

**Subject Access Request Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN**



**MMA LEGAL
STOK, 43 - 59 PRINCES STREET,
STOCKPORT,
SK1 1RY**

**Date: 11th MAY 2026
Your Ref: 100183
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot**

Dear Sir/Madam

**Re: Subject Access Request under the General Data Protection
Regulation**

Patient: GEORGINA LOGAN Date: 19.08.1954

Thank you for your request received **22ND APRIL 2026** in which you seek a copy of your client's personal information.

Your request has been dealt with in line with our requirements under Article 15 of the General Data Protection Regulation and I now attach the following:

**GARTNAVEL GENERAL HOSPITAL – QUEEN ELIZABETH
UNIVERSITY HOSPITAL – WEST AMBULATORY CARE HOSPITAL – NEW
VICTORIA INFIRMARY HOSPITAL RECORDS**

Please be aware that these health records have been reviewed by a clinician and any information identifying or provided by a third party has been removed.

We process personal information to enable us to provide healthcare services for patients; support and manage our employees; to carry out research and clinical trials; maintain our accounts and records and to carry out data matching under the national fraud initiative. We also use CCTV systems for crime prevention.

This personal information can be both clinical and non-clinical in nature and can include

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images



- Witness statements
- Incident reports
- Complaints files
- Emails

The source of our data includes Patients, General Practitioners, Healthcare, Social and Welfare organisations, Legal representatives and Police forces.

We sometimes need to share the personal information we process with the individual themselves and also with other organisations as listed above. Where this is necessary we are required to comply with all aspects of the General Data Protection Regulation

Where these organisations are based outside Europe we take all appropriate safeguards to protect your information.

Health records are kept for a limited time and this is noted below for your information

- Adult general hospital records – six years after the date of last entry
- Maternity records – 25 years after the birth of the last child
- Children's and young people's records – until the child or young person's 25th birthday.
- Mental health records – 20 years after the date of the last contact

If you have any queries, please do not hesitate to contact us.

If you are unhappy with how your request has been dealt with please contact the NHSGGC Data Protection Officer. Their contact details are noted below:

Data Protection Officer
Information Governance Department
NHS GG&C – 2nd Floor
1 Smithhills Street
Paisley
PA1 1EB
Email: data.protection@ggc.scot.nhs.uk

Yours sincerely

SAR Team

ELECTRONIC PATIENT RECORDS

3

ALL HOSPITAL RECORDS HELD NHSGGC	☐	
ACS	☐	
BEATSON HOSPITAL	☐	
CANNIESBURN HOSPITAL	☐	
DENTAL HOSPITAL	☐	
GARTNAVEL GENERAL HOSPITAL	☐	
GLASGOW ROYAL INFIRMARY	☐	
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY ☐
NEW VICTORIA ACH	☐	
PRINCESS ROYAL MATERNITY	☐	
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY ☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY ☐
ROYAL HOSPITAL FOR CHILDREN	☐	
STOBHILL HOSPITAL	☐	
VALE OF LEVEN	☐	MATERNITY ☐
WEST AMBULATORY CARE HOSPITAL	☐	
WESTERN INFIRMARY RECORDS	☐	

Including:

ADGNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☐
WEST MARC	☐
LABS	☐

Date & Time	Signature, Print Name & Designation
	Clb Sore (D) head, phlebotomy evident from previous venipuncture site - F11 infirmed. Working with Spontaneously Sept for lung sounds NEWS (1) BP 103 SpO2 95 Independent with hygiene Active care plan 6 hourly R.R. 16 Sats 96% T36.4 P-90 109%60 NEWS 1. Nausea improved today, and patient has made effort to increase intake. Stools barretts have not moved since last Friday - following taking 6 x loperamide tablets? requires laxatives. Clb Nausea - cyclizine 50mg given orally @ lunchtime. SPUTUM specimen requested - as pt states sputum being expectorated. SIB Medic - For laxids one off x1 sachet Amoxicillin for LRTI. - orally Sputum spec sent Lying standing BPs. PRN Nebbs. (A) 24-48 1800 Lying BP 124/73 Standing 105/62 0200 Seated at time of waiting Diet & fluids tolerated Working Spontaneously Barretts inactive Lying BP 110/72 Standing 87/53 All other obs stable.



1908546042

LOGAN

Georgina

19/08/1954

17, SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

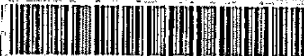
G13 4NA

CLINICAL NOTES - NURSING

Date & Time		Signature, Print Name & Designation
	Oral amoxicillin continues	
	Tramadol 50mg given prior to settling	Knurran
29/1/15	Plan for Patient	Shawna S/N
16 ⁰⁰	Independent with personal hygiene tolerating fluid & diet well voiding more spontaneously Mobile independently Observations - lying & sitting bow continue difficult stool lying BP 98/56 (sitting 88) Complain of jerking movements await review by medical staff. Continues on oral amoxicillin	K. K. K.
20/1/15	Oral amoxicillin continues. Laxatives taken prior to sleep Lying BP - 106/66 - Standing BP - 101/62 Voiding more spontaneously Patient states she has brontising/shaking short episodes but has cut down using her inhaler as she thinks she may have used it too much	SLA Shawna
0530	Sept for s/s p/	SL
06 ⁰⁰	No abdominal/upper chest pain - SLs F11 - trapped sent off but no more gastric distal.	SL
1800	Independent with personal hygiene tolerating fluid & diet voiding more spontaneously bowels remain inactive & p/ phosphate enema	

Date & Time		Signature, Print Name & Designation
20/1/15	Mobile independently	
0800	Observations OK only very slight deficit in lying & standing BP. Reviewed by medics to have abdo xray post pr enema until results available for home when bowels moved	ESTERMAN, J. J. Esterman
31/1/15	ADVICE / DIET TAKEN	
0800	VOIDING URINE SPONTANEOUSLY, BOWELS INTAKE - LIMITED GUEN FULLY MOBILE LYING / STANDING BLOOD PRESSURE UNCHANGED OUT - DEFLAT NOTES MEDICATIONS GIVEN TO PATIENTS ADVICE ABDO X-RAY RESULTS SERIES AND SLEEPING AT TIME OF WAKING	E. Esterman J. Esterman J. Esterman
0715	NO COMPLAINING OFFERED	
31/1/15	Independent with shower and personal hygiene.	
1700		
1640	This morning. Voiding spontaneously - bowels have moved slightly this morning - enema refused. Independently mobile to front door. Remains hypotensive NEWS 3 and 2 Patient feels well all other obs stable. Medics have not been to	

NHS GREATER GLASGOW & CLYDE



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

CLINICAL NOTES - NURSING

Date & Time		Signature, Print Name & Designation
cont	reviewed patient. Medical ward contacted and no ward rounds at the weekend. Reading from notes on 30/08/15. patient not for enema until medics have reviewed abdo xray. No complaints of sickness patient in good spirits this afternoon. no complaints offered.	V. PATTERSON V. Patterson V. Patterson
11:21:15	Notes taken	
01:00	Voiding urine spontaneously. (meds. 04:15)	
	BOWEL HAVE MOVED - REUSED LAXIDOL	
	SENA TAKEN	
	WELL MOBILE, INSURE MEDS. INTAKE	
	NEWS. SLIDE 1. PAIN NOTES BETWEEN	
	LIVING STANDING, BLOOD PRESSURE - (PATIENT)	
	ASYMPTOMATIC	
	MEDICATIONS GIVEN AS PRESCRIBED	E. BROWN
	SERIES AND SLEEPING AT (PATIENT)	E. Brown SD
07:00	SERIES EVENING, NO COMPLAINTS UNLESS	E. Brown SD
17:05	Pt independent with personal care	
	Voiding urine spontaneously	
	Reports having small bowel movements - continues on Laxido.	
	Obs stable. Little deficit in L+S BP - Apyrexia	

Date & Time		Signature, Print Name & Designation
	GD good amounts. No complaints of pain/fracture. Independently mobile. Awaiting medicals to receive another pt however on call medic does not think she will be received today as there is not normally a ward round at weekends.	L. Maclean L. Maclean (N)
21/11/15	Fluorid / HED taken	
03 ⁰⁰	Widely awake spontaneously, refuses STRA TONIC - HED taken fully mobile, measure ment 147mm NEWS score 0 whilst lying down DECI notes in BP whilst standing - ADDITIONAL medications given to measures sleeping at time of waking TRANSDOL given 40 pain Patient has own supply of band-aids. PATCHES IN MANSBAG AND CHANGED THE PATCH ON 30/11/15 & PATCHES NOW LOOKS AWAY IN CONFINES ONLY WOUNDS AND PRESSURES ON ONLY HAND & HUMAN SH	
15 ³⁰	Independent with personal hygiene Plenty food & diet Bowels now active Mobile around ward Observation while receiving hypotensive Referred by medical reg can be discharged home on 3/1 pre-discharge. Referred to	E. Gorman

CLINICAL NOTES - NURSING



LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

[illegible]

G13 4NA

PATIENT CARE PLAN
CONFIDENTIAL

HOSP: GGH DATE OF ADMISSION: 7/6/15 WARD: 6A CHART NO: _____

This care plan has been discussed and agreed with the patient and/or main carer Yes ☐ No ☐ Date.....

[illegible]

DATE COMM	PATIENT'S PROBLEM (S)	ACTIL	INITIAL	REVIEW DATE	INITIAL	REVIEW DATE	INITIAL	REVIEW DATE	INITIAL	DATE DISC	INITIAL
4. MOBILISING											
GOAL: Prevention and/or early detection of complications of immobility ☐											
	A. Patient has reduced mobility due to	Assess risk of venostasis	☐								
		Measure and apply anti-embolic stockings (if applicable)	☐								
		Encourage passive/active limb exercises	☐								
GOAL: Promote safe and effective mobility ☐											
	B. Assistance required with mobility due to	Transfer Requirements:									
		Assistance required with nurses	☐								
		Walking stick x 1	☐								
		Walking stick x 2	☐								
		Crutches	☐								
		Pulpit	☐								
		Zimmer	☐								
		Standing aid	☐								
		Dextra Lift	☐								
		Maxi Hoist	☐								
		Mobilising Requirements:									
		Assistance required with nurses	☐								
		Walking stick x 1	☐								
		Walking stick x 2	☐								
		Crutches	☐								
		Pulpit	☐								
		Zimmer	☐								
		Standing aid	☐								
		Dextra Lift	☐								
		Maxi Hoist	☐								
5. PERSONAL DRESSING AND CLEANSING											
GOAL: All personal hygiene requirements will be met ☐ Promote and encourage independence ☐ Maintain privacy ☐											
	Patient is unable to maintain personal hygiene due to	Bed Bath Please specify frequency:	☐								
		Daily ☐ Twice Daily ☐ Other ☐ Specify:									
		Assisted Wash Please specify frequency:	☐								
		Daily ☐ Twice Daily ☐ Other ☐ Specify:									
		Assistance Req'd:									
		Assisted Shower/Immersion Bath	☐								
		Daily ☐ Twice Daily ☐ Other ☐ Specify:									
		Assistance Req'd:									
		Independent and Self-Caring	☒	SA	312						
		Oral/Denture Care - Please specify frequency:	☐								
		Eye care - Please specify frequency:	☐								
		Nail care - Please specify frequency:	☐								
		Podiatry referral	☐								

26
1
K

DATE COMM	PATIENT'S PROBLEM(S)	INITIAL	REVIEW DATE	REVIEW DATE	INITIAL	REVIEW DATE	INITIAL	DATE DISC	INITIAL	
6. BREATHING										
GOAL: Early detection and treatment of deterioration in condition ☐ Safe and effective administration of oxygen ☐										
26 1/15	Patient unable to maintain adequate oxygenation due to:	Support patient's position for maximum expansion of chest	☐							
		Record respiration rate	☒	SL	312					
		Specify frequency AS NEWS								
		Monitor & record O ₂ saturation on observation chart	☒	S	312					
		Specify frequency AS NEWS								
		Administer oxygen therapy as prescribed	☐							
		Maintain safety issues with oxygen delivery	☐							
		Encourage deep breathing exercises	☐							
		Encourage coughing & expectoration	☐							
		Note colour, amount & consistency of sputum	☐							
Administer mouth and nasal care (where applicable)	☐									
		☐								
		☐								
7. CONTROLLING BODY TEMPERATURE (AND HAEMODYNAMICS)										
GOAL: Early detection and treatment of haemodynamic instability ☐										
26 1/15	A. Patient potentially haemodynamically unstable due to:	Monitor and record blood pressure	☒	SL	312					
		Specify frequency AS NEWS								
		Monitor and record pulse	☒	SL	312					
		Specify frequency AS NEWS								
		Inform medical staff of any significant changes	☒	S	312					
			☐							
		☐								
GOAL: Early detection and treatment of any dysrhythmias ☐										
	B. Patient has potential for cardiac dysrhythmias due to:	Monitor ECG continuously	☐							
		Maintain integrity of ECG electrodes	☐							
		Record rate & rhythm in appropriate chart	☐							
		Specify frequency								
		Inform medical staff of any significant changes	☐							
			☐							
GOAL: Early detection and treatment of high temperature disturbance ☐										
26 1/15	C. Patient has high temperature disturbance due to:	PYREXIA	☐							
		Monitor tympanic/peripheral temperature	☒	SL	312					
		Specify frequency AS NEWS								
		Administer tepid sponge therapy (if appropriate)	☐							
		Obtain blood cultures if temp $\geq 38^{\circ}\text{C}$	☐							
			☐							

[illegible]

ADULTS
≥ 18 YEARS

Nutrition Risk Score

Complete **ON ADMISSION AND WEEKLY** if patient's condition changes.

	DATE	HEIGHT (CM)	WEIGHT (KG)	BMI	COMMENTS
On Admission:					
Week 1:					
Week 2:					
Week 3:					
Week 4:					

A. Please circle relevant score. B. Only select one score from each section.

C. Select the highest score that applies.

SCORE

		On Admission	Reassessment		
1	WEIGHT LOSS IN LAST 3 MONTHS (unintentional)				
	▪ No weight loss	0	0	0	0
	▪ 0 – 3 kg weight loss	1	1	1	1
	▪ 3 – 6 kg weight loss	2	2	2	2
	▪ 6 kg or more	3	3	3	3
2	BMI - BODY MASS INDEX				
	▪ 20 or more	0	0	0	0
	▪ 18 or 19	1	1	1	1
	▪ 15 – 17	2	2	2	2
	▪ Less than 15	3	3	3	3
3	APPETITE				
	▪ Good appetite, manages most of 3 meals / day (or equivalent)	0	0	0	0
	▪ Poor appetite, poor intake – leaving > half of meals provided (or equivalent)	2	2	2	2
	▪ Appetite nil or virtually nil, unable to eat, NBM (for > 4 meals)	3	3	3	3

SCORE

ABILITY TO EAT / RETAIN FOOD / STATE OF HYDRATION

▪ No difficulties eating, able to eat independently/ tolerating enteral feeds. No diarrhoea or vomiting / well hydrated.	0	0	0	0
▪ Problems handling food e.g. needs special cutlery. Vomiting / frequent regurgitation (or possetting) mild diarrhoea	1	1	1	1
▪ Difficulty swallowing, requiring modified consistency. Problems with dentures, affecting food intake. Problems with chewing, affecting food intake. Problems tolerating enteral feeds. Moderate vomiting and / or diarrhoea (1-2 / day). Needs help with feeding (e.g. physical handicap).	2	2	2	2
▪ Unable to take food orally. Unable to swallow (complete dysphagia). Severe vomiting and / or diarrhoea (>2 / day). Malabsorption, Dehydrated.	3	3	3	3

STRESS FACTOR

▪ No Stress Factor - (includes admission for investigation only)	0	0	0	0
▪ Mild - Minor surgery. Minor infection. CVA	1	1	1	1
▪ Moderate - Chronic disease, major surgery, infections, fractures, pressure sores/ulcers, inflammatory bowel disease. Other gastrointestinal disease	2	2	2	2
▪ Severe - Multiple injuries, multiple fractures/burns, multiple deep pressure sores/ulcers, severe sepsis, carcinoma / malignant disease.	3	3	3	3

SCORE TOTALS

SCORE
0-3

LOW RISK

ACTION
 ▪ No action necessary
 ▪ Check weight weekly

SCORE
4-5

NEEDS MONITORING

ACTION
 ▪ Check weight weekly
 ▪ Encourage eating & drinking
 ▪ Replace missed meals with snacks e.g. sandwiches, crackers/cheese, pancakes, yoghurts, full cream milk
 ▪ Record patients dietary intake on food diet chart
 ▪ Repeat score after one week (ask medical staff to refer patient to dietitian if no improvements)

SCORE
6-15

HIGH RISK

ACTION
 ▪ Refer patient to dietitian

ALSO REFER TO DIETITIAN IF:

- The patient needs a special diet not available on normal menu
- The patient needs advice about a special diet
- Patient needs a therapeutic diet not available on the normal menu
- The patients needs specific advice (as requested by medical staff)

Contact the catering department if : The patient is following a special diet e.g. Muslim/vegetarian



DATE COMM	PATIENT'S PROBLEM (S)	INITIAL	REVIEW DATE	REVIEW DATE	INITIAL	REVIEW DATE	INITIAL	DATE DISC	INITIAL
GOAL: Maintain blood sugar levels within normal limits ☐									
	D. Patient may have blood sugar problems due to	Check blood sugar levels ☐							
		Specify frequency							
		Check urinalysis ☐							
		Specify frequency							
		Record results in diabetic chart ☐							
		Refer to Diabetic Nurse Specialist ☐							
9. ELIMINATING									
GOAL: Early detection and treatment of reduced urinary output ☐ Maintain urinary continence and skin integrity ☐ Safe and effective care of indwelling catheter ☐									
Prevention and treatment of urinary infection ☐									
	A. Patient has reduced urinary output due to	Maintain adequate fluid balance ☐							
		Observe for signs of urinary retention, infection ☐							
		Insertion of urinary catheter ☐							
		Catheter type: ☐ Catheter size: ☐	Comments:						
		Balloon size: ☐ H ₂ O in balloon: ☐							
		Date inserted: ☐ Due changed: ☐							
	B. Catheterised due to:	Serial No: ☐							
		Observe urinary output ☐							
		Hourly ☐ 4hrly ☐ Free drainage ☐							
	C. Patient has dysfunctional bladder problems due to	Catheter hygiene ☐							
		Adhere to hospital indwelling catheter policy ☐							
		Educate patient about self-catheter care (if applicable) ☐							
		Send MSSU or CSU to microbiology ☐							
		Remove catheter ☐							
		Complete voiding trial and record outcome ☐							
		Bladders scan to be performed on ☐							
		Observe post residual volumes ☐							
		☐							
		☐							
GOAL: Regain regular bowel pattern ☐ Maintain bowel continence and skin integrity ☐									
	D. Patient has dysfunctional bowel problems due to	CONSTIPATION							
		Encourage oral fluids to maintain hydration ☐							
		Encourage high fibre nutritional input ☐							
		Offer oral aperients/suppositories/enema (if applicable) ☐							
		Record bowel function on observation chart ☐							
		☐							
		☐							
		DIARRHOEA							
		Encourage oral fluids to maintain hydration ☐							
		Observe consistency of diarrhoea ☐							
		Send stool sample to microbiology ☐							
		Adhere to hospital infection control policy (if applicable) ☐							
		☐							
		☐							

[illegible]

[illegible]

[illegible]

Cannard Falls Risk Assessment Pack

Patient name:	1908546042	
Ward:	LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD	F 19/08/1954
CHI number:	Glasgow, Lanarkshire	Unit/Hospital number
	G13 4NA	

Contents

1. Cannard Falls Risk Assessment Scoring Form
2. Falls Assessment Care Plan
3. Glossary of terms used in risk assessment

Notes: Risk assessment should be completed within 24 hours of admission to each ward.

