Sleep and rest

Do you usually have trouble sleeping? ☐ YES ☐ NO

Do you use any particular techniques to help you sleep? ☐ YES ☐ NO

How do you like to relax? reading ☐ listening to music ☐ TV ☐ other: _____

On medication? ☐ YES ☐ NO

or No Issues / Risk ☐

End of Life Care

Is this relevant to patient? ☐ YES ☐ NO

Referral to palliative care required? ☐ YES ☐ NO

Referral made to palliative care (date): ____ / ____ / ____

Patient Specific Area Specific

Signature: _____

Time: _____

DAILY CARE PLAN

Date: 31 / 8 / 25

Discussed with patient / carer on: / /

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☒ Patient's personal goals ☐ ☒ Carer / family discussion		On going Care
Communication	☐ ☒ Ensure environment conducive to communication ☐ ☒ Call buzzer ☐ ☒ Patient wears glasses ☐ ☒ Patient uses a hearing aid ☐ ☒ Refer to Speech and Language therapy ☐ ☒ Arrange Interpreter service ☐ ☒ Use written communication ☐ ☒ Use communication aid (specify):		Communicates well Can hear to hear
Stressed or Distressed Behaviour	☐ ☒ Reduce stress / distress – specify: ☐ ☒ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☒ Implement safe working procedures		Settled
Cognitive Impairment / Delirium	☐ ☒ Inform medical staff of change ☐ ☒ Consider further frailty screen if previously negative ☐ ☒ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☒ Encourage involvement of relatives and carers		Alert
Observations	☐ ☒ T,P,R,BP ☐ ☒ Fluid balance ☐ ☒ Weight ☐ ☒ Neuro obs ☐ ☒ Blood Glucose ☐ ☒ Circulation check		as per track daily Bms
Symptom Relief	☐ ☒ Pain relief ☐ ☒ Pain assessment tool ☐ ☒ Nausea relief ☐ ☒ Other (specify):		as per Kache
Respiration / Airway	☐ ☒ Oxygen required ☐ ☒ Nebulisers / Inhalers ☐ ☒ Compromised swallow ☐ ☒ Tracheostomy ☐ ☒ Hospital Acquired Pneumonia intervention		NC

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)		PERSON-CENTRED INTERVENTIONS	
			DAY	NIGHT
Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian			DD, NF
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above -Datix			daily pur
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT			incl
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care			incl using bottles
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails			Falls pathway in place
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry			skin is a mass due to eczema
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required			incl
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward			standard APE
Sleep / Rest	☐ Medication ☐ Specify interventions:			
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management			as per Kandy
Signature:				
Time:				

DAILY CARE PLAN

Date: 1, 9, 25

Discussed with patient / carer on: / /

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion	awaiting ward round.	Wean O2 as able.
Communication	☒ ☐ Ensure environment conducive to communication ☒ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Nursed in bay Call bell band Can make needs known	call bell to hand. Can communicate needs well.
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures	No signs of distress or stress noted at this time	No issues.
Cognitive Impairment / Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	Patient appears alert.	Alert + orientated
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	4 hourly observations Revs ② temperature 35.9 spo2 93% 4 litres O2	Obs stable
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):	oppr Kardoa	As charted-
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention	On 4 litres O2 therapy via nasal cannula > 94%	SpO2 > 94% on 3L N/C

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)		PERSON-CENTRED INTERVENTIONS	
			DAY	NIGHT
Nutrition / hydration	☒ MUST rescreen due ☒ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian		Weight done 124.56Kg Diabetic diet Normal fluids	DD/NF
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above -Datix		Daily Pura	Daily PURA-
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT		Independant	Ind
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care		Independant Bottles	Ind
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails		4 Comfort Clock	4 th Comfort round-
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry		Psoriasis Pressure areas Intact	Na
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required		Basin and shower offered	Ind
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward		Standard PPE	SKPS
Sleep / Rest	☐ Medication ☐ Specify interventions:		Settled	settled
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management		Oral	Meals as chart
Signature:		Rhe	McNaylan	
Time:		0945	00:20	

DAILY CARE PLAN

Date: 21.9.25

Discussed with patient / carer on: / /

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion	Continued Care	Wean O2 as able -
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Nursed in bay Call bell to hand Can make needs known	can call bell to hand - can communicate needs well.
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures	No Sign of Stress/distress noted	No issues
Cognitive Impairment / Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	Alert + orientated	Alert + orientated
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	4 hourly	Obs stable -
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):	as per Kardex	As charted.
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention	on 2 litres O2 therapy	SpO2 > 92% on 1L N/A

DAILY CARE PLAN

Date: 3 / 9 / 25

Discussed with patient / carer on: / /

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☒ Patient's personal goals ☐ ☒ Carer / family discussion	on going care	Ongoing medical care
Communication	☐ ☒ Ensure environment conducive to communication ☐ ☒ Call buzzer ☐ ☒ Patient wears glasses ☐ ☒ Patient uses a hearing aid ☐ ☒ Refer to Speech and Language therapy ☐ ☒ Arrange Interpreter service ☐ ☒ Use written communication ☐ ☒ Use communication aid (specify):	Communicates well can hear to hand	can communicate the needs. CB within reach
Stressed or Distressed Behaviour	☐ ☒ Reduce stress / distress – specify: ☐ ☒ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☒ implement safe working procedures	Settled at this time	Not stressed / distressed.
Cognitive Impairment / Delirium	☐ ☒ Inform medical staff of change ☐ ☒ Consider further frailty screen if previously negative ☐ ☒ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☒ Encourage involvement of relatives and carers	Alert / Orientated	A + O
Observations	☐ ☒ T,P,R,BP ☐ ☒ Fluid balance ☐ ☒ Weight ☐ ☒ Neuro obs ☐ ☒ Blood Glucose ☐ ☒ Circulation check	check Bms as per handbook protocol	As per patient book
Symptom Relief	☐ ☒ Pain relief ☐ ☒ Pain assessment tool ☐ ☒ Nausea relief ☐ ☒ Other (specify):	as per handbook	As per handbook
Respiration / Airway	☐ ☒ Oxygen required ☐ ☒ Nebulisers / Inhalers ☐ ☒ Compromised swallow ☐ ☒ Tracheostomy ☐ ☒ Hospital Acquired Pneumonia intervention	1 LTR NC	on 1L NC 2947

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)		PERSON-CENTRED INTERVENTIONS	
			DAY	NIGHT
Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian	☐ DD/NF ☐ wean must	DD/NF	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above -Datix	check PURA	Daily PURA	
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT	incl	and	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	incl	and	
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails	↓ Risk	↓ risk	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	psoriasis all over body	psoriasis all over body	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required	incl	and	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward	Standard PPE	SIPS	
Sleep / Rest	☐ Medication ☐ Specify interventions:		—	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management	as per	oral meds	
Signature:		Healy	cb	
Time:		10		

DAILY CARE PLAN

Date: 4/9/25

Discussed with patient / carer on: / /

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☒ Patient's personal goals ☐ ☒ Carer / family discussion	on going care	aim to sleep well
Communication	☐ ☒ Ensure environment conducive to communication ☐ ☒ Call buzzer ☐ ☒ Patient wears glasses ☐ ☒ Patient uses a hearing aid ☐ ☒ Refer to Speech and Language therapy ☐ ☒ Arrange Interpreter service ☐ ☒ Use written communication ☐ ☒ Use communication aid (specify):	Communicates well can hear to hand	Communicates needs utilizes call bell
Stressed or Distressed Behaviour	☐ ☒ Reduce stress / distress – specify: ☐ ☒ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☒ Implement safe working procedures	Settled	Settled
Cognitive Impairment / Delirium	☐ ☒ Inform medical staff of change ☐ ☒ Consider further frailty screen if previously negative ☐ ☒ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☒ Encourage involvement of relatives and carers	Alert, orientated	ALSO
Observations	☐ ☒ T,P,R,BP ☐ ☒ Fluid balance ☐ ☒ Weight ☐ ☒ Neuro obs ☐ ☒ Blood Glucose ☐ ☒ Circulation check	check Bms as per trace	Bms TDS few daily
Symptom Relief	☐ ☒ Pain relief ☐ ☒ Pain assessment tool ☐ ☒ Nausea relief ☐ ☒ Other (specify):	as per kache	as per kardex
Respiration / Airway	☐ ☒ Oxygen required ☐ ☒ Nebulisers / Inhalers ☐ ☒ Compromised swallow ☐ ☒ Tracheostomy ☐ ☒ Hospital Acquired Pneumonia intervention	1Ltr AC	Room air currently

	MANAGEMENT / INTERVENTIONS (Tick appropriate boxes)		PERSON-CENTRED INTERVENTIONS	
			DAY	NIGHT
Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian	DD, NDF	NDNF Weekly Most	
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above - Datix	daily purg	daily Pura	
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT	incl	Independence	
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	incl	independence	
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails	↓ Risk	Low risk	
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	presents all over body	psoriasis	
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required	incl	independence	
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward	standard PPE	SLIPS	
Sleep / Rest	☐ Medication ☐ Specify interventions:		as Kardex	
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management	as per Kardex	oral	
Signature:			ASCOA 2200	
Time:				

Care and Comfort Clock

Date: 5/9/25

GRATTON
LEON

17-03-1975



1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1

☐ 2

☐ 3

☐ 4 hourly

☐ Food chart in place

☐ Fluid chart in place

NHS

Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.

Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)

†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 4/9/25

Gratton Leon

Patient label here

170375191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1 ☐ 2 ☐ 3 ☒ 4 hourly

☐ Food chart in place

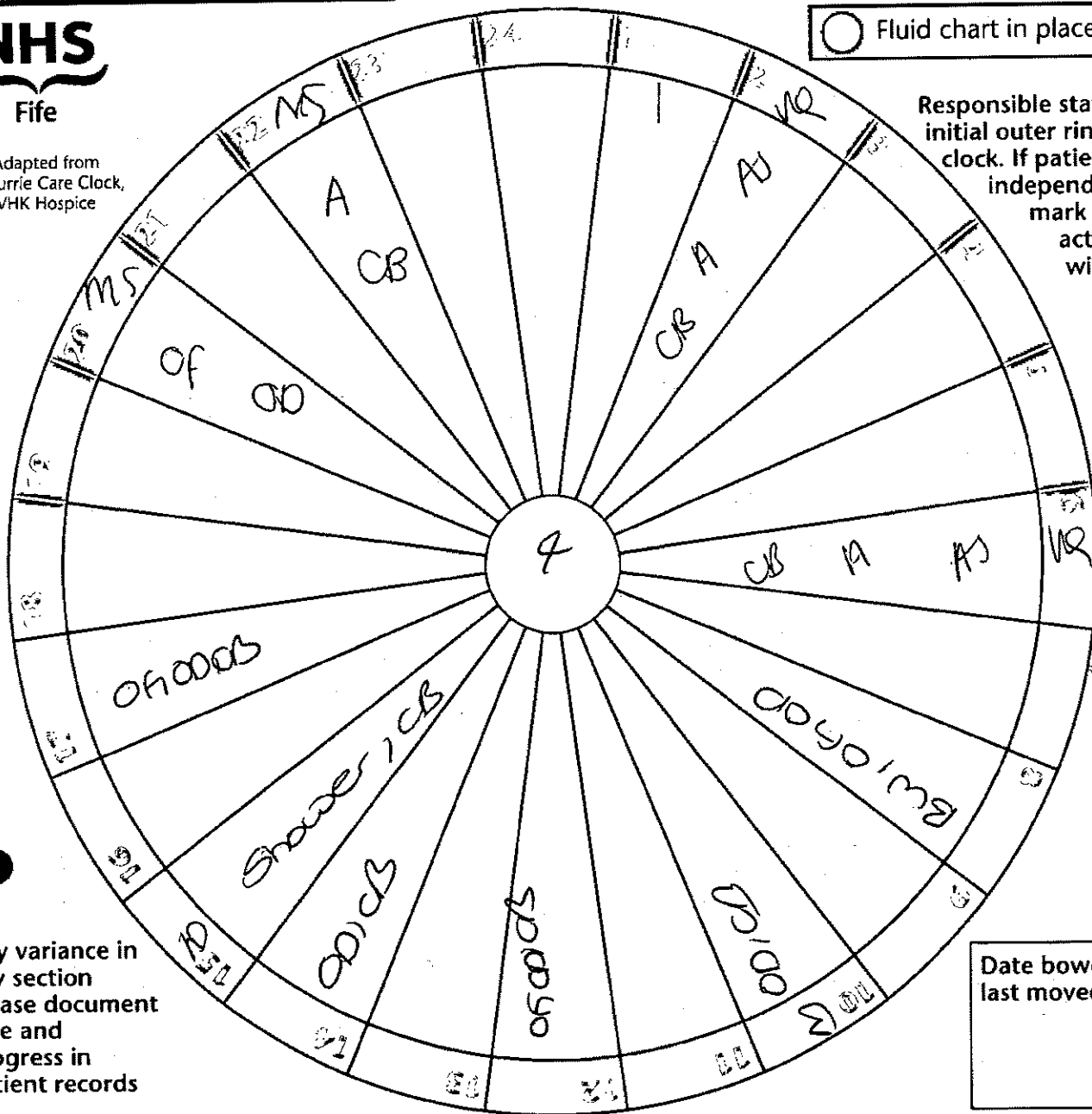
☐ Fluid chart in place

NHS

Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 3/9/25

GRATTON
LEON

17-03-1975