Assessment Wards: Risk assessment and care plan should be reviewed weekly.

Continuing Care Wards: Risk assessment and care plan reviewed monthly.

Referral Criteria for Hospital Falls Prevention Co-ordinator

1. Cannard score of 18+.
2. Second or subsequent fall
3. Significant Injury caused by a fall. (Significant Injury defined as any fracture, significant bruising or laceration to head or body.)

The patient should be referred with any of the above criteria.

General Safety Precautions

- Ensure patient has buzzer to hand
- Check patient has the manual dexterity and cognitive ability to operate buzzer
- Place personal items within easy reach
- Keep the bed in lowest position possible (use low bed if available)
- DO NOT leave patients with cognitive impairment unattended on commodes, in toilets, baths and showers.
- Patients with poor mobility, who are known not to ask for assistance, should not be left unattended on commodes, toilets, baths and showers.
- If noted that mobility / transfers are unsafe refer to physio / OT for assessment
- If patient wears glasses, ensure they are clean
- Ensure patient's footwear is adequate
- Lock wheels on all wheelchairs, beds, commodes and trolleys when in use
- Provide adequate lighting at night
- Request medication review if appropriate
- Clean up spills immediately
- Orientate patient to the ward environment

Cannard Falls Risk Assessment

(Must be completed within 24 hours of admission to each ward)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION				Date: <u>21/11/14</u>	Date: <u>21/11/14</u>	Date: <u>21/11/14</u>	Date: <u>21/11/14</u>	Date: <u>21/11/14</u>	Date: <u>21/11/14</u>
				Ward: <u>W4M</u>	Ward:	Ward:	Ward:	Ward:	Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0						
Sex	Male 1	Female 2							
Age	13-59 0	60-70 1	71-80 2	81+ 1					
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0					
Medication type	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0					
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1				
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound / wheel-chair 1					
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3					
TOTAL SCORE				8					
ACTION(S) TAKEN Enter action code(s) from Care Plan below				1, 3, 5					
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				AC					

Please see back page for glossary of terms relating to the assessment above.

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

WRITE, IMPR



Surname 1908546042
 Forenames Logan, Georgina F
 DoB 19/08/1954
 Location 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA

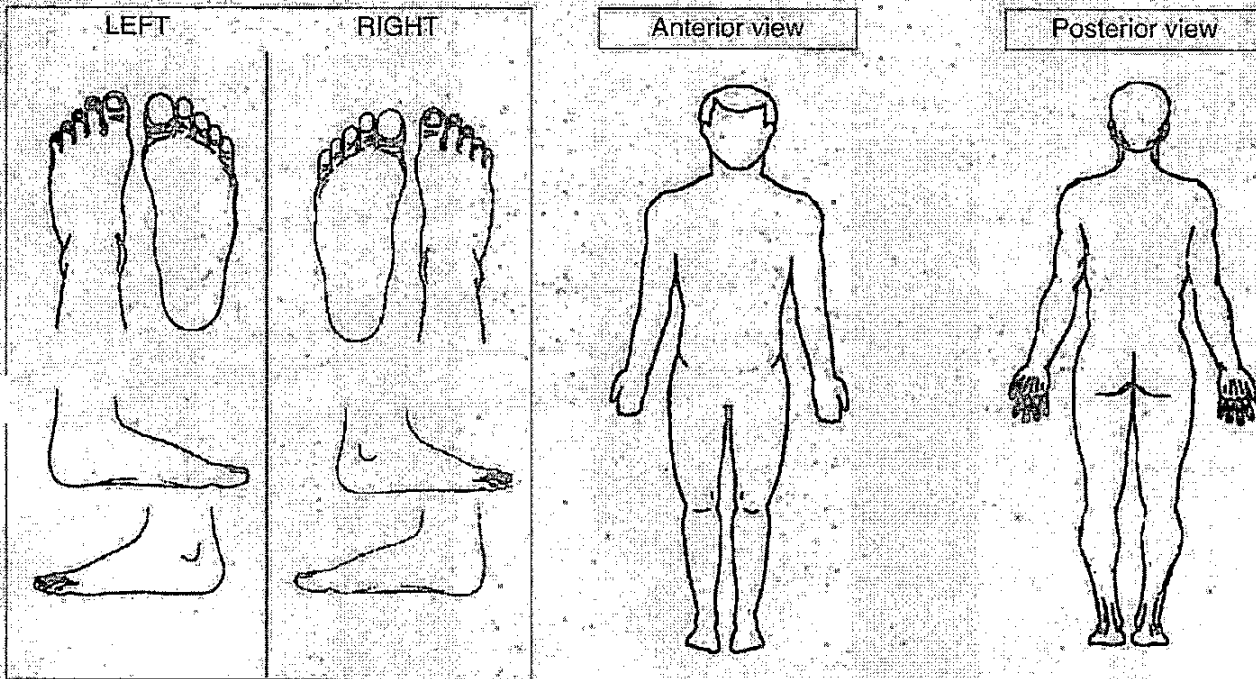
More than one score/category can be used: 10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'
Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

[illegible]

Ensure plan of care is implemented / reviewed for all identified areas of concern.

PRESSURE ULCER RECORD

Indicate by circling and numbering all pressure damage on diagrams, then complete box below.
Indicate care plan/wound assessment chart.



SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

- GRADE 1** Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.
- GRADE 2** Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.
- GRADE 3** Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.
- GRADE 4** Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

DATE	NUMBER OF ULCER(S)	LOCATION OF ULCER(S)	GRADE OF ULCER(S)	LOCATION OF ULCER(S)

Pressure Ulcers may deteriorate from Grade 1 to Grade 4, but can not be reversed and should be documented as a healing grade of pressure ulcer, eg healing grade 4.

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: 25/11	Date:	Date:	Date:	Date:	Date:	Date:
		Ward: 11	Ward:	Ward:	Ward:	Ward:	Ward:	Ward:
1	Falls prevention and general safety precautions discussed with patient and family.	✓						
2	Move to more observable area of ward to optimise supervision.							
3	Advise patient they may experience dizziness when they mobilise initially.	✓						
4	Requires assistance with mobilisation.							
5	Observe trip hazard due to invasive lines, drains and catheters.	✓						
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.							
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
8	Monitor lying and standing / sitting BP and pulse.							
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested:) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment; follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair / floor following advice from therapists.							
14	Refer to Physiotherapist.							
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy).							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).							
23	Other interventions.							
		AC						

Review Cannard score weekly / monthly as per policy. Enter action code(s) selected in action taken section on Falls Risk Assessment page above.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

SIGHT DEFICIT means patient cannot see well even when wearing glasses or is registered blind.

HEARING DEFICIT means person has hearing problems even with a hearing aid or has hearing problems and does not wear a hearing aid.

BALANCE DEFICIT means person is unable to stand without the support of another person or a walking frame.

MEDICINES FOR SOME MENTAL ILLNESSES include Chlorpromazine (Largactil), Risperidone (Risperdal), Lithium (Camcolit or Priadel), Haloperidol, Chloral hydrate (Welldorm), Clomethiazole (Heminevrin), antidepressants, Diazepam, Lorazepam and Amitriptyline.

CARDIOVASCULAR SYSTEM MEDICATION all antihypertensive medication and inotropes including Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilorfruse.

SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycotin.

INABILITY TO CO-OPERATE includes failure to use walking aids or putting themselves in situations with a high risk of falling (usually due to mental impairment).

RESTRICTED MOBILITY means the person requires supervision and/or help to walk (i.e. is not safe to walk alone even with an aid).

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

POOR TRANSFER means the person requires help and is not safe to do the following alone - get in or out of bed, on or off a chair, move from chair to standing.

NEWS – National Early Warning Score



Name
Address

CHI No.
DoB

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

19/08/1954

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1-4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE: 25.1.15														DATE		NEW	
TIME: 00:00 04:00 08:00 12:00 16:00 20:00 24:00														TIME		0 1	
Resp. Rate	35													35			
	30													30			
Rate	25													25			
	20													20			
Mark: *	16													16			
	12													12			
SpO ₂	≥96													≥96			
	94-95													94-95			
(Enter Value)	92-93													92-93			
	≤91													≤91			
Any Sup'l O ₂	%													%			
	Room air													Room air			
Temp.	39°													39°			
	38.5°													38.5°			
Mark: X	38°													38°			
	37.5°													37.5°			
Pulse	37°													37°			
	36.5°													36.5°			
Mark: •	36°													36°			
	35.5°													35.5°			
Blood Pressure	170													170			
	160													160			
Mark: •	150													150			
	140													140			
NEWS SCORE using Systolic BP	130													130			
	120													120			
Conscious Level	110													110			
	100													100			
Mark: •	90													90			
	80													80			
Total NEWS (with all obs)	70													70			
	60													60			
BM	50													50			
	40													40			
Pain	30													30			
	20													20			
Nausea	10													10			
	0													0			
Urine output																	
Obs. due																	
Initials																	

DATE	TIME	Resp. Rate	SpO ₂	Temp.	Pulse	Blood Pressure	Alert	Verbal	Unresp	NEWS SCORE	BM	Pain	Nausea	Input	Obs due	Initials
3/1	09	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	10	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	11	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	12	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	13	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	14	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	15	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	16	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	17	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	18	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	19	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	20	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	21	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	22	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	23	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	24	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	25	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	26	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	27	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	28	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	29	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	30	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	31	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	32	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	33	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	34	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	35	12	96	36.5	90	108/68	✓	✓	✓	2	✓	0	0	✓	10:00	MM
3/1	36	12	96	36.5	90											

[illegible]

Pupil size (mm)

1

10

2

”

10

10

7

8

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

0	= None
1	= Mild (Not distressing – no retching/vomiting)
2	= Moderate (Troublesome – occasional retching/vomiting)
3	= Severe (Distressing – frequent retching/vomiting)

[illegible]

NEWS – National Early Warning Score



Name: *Gillian Logan*
 Address: *AFDIX*
PATIENT
 CHI No. *ID*
 DoB:

	Date	Ward
Admitted		
Transferred		
Transferred		

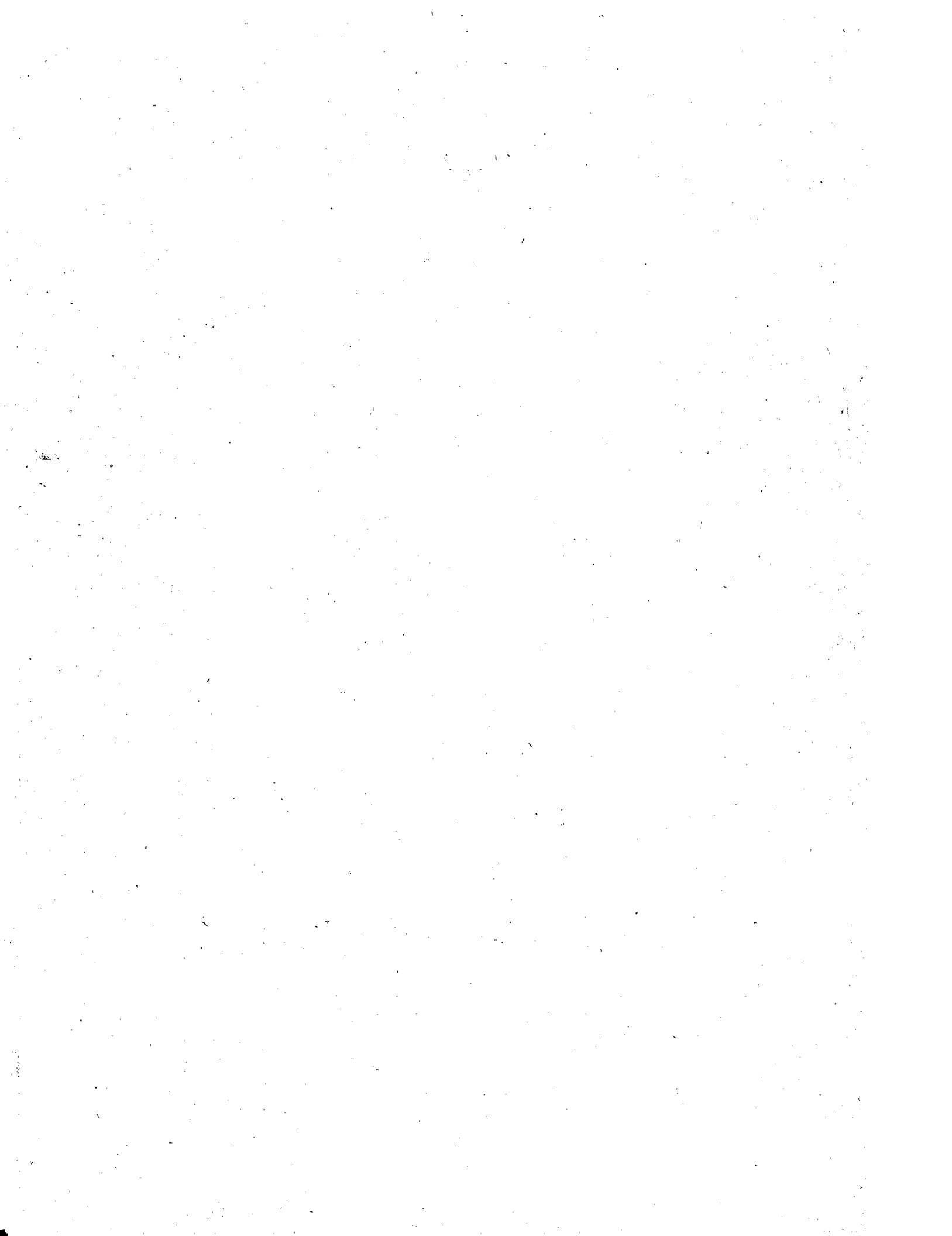
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1-4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE		TIME		NEWS	
DATE	TIME	0	1	0	1
1/2	10:00				
1/2	10:30				
1/2	11:00				
1/2	11:30				
1/2	12:00				
1/2	12:30				
1/2	13:00				
1/2	13:30				
1/2	14:00				
1/2	14:30				
1/2	15:00				
1/2	15:30				
1/2	16:00				
1/2	16:30				
1/2	17:00				
1/2	17:30				
1/2	18:00				
1/2	18:30				
1/2	19:00				
1/2	19:30				
1/2	20:00				
1/2	20:30				
1/2	21:00				
1/2	21:30				
1/2	22:00				
1/2	22:30				
1/2	23:00				
1/2	23:30				
1/2	24:00				
1/2	24:30				
1/2	25:00				
1/2	25:30				
1/2	26:00				
1/2	26:30				
1/2	27:00				
1/2	27:30				
1/2	28:00				
1/2	28:30				
1/2	29:00				
1/2	29:30				
1/2	30:00				
1/2	30:30				
1/2	31:00				
1/2	31:30				
1/2	32:00				
1/2	32:30				
1/2	33:00				
1/2	33:30				
1/2	34:00				
1/2	34:30				
1/2	35:00				
1/2	35:30				
1/2	36:00				
1/2	36:30				
1/2	37:00				
1/2	37:30				
1/2	38:00				
1/2	38:30				
1/2	39:00				
1/2	39:30				
1/2	40:00				
1/2	40:30				
1/2	41:00				
1/2	41:30				
1/2	42:00				
1/2	42:30				
1/2	43:00				
1/2	43:30				
1/2	44:00				
1/2	44:30				
1/2	45:00				
1/2	45:30				
1/2	46:00				
1/2	46:30				
1/2	47:00				
1/2	47:30				
1/2	48:00				
1/2	48:30				
1/2	49:00				
1/2	49:30				
1/2	50:00				
1/2	50:30				
1/2	51:00				
1/2	51:30				
1/2	52:00				
1/2	52:30				
1/2	53:00				
1/2	53:30				
1/2	54:00				
1/2	54:30				
1/2	55:00				
1/2	55:30				
1/2	56:00				
1/2	56:30				
1/2	57:00				
1/2	57:30				
1/2	58:00				
1/2	58:30				
1/2	59:00				
1/2	59:30				
1/2	60:00				
1/2	60:30				
1/2	61:00				
1/2	61:30				
1/2	62:00				
1/2	62:30				
1/2	63:00				
1/2	63:30				
1/2	64:00				
1/2	64:30				
1/2	65:00				
1/2	65:30				
1/2	66:00				
1/2	66:30				
1/2	67:00				
1/2	67:30				
1/2	68:00				
1/2	68:30				
1/2	69:00				
1/2	69:30				
1/2	70:00				
1/2	70:30				
1/2	71:00				
1/2	71:30				
1/2	72:00				
1/2	72:30				
1/2	73:00				
1/2	73:30				
1/2	74:00				
1/2	74:30				
1/2	75:00				
1/2	75:30				
1/2	76:00				
1/2	76:30				
1/2	77:00				
1/2	77:30				
1/2	78:00				
1/2	78:30				
1/2	79:00				
1/2	79:30				
1/2	80:00				
1/2	80:30				
1/2	81:00				
1/2	81:30				
1/2	82:00				
1/2	82:30				
1/2	83:00				
1/2	83:30				
1/2	84:00				
1/2	84:30				
1/2	85:00				
1/2	85:30				
1/2	86:00				
1/2	86:30				
1/2	87:00				
1/2	87:30				
1/2	88:00				
1/2	88:30				
1/2	89:00				
1/2	89:30				
1/2	90:00				
1/2	90:30				
1/2	91:00				
1/2	91:30				
1/2	92:00				
1/2	92:30				
1/2	93:00				
1/2	93:30				
1/2	94:00				
1/2	94:30				
1/2	95:00				
1/2	95:30				
1/2	96:00				
1/2	96:30				
1/2	97:00				
1/2	97:30				
1/2	98:00				
1/2	98:30				
1/2	99:00				
1/2	99:30				
1/2	100:00				
1/2	100:30				
1/2	101:00				
1/2	101:30				
1/2	102:00				
1/2	102:30				
1/2	103:00				
1/2	103:30				
1/2	104:00				
1/2	104:30				
1/2	105:00				
1/2	105:30				
1/2	106:00				
1/2	106:30				
1/2	107:00				
1/2	107:30				
1/2	108:00				
1/2	108:30				
1/2	109:00				
1/2	109:30				
1/2	110:00				
1/2	110:30				
1/2	111:00				
1/2	111:30				
1/2	112:00				
1/2	112:30				
1/2	113:00				
1/2	113:30				
1/2	114:00				
1/2	114:30				
1/2	115:00				
1/2	115:30				
1/2	116:00				
1/2	116:30				
1/2	117:00				
1/2	117:30				
1/2	118:00				
1/2	118:30				
1/2	119:00				
1/2	119:30				
1/2	120:00				
1/2	120:30				
1/2	121:00				
1/2	121:30				
1/2	122:00				
1/2	122:30				
1/2	123:00				
1/2	123:30				
1/2	124:00				
1/2	124:30				
1/2	125:00				
1/2	125:30				
1/2	126:00				
1/2	126:30				
1/2	127:00				
1/2	127:30				
1/2	128:00				
1/2	128:30				
1/2	129:00				
1/2	129:30				
1/2	130:00				
1/2	130:30				
1/2	131:00				
1/2	131:30				
1/2	132:00				
1/2	132:30				
1/2	133:00				
1/2	133:30				
1/2	134:00				
1/2	134:30				
1/2	135:00				
1/2	135:30				
1/2	136:00				
1/2	136:30				
1/2	137:00				
1/2	137:30				
1/2	138:00				
1/2	138:30				
1/2	139:00				



[illegible]



NHS Greater Glasgow and Clyde Active Care Checklist

Date: 28/1/15

Attach Addressograph label

Georgina Logan
17 Sallas Place
Knightswood.