1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1

☐ 2

☐ 3

☒ 4 hourly

☐ Food chart in place

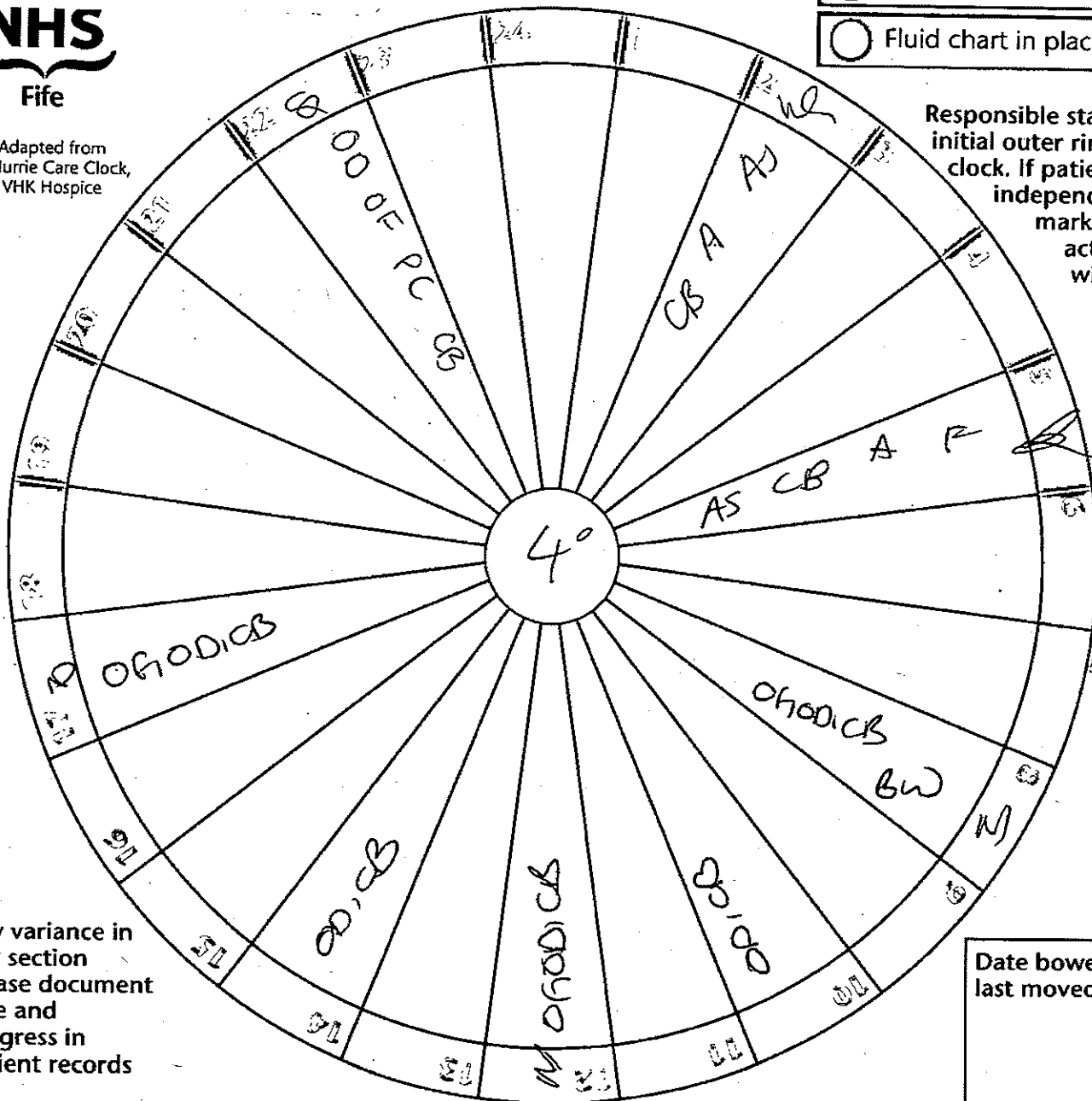
☐ Fluid chart in place

NHS

Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 2/9/25

Leon Watson

Patient label here

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1

☐ 2

☐ 3

☐ 4 hourly

☐ Food chart in place

☐ Fluid chart in place

NHS

Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.

Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 1/9/25

Heen Grotton

Patient label here

170375/191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1

☐ 2

☐ 3

☒ 4 hourly

☐ Food chart in place

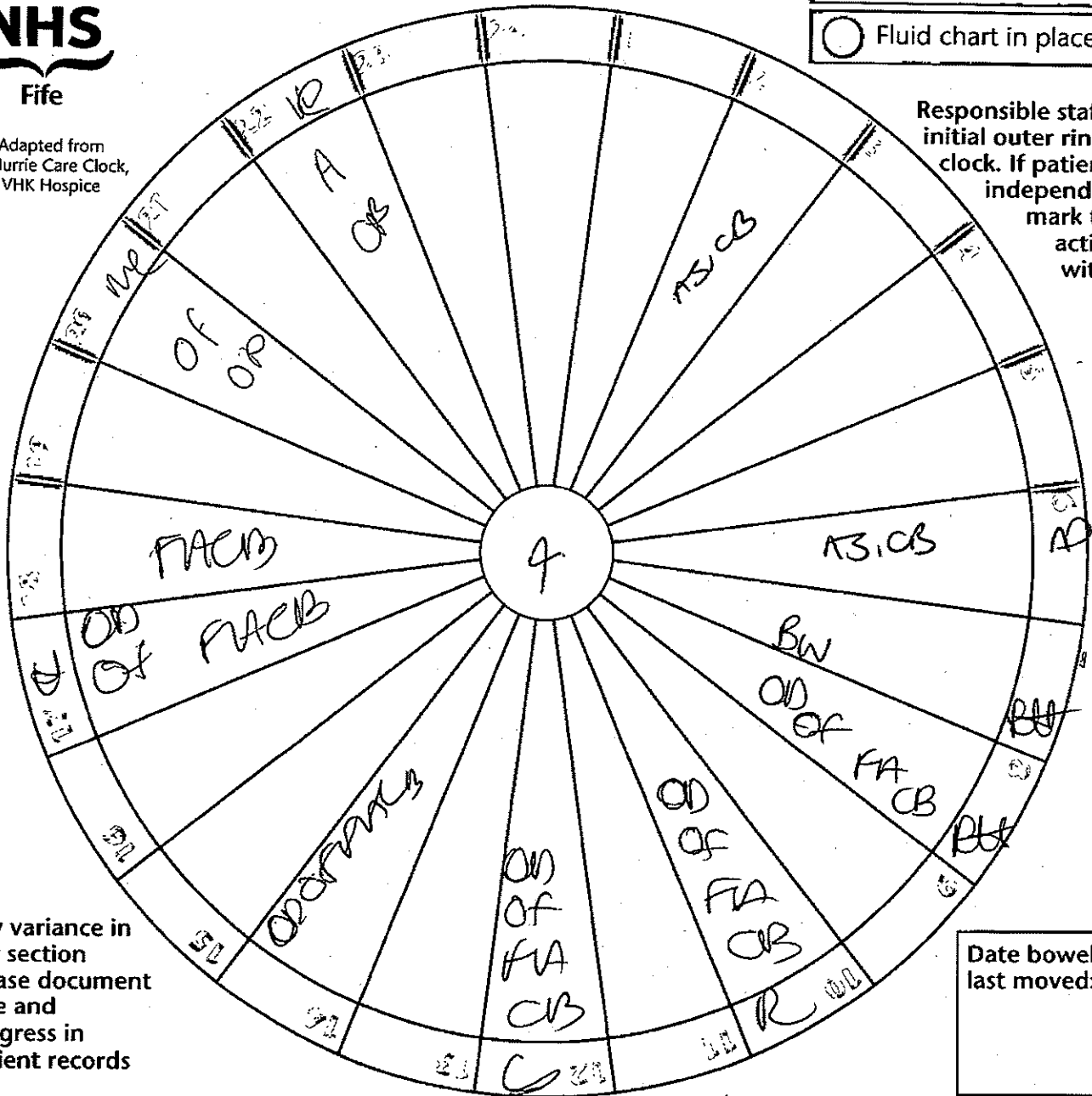
☐ Fluid chart in place

NHS

Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 31-8-25

GRATTON
LEON

17-03-1975



1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1
☒ 3