Ward: 66

NHS
Greater Glasgow
and Clyde

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 **6r**

1. Signed K. G. S. K. Name K. G. S. K. Designation SN

2. Signed [Signature] Name K. WILKINSON Designation S/N

3. Signed _____ Name _____ Designation _____

Individual patient needs: Red mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

[illegible]

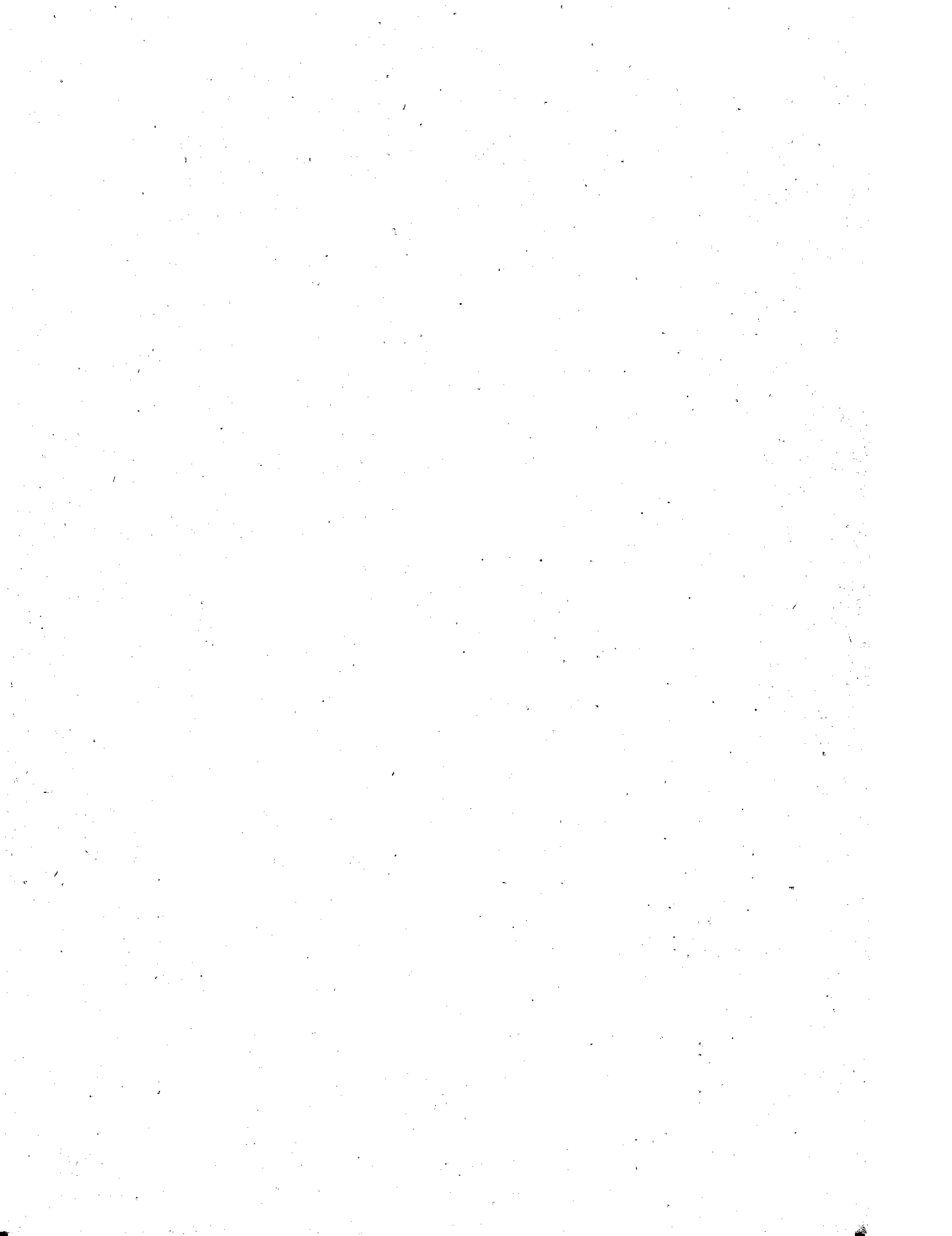


Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Specialist Pressure Redistributing equipment ordered and in place:

Attach Addressograph label



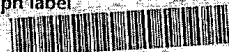
NHS Greater Glasgow and Clyde Active Care Checklist

Date: 7/1/15

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 (6r)

1. Signed SL Name SGM Designation SL
2. Signed mmaclean Name mmaclean Designation SN
3. Signed SL Name SGM Designation SL

Attach Addressograph label



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Individual patient needs: Red-mat required: Y / N Bed rails: Y / N
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

[illegible]

Active Care variant sheet - Care Number

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

Specialist Pressure Redistributing equipment ordered and in place:

Attach Addressograph label





Date: 3/1/15



Attach Address _____



1908546042

LOGAN

Georgina
17, SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshi

19/08/1954

G13.4NA

1. Signed  Name: E. B. Brown Designation: JN

2. Signed  Name: M. M. Brown Designation: JN

3. Signed  Name: E. B. Brown Designation: JN

Individual patient needs: Red mat required: Y / (N) Bed rails: Y (N)
Must do's for me. Ask the patient if there is anything they want specifically done today:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

[illegible]

Ward:



Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

[illegible]

MIS 258902

NHS Greater Glasgow and Clyde Active Care Checklist

Date: 2/2/15

Attach Addressograph label:



Georgina Logan
190826042

Ward: CB

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 6hr

1. Signed L Maclean Name L Maclean Designation SW
2. Signed E Logan Name E Logan Designation SW
3. Signed L Maclean Name L Maclean Designation SW

Individual patient needs: Red mat required: Y/(N) Bed rails: Y/(N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

		Times	12	13	14	15	16	17	18	19	20	21	22	23	24
1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	W	Y	S	S	L							
2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	I	I	S	S	I							
	Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		I	I	I	S	S	I							
3.	KEEP MOVING: Have you moved or walked Y / N / I (Independent)		I	I	I	S	S	I							
	Bed Right side (30° tilt) - R Left Side (30° tilt) - L Back- B		I	I	I	S	S	I							
	Chair Assist to walk, stand or tilt (W / ST / T)		I	I	I	S	S	I							
4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I	S	S	I							
5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	S	S	N							
	Encourage the patient to drink? Y / N / N/A		Y	Y	Y	S	S	Y							
	Food, snack or supplement taken? Y / N / N/A		Y	Y	N	S	S	Y							
6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y	Y	Y							
7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return: Y/N/O/S		Y	Y	N	S	S	N							
8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		N/A	N/A	N/A	S	S	N/A							
	Nurse Initials		W	Y	CF	GB	CB	W							

Ward:



Dynamic Mattress:	
Cushion:	
Orthotic footwear:	
Moving & handling aids:	
Other:	

1. Pain
2. A / B Skin Inspection
3. A/B/C Keep Moving
4. Elimination
5. Food, Fluid, Nutrition
6. Environment
7. Information
8. Escalation

[illegible]

41525802

Hospital Name:

Height:	
Weight:	
Surface area:	
Ward:	

		DATE																
		MONTH																
		RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y/N																		
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y/N																		
SIGNATURE OF ASSESSOR																		
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																		
Parenteral Drugs : Regular Prescription																		
BEFORE ADMISSION ☐	NEW DOSE ☐	NEW MEDICATION ☐	A DRUG		Other time											Patient's Own Medicine For Use: Y/N Qty: Date: Assessed by: Ordered from Pharm:		
			DOSE	ROUTE	DATE	DATE:												
			PRESCRIBER (PRINT & SIGN)				STOPPED											
							INITIALS:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
☐	☐	☐	B DRUG		Other time											For Use: Y/N Qty: Date: Assessed by: Ordered from Pharm:		
			DOSE	ROUTE	DATE	DATE:												
			PRESCRIBER (PRINT & SIGN)				STOPPED											
							INITIALS:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
☐	☐	☐	C DRUG		Other time											For Use: Y/N Qty: Date: Assessed by: Ordered from Pharm:		
			DOSE	ROUTE	DATE	DATE:												
			PRESCRIBER (PRINT & SIGN)				STOPPED											
							INITIALS:											
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE
MONTH

Parenteral Drugs: Regular Prescription				DATE MONTH													Patient's Own Medicine	
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	D	DRUG		Other time													For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
		DOSE	ROUTE	DATE	DATE:													
		PRESCRIBER (PRINT & SIGN)			INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time													
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	E	DRUG		Other time													For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
		DOSE	ROUTE	DATE	DATE:													
		PRESCRIBER (PRINT & SIGN)			INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time													
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	F	DRUG		Other time													For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
		DOSE	ROUTE	DATE	DATE:													
		PRESCRIBER (PRINT & SIGN)			INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time													
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	G	DRUG		Other time													For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
		DOSE	ROUTE	DATE	DATE:													
		PRESCRIBER (PRINT & SIGN)			INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			Other time													

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

[illegible]

[illegible]

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

[illegible]

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE		MONTH		DAY		YEAR		PATIENT'S OWN MEDICINE	
BEFORE ADMISSION	☐	CC	DRUG	Amoxicillin	ROUTE	PO	DATE	2/28/10	STOPPED
NEW DOSE	☐	DOSE	500 mg	PRESCRIBER (PRINT & SIGN)	MC	DATE			INITIALS
NEW MEDICATION	☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY							
DATE	2/28/10	1200-1400	1400-1800	1800-2200	2200-2400	0700-0900	0900-1200	1200-1400	1400-1600
1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30	30	30	30	30
31	31	31	31	31	31	31	31	31	31
32	32	32	32	32	32	32	32	32	32
33	33	33	33	33	33	33	33	33	33
34	34	34	34	34	34	34	34	34	34
35	35	35	35	35	35	35	35	35	35
36	36	36	36	36	36	36	36	36	36
37	37	37	37	37	37	37	37	37	37
38	38	38	38	38	38	38	38	38	38
39	39	39	39	39	39	39	39	39	39
40	40	40	40	40	40	40	40	40	40
41	41	41	41	41	41	41	41	41	41
42	42	42	42	42	42	42	42	42	42
43	43	43	43	43	43	43	43	43	43
44	44	44	44	44	44	44	44	44	44
45	45	45	45	45	45	45	45	45	45
46	46	46	46	46	46	46	46	46	46
47	47	47	47	47	47	47	47	47	47
48	48	48	48	48	48	48	48	48	48
49	49	49	49	49	49	49	49	49	49
50	50	50	50	50	50	50	50	50	50
51	51	51	51	51	51	51	51	51	51
52	52	52	52	52	52	52	52	52	52
53	53	53	53	53	53	53	53	53	53
54	54	54	54	54	54	54	54	54	54
55	55	55	55	55	55	55	55	55	55
56	56	56	56	56	56	56	56	56	56
57	57	57	57	57	57	57	57	57	57
58	58	58	58	58	58	58	58	58	58
59	59	59	59	59	59	59	59	59	59
60	60	60	60	60	60	60	60	60	60
61	61	61	61	61	61	61	61	61	61
62	62	62	62	62	62	62	62	62	62
63	63	63	63	63	63	63	63	63	63
64	64	64	64	64	64	64	64	64	64
65	65	65	65	65	65	65	65	65	65
66	66	66	66	66	66	66	66	66	66
67	67	67	67	67	67	67	67	67	67
68	68	68	68	68	68	68	68	68	68
69	69	69	69	69	69	69	69	69	69
70	70	70	70	70	70	70	70	70	70
71	71	71	71	71	71	71	71	71	71
72	72	72	72	72	72	72	72	72	72
73	73	73	73	73	73	73	73	73	73
74	74	74	74	74	74	74	74	74	74
75	75	75	75	75	75	75	75	75	75
76	76	76	76	76	76	76	76	76	76
77	77	77	77	77	77	77	77	77	77
78	78	78	78	78	78	78	78	78	78
79	79	79	79	79	79	79	79	79	79
80	80	80	80	80	80	80	80	80	80
81	81	81	81	81	81	81	81	81	81
82	82	82	82	82	82	82	82	82	82
83	83	83	83	83	83	83	83	83	83
84	84	84	84	84	84	84	84	84	84
85	85	85	85	85	85	85	85	85	85
86	86	86	86	86	86	86	86	86	86
87	87	87	87	87	87	87	87	87	87
88	88	88	88	88	88	88	88	88	88
89	89	89	89	89	89	89	89	89	89
90	90	90	90	90	90	90	90	90	90
91	91	91	91	91	91	91	91	91	91
92	92	92	92	92	92	92	92	92	92
93	93	93	93	93	93	93	93	93	93
94	94	94	94	94	94	94	94	94	94
95	95	95	95	95	95	95	95	95	95
96	96	96	96	96	96	96	96	96	96
97	97	97	97	97	97	97	97	97	97
98	98	98	98	98	98	98	98	98	98
99	99	99	99	99	99	99	99	99	99
100	100	100	100	100	100	100	100	100	100

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription				DATE																									Patient's Own Medicine
				MONTH																									
BEFORE ADMISSION ☐	GG	DRUG <i>Paracetamol</i>		Other time																									
NEW DOSE ☐	DOSE <i>400</i>	ROUTE <i>PO</i>	DATE <i>2/2/15</i>	DATE: <i>0700-0900</i>																									
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) <i>Dr. M. S. 4/1/15</i>		STOPPED INITIALS:	1200-1400																									
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY <i>3/7</i>				1600-1800																									
				2200-2400																									
				Other time																									
BEFORE ADMISSION ☐	HH	DRUG		Other time																									For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE: 0700-0900																									Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:	1200-1400																									Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																									Assessed by
				2200-2400																									Ordered from Pharm.
				Other time																									
BEFORE ADMISSION ☐	JJ	DRUG		Other time																									For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE: 0700-0900																									Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:	1200-1400																									Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																									Assessed by
				2200-2400																									Ordered from Pharm.
				Other time																									
BEFORE ADMISSION ☐	KK	DRUG		Other time																									For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE: 0700-0900																									Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:	1200-1400																									Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																									Assessed by
				2200-2400																									Ordered from Pharm.
				Other time																									

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Patient's Own Medicine

BEFORE ADMISSION		LL		DRUG	GLYCERYL TRINITRATE	DATE	DATE													For Use Y/N
NEW DOSE		DOSE		ROUTE	INDICATION	INITIALS	TIME													Qty:
NEW MEDICATION		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE	DATE	DOSE													Date:
		N CHAN		PRN	25/1/15	DATE	GIVEN BY													Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														Ordered from Pharm:				
BEFORE ADMISSION		MM		DRUG	SALBUTAMOL	DATE	DATE													For Use Y/N
NEW DOSE		DOSE		ROUTE	INDICATION	INITIALS	TIME													Qty:
NEW MEDICATION		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE	DATE	DOSE													Date:
		N CHAN		PRN	25/1/15	DATE	GIVEN BY													Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														Ordered from Pharm:				
		100 MICROGRAM /PUKE																		
BEFORE ADMISSION		NN		DRUG	SUBCUTANEOUS PAIN	DATE	DATE													For Use Y/N
NEW DOSE		DOSE		ROUTE	INDICATION	INITIALS	TIME													Qty:
NEW MEDICATION		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE	DATE	DOSE													Date:
					25/1/15	DATE	GIVEN BY													Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														Ordered from Pharm:				
BEFORE ADMISSION		PP		DRUG	PREGABALIN	DATE	DATE													For Use Y/N
NEW DOSE		DOSE		ROUTE	INDICATION	INITIALS	TIME													Qty:
NEW MEDICATION		PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE	DATE	DOSE													Date:
		ON		PRN	25/1/15	DATE	GIVEN BY													Assessed by:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY														Ordered from Pharm:				
		300mcg																		

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

958546042

Name _____

Geometric Logarithm

Drug Allergies / Sensitivities

[illegible]

- Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

[illegible]

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
 2. All prescription entries must be legible and made so as to be indecipherable (black ink is recommended).
 3. Print & Sign your full name clearly against each prescription entry.
 4. Time should be recorded in 24hr format e.g. 0600, 1800.
 5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason:
 6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
 7. The following metric unit abbreviations must be used –
Milligram = mg Gram = g
Millilitre = ml Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**
- Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (o.g. 0.5ml **NOT** .5ml).
8. The route of administration can be abbreviated using the following -

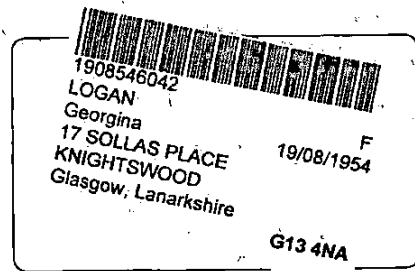
O = oral	ID = Intradermal
IM = Intramuscular	SL = sublingual
SC = subcutaneous	PR = per rectum
NG = nasogastric	PGR = percutaneous endoscopic gastrostomy
NV = per vagina	RIG = radiologically inserted gastrostomy
PJ = nasojejunosotomy	PEJ = percutaneous endoscopic jejunostomy
TOP = topical	ETT = endotracheal
NEB = nebulised	INHAL = inhaled
IV = Intravenous	
- Please note - Intra-thecal must be written in full.