☐ 2
☐ 4 hourly

☐ Food chart in place

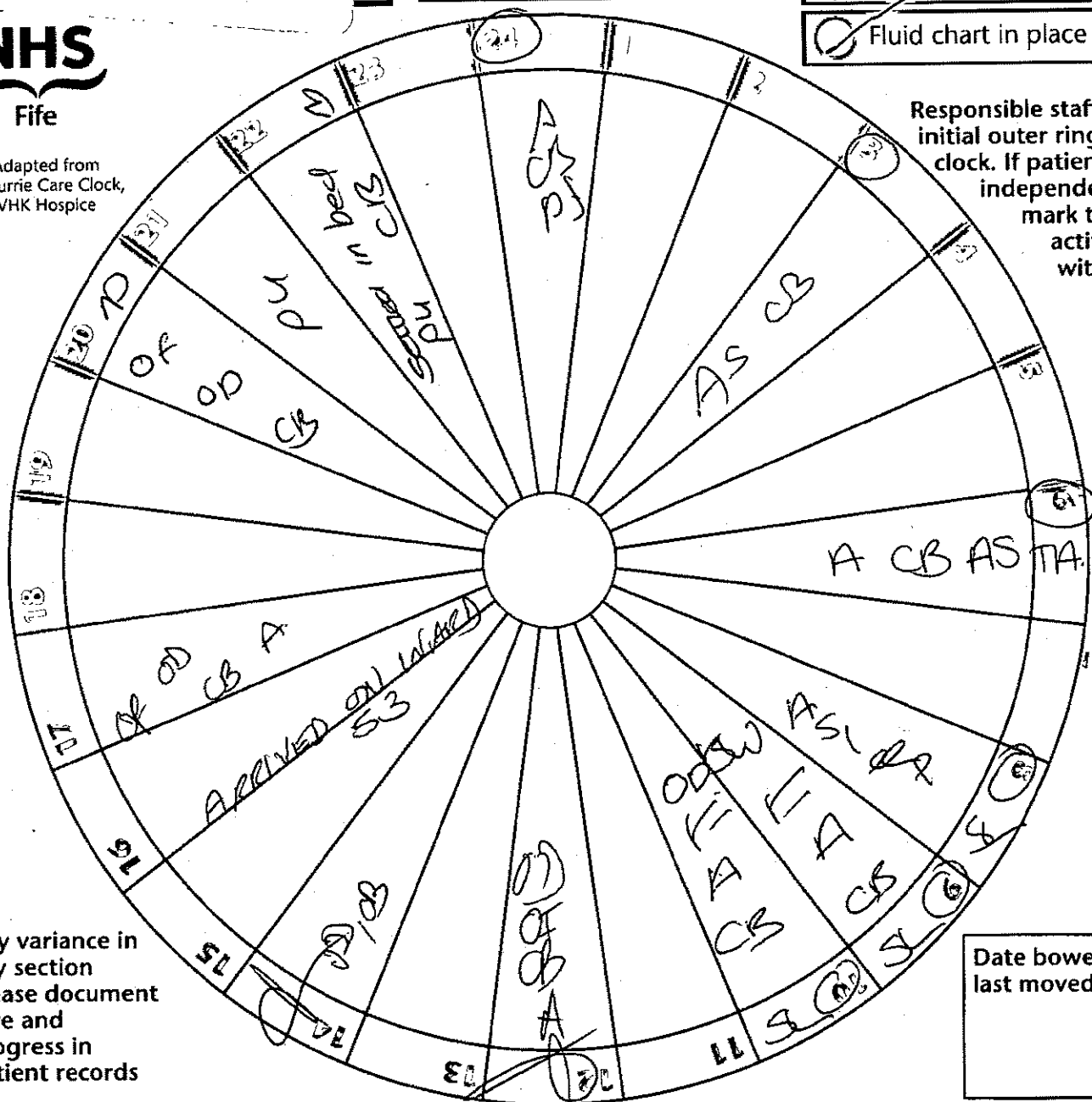
☒ Fluid chart in place



Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 30-8-25

GRATTON
LEON

17-03-1975



1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:

☐ 1

☐ 2

☐ 3

☐ 4 hourly

☐ Food chart in place

☐ Fluid chart in place



Fife

Adapted from
L Murrie Care Clock,
VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.

Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

FALLS & BEDRAILS ASSESSMENT AND INTERVENTION CARE PLAN



Fife

17-03-1975

- F** has patient had a FALL since last review?
- A** is the patient AGITATED or confused today?
- L** is the patient LIKELY to forget instructions?
- L** is the patient LIKELY to mobilise without supervision?
- S** Ensure SAFE environment every time you leave patient/
call bell to hand/walking aid

GRATTON
LEON



Admission / Transfer to Ward (MUST BE COMPLETED FOR EVERY TRANSFER)	Date	30/8/25			1/8/25					
	Ward	ACU								
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	
Provide FALLS leaflet to patient carer/family				✓						
Check E + S BPs completed on Patient Trak					✓					
Medical staff asked to complete falls assessment				✓						

Record your answer in the grid below with Y = Yes and N = No - If Yes to any of these, activate daily bundle overleaf

Date	Time	F	A	L	L	S	Signature

Date	Time	Why has the FALLS daily bundle not been implemented?	Signature
30/8/25	2115	Independent with ADOL	KS

Mental		Mobility		
		Patient is very immobile (bed fast or hoist - dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff
	Patient is confused & disorientated	A - Use bed rails with care	B - Bed rails NOT recommended	C - Bed rails NOT recommended
	Patient is drowsy	D - Bed rails recommended	E - Use bed rails with care	F - Bed rails NOT recommended
	Patient is orientated and alert	G - Bed rails recommended	H - Bed rails recommended	I - Bed rails NOT recommended
	Patient is unconscious	J - Bed rails recommended	N/A	N/A

Bed Rails Assessment Matrix - The matrix and the codes must be used in conjunction with NHS Fife Bed Rail Policy as combination of clinical judgement and awareness. Patients with capacity can make their own decisions about bed rail use. Patients with visual impairment may be more vulnerable to falling from bed. Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed and if bed rails are used, may need padded covers. Discuss with welfare POA/NOK if patient does not have capacity and document in notes.

F has patient had a FALL since last review? A is the patient AGITATED or confused today? L is the patient LIKELY to forget instructions? L is the patient LIKELY to mobilise without supervision? S Ensure SAFE environment every time you leave patient/ call bell to hand/walking aid		Patient Label CHI									
KEY = YES = Y; NO = N; NOT APPLICABLE = N/A											
F	Falls and Bedrail Care Planning Daily Bundle / Post Fall	Date 30/8									
	Patient uses - glasses /hearing aid (circle as appropriate)	☒									
	Advise patient to take time when rising from sitting/lying to standing	☒									
	Ask medical staff to complete medical falls review										
A	Complete 4AT and start TIME bundle if new 4AT 4 or above										
	Consider placement in the ward and patients orientation to ward										
	Ask/encourage patient to sit-stand. Change position										
	Call bell within reach										
L	Care and comfort frequency (1/2/3/4 hourly) (add number to box)										
	Consider whether enhanced or 1:1 supervision or use of Chair/Bed alarm (circle appropriate)										
L	Follow mobility risk assessment/care plan. Consider referral to Physiotherapy and/or OT										
	If patient requires walking aid is it within easy reach?										
	Assess continence. Document support required in care plan.										
S	Area hazard free, personal belongings within easy reach										
	Select suitable seating										
	Bed at lowest level and brakes applied										
	Consider suitability and appropriateness of clothing / footwear /referral to podiatry										
BEDRAIL ASSESSMENT											
	Bedrails Appropriate, as per Matrix (Yes/No)	Y									
	Bedrails used (Yes/No) * document professional judgement on page 3	Y									
	Bedrail Bumpers Appropriate (Yes/No) *document rationale on page 3	Y									
	Discuss with Patients Next of Kin (Yes/No) *document outcome on page 3	Y									
	Matrix Code	1									
	Signed	16/8									

RADIOMETER ABL90 SERIES

ABL90 Ward 43 I393-092R0352N0004

14:49

01/09/2025

PATIENT REPORT

Syringe - S 65uL short
probe

Sample #

238

Identifications

Patient ID 8173321X
Operator Suzanne Artley
Patient last name
Patient first name
Date of birth
Sample type Arterial
T 37.0 °C
FO₂(I) 21.0 %
Note

Blood gas values

pH	7.433		[7.350 - 7.450]
cH ⁺ _c	36.9	nmol/L	[35.0 - 45.0]
pCO ₂	5.93	kPa	[4.67 - 6.00]
↓ pO ₂	9.78	kPa	[10.0 - 14.0]
cHCO ₃ ⁻ (P,st) _c	28.6	mmol/L	[22.0 - 32.0]
cBase(B) _c	4.7	mmol/L	[- -]
sO ₂	96.1	%	[95.0 - 98.0]
cLac	1.0	mmol/L	[1.0 - 2.1]
cCa ²⁺	1.16	mmol/L	[1.15 - 1.35]
cK ⁺	3.7	mmol/L	[3.5 - 5.3]
cNa ⁺	142	mmol/L	[133 - 146]
ctHb	139	g/L	[120 - 175]
↑ FO ₂ Hb	94.9	%	[0.9 - 1.0]
FCOHb	0.8	%	[0.5 - 1.5]
FMetHb	0.4	%	[0.1 - 1.5]
FHHb	3.9	%	[1.0 - 5.0]

Notes

↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)

Solution pack lot: RE-02

Sensor cassette run #:

Printed 14:50:29 01/09/2025

1978-150

RADIOMETER ABL90 SERIES

ABL90 Ward 43 I393-092R0352N0004

14:49

01/09/2025

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probe

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4L O₂ NC.

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Notes

↑ Value(s) above reference range
↓ Value(s) below reference range
c Calculated value(s)

Solution pack lot: RE-02

Sensor cassette run #:

Printed 14:50:25 01/09/2025

1978-150

17-03-1975

Compliance mo

Review Date: Feb 2017

MS2791

THROMBOPROPHYLAXIS

THROMBOPROPHYLAXIS SHOULD BE REASSESSED EVERY 48 HOURS		Times to be given	Date ↓ and Month ⇒											
DRUG <u>DALTEPARIN</u>		<u>q12h</u>												
Dose <u>5000 unit</u>	Route <u>SC</u>	Start Date <u>2016</u>												
Reason for Change/Stopping:		<u>1800</u>	<u>1800</u>											
Prescriber's signature <u>Kath</u>		Comments <u>review closed</u>												

VTE RISK ASSESSMENT - STOP !!!!

- 1 Patient VTE Risk Assessment completed on admission (medical clerking) yes
- 2 For Dalteparin YES / NO
- 3 If YES give patient VTE information leaflet prior to 1st dose

REASSESS IN 48hrs

Date Reassessed: _____

Continue with Dalteparin

YES / NO

OXYGEN PRESCRIPTIONS

DRUG OXYGEN		Observation 4 hourly ☐ 12 hourly ☐ Daily ☐ Other	Date ↓ and Month ⇒											
Titrate to achieve target oxygen saturation as indicated			Time											
Not Indicated (see oxygen policy) ☐														
94% - 98% ☐ 88% - 92% ☐ Other _____ ☐														
Starting device/flow rate	Start Date													
As required ☐ Continuous ☐ (Refer to oxygen policy)	Route: Inhaled													
Prescribers Signature														
DRUG OXYGEN		Observation 4 hourly ☐ 12 hourly ☐ Daily ☐ Other	Date ↓ and Month ⇒											
Titrate to achieve target oxygen saturation as indicated			Time											
Not Indicated (see oxygen policy) ☐														
94% - 98% ☐ 88% - 92% ☐ Other _____ ☐														
Starting device/flow rate	Start Date													
As required ☐ Continuous ☐ (Refer to oxygen policy)	Route: Inhaled													
Prescribers Signature														

PATIENT NAME CHI CONSULTANT

REGULAR PRESCRIPTIONS			Times to be given	Date ↓ and Month ⇒											
			24/6	25/6	26/6	27/6	28/6	29/6	30/6	1/7	2/7	3/7	4/7	5/7	6/7
DRUG DOXYCYCLINE															
Dose 100 mg	Route PO	Start Date 30/08/25	0800	X											
Reason for Change/Stopping															
Indication CAP	Comments														
Prescriber's Signature <i>Karthi</i>															
DRUG CO-AMOXICLAV															
Dose 1.2g	Route IV	Start Date 30/08/25	0800	X											
Reason for Change/Stopping															
Indication CAP	Comments		1400	X											
Prescriber's Signature <i>Karthi</i>			2200												
DRUG CLOZAPINE															
Dose 300mg	Route PO	Start Date 30/08													
Reason for Change/Stopping M319															
Indication	Comments Dettix report when 2400 baw is finished		2200												
Prescriber's Signature <i>Karthi</i>															
DRUG SOTROBEC 100 micrograms															
Dose 2puffs	Route INH	Start Date 30/08	0800												
Reason for Change/Stopping															
Indication Asthma	Comments M419 Dns		2200												
Prescriber's Signature <i>Karthi</i>															
DRUG ARIPIRAZOLE															
Dose 20mg	Route PO	Start Date 30/08	0800												
Reason for Change/Stopping															
Indication	Comments Dns M419														
Prescriber's Signature <i>Karthi</i>															
DRUG FLUOXETINE															
Dose 60mg	Route PO	Start Date 30/8	0800												
Reason for Change/Stopping															
Indication	Comments M419														
Prescriber's Signature <i>Karthi</i>															

Completed 5/7 course

ORAL SWITCH