FOR NURSES:

1. The 'Once only', 'Regular', and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

- | | | | |
|------------------------|--|---|---------------------------------------|
| ③ Patient refused | ⑦ Patient asleep | ⑪ Unable to swallow | ⑭ Other - Record in nursing notes |
| ④ Drug not available | ⑧ Time varied on doctor's instructions | ⑫ No Intravenous access | ⑮ Prescription clarification required |
| ⑤ Nil by mouth/fasting | ⑨ Dose withheld on doctor's instructions | ⑬ Patient Self-Administration of Medicine | |
| ⑥ Patient unavailable | ⑩ Nausea/vomiting | | |

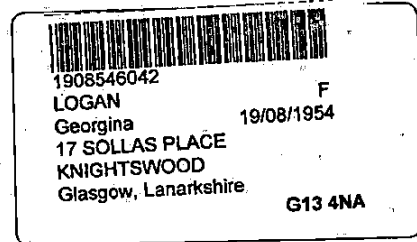


Nurses notes

16/01/21 Attended for covid test Temp 35.9
answered no to all first line questions
COVID swabs taken advised to self isolate
until after procedure. Pt has lost her instructions
+ Klean Prep in her house and said Klean prep
was making her sick last time + procedure
had to be cancelled. Given Movi prep +
new set of instructions. Pt vomited ≤ 20 mls
mucous/bile stained fluid before test and
attributed it to taking her tabs on an empty
stomach and being nervous about Covid test.
Nausea and wretching resolved before
leaving dept. SM *ElmChen*
LIZ M *Quade*



Greater Glasgow & Clyde Endoscopy Care Plan



Date: 6-11-15

Consultant / Endoscopist: Sr Wilkie

Patient liked to be known as: Gina

Procedure

Gastroscopy ☒ E.R.C.P ☐ EBUS ☐
Colonoscopy ☐ E.U.S ☐ Enteroscopy ☐
Sigmoidoscopy ☐ Bronchoscopy ☐ Thoracoscopy ☐

Discharge Arrangements

Name of Escort /contact Betty Graham	Escort Required Yes ☒ No ☐	Overnight supervision arranged Yes ☒ No ☐
Relationship Sister	Escort to be contacted Yes ☒ No ☐	Overnight stay in ward Yes ☐ No ☒
Contact tel no 07729941737		

Have you received Patient Information and understood it: Yes ☒ No ☐

Medical History and Pre Procedure check

Condition	Yes	No	Details
Diabetes		☒	Type 1 ☐ Type 2 ☐
Angina/ Ischaemic heart Disease	☒		Angina
Hypertension		☒	Date:
Myocardial Infarction		☒	
Artificial valves		☒	
Pacemaker		☒	
CABG		☒	
Coronary artery stent		☒	
Stroke/TIA		☒	
Asthma	☒		
COPD		☒	
Epilepsy		☒	
Liver disease		☒	
Arthritis	☒		both feet
Orthopaedic implants		☒	Specify:
Glaucoma		☒	
Anaemia		☒	
Recent surgery		☒	
Previous endoscopy		☒	
CJD/VCJD risk		☒	



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Presenting complaint	Yes	No	Detail if applicable
Reflux			
Dysphagia			
Barretts			
Oesophageal/Gastric Varices			
Gastric ulcer			
Altered bowel habit			
PR bleeding			
Crohns disease			
Ulcerative colitis			
Surveillance colonoscopy			
Screening programme			
Other:	✓		ABDOMINAL PAIN

Mobility AssessmentIndependent Yes ☒ No ☐Aids and/ or assistance required Yes ☐ No ☐Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ SpecifySight impairment Yes ☐ No ☐ If yes specify**Communication Needs**Hearing impairment Yes ☐ No ☒Hearing aid Yes ☐ No ☒ right ear ☐ left ear ☐ both ears ☐Sign Interpreter required Yes ☐ No ☒Lip reads Yes ☐ No ☒Interpreter Required Yes ☐ No ☒ LanguageInterpreter present Yes ☐ No ☒Relative / friend present Yes ☐ No ☒

The use of relatives and friends as interpreters is discouraged unless it is the patient's choice to use them.

Learning Disability Yes ☐ No ☒ Carer present Yes ☐ No ☒Dementia Yes ☐ No ☒ Incapacity form completed Yes ☐ No ☒

Current Medication (list below and tick those taken today)

morphine patch	✓	diazepam		buclosan	✓
buprenorphine patch	✓	metronidazole			
tramadol		loperamide			
amitriptyline		amoxicillin			
oxycodone		asacol	✓		

Anticoagulation therapy Yes ☐ No ☒ If yes current medication

When was this medication last taken Specify

INR Result



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F

19/08/1954

G13 4NA

Admission Observations

BP119/118.....Pulse75.....Oxygen Saturation96.9o.....

BM (if applicable)✓.....Respirations (if applicable)✓.....

Fasted since8am.....

Bowel prep	Please tick	No of sachets	Result good	Result poor
Not applicable	✓			
Klean prep				
Movi prep				
Enema at home				
Enema on arrival				
Picolax				
Fleet				

Patient requests	Please tick	IV Cannula inserted	Please tick	Time	Inserted by (please print)
Throat spray		Right hand			
IV Sedation	✓	Right arm	✓	14 20	J. Bartrop
No Sedation		Left hand			
Not applicable		Left arm			
		Other(specify)			

Dentures removed (if applicable) Yes ☒ No ☐ ~~TOP~~Crowns Yes ☐ No ☒ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐Bridgework Yes ☐ No ☒ upper ☐ lower ☐ front ☐ back ☐ R side ☐ L side ☐Identiband details checked Yes ☒ No ☐Consent form signed Yes ☒ No ☐Consent form countersigned Yes ☒ No ☐Underwear removed (if applicable) Yes ☐ No ☐Jewellery removed Yes ☐ No ☒Allergies Yes ☐ if yes detail below No ☒

Details

Name of Admission Nurse (Print)JONA BARTROP.....

Signature of Admission NurseJ. Bartrop.....



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Patient's Declaration

I have read and understood the warnings regarding the after effects of sedation.

Patient's signature g. Logan**Intra Procedure**Endoscopist(print) Sr W. L. C.Endoscopy Room Nurses (print) S. M. D. V. P. & M. BrownSurgical Pause carried out Yes ☒ No ☐**Medication Administered**

Drug	Yes	No	Time	Dose	Route
Xylocaine spray					
Midazolam	/		2 ³⁰ p.m.	3 mg	IV
Midazolam				mg	
Midazolam				mg	
Pethidine				mg	
Pethidine				mg	
Pethidine				mg	
Fentanyl				mcg	
Fentanyl				mcg	
Fentanyl				mcg	
Buscopan				mg	
Buscopan				mg	
Buscopan				mg	
Antibiotics					
				mg	
				mg	
				mg	
Reversal Agents					
				mg	
				mg	
Local anaesthetic					
				mg	
				mg	
Other					
Botox				mg	

Endoscopist Signature [Signature]Start Time 2³⁰ p.m. Finish Time 2³⁵ p.m.



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Patient position Left Lateral ☒ Supine ☐ Prone ☐ All ☐Oxygen therapy Yes ☒ No ☐ nasal sponge ☒ cannula ☐ mask ☐ rate 2 l/min**Observations during procedure**

Time	230 P -	235 P -	
Pulse	86 P	106 P	
SpO2	95.96	97.90	
BP	/	129/75	
Resps	/		

Procedure (please tick all relevant)

Gastroscopy	☒	Biopsy	☒	Varices	☐	Adrenaline	☐
Colonoscopy	☐	Hot Biopsy	☐	Gastric Ulcer	☐	Spot Dye	☐
Sigmoidoscopy	☐	Snare Polypectomy	☐	Duodenal Ulcer	☐	Indigo Carmine	☐
E.R.C.P.	☐	Balloon dilatation	☐	Oesophagus	☐	Gelofusine	☐
E.U.S	☐	Injection	☐	Duodenum	☐	Normal Saline	☐
Bronchoscopy	☐	Laser	☐	Biliary	☐	Haemospray	☐
E.B.U.S	☐	Heater Probe	☐	Pancreatic	☐		☐
Thoracoscopy	☐	Endo clip	☐	Haemorrhoids	☐		☐
Enteroscopy	☐	Insertion of Stent	☐	Rectum	☐		☐
	☐	EMR	☐	Sigmoid	☐		☐
	☐	PEG	☐	Descending	☐		☐
	☐	Needle Aspiration	☐	Splenic flexure	☐		☐
	☐	Brushings	☐	Transverse	☐		☐
	☐	Washings	☐	Hepatic flexure	☐		☐
	☐	Banding	☐	Ascending	☐		☐
	☐	Insert of NJ tube	☐	Caecum	☐		☐
	☐	Gastric Pacing Wire	☐	Terminal Ileum	☐		☐

LOT 518538



OLV_OIF-11260 2244022

Other

Sedation score	Tick	Comfort Score	Tick
Asleep	☐	None, resting comfortably	☐
Alert	☐	One or two episodes of mild discomfort, well tolerated	☒
Responds to Verbal stimuli	☒	More than two episodes of discomfort, adequately tolerated.	☐
Responds to Painful stimuli	☐	Significant discomfort experienced several times	☐
Unresponsive	☐	Extreme discomfort frequently during procedure	☐

Specimens Yes ☒ No ☐Pathology ☒ No of pots 2. H pylori test ☐ bacteriology ☐ cytology ☐ mytology ☐



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Diathermy Yes ☐ No ☒ Type mono ☐ Argon ☐

Site of diathermy pad leg ☐ back ☐ R side ☐ L side ☐ Upper ☐ Lower ☐

Other

Condition of skin post diathermy normal ☐ other ☐ comment below

.....

Recovery Room Instructions (if applicable)

Oxygen 4 litres per minute if SpO2 drops below 95% ☐

Oxygen 4 litres per minute until fully awake ☐

Oxygen per minute viauntil ☐

Normal Diet ☒ Fluids only ☐ Soft Diet ☐ Nil orally till further medical instructions ☐

To be seen by endoscopist before discharge ☐

Further Instructions Nil B, Mouth Wash Alcat and observe ch,

.....

Endoscopy Room Nurse Signature KDive 2

Recovery care

Post endoscopy observations

Time	1500	1520								
Blood pressure	115/60	109/62								
Pulse	90	79								
O2 Saturation	98%	96%								
Respiratory Rate		18								
Sedation score		0								
Pain score		0								
Oxygen		-								
IV Cannula		Remain								
BM		-								
Nurse initials		2								

Pain score 0 = no pain, 1 = minimal, 2 = mild, 3 = moderate, 4 = severe

Sedation score A - Asleep Drowsy - 0 Awake - 1



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Nurses notes

Pt's right arm became noticeably red and raised. Pt stated she is allergic to meperone, elastoplast, and latex. SR Wulke informed whom will review pt prior to discharge. Further Pt reviewed by SR Wulke advised to discharge pt. J. Bartley

Patient addressograph label

Discharge Criteria

Stable vital signs

Alert and Orientated

Pain score is 2 or below

Diet and fluids taken

V Cannula removed

Received written instructions regarding sedation

Received verbal and written aftercare instructions

Patient Advice Leaflet given (if applicable)

Yes

No



Received Endoscopy Report/ Patient letter

Yes ☐

No ☐

If no Deemed inappropriate ☐

Verbal report by Doctor ☐

Verbal report by nurse endoscopist ☐

Follow up appointment indicated on report

Yes ☒

No ☐

Follow up appointment (if given in department)time

Comments.....

.....

.....

I confirm patient is satisfactory for discharge

Print Name Iona Barltrop Signature I Barltrop

Discharged at 4 PM to care of general

Irregular discharge Reason

.....

Patients' Signature Nurses' Signature

Previous Patient Notes for Gastroenterology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		Other
Date/Time: 23-Jun-2025 15:20	Created By: Consultant in Gastroenterology and General Internal Medicine - Helen Cairns1	Role: Doctor - GGC
Specialty: Gastroenterology	Organisation:	Sensitive
Note: Nil to add to IDL d/c 8b on 11/6/25 - OP MRI awaited		

Patient Note		Inpatient Note
Date/Time: 15-Dec-2020 12:48	Created By: Consultant Gastroenterologist - Dan Lassman	Role: Doctor - GGC
Specialty: Gastroenterology	Organisation: Queen Elizabeth University Hospital	Sensitive
Note: 181120fdl=idl not seen by me		



Previous Patient Notes for General Surgery (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		MDT Note
Date/Time: 02-Feb-2023 12:39	Created By: Consultant Colorectal and General Surgeon - James Park	Role: Doctor - GGC
Specialty: General Surgery	Organisation:	Sensitive
Note: Radiology meeting, adnexal cyst present on all scans since 2014. Minimally larger (4.8cm). Unlikely to be suspicious but would be helpful to refer to gynaecology for formal assessment. Check Ca125.		

Previous Patient Notes for Urology (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		Outpatient Note
Date/Time: 27-Sep-2020 20:59	Created By: Consultant - Mark Salji	Role: Doctor - GGC
Specialty: Urology	Organisation: Queen Elizabeth University Hospital	Sensitive
Note: Seen in Surgical IAU - Left loin pain ongoing since stent insertion. Main complaint is urgency and LUTs, mild VH only, normal bloods. Pt drinks mainly iron bru ~ 1L / day. Advised to stop iron bru and avoid caffeine and ETOH. Drink water/squash only and explained stent symptoms only no infection on bloods therefore stop Abx. Given Tamsulosin and mirabegron to add to solifenacin already taking 5mg OD. Advised will expedite f/u with L URS + laser via email but cannot guarantee date today, pt happy with plan and discharged home from IAU.		

Patient Note		Inpatient Note
Date/Time: 26-Aug-2020 22:40	Created By: Clinical Fellow - Mari Claire McGuigan	Role: Doctor - GGC
Specialty: Urology	Organisation:	Sensitive
Note: Seen on call for Urology in IAU 26/08- discharge letter under A&E section of portal with clinical information.		

Previous Patient Notes for Clinical Pharmacology & Therapeutics (newest at the top).

Note: Specialty search returns patient notes from 13th November 2018 onwards. Patient notes older than that date, tagged Historical Notes, that don't have a specialty assigned can only be viewed within the Patient Notes section in the Clinical Documents tree.

Patient Note		Inpatient Note
Date/Time: 10-Dec-2019 13:26	Created By: Consultant Clinical Pharmacologist and Acute Physician - Lindsay McCallum	Role: Doctor - GGC
Specialty: Clinical Pharmacology & Therapeutics	Organisation:	Sensitive
Note: IDL 03/12/2019 nil to add no fdl required		



Acute Services Division

Gynaecology Department

Gynaecology Emergency Dept - Admission Document



Date 11.7.25

Consultant on call: DR. DATSON

Time Seen: 12.10

Triage Nurse: JOAN WARREN (HCSW)

Name	
Address	1908546042 LOGAN Georgina 17 Solias Place Glasgow, Lanarkshire G13 4N
D.O.B	9/08/1985
Age	40
Telephone	07760159467
Occupation	RETIRED

GP	P	Dr. RP Murphy 1398 Dumbarton Road Glasgow G14 9DR
Name		
Address		
Telephone		

Emergency Contact	
Name	GEORGE LOGAN
Address	AS ABOVE
Telephone	07760159467
Relationship	HUSBAND
Comments	

Triage Notes		
R	BP 111/56 P 52 T 36.2	
BM	SpO2 99%	
Urine: Leuco	Prot	Blood
Ket	Gluc	Nitrites
MSSU sent		
Pregnancy Test Result:		
Height		
Weight	(If required)	
BMI		

Clinical Assessment	
Presenting complaint	? PVB (PMS)
Source of referral	88
LMP	11/1 N/A
Allergies	AMOXICLAVIN

Gynaecology Department

Emergency Dept. Admission Document



1908546042

LOGAN

Georgina

19/08/1995

Date 11/09/25

Patient name: _____

Time Seen: _____

12:30

Hospital number _____

Presenting complaint:

70♀ - current IP 86

- admitted with diarrhoea
- ? passing faeces Pr + episode PrB
- complex ⊖ ovarian cyst on CT abdo

History of presenting complaint:

Reports long hx of abdominal pain.

Last week episode of fresh Pr bleeding - states had small amount of pad also having diarrhoea and ~~menstr~~ thrins. ^{passed faeces Pr} ~~was passing faeces Pr~~ ^{by state was being to thrust} had just inserted pessary before bleeding happened. Nil further episodes. Reports longstanding itch Pr. Nil weight loss; nil bloating. Reports appetite.

Past Obstetric/Gynaecology History:

Parity: G4 P4

Contraception: nil

Date of Last Smear: ? Thins last smear (N) Result: _____

Labiapex

Age of menopause - 50 yrs.

Past Medical/Surgical History:

Cholecystectomy

pericarditis

AF

Diverticulosis

prev. uterine sent.

Crohn's

spinal surgery

IBS

Asthma

Family History:

hx lung + breast ca.

Social History:

o non smoker

o nil eth.

o career 27 yrs (retired)

Medication:

Two sources are required

Medication	Dose	Frequency	Comment
Apixaban			
Pegabalin			
Methocarbamol			
Omeprazole			
atenolol			
Bupropion			
Risperidone			
Sildenafil			

Allergies:

Dosette box used:

CO - a moxidav + trimethoprim

Examination:

O/E: Whitish discolouration of vulval skin and loss of labial architecture - appearances consistent c lichen sclerosis.

Attempted spec - unable to tolerate due to discomfort.

Scan findings:

TUS - (L) complex adnexal cyst noted measuring $51.4 \times 34 \times 24.7$ mm. Slightly thickened endometrium at fundus 7.3mm.

Blood results:

Clinical Impression:

① Complex ② adnexal cyst as before, persistent for at least 11 years with no change in size. CA125 15.

↳ FU scan in 1 year to assess for interval scan.

② PVB? faeculent discharge - on questioning had small amount fresh red PVB on inserting clotrimazole pessary - likely local trauma.

Then awake to find faecal matter on pad - suspect episode of faecal incontinence rather than PV. Slightly thickened endometrium 7.3mm - unable to tolerate spec/pipelle but

Doctors Signature _____

Designation _____

Print Name _____

think this is incidental finding rather than true PVB.

Management plan:

Can reassess appearances at FU scan in 1 yr. - Dr Datsun in agreement.

Follow-up Plan:

① Dermovate ointment: od for 4/52 then every other day 4/52 then twice weekly 8/52.

Requires Admission:

☐ Yes

☐ No

Admitted to:

Outpatient Clinic Letter completed:

☐ Yes

☐ No

Dermol as soap sub.
One Stop Clinic 1 year

Once Only Prescriptions

Date Given	Drug (Block Capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

Discharge Prescription Packs

Date Given	Drug (Block Capitals)	Dose	Method of Administration	Frequency	Signature	Given By



1908546042

LOGAN

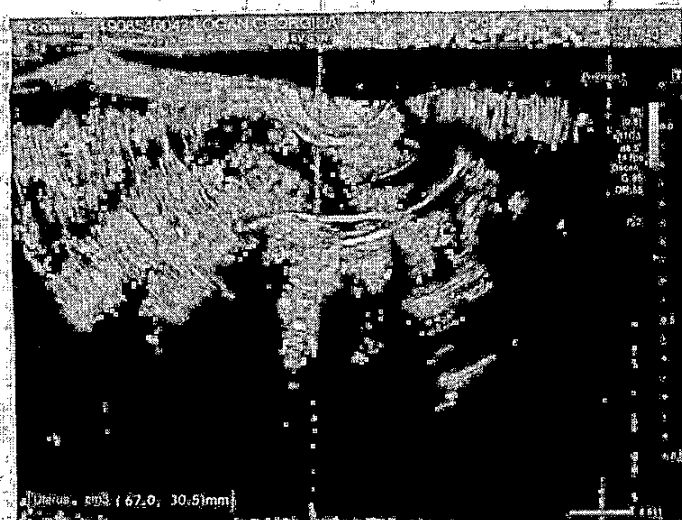
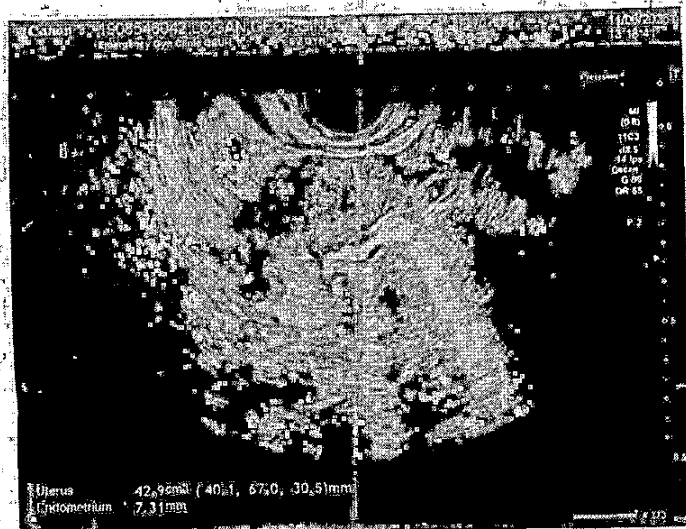
Georgina

19/08/1954

17 Sollas Place

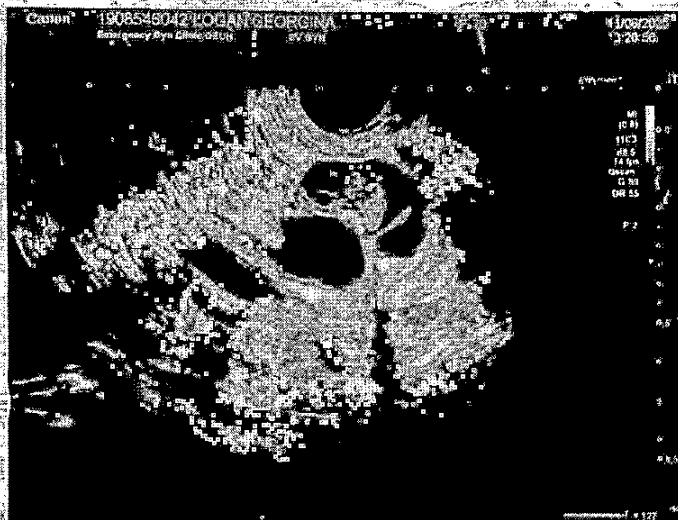
Glasgow, Lanarkshire

G13 4NA



Signature, Print Name
& Designation

Date &
Time



1908546042

LOGAN

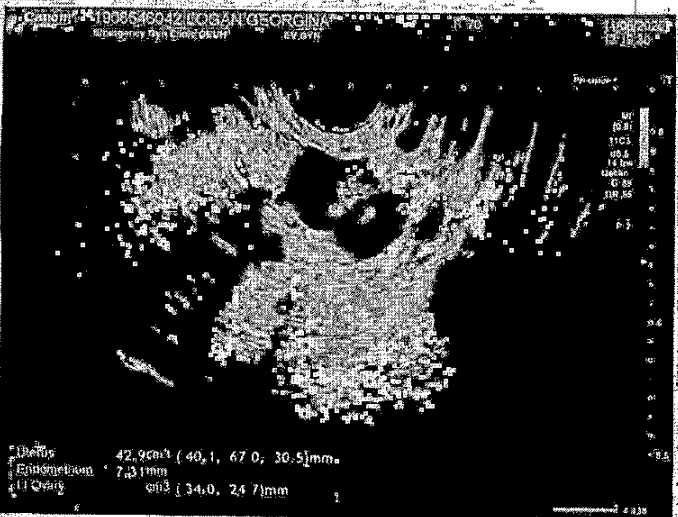
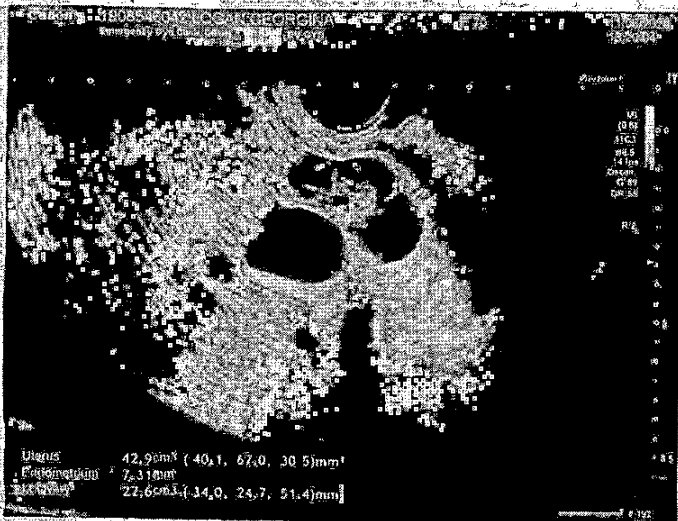
Georgina

17 Sallas Place

Glasgow, Lanarkshire

19/08/1954

G13.4NA



MWR . ? Bldsta.

Called 1530

NHS GGC Hospitals, Emergency Department



Affix Label



CHI: 1908546042

Queen Elizabeth University Hospital

Title: MRS

LOGAN

DOB 19/08/1954

Age: 69y

Georgina

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, George
Relationship: Husband
01419523728

GP: RP Murphy
0141 212 7082

Attendance Date: 19/04/2024

Arrival Time: 13:13

Registration Time: 13:13

Date of Incident: 19/04/2024

Major Incident Desc:

Reason for Attendance: abdo pains

Affix Label

Nursing Assessment

Alerts:

Nursing Assessment

Alerts: Not Recorded

Allergies: None Known

Pain Score:

Triage Category: 4

Tetanus up to date/fully immunised:

Presenting Complaint: Abdomen Pain

Observation Date: 19/04/2024 13:37

Nurse name: Nurse Anna Lee

Temp	35.8	C
HR	65	bpm
BP	130/54	mmHg
MAP	79.33	mmHg
RR	17	bpm
SpO2	97	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right	Pupils-Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "Pain in abdomen for 3 weeks; had made an emergency GP app today for 1600pm as pain ongoing for 3 weeks and states cant cope with pain. Taking regular strong analgesia. No other symptoms. On abx for UTI started 2 days ago and symptoms of UTI have got better. Advised to contact GP again in MWR for her App at 1600pm. Seen last year with abdo pain+ infection - seen by surgeons in 2023" obs ok.

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

**DO NOT WRITE
HERE PLEASE**

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date	CLINICAL NOTES	
Seen by (Dr)		Time seen
		 1908546042 19/08/1954 LOGAN Georgina

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE) 1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below) 5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.								Discharge date	
								Discharge time	
Ward number (if admitted):			Transfer to hospital:				Consultant if admitted:		
Follow up	Arranged			Not arranged			To be arranged		
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):	
Discharge Prescription Packs									
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By			

Affix Label



CHI: 1908546042

Queen Elizabeth University Hospital

GEUH

Total Att: 31

12 Mth Att: 2

Title: MRS

LOGAN

Georgina

DOB 19/08/1954

Age: 68y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, George
Relationship: Husband
01419523728

GP: DF Spence
0141 212 7082

Attendance Date: 27/03/2023

Arrival Time: 17:35

Registration Time: 17:35

Date of Incident: 27/03/2023

Major Incident Desc:

Reason for Attendance: gp referral surgical lft pain

Nursing Assessment

Alerts: Not Recorded

Triage Category: 3

Allergies: None Known

Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 27/03/2023 17:50

Nurse name: Nurse Louise Adshead

Temp	36.5	36	C
HR	95	94	bpm
BP	144/96	135/117	mmHg
MAP	112.00		mmHg
RR	17		bpm
SpO2	98		%
Oxygen			%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right	Pupils-Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes:



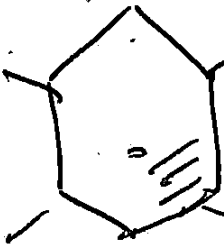
1908546042 19/08/1954
LOGAN
Georgina

Date	Emergency Department Notes	Admission (508)
	Ambulance Proforma reviewed Yes / No	Seen by (Doctor)
		Time seen 12:19
27/03/22 19:40	<u>Background</u> : 50 years old male → from road accident → no trauma → no trauma no trauma <u>PC</u>: LIF pin <u>HMC</u>: → 717 Hx of LIF pin → pinlock for LIF 48 hours → Nausea but no vomiting → No urge in my system → No PR bleeding → no trauma No trauma → No aggression - relay <u>Facts</u> <u>AMH</u>: No abuse <u>Alt</u>: As per ECJ NCCB <u>Date</u> <u>Case</u> 508/2022 Capitol = 2022 <u>CB</u>: Relay Relay <u>Blow</u> 5 CN = 4 WCC = 10.1	

Patient ID label



1908546042 19/08/1954
LOGAN
Georgina

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	 → LUP in a day perfect PK → Mucous (SN diagnosis) → No Heat → No Numb (I) Examination of Ovaries (2) → plant as per not setting → EDD → Analgesic	

Differential Diagnosis/Problem	→ LUP → Not coming for ABX NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ ARM ☐
--------------------------------	--

Done/ completed	Immediate Management Plan
	808

Signature:	Designation:	Page No:
------------	--------------	----------

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label

Seen By:

Print:

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

Social History / Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☐ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

General Examination

Temp:

RR:

Pulse:

CBC:

SpO₂:

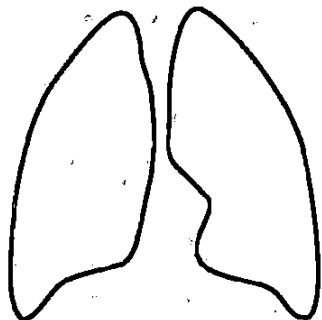
Weight:

BP:

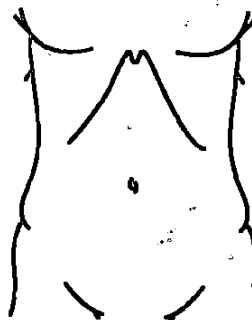
Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

Pupils/fundoscopy:

**Cerebellar and
extrapyramidal:**

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME

PRINT GRADE

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: **FOR RESUSCITATION** / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

28/8/23 Mr Park - WR
0125

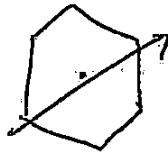
Ⓔ PC: Lower abdo pain.

HPC: - Pain ~5 days.

- No fevers
- BNO ~ 1 week. Normally has loose stool.
- Pain worse after eating.

PMH: Diverticular disease

O/E:



Abdo SNT.

Bloods (N)

Imp: ? Constipation.

Plan:

- 1) Laxatives - patient already has at home.
- 2) Anti-emetics
- 3) Home. Clinic fu w. Mr Park.

ABg.

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label**Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED**

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days

☐ Yes

☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive	
Age > 60	Hormone replacement therapy	
Dehydration	Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophilia	Critical care admission	
BMI >30	Varicose veins with phlebitis	
Personal/1st degree relative history of VTE	Current significant medical condition e.g. Infection, inflammation, cardio resp disease	
Hip fracture		

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia <75 x10 ⁹ /l	
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR >2	Uncontrolled hypertension (>230/120)	
Acute stroke	Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic		
Other - Document		

☐ No

☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	()								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 - 10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female: 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 - 2.0								

Patient ID label

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO₂:

FIO₂:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
Date: Time	

Date: Time.[illegible]

Patient ID label

[illegible]

Date: Time

Patient ID label

Continuation Sheet

[illegible][illegible]

[illegible]

A + B		Respirations'		Breaths/min	
15	4	25	3		
21-24		2			
12-20		0			
9-11		1			
5-8		3			

[illegible][illegible][illegible]

C

Blood Pressure mmHg

(Score uses systolic BP only)

Blood Pressure (mmHg)	Score
220	1
201-219	0
181-200	0
161-180	0
141-160	0
121-140	0
111-120	0
101-110	1
91-100	2
81-90	3
71-80	3
61-70	3
51-60	3
≤50	3

C	Pulse	Beats / min	2131	3
			121-130	2
			111-120	2
			101-110	1
			91-100	1
			81-90	0
			71-80	0
			61-70	0
			51-60	0
			41-50	1
			31-40	3
			21-30	3

[illegible][illegible][illegible][illegible]

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

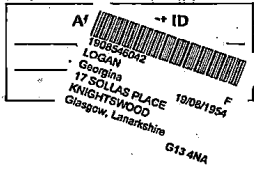
1. Give oxygen to target saturation >94% (COPD >92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE		
A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.	
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.	
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.	

19085456042
LOGAN
Georgia
17 SOLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

Abbreviations for recording oxygen device	
A	Room Air
N	Nasal Cannulae
SM	Simple Mask
V	Ventilator Mask and % eg. V24
NIV	Non Invasive Ventilation
IV	Invasive Ventilation
T	Tracheostomy
CP	CPAP Mask
HFN	High Flow Nasal Oxygen
NEB	Nebuliser
RM	Reservoir Mask (Emergency use only)

Affix Patient ID



	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1
Target >96%

Signature: _____
Print Name: _____
Dr/ANP initials ONLY: _____
Date: _____

SpO2 Scale 2
Target 88-92%

Signature: _____
Print Name: _____
Dr/ANP initials ONLY: _____
Date: _____

Patient on home oxygen Y ☐ N ☐

If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed: _____

Medical: _____

Date: _____

Glasgow Coma Scale

Eye opening
E = 4
S = 3
+ = 2
- = 1
No reaction = 0

Verbal
V = 5
O = 4
O = 3
O = 2
O = 1
No response = 0

Motor
M = 6
M = 5
M = 4
M = 3
M = 2
M = 1
No response = 0

Pupil reaction and size
Pupils (mm)
1 2 3 4 5 6 7 8

Pain Score
Ask the patient to rate their pain by using numerical scale 0-10. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain Mild Pain Moderate Pain Severe Pain
0 1 2 3 4 5 6 7 8 9 10

Pain Function Score
A No limitations, activity unrestricted by pain or settles quickly
B Mild limitations, mild activity restrictions
C Moderate limitations, attempt but reluctant to continue because of pain. Seek Advice
D Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Affix Patient ID

1908546042
LOGAN F
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature: _____	Signature: _____	If yes, add details of oxygen therapy
Print Name: _____	Print Name: _____	
Dr/ANP Initials ONLY: _____	Dr/ANP Initials ONLY: _____	
Date: _____	Date: _____	

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
Agree Frequency of Observation Required		ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis If Suspicion of Infection	Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations

Signed:

Medical:

Date:

[illegible]

NEWS 2 Key 1 2 3

Date	1/1/11
Time	11:05

A + B Respirations breaths/min	23	225	3
		21-24	2
		12-20	0
		9-11	1
		≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)	97	296	0
	95	94-95	1
		92-93	2
		≤91	3

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure Only use scale 2 under direction of qualified clinician		≥97 on O2	3
		95-96% on O2	2
		93-94% on O2	1
		≥93 on air	0
		88-92	0
		≤87	1
	84-85	2	
	≤83	3	

Air or oxygen?	A	0
	02 1/min 2	2

C Blood Pressure mmHg Please give systolic BP only	132	≥220	3
	127	201-219	0
		181-200	0
		161-180	0
		141-160	0
		121-140	0
		101-120	0
		91-100	1
		81-90	2
		71-80	3
		61-70	3
		≤60	3
		≤50	3

C Pulse beats / min	57	≥191	3
		121-150	2
		111-120	2
		101-110	1
		91-100	1
		81-90	0
		71-80	0
		61-70	0
		51-60	0
		41-50	1
		31-40	3
		≤30	3

D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.	0	A Alert	0
		C New Confusion	3
		V Verbal	3
		P Pressure	3
		U Unresponsive	3
		≥39	2

E Temperature	36.0	38.1-39.0	1
		37.1-38.0	0
		36.1-37.0	0
		35.1-36.0	1
		≤35.0	3

NEWS Total	3
------------	---

Blood glucose	7.0	NA
Pain / function score	0A	0A
Time Pt last passed urine	10.20	0A
Fluid balance chart indicated Y/N	N	2
GCS indicated Y/N	N	1
Time NEWS due	23.00	2°
Escalation of care Y / N	N	1
Initials	AB	BM

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE

A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.

C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.

E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.

180846042
LOGAN
Georgina
17 SOLILAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 9NA

Abbreviations for recording oxygen device

A Room Air
N Nasal Cannulae
SM Simple Mask
V Venturi Mask and %
eg. V24
NIV Non Invasive Ventilation
IV Invasive Ventilation
T Tracheostomy
CP CPAP Mask
HFN High Flow Nasal Oxygen
NEB Nebuliser

Affix Patient ID

Queen Elizabeth University Hospital

Affix Label



CHI: 1908546042

Title: MRS

Total Att: 28

12 Mth Att: 1

LOGAN

Georgina

DOB 19/08/1954

Age: 67y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire

Next of kin: LOGAN, George
Relationship: Husband
01419523728

G13 4NA
01419523728

GP: DF Spence
0141 212 7082

Attendance Date: 24/01/2022 Arrival Time: 20:12

Registration Time: 20:12 Date of Incident: 24/01/2022

Major Incident Desc:

Reason for Attendance: chest pains

Affix Label

Nursing Assessment

Alerts: Yes

Allergies: None Known Pain Score: 5
Tetanus up to date/fully immunised:

Triage Category: 2

Presenting Complaint: Chest Pain

Observation Date: 24/01/2022 21:45

Nurse name: Nurse Keighley Doyle

Temp	36.0	C
HR	65	bpm
BP	122/57	mmHg
MAP	78.67	mmHg
RR	23	bpm
SpO2	95	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "C/O central chest pain since last night. Prev pericarditis. Pain score of 5 but refusing pain relief at triage."

Patient ID label

Georgina Logan

Date	Emergency Department Notes	
	Ambulance Proforma reviewed Yes / No	Seen by <u>Kath UK HP</u> Time seen
<u>PC</u> <u>HPC</u> <u>PHH</u> <u>DH</u> <u>Q</u>	Chest pain. Indicating well localised point to left of midline in lower abdominal area. Pain persistent for several hours No associated symptoms. H/S now settled - pain free / comfortable Not breathless. Known angina - did not use spray tonight Generally - looks well, undistressed Obs @ H/S 1+1+0 Chest clear to both bases No oedema, cyanosis, dehydration No creps or wheeze. CXR/ECG/Bloods and review in ED.	

 1909546042 LOGAN Georgia		F 19/08/1954
<i>[Handwritten signature]</i>		

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	Trop < 4. (XR. ECG - T wave flattening laterally with @ top end non cardiac pain. Discharge - likely costochondritis	

Differential Diagnosis/Problem List	
	NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ CURB 65 ☐

Done/ completed	Immediate Management Plan

Signature:	Designation:	Page No:
<i>[Handwritten signature]</i>	<i>[Handwritten initials]</i>	

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label



1908546042

19/08/1954

LOGAN

Georgina

Seen By:

Print:

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)

Presenting complaint

History of presenting complaint

Past Medical History / Review of portal

Systemic Enquiry

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)

☐ Patient/Relative/carer	☐ GP Phone call	☐ ECS
☐ Patient own drugs	☐ Com. Pharmacist	☐ GP letter/summary
☐ Repeat Prescription		

Other (please specify) _____

[illegible]

Allergies

List any over-the-counter or alternative medicines

Do medicines need further clarification ? ☐ Yes ☐ No

List collected by :

Plan approved by :

Designation :

Date.:

Designation :

Date :

Pharmacy review

Comments

Compliance aid :

☐ Yes ☐ No

Community pharmacist

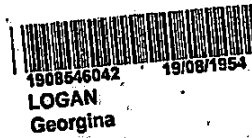
Phone

Reviewed by :

Designation :

Date :

Patient ID label



Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☐ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

General Examination

Temp:

RR:

Pulse:

CBG:

SpO₂:

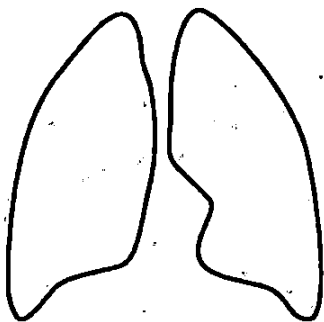
Weight:

BP:

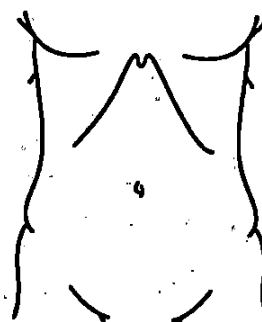
Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

Pupils/fundoscopy:

**Cerebellar and
extrapyramidal:**

Cranial Nerves:

Neck:

Reflexes:

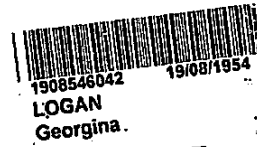


	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label



Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME

PRINT GRADE

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient:

1908546042
 LOGAN
 Georgina F
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days

☐ Yes☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive	
Age > 60	Hormone replacement therapy	
Dehydration	Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophilia	Critical care admission	
BMI >30	Varicose veins with phlebitis	
Personal/1st degree relative history of VTE	Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture		

☐ Yes☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia <75 x10 ⁹ /l	
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR >2	Uncontrolled hypertension (>230/120)	
Acute stroke	Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic		
Other - Document		

☐ No☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A

(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____



Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	()								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 - 10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 - 2.0								

Patient:



1908546042

LOGAN

Georgina,

19/08/1954

17 SOLLA'S PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO₂:

FIO₂:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

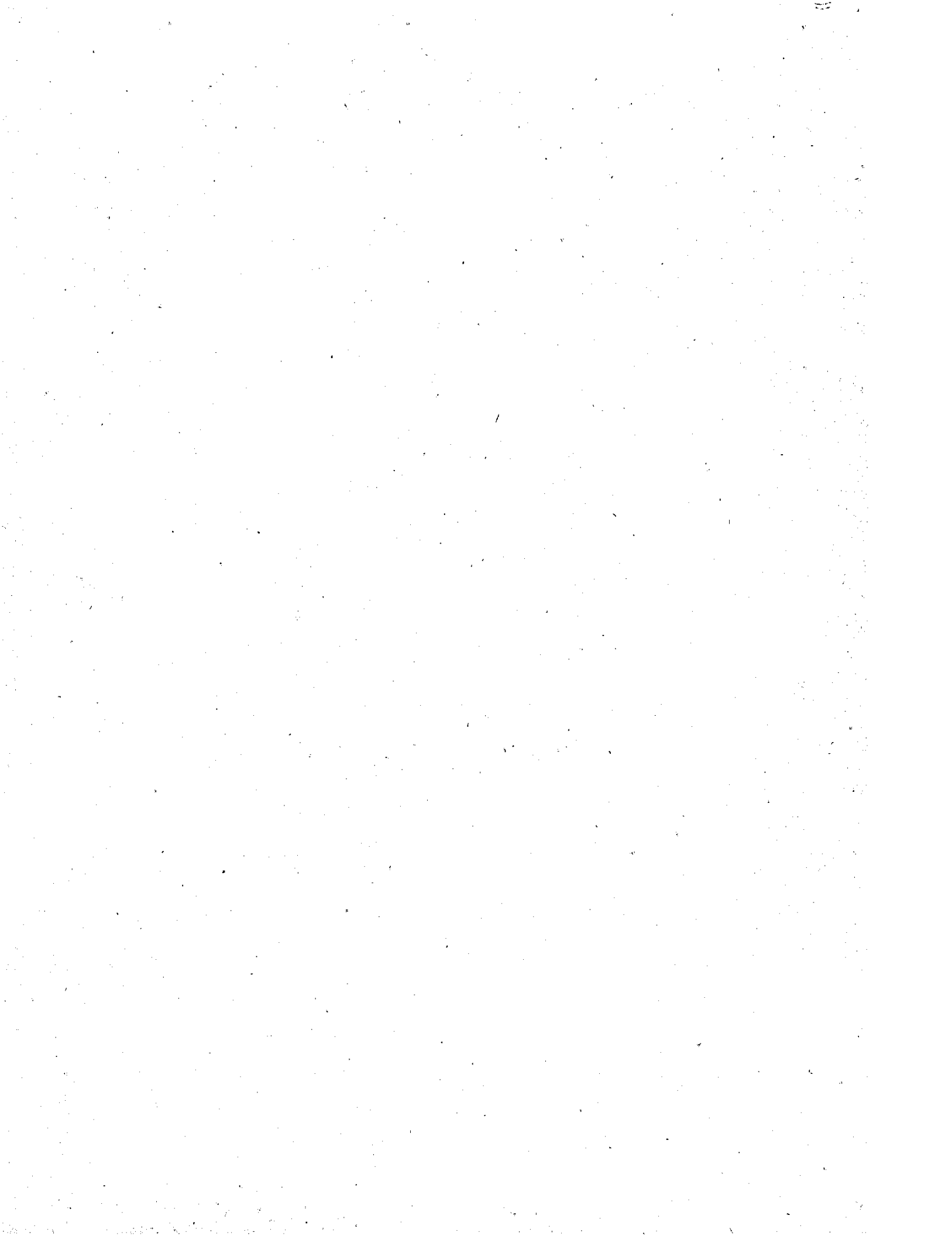
Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time

[illegible]



Patient ID label

1908546042

LOGAN

Georgina

19/08/1954

F



1908546042

LOGAN

Georgina

1

19/08/1954

Date: Time

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or printed text on the paper.



Patient ID label

Continuation Sheet

Date: Time

Patie

1908546042

LOGAN

Georgina

F

19/08/1954

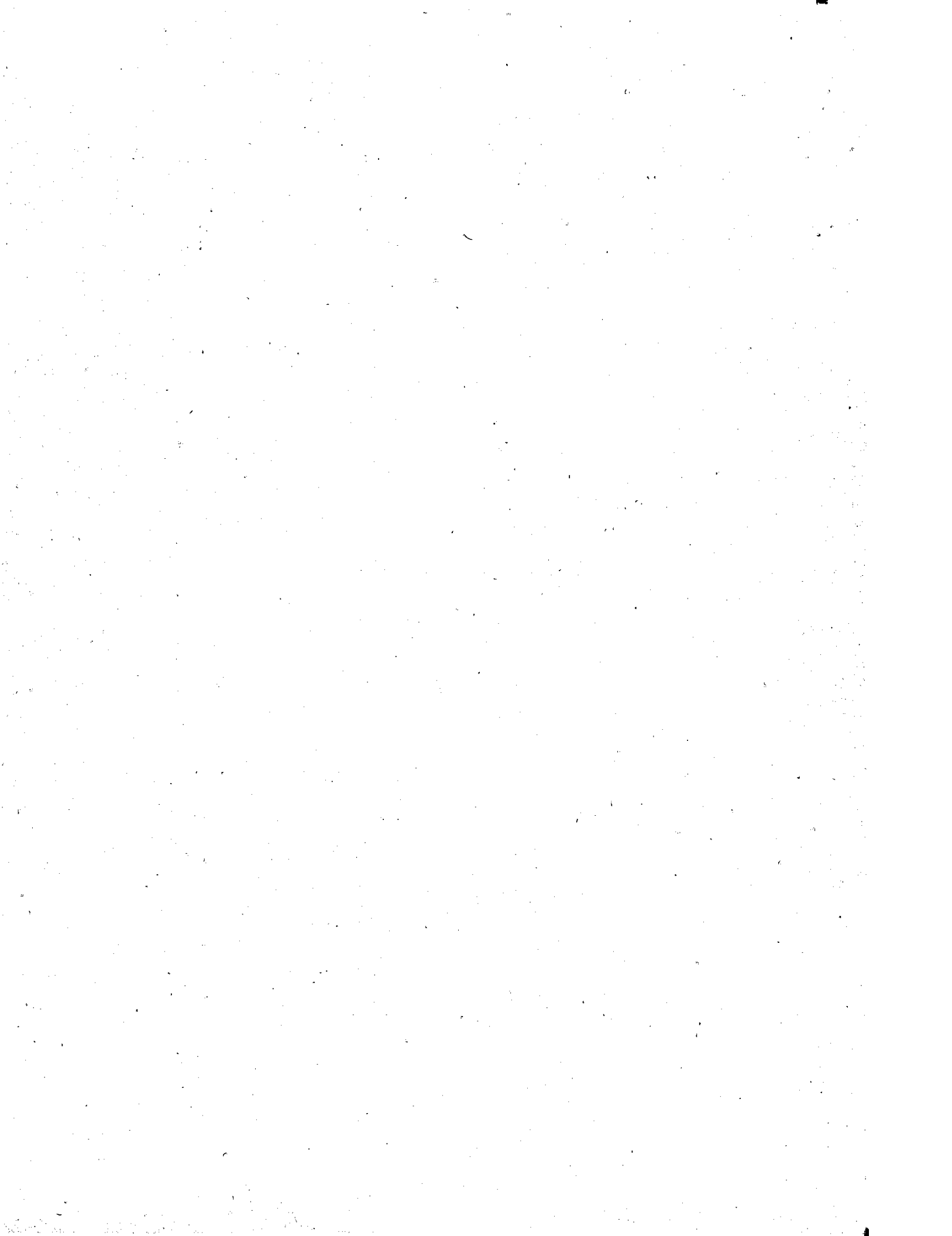
Continuation Sheet

Date: Time



1908545042
LOGAN
Georgia
F
19/08/1954





Patient name

Patient C



Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time	Name/Signature
24.1.22 PT admitted with chest pain started last night	

Nursing notes - on admission

Date and Time	Name/Signature
24.1.22. PT stripped into gown.	
2230. Connected to ECG monitor.	
Bloods obtained + ECG.	
PT settled.	
Await medical review RM.	

Triage

Patient prepared for exam - clothing bagged	☒	☐
NEWS Chart	☒	☐
ID band	☒	☐
Peak Flow	☐	☐
12-lead ECG	☒	☐
IV access	☐	☐
Blood samples	☒	☐
Blood Gas	☐	☐
X-rays	☐	☐
Urinalysis	☐	☐
B-HCG	☐	☐

Communication

GGC Red Bag with Patient (nursing home resident)	☐	☒
Language or hearing difficulty	☐	☒
Interpreter required	☐	☒
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☐	☒
name, relationship, location, particular concerns		

Risk Assessments and Screening Tools

SEPSIS	☐	☒
FAST	☐	☒
Swallow Testing	☐	☒
Falls Risk (clinical judgement)	☐	☒
GMAWS	☐	☒
Adult Support and Protection	☐	☒
Mental Health Triage Assessment	☐	☒
Child Protection Concerns	☐	☒

Signature:

Patient name

Patier



Care Rounds Checklist

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 [Signature] Designation SN

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

		Times																
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.	N															
	2	PAIN: ASSESS AND ADDRESS. Is the patient distressed or in pain? If yes inform registered nurse.	N															
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Disclosed PU = Pressure Ulcer INT = Intact M = Moisture	N NO															
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand	N B															
		ELIMINATION. Does the patient need the toilet?	N															
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)	I															
N	6	FOOD FLUIDS AND NUTRITIO. Is the patient nil by mouth? Drink taken? Food, snack, or supplements taken? Has oral hygiene been carried out as per care plan?	N NT NT NT															
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?	Y															
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return	NT															
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return	NT															
Care provider			MM															
Role			SN															

Ask the patient if there is anything they specifically want done today:

Patient name.....
 Pa.....
 1908546042:
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA
 Ticker

Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes



PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.
---	------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____ hrly	
/ /	:							____ hrly	
/ /	:							____ hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/carer YES / NO

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

Date and Time		Name/Signature	

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

[illegible]

Signature:



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA use sticker

4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS

This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.

Normal (alert, but not agitated, through assessment) 0
Mild sleepiness (<10 secs) after waking, then normal 0
Clearly abnormal 4

Circle
Score

(2) AMT4

Age, date of birth, place (name of the hospital/building), current year.

No mistakes 0
1 mistake 1
2 or more mistakes/untestable 2

(3) ATTENTION

Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.

Wachieves 7 months or more correctly 0
Starts but scores <7 months / refuses to start 1
Untestable (cannot start, unwell, drowsy, inattentive) 2

(4) ACUTE CHANGE OR FLUCTUATING COURSE

Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.

No 0
Yes 4

4 or more possible delirium + /- cognitive impairment
1-3 possible cognitive impairment
0 delirium or severe cognitive impairment unlikely
(but delirium still possible if (4) information incomplete)

TOTAL

Frailty Assessment Tool

(Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

circle Y or N

F	Functional impairment	(new or worsening) eg difficulty with self care	Y	N
R	Resident	in a care home	Y	N
A	Altered mental state	such as delirium or dementia (4AT Assessment)	Y	N
I	Immobility/instability	decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N
L	Living at home with support	on a daily basis (homecare, one visit or more per day)	Y	N

If YES to any of the criteria in Step 1 move to Step 2

Step 2 Would this person be better managed by another speciality team at present?

circle Y or N

Clear need for other specialty input eg exacerbation of known long-term condition such as COPD	Y	N
Need for HDU/ITU (including non-invasive ventilation)	Y	N
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit	Y	N
Head injury with loss of consciousness	Y	N
Acute abdominal pain/ surgical presentation	Y	N
Upper GI Bleed	Y	N
Chest pain with suspected acute coronary syndrome	Y	N
Trauma with suspected fracture	Y	N

Are any of the criteria met?

If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate.

If necessary consider geriatric advice on parent ward.

If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient



Nursing notes - ongoing care

[illegible]

Affix Label



CHI: 1908546042

Queen Elizabeth University Hospital

Total Att: 27

12 Mth Att: 2

Title: MRS

LOGAN

Georgina

DOB 19/08/1954

Age: 67y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, George
Relationship: Husband
01419523728

GP: DF Spence
0141 212 7082

Attendance Date: 03/10/2021

Arrival Time: 12:02

Registration Time: 12:02

Date of Incident: 02/10/2021

Major Incident Desc:

Reason for Attendance: fall-shoulder inj

Affix Label

Nursing Assessment

Alerts: Yes

Allergies: None Known

Pain Score:

Triage Category: 4

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 03/10/2021 12:05

Nurse name: Nurse Elaine McMaster

Temp		C
HR		bpm
BP	/	mmHg
MAP		mmHg
RR		bpm
SpO2		%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes:

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby or non-mobile toddler		

Discuss with Senior Medical Staff / Nurse on duty any factors identified

X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

**DO NOT WRITE
HERE PLEASE**

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

Date

3/10/21

CLINICAL NOTES

Seen by (Dr)

Rono Thomson (ENP)

Time seen

12⁴⁰

PC / L shoulder injury

HPC / 67y female fall onto L shoulder last night

PMH / Chronic

back pain

DH / see ECS

Allergies / NKDA

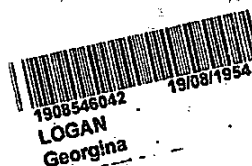
IMP, slight swelling
over humeral head
No bruising
wounds
deformity
bleeding

NVI
CRT 3 seconds
BT over humeral
head only
No BT over scapula
→ clavicle, ac joint

GIROM

PLAN / x-ray L shoulder
- No acute bony injury

D/c home
advice
analgesia



R. Thomson
ENP

Date	CLINICAL NOTES

Discharge Codes (Please CIRCLE)								Discharge date		
1. Admission		2. Discharge		3. Refer to GP		4. Transfer to other (see below)		Discharge time		
5. Died		6. Refer to OP Clinic (see below)		7. Irregular Discharge		8. D.O.A.				
Ward number (if admitted):			Transfer to hospital:				Consultant if admitted:			
Follow up		Arranged			Not arranged			To be arranged		
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):		
Discharge Prescription Packs										
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By				



CHI: 1908546042

Queen Elizabeth University Hospital

Total Att: 24

12 Mth Att: 6

Title: MRS

LOGAN

Georgina

DOB 19/08/1954

Age: 66y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: DF Spence
0141 212 7082

Attendance Date: 27/09/2020

Arrival Time: 18:25

Registration Time: 18:25

Date of Incident: 27/09/2020

Major Incident Desc:

Reason for Attendance: UROLOGY haematuria and pain Hx of renal stones wth stent in situ.

Nursing Assessment

Alerts: Not Recorded

Allergies: None Known

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 27/09/2020 18:45

Nurse name: Nurse Jennifer Laing2

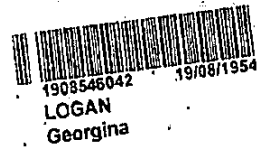
Temp	36.2	C
HR	65	bpm
BP	115/59	mmHg
MAP	77.67	mmHg
RR	14	bpm
SpO2	97	%
Oxygen	21	%

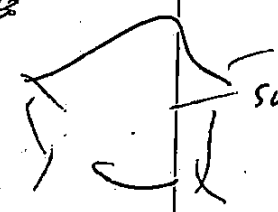
BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	
Pupils-Right	Pupils-Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes:

Patient ID label



Date	Emergency Department Notes		
	Ambulance Proforma reviewed Yes / No	Seen by (Doctor)	Time seen
27/9/20. 2100.	Swart (St) Uro - LD on call. (66) (L) Start intake. - No wgt/freq/V.H. dysuria. - Seen GP 19/8 - int helping explained Start SX. - looks well, X-ray Lumb. 12/9 - Normal (L) Start pos. Hx  swt operation oral angle tenderness. Amu - Edoxiban → AF. stands normal. CRP < 6. Hb 11.0. Drinks mainly iron beer (7) Advised stop iron-beer - correct fluids intake. - Add Tamoxifen / nitroglycerine + Stop 196x as Start SX. - Expidite (L) Uro. - (8) + advice. 8276.		

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

	NEWS	☐	0-7
	RED FLAG	☐	(Tick)
	SEPSIS	☐	
	CURB 65	☐	

Done/ completed	Immediate Managment Plan

Signature:

Designation:

Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes**Patient ID label**

Seen By:

Print:

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)

Presenting complaint

History of presenting
complaint**Past Medical History / Review of portal****Systemic Enquiry**

Patient ID label

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history (>1 source preferred)	☐ Patient/Relative/carer	☐ GP Phone call	☐ ECS
	☐ Patient own drugs	☐ Com. Pharmacist	☐ GP letter/summary
	☐ Repeat Prescription		
Other (please specify)			

Source of medication history (>1 source preferred)	☐ Patient/Relative/carer	☐ GP Phone call	☐ ECS
	☐ Patient own drugs	☐ Com. Pharmacist	☐ GP letter/summary
	☐ Repeat Prescription		
Other (please specify)			

[illegible][illegible]

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification? ☐ Yes ☐ No

Allergies	List any over-the-counter or alternative medicines
	Do medicines need further clarification? ☐ Yes ☐ No

List collected by :	Plan approved by :
---------------------	--------------------

Designation :	Date :	Designation :	Date :
---------------	--------	---------------	--------

Designation :	Date :	Designation :	Date :
---------------	--------	---------------	--------

Designation:	Date:	Designation:	Date:

Designation:	Date:	Designation:	Date:

Designation:	Date:	Designation:	Date:

Designation:	Date:	Designation:	Date:

Pharmacy review	Comments

Pharmacy review	Comments

Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
---	---------------------------------

Compliance aid : ☐ Yes ☐ No	Community pharmacist Phone
---	---------------------------------

Reviewed by :	Designation :	Date :
---------------	---------------	--------

Reviewed by :	Designation :	Date :
---------------	---------------	--------

Reviewed by :	Designation :	Date :
---------------	---------------	--------

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☐ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

General Examination

Temp:

RR:

Pulse:

CBG:

SpO₂:

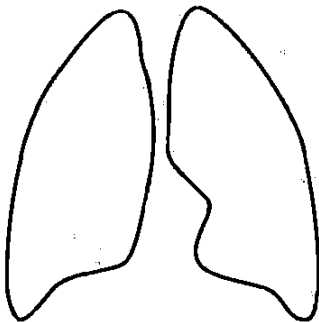
Weight:

BP:

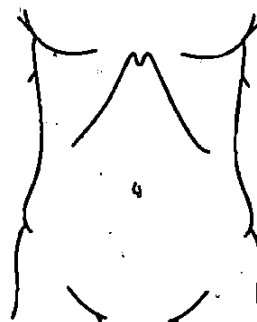
Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

Pupils/fundoscopy:

Cranial Nerves:

Reflexes:



Plantars: R L

**Cerebellar and
extrapyramidal:**

Neck:

	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Skin/Other

Patient ID label

Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME

PRINT GRADE

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: **FOR RESUSCITATION** / **DNA CPR**
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label**Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETED**

Is the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days

☐ Yes

☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive	
Age > 60	Hormone replacement therapy	
Dehydration	Pregnancy or < 6 weeks post partum (seek specialist advice)	
Known thrombophilia	Critical care admission	
BMI > 30	Varicose veins with phlebitis	
Personal/1st degree relative history of VTE	Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture		

☐ Yes

☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia $< 75 \times 10^9/l$	
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR > 2	Uncontrolled hypertension ($> 230/120$)	
Acute stroke	Varicose veins	
Recent (< 4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic		
Other - Document		

☐ No

☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50 kg or eGFR < 30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	()								
Thromb T	11-15-secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 103								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 - 10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female: 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 - 2.0								

Patient ID label

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO₂:

FiO₂:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet	
--------------------	--

Date: Time

[illegible]

Patient ID label

Date: Time

[illegible]

Patient ID label

Continuation Sheet

[illegible]

Patient ID label

Continuation Sheet

Date: Time	Lat	Long	Wind	Temp	Pressure	Clouds	Sea	Remarks
10/10/10 0000	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0100	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0200	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0300	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0400	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0500	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0600	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0700	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0800	10 00	105 00	10	28.0	1010	0	0	
10/10/10 0900	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1000	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1100	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1200	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1300	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1400	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1500	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1600	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1700	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1800	10 00	105 00	10	28.0	1010	0	0	
10/10/10 1900	10 00	105 00	10	28.0	1010	0	0	
10/10/10 2000	10 00	105 00	10	28.0	1010	0	0	
10/10/10 2100	10 00	105 00	10	28.0	1010	0	0	
10/10/10 2200	10 00	105 00	10	28.0	1010	0	0	
10/10/10 2300	10 00	105 00	10	28.0	1010	0	0	

[illegible]



Patient ID label

[illegible][illegible]

Discharge prescription packs							
Date Given	Drug (Block Capitals)		Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle						Time Ready to Depart		
1. Admission		2. Discharge		3. Refer to G.P.		4. Transfer to other hospital (see below)		
5. Died		6. Refer to O.P. Clinic (see below)		7. Irregular Discharge		8. D.O.A.		
Ward No. (If admitted)				Transfer to Hospital			Consultant (if admitted)	
Outpatient clinic specialty				Admission or specialty clinic consultant				
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

NHSGGC NEWS – National Early Warning Score



1908546042	F
LOGAN	19/08/1954
4 Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

SpO2 Scale 1 Target >96%	SpO2 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐ If yes, add details of oxygen therapy
Signature:	Signature:	
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
Min 12 Hourly Observations	Low Clinical Risk Min 4 Hourly Observation Inform Registered Nurse Agree Frequency of Observation Required	Medium Clinical Risk Min Hourly Observations Urgent Assessment by Medical Team ACE Response in Medical Notes Think Sepsis if Suspicion of Infection	High Clinical Risk Continuous Monitoring Urgent Assessment by Senior Medical Team ACE Response in Medical Notes Consider 2222

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS Following MDT discussion, it has been agreed that this patient no longer has a requirement for observations Signed: Medical: Date:

[illegible][illegible][illegible][illegible]

Blood glucose	7.0	N/A
Pain / function score	OA	5A
Time Pt last passed urine	10.20	8 ²⁰
Fluid balance chart indicated Y/N	N	S
GCS Indicated Y/N	N	N
Time NEWS due	23.00	
Escalation of care Y / N	N	N
Initials	AB	TB

ELEVATED NEWS2 ≥ 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

1. Give oxygen to target saturation >94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart

Think ACE	
A	Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C	Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E	Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.



[illegible][illegible][illegible][illegible][illegible]

C Blood Pressure mmHg
(Score uses systolic BP only)

Blood Pressure mmHg	Frequency
201-219	0
181-200	0
161-180	0
141-160	0
121-140	0
111-120	0
101-110	1
91-100	2
81-90	3
71-80	3
61-70	3
51-60	3
≤50	3

[illegible]

LOGAN
Georgina

19/08/1954

Abbreviations for recording oxygen device

A Room Air

N Nasal

SM Simple Mask

V Venturi Mask
and 96%
eq. V24

NIV Non Invasive Ventilation

IV Invasive Ventilation

T. Tracheostomy

cp CPAP Mask

HFN High Flow Nasal Oxygen

NEB Nebuliser

RM	Reservoir Mask (Emergency use only)
----	--

Glasgow Coma Scale

[illegible]

Pupil Reaction and size

s = sluggish
+ = reaction
- = no reaction
c = eyes closed

Pupil Size (mm)

1

2

3

•

1

6

1

1

Pain Score

Ask the patient to rate his/her pain by using numerical scale 0 to 10. Use the chart below to assist the patient. If the patient is unable to communicate, use alternative pain scoring tools.

No Pain	Mild Pain			Moderate Pain			Severe Pain			
0	1	2	3	4	5	6	7	8	9	10

Pain Function Score

A	No limitations, activity unrestricted by pain or settles quickly
B	Mild limitations, mild activity restrictions
C	Moderate limitations, attempts but reluctant to continue because of pain. Seek Advice
D	Severe limitations, unable to or refuse to perform because of pain. Urgent Review Required

Affix Patient ID

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Writ

Nar

DO

Wa

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire

Ill:

Address:

Fospital:

19/08/195



Insertion criteria:

at time of insertion.

Intravascular devices are associated with an increased risk of pneumonia, G13 4NA, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☒

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☐

Transfusion ☐

PVC Inserted: Day 0	Date: 27.09.2020	Hospital: G13 4NA
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ Unknown ☐	
Insertion site:	R Hand ☐ R Arm ☒ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____	
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐	
Explanation and PVC leaflet provided to patient/ carer	Yes ☒ No ☐ If No, state reason: <u>not applicable</u>	

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score			
IV site appears healthy		0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site		1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling		2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue		3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord		4	Seek further advice
As above including: pyrexia		5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:

Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Majors 11

Affix Label



CHI: 1908546042

Queen Elizabeth University Hospital

Total Att: 23

12 Mth Att: 5

Title: MRS

LOGAN

Georgina

DOB 19/08/1954

Age: 66y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: Dr Spence
0141 212 7082

Attendance Date: 23/09/2020

Arrival Time: 13:47

Registration Time: 13:47

Date of Incident: 23/09/2020

Major Incident Desc:

Reason for Attendance: blood in urine, kidney

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: None Known

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint: Back Pain

Observation Date: 23/09/2020 14:06

Nurse name: Nurse Samantha Birrell

Temp	35.8	C
HR	67	bpm
BP	126/70	mmHg
MAP	83.67	mmHg
RR	20	bpm
SpO2	97	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: left sided lower back pain and blood in urine. stent inserted in left kidney for renal stone. admitted last week for same and was for theatre but symptoms improved

Previous attendance
History variable betw
Examination not cor
Delay in presentation
Fracture/head injury



Printed: 23/09/2020 14:40:57

Status: ACCEPTED

Analyzed: 23/09/2020 14:39:58

Sample Type: Venous

Operator ID: RUAIRI WILSON1

ID: 1908546042
Last Name: LOGAN
First Name: GEORGINA
Gender/Age: Female, 66 years
Birth Date: 19/08/1954

Lot No.: 200805E
S/N: 000000000500090825
Exp. Date: 10/10/2020

Model: GEM® Premier 5000
Area: AH_LOED_B
Name: ED-MAJ-IN
S/N: 17030619

Crit.	Reference	Crit.
Low	Low High	High

Measured (37.0°C)

pH	42.7	nmol/L	[-- -- -- --]
pCO ₂	6.3	kPa	[-- -- -- --]
pO ₂	5.1	kPa	[-- -- -- --]
Na ⁺	137	mmol/L	[-- 133 146 --]
K ⁺	4.1	mmol/L	[-- 3.5 5.3 --]
Cl ⁻	106	mmol/L	[-- 95 108 --]
Ca ⁺⁺	1.16	mmol/L	[-- 1.15 1.27 --]
Hct	51	%	[-- -- -- --]
Glu	↑ 6.1	mmol/L	[-- 3.5 6.0 --]
Lac	1.6	mmol/L	[-- 0.6 2.2 --]

CO-Oximetry

tHb	173	g/L	[-- -- -- --]
O ₂ Hb	↓ 67.9	%	[-- 95.0 98.0 --]
COHb	1.0	%	[-- 0.5 1.5 --]
MetHb	↓ 0.3	%	[-- 0.5 1.5 --]
tHb	↑ 30.8	%	[-- 0.0 5.0 --]
sO ₂	↓ 68.8	%	[-- 95.0 98.0 --]

Derived

BE(B)	1.3	mmol/L	[-- -- -- --]
HCO ₃ ⁻ (c)	27.2	mmol/L	[-- -- -- --]

↑↓ Outside Reference Range

Operator Entered

-Temp 37.0 °C

	YES	NO
ations)		

any factors identified

patient is not being admitted)



Accident and Emergency

Date: 23-09-2020 17:34
Sample ID: #0044168
Patient ID: 1908546042
Device S/N: 6101465
Operator ID: autologin
Strip LOT: 0790/8956(2021/09)

Bil	neg	
* Ubg	140 $\mu\text{mol/l}$	+++
* Ket	10 mmol/l	++
Asc	0.2 g/l	+
* Glu	2.8 mmol/l	+
* Pro	0.3 g/l	+
* Ery	300 $\text{Ery}/\mu\text{l}$	+++
pH	5	
* Nit	pos	+
* Leu	500 $\text{Leu}/\mu\text{l}$	+++
SG	1.025	

5 Prophylaxis)

Time of Administration	Signature	Given By
------------------------	-----------	----------

[illegible]

1908546042

Date	CLINICAL NOTES	
28/9/20.	Seen by (Dr) <u>Rutwan Cn</u>	Time seen 1430
66 + PC: Worsening haematuria, back and loin pain HPC: 3/7 Worsening haematuria, 2/7 Left back pain Last night experienced several hours of severe left-sided loin to groin pain, spasmodic. Spontaneously resolved. Has worsening urinary incontinence, dysuria, frequency. Denies fevers / Rigors / Vomiting / Abdo pain / bowel disturbance. No cough / Sputum x6 Courses of Abx for UTI / Unsepsis Since August. PMHx: Left ureteric Calculus -> Received Ureteric Stent insertion 20/8/20 for obstructive uropathy with pyuria / Sepsis. Readmitted 13/09/20 for 24h worsening from haematuria + UTI symptoms with mild renal impairment - X-ray demonstrated no change in Stent position. Renal function improved -> DC with Urgent urology. F/U for ureteroscopy + FURS PAF IBS Diverticulosis Asthma Chronic pain Prex. cholecystectomy Drx: Methocarbamol, Pregabalin, Sumatriptan, Bisoprolol, Hydroscine, Lansoprazole, Edoxaban, Omeprazole, Bupropion, Diclofenac gel, Amitriptyline, Salbutamol, Salifenon Sfx: Lives at home with husband independent. O/E: Alert, oriented, Declined Analgesia A- own B-  Chest sounds clear, NI added RR20 SpO2 99%. RA No FWOB. C- WWP to edges. CRT < 2s hands HR67 BP126/70 mmHg. ECG - SR HR60bpm. No new ischaemic changes. D-GCS 15 E-  Mid Suprapubic tenderness BSve Renal Angle tenderness Abdomen soft, No Periton or Guarding		

Date	CLINICAL NOTES
23/9/20	Frank Haematuria → Urinalysis: Ubg +++ Ket ++ Gluc + Prot + Ery +++ Nit + Leuk +++ Dx Urology Registrar 82765 - for Abdominal xR to assess stent / stent position → W Access + Bloods (sent) if Bloods abnormal, rediscuss. if Normal, ① with Abx for upper UTI + ensure Ureat of F/U. Abdo xR - Ureteric stent position unchanged from 12/09/20. Bloods: Hb 125 WCC 7.4 Neut 48 Plt 282 LFT (N) Ure (N) (Creat 52 eGFR >60) CRP 3 HCO₃ 21 Gluc 6.3 <u>Baseline</u> Urine culture from 26/8/20 grew +ve E.coli: Resistant to Ciprofloxacin + Amoxicillin Sensitive to Gent, Trimethoprim + Nitrofurantoin Patient states unable to take trimethoprim: Dic with 7/7 Nitrofurantoin for Upper UTI without Sepsis. Will see GP in 10/17 to hand in Urine Culture Awaits Urology follow-up. Will attend ED if unwell with fevers / rigors / more unwell.

Discharge Codes (Please CIRCLE)						Discharge date	
1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below)							
5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.						Discharge time	
Ward number (if admitted):			Transfer to hospital:			Consultant if admitted:	
Follow up		Arranged		Not arranged		To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT Others (specify):
Discharge Prescription Packs							
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By	

Majors 4

Affix Label

Hospital (circle)	IRH	RAH	RHSC	GRI	WIG	VI	VIMI	Stob	VOL	SGH
-------------------	-----	-----	------	-----	-----	----	------	------	-----	-----



Queen Elizabeth University Hospital

CHI: 1908546042

Total Att: 21

12 Mth Att: 3

Title: **MRS**

LOGAN

Georgina

DOB **19/08/1954**

Age: **66y**

Sex: **Female**

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow

Lanarkshire

G13 4NA

01419523728

Next of kin: **LOGAN, GEORGE**

Relationship: **Husband**

07774400790

GP: **DF Spence**

0141 212 7082

Attendance Date: **04/09/2020**

Arrival Time: **05:09**

Registration Time: **05:09**

Date of Incident: **04/09/2020**

Major Incident Desc:

Reason for Attendance: **unwell adult**

Nursing Assessment

Alerts: **Not Recorded**

Allergies: **Not Recorded**

Pain Score:

Triage Category: **3**

Tetanus up to date/fully immunised:

Presenting Complaint: **Abdomen Pain**

Observation Date: **04/09/2020 05:45**

Nurse name: **Nurse Caitlin Chalmers**

Temp	36.1	C
HR	98	bpm
BP	141/80	mmHg
MAP	100.33	mmHg
RR	13	bpm
SpO2	95	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: **Self presents c/o generalised abdo/upper epigastric pain which woke pt at approx 2300hrs last night. On co-amox for ?kidney infection. +ve urinalysis at triage**

Child Assessment Questionnaire

	YES	NO
Previous attendance (consider any relevant trauma from previous presentations)		
History variable between accounts		
Examination not compatible with history/presentation		
Delay in presentation		
Fracture/head injury or significant bruising in baby		

Discuss with Senior Medical Staff
 1908546042 19/08/1954
 LOGAN
 Georgina factors identified

X-Ray and Other Reports to be fil

: is not being admitted)

Accident and Emergency
 Date: 04-09-2020 08:25
 Sample ID: #0043672
 Device S/N: 6101465
 Operator ID: autologin
 Strip LOT: 0790/8956(2021/09)

Bil neg
 Ubg norm
 * Ket 1 mmol/l (+)
 Asc 0.2 g/l +
 Glu norm
 * Pro 1 g/l ++
 * Ery 300 Ery/ul +++
 pH 5
 * Nit pos +
 * Leu 500 Leu/ul +++
 SG 1.020

DO NOT
 HERE PLEASE

ONCE ONLY PRESCRIPTIONS (including Tetanus Prophylaxis)						
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By
04/09/20	MTROFURAN	Soms	Oral	07:10	a	Tina

Date

CLINICAL NOTES

Seen by (Dr) THILAKA VICKRAMTime seen 06:05

66
+

PC: abdominal pain

HPC: Last night abdo pains, epigastric region.

not 40 heartburns. extremely anxious.

nauseous, no vomiting. Haematuria +

no palpitations/100. slight chest tightness.

BG: ① ureter stone inserted (2/52 ASD) Allergy: NCDP

As time

AF

SH: Lives with husband

Chronic back pain

Dyspareunia

Pain less

TBS

Pencodin 2019



O/E: HSI + HTO, Lungs were
clear 

Abdomen soft → generalized tenderness
BS +



Imp: Abdo pain likely 2° to ureter stone

②: Antibiotic as per sensitivities (d/o Urinary reg
↳ Nitrofurantoin 50mg / 7 days (MSJADE)

Bloods ✓

Dx (H) if blood okay

Date	CLINICAL NOTES						
Discharge Codes (Please CIRCLE) 1. Admission 2. Discharge 3. Refer to GP 4. Transfer to other (see below) 5. Died 6. Refer to OP Clinic (see below) 7. Irregular Discharge 8. D.O.A.							Discharge date
							Discharge time
Ward number (if admitted):		Transfer to hospital:				Consultant if admitted:	
Follow up	Arranged		Not arranged			To be arranged	
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT
Others (specify):							
Discharge Prescription Packs							
Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By	
02/09/20	NT PROURANOLIN	50mg	ORAL	QDS		THU	

NEWS – National Early Warning Score



Name			
Address	1908546042	LOGAN	F
	Georgina	19/08/1954	
	17 SOLLAS PLACE		
	KNIGHTSWOOD		
	Glasgow, Lanarkshire		
CHI No.		G13 4NA	
DoB			

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8	92-93 Yes	9-11	12-20		21-24	≥25
Oxygen Saturations	≤91		94-95	≥96			
Any Supplemental Oxygen				No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40	91-100	41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90		101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE: 04/09	NEW
TIME: 08:45	0 1
Resp. Rate	35
Mark: •	30
	25
	20
	16
	12
	8
	2.96
SpO ₂	94.95
(Enter Value)	92.93
Any Suppl O ₂	≤ 91
Room air	%
	39°
	38.5°
	38°
	37.5°
	37°
	36.5°
	36°
	35.5°
	35°
	170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
	40
	30
	230
	220
	210
	200
	190
	180
	170
	160
	150
	140
	130
	120
	110
	100
	90
	80
	70
	60
	50
	Alert
	Verbal
	Pain
	Unresp
	NEWS SCORE
	BM
	Pain
	Nausea
	U/O
	Obs due
	Initials

[illegible]

Neurological Observations

Date:					
Time:					
COMA SCALE	E Eyes open	Spontaneously	4		Eyes closed by swelling = C
		To speech	3		
		To pain	2		
		None	1		
	V Best Verbal response	Orientated	5		Endotracheal tube or tracheostomy
		Confused	4		
		Inappropriate words	3		
Incomprehensible sounds		2			
None		1			
M Best motor response	Obeys	6		Usually record the best arm response	
	Localises	5			
	Flexion - withdrawal	4			
	Flexion - abnormal	3			
	Extension to pain	2			
	None	1			
TOTAL SCORE					
PUPILS	R	Size			+ reacts - no reaction C. eyes closed
		Reaction			
	L	Size			
		Reaction			
LIMB MOVEMENT	ARMS	Normal power		Record right (R) and left (L) separately if there is a difference between the two sides	
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
	LEGS	No response			
		Normal power			
		Mild weakness			
		Severe weakness			
		Spastic flexion			
		Extension			
		No response			

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting

0	= None
1	= Mild (<i>Not distressing – no retching/vomiting</i>)
2	= Moderate (<i>Troublesome – occasional retching/vomiting</i>)
3	= Severe (<i>Distressing – frequent retching/vomiting</i>)

Management Plan and Patient Exclusions

[illegible]

Patient name



1908546042

LOGAN

Georgina

F

19/08/1954

Patient CHI

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time

Name/Signature

04/09/2020 upper abdo pain.
0745

Nursing notes - on admission

Date and Time

Name/Signature

04/09/2020 Handed over from n/s.
for (H) if bloods normal.
0745

Triage

Patient prepared for exam - clothing bagged		Y	N
NEWS Chart	(Y) N	X-rays	Y N
ID band	Y N		
Peak Flow	Y (N)		Please specify
12-lead ECG	Y N	Urinalysis	Y N
IV access	Y N		
Blood samples	(Y) N	Positive findings	
Blood Gas	Y N	B-HCG	Y N

Communication

GGC Red Bag with Patient (nursing home resident)	Y	N
Language or hearing difficulty	Y	N
Interpreter required	Y	N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	Y	N
name, relationship, location, particular concerns		

Risk Assessments and Screening Tools

SEPSIS	Y	N	GMAWS	Y	N
FAST	Y	N	Adult Support and Protection	Y	N
Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N

Signature:

Patient name

Patient CHI

or use sticker



Care Rounds Checklist

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 _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

		Times													
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.													
	2	PAIN: ASSESS AND ADDRESS. Is the patient distressed or in pain? If yes inform registered nurse.													
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU = Pressure Ulcer INT = Intact M = Moisture													
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk / stand													
		ELIMINATION. Does the patient need the toilet?													
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)													
N	6	FOOD FLUIDS AND NUTRITIO. Is the patient nil by mouth? Drink taken? Food, snack, or supplements taken? Has oral hygiene been carried out as per care plan?													
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?													
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return													
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return													
Care provider															
Role															

Ask the patient if there is anything they specifically want done today:

Pa 1908546042
 Pa LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1955
 sticker
 G13 4NA

Hospital:	Points to consider:
Ward:	• Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes



PUDRA

1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.
---	------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____ hrly	
/ /	:							____ hrly	
/ /	:							____ hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/ continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/ family/carer YES / NO 2. Prevent Pressure Ulcers"- leaflet given to patient/family/ carer YES / NO

Patient name

Patient CHI

or use sticker

Nursing notes - discharge planning

Date and Time	Name/Signature

Outcomes and outstanding issues

Date and Time	Name/Signature

Pause for Discharge or Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band	Y	N
Nursing Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart NEWS completed within 1 hour of transfer/discharge	Y	N
Prescriptions and fluid charts signed	Y	N
Cannula	Y	N
Notes Complete	Y	N
Analgesia	Y	N
Belongings	Y	N
Transport	Y	N

Signature:

Contact with relatives

Signature:

Patient name

Patie

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/195

F.....

er

G13 4NA



4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS		Circle Score
This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.		
Normal (alert, but not agitated, through assessment)		0
Mild sleepiness (<10 secs) after waking, then normal		0
Clearly abnormal		4
(2) AMT4		
Age, date of birth, place (name of the hospital/building), current year.		
No mistakes		0
1 mistake		1
2 or more mistakes/untestable		2
(3) ATTENTION		
Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.		
wAchieves 7 months or more correctly		0
Starts but scores <7 months / refuses to start		1
Untestable (cannot start, unwell, drowsy, inattentive)		2
(4) ACUTE CHANGE OR FLUCTUATING COURSE		
Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.		
No		0
Yes		4
4 or more possible delirium +/- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)		TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?				circle Y or N	
F	Functional Impairment	(new or worsening) eg difficulty with self care	Y	N	
R	Resident	in a care home	Y	N	
A	Altered mental state	such as delirium or dementia (4AT Assessment)	Y	N	
I	Immobility/Instability	decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N	
L	Living at home with support	on a daily basis (homecare, one visit or more per day)	Y	N	
If YES to any of the criteria in Step 1 move to Step 2					
Step 2 Would this person be better managed by another speciality team at present?				circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD			Y	N	
Need for HDU/ITU (including non-invasive ventilation)			Y	N	
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit			Y	N	
Head injury with loss of consciousness			Y	N	
Acute abdominal pain/ surgical presentation			Y	N	
Upper GI Bleed			Y	N	
Chest pain with suspected acute coronary syndrome			Y	N	
Trauma with suspected fracture			Y	N	
Are any of the criteria met?					
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.					
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.					

Patient CHI

NHS
Greater Glasgow
and Clyde

[illegible]

NEWS – National Early Warning Score



Name	
Address	1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire
CHI No.	G13 4NA
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

2020	DATE: 4/9	TIME: 05:30	NEW
			0 1
Resp. Rate	35		
Mark: •	30		
	25		
	20		
	16		
	12		
	8		
SpO ₂	2.96		
(Enter Value)	94.95		
Any Sup'l O ₂	92.93		
Room air	≤ 91		
	%		
Temp.	39°		
Mark: X	38.5°		
	38°		
	37.5°		
	37°		
	36.5°		
	36°		
	35.5°		
	35°		
Pulse	170		
Mark: •	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
	40		
	30		
	230		
	220		
	210		
	200		
	190		
	180		
	170		
	160		
	150		
	140		
	130		
	120		
	110		
	100		
	90		
	80		
	70		
	60		
	50		
Blood Pressure	141		
Mark: ∇	141		
NEWS SCORE	1		
using Systolic BP	80		
Conscious Level	Alert		
Mark: •	Verbal		
	Pain		
	Unresp		
Total NEWS (with all obs)	2		
BM			
Pain	6/10		
Nausea			
Urine output			
Obs due			
Initials	CU		

[illegible]

Patient name ... 1908546042
 LOGAN F
 Georgina 19/08/1954
 Patient CHI ... 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA



Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time	Self presents c/o generalised	Name/Signature
4/9/2020	OS abdominal upper epigastric pain which	
	woke pt at approx 23 ⁰⁰ hrs last night	

Nursing notes - on admission

Date and Time	On co-amox for a kidney	Name/Signature
	injection. +ve urinalysis at	(CHAMBER)
	triage.	Chamber

Triage

Patient prepared for exam - clothing bagged		☒ Y	☐ N	
NEWS Chart	☒ Y	☐ N	X-rays	
ID band	☒ Y	☐ N		
Peak Flow	☒ Y	☒ N	Please specify	
12-lead ECG	☒ Y	☐ N	Urinalysis	
IV access	☒ Y	☐ N		
Blood samples	☒ Y	☐ N	Positive findings	
Blood Gas	☒ Y	☐ N		
		B-HCG	☒ Y	☐ N

Communication

GCG Red Bag with Patient (nursing home resident)	☒ Y	☒ N
Language or hearing difficulty	☒ Y	☒ N
Interpreter required	☒ Y	☒ N
what arrangements have been made?		
Relatives / Carer / Next of Kin present	☒ Y	☒ N
name, relationship, location, particular concerns		

Risk Assessments and Screening Tools

SEPSIS	☒ Y	☐ N	GMAWS	☒ Y	☐ N
FAST	☒ Y	☐ N	Adult Support and Protection	☒ Y	☐ N
Swallow Testing	☒ Y	☐ N	Mental Health Triage Assessment	☒ Y	☐ N
Falls Risk (clinical judgement)	☒ Y	☐ N	Child Protection Concerns	☒ Y	☐ N

Signature:

Patient name

Patient CHI

or use sticker

Care Rounds Checklist

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 _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:

Y = Yes **N** = No **NA** = Not Applicable **NT** = No Thanks **S** = Sleeping **O** = Off the ward **I** = Independent

		Times															
	1	THINK DELIRIUM Is the patient more confused/drowsy than normal? If yes inform registered nurse.															
	2	PAIN: ASSESS AND ADDRESS. Is the patient distressed or in pain? If yes inform registered nurse.															
S	3	SKIN INSPECTION Pressure areas checked? R = RED D = Discoloured PU = Pressure Ulcer INT = Intact M = Moisture															
K	4	KEEP MOVING Has the patient moved or walked? Bed R = Right side (30°) tilt L = Left side (30°) tilt B = Back Chair W/ST = Assist to walk/ stand															
		ELIMINATION. Does the patient need the toilet?															
I	5	I = Independent A = Assistance given IC = Incontinent (urine/faeces)															
N	6	FOOD FLUIDS AND NUTRITIO. Is the patient nil by mouth?															
		Drink taken?															
		Food, snack, or supplements taken?															
		Has oral hygiene been carried out as per care plan?															
	7	ENVIRONMENT CHECK Is the patient's call buzzer to hand? Is the area clutter free clean and safe? Does the patient have everything they require in safe reach? Is the bed in the lowest position?															
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return															
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return															
Care provider																	
Role																	

Ask the patient if there is anything they specifically want done today:

Patient CHI

NHS
Greater Glasgow
and Clyde

Date and Time

Name/Signature

Date and Time

Name/Signature

GGC Red Bag with Patient (nursing home resident)

Y | N

Relatives / Carer with Patient

	Y	N
1. The company has a clear vision and mission statement.		
2. The company has a strong leadership team.		
3. The company has a solid financial foundation.		
4. The company has a diverse and talented workforce.		
5. The company has a strong customer base.		
6. The company has a competitive advantage.		
7. The company has a strong brand identity.		
8. The company has a strong commitment to social responsibility.		
9. The company has a strong track record of innovation.		
10. The company has a strong reputation in its industry.		

Name Band

	Y	N
Q1	0.78	0.22
Q2	0.65	0.35
Q3	0.52	0.48
Q4	0.40	0.60
Q5	0.30	0.70
Q6	0.20	0.80
Q7	0.15	0.85
Q8	0.10	0.90
Q9	0.08	0.92
Q10	0.05	0.95
Q11	0.03	0.97
Q12	0.02	0.98
Q13	0.01	0.99
Q14	0.01	0.99
Q15	0.01	0.99
Q16	0.01	0.99
Q17	0.01	0.99
Q18	0.01	0.99
Q19	0.01	0.99
Q20	0.01	0.99
Q21	0.01	0.99
Q22	0.01	0.99
Q23	0.01	0.99
Q24	0.01	0.99
Q25	0.01	0.99
Q26	0.01	0.99
Q27	0.01	0.99
Q28	0.01	0.99
Q29	0.01	0.99
Q30	0.01	0.99
Q31	0.01	0.99
Q32	0.01	0.99
Q33	0.01	0.99
Q34	0.01	0.99
Q35	0.01	0.99
Q36	0.01	0.99
Q37	0.01	0.99
Q38	0.01	0.99
Q39	0.01	0.99
Q40	0.01	0.99
Q41	0.01	0.99
Q42	0.01	0.99
Q43	0.01	0.99
Q44	0.01	0.99
Q45	0.01	0.99
Q46	0.01	0.99
Q47	0.01	0.99
Q48	0.01	0.99
Q49	0.01	0.99
Q50	0.01	0.99
Q51	0.01	0.99
Q52	0.01	0.99
Q53	0.01	0.99
Q54	0.01	0.99
Q55	0.01	0.99
Q56	0.01	0.99
Q57	0.01	0.99
Q58	0.01	0.99
Q59	0.01	0.99
Q60	0.01	0.99
Q61	0.01	0.99
Q62	0.01	0.99
Q63	0.01	0.99
Q64	0.01	0.99
Q65	0.01	0.99
Q66	0.01	0.99
Q67	0.01	0.99
Q68	0.01	0.99
Q69	0.01	0.99
Q70	0.01	0.99
Q71	0.01	0.99
Q72	0.01	0.99
Q73	0.01	0.99
Q74	0.01	0.99
Q75	0.01	0.99
Q76	0.01	0.99
Q77	0.01	0.99
Q78	0.01	0.99
Q79	0.01	0.99
Q80	0.01	0.99
Q81	0.01	0.99
Q82	0.01	0.99
Q83	0.01	0.99
Q84	0.01	0.99
Q85	0.01	0.99
Q86	0.01	0.99
Q87	0.01	0.99
Q88	0.01	0.99
Q89	0.01	0.99
Q90	0.01	0.99
Q91	0.01	0.99
Q92	0.01	0.99
Q93	0.01	0.99
Q94	0.01	0.99
Q95	0.01	0.99
Q96	0.01	0.99
Q97	0.01	0.99
Q98	0.01	0.99
Q99	0.01	0.99
Q100	0.01	0.99

Nursing Screening Tools Complete

Y	N
1	1
2	1
3	1
4	1
5	1
6	1
7	1
8	1
9	1
10	1
11	1
12	1
13	1
14	1
15	1
16	1
17	1
18	1
19	1
20	1
21	1
22	1
23	1
24	1
25	1
26	1
27	1
28	1
29	1
30	1
31	1
32	1
33	1
34	1
35	1
36	1
37	1
38	1
39	1
40	1
41	1
42	1
43	1
44	1
45	1
46	1
47	1
48	1
49	1
50	1
51	1
52	1
53	1
54	1
55	1
56	1
57	1
58	1
59	1
60	1
61	1
62	1
63	1
64	1
65	1
66	1
67	1
68	1
69	1
70	1
71	1
72	1
73	1
74	1
75	1
76	1
77	1
78	1
79	1
80	1
81	1
82	1
83	1
84	1
85	1
86	1
87	1
88	1
89	1
90	1
91	1
92	1
93	1
94	1
95	1
96	1
97	1
98	1
99	1
100	1

Bed Available

	Y	N
1	0	0
2	0	0
3	0	0
4	0	0
5	0	0
6	0	0
7	0	0
8	0	0
9	0	0
10	0	0
11	0	0
12	0	0
13	0	0
14	0	0
15	0	0
16	0	0
17	0	0
18	0	0
19	0	0
20	0	0
21	0	0
22	0	0
23	0	0
24	0	0
25	0	0
26	0	0
27	0	0
28	0	0
29	0	0
30	0	0
31	0	0
32	0	0
33	0	0
34	0	0
35	0	0
36	0	0
37	0	0
38	0	0
39	0	0
40	0	0
41	0	0
42	0	0
43	0	0
44	0	0
45	0	0
46	0	0
47	0	0
48	0	0
49	0	0
50	0	0
51	0	0
52	0	0
53	0	0
54	0	0
55	0	0
56	0	0
57	0	0
58	0	0
59	0	0
60	0	0
61	0	0
62	0	0
63	0	0
64	0	0
65	0	0
66	0	0
67	0	0
68	0	0
69	0	0
70	0	0
71	0	0
72	0	0
73	0	0
74	0	0
75	0	0
76	0	0
77	0	0
78	0	0
79	0	0
80	0	0
81	0	0
82	0	0
83	0	0
84	0	0
85	0	0
86	0	0
87	0	0
88	0	0
89	0	0
90	0	0
91	0	0
92	0	0
93	0	0
94	0	0
95	0	0
96	0	0
97	0	0
98	0	0
99	0	0
100	0	0

SBAR complete

Y	N
---	---

NEWS Chart NEWS completed within 1 hour of transfer/discharge

Y	N
---	---

Prescriptions and fluid charts signed

Y	N
---	---

Cannula

Y	N
---	---

Notes Complete

	Y	N
1. The company has a clear vision and mission statement.		
2. The company has a strong leadership team.		
3. The company has a solid financial foundation.		
4. The company has a diverse and talented workforce.		
5. The company has a strong commitment to social responsibility.		
6. The company has a strong customer base.		
7. The company has a strong brand identity.		
8. The company has a strong competitive advantage.		
9. The company has a strong innovation culture.		
10. The company has a strong global presence.		

Analgesia

	Y	N
--	---	---

Belongings

Y	N
----------	----------

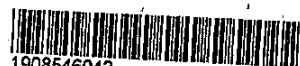
Transport

Y	N
---	---

Signature:

[illegible]

Signature:



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

F

se sticker

G13 4NA

Hospital:

Ward:

Points to consider:

- Use within 8 hrs of admission to care area
- Re-assess daily and more frequently if a person's condition changes

**PUDRA**

1	Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan.
----------	------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise or change position (inappropriate for age)?
3	Continence	Does the person have continence issues with urine and/or faeces (inappropriate for age)?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink/ PYMS score>2?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Pressure Relieving Care interventions and complete the pressure ulcer interventional plan.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
/ /	:							____ hrly	
/ /	:							____ hrly	
/ /	:							____ hrly	

Complete prevention of pressure ulcer interventional plan below for all patients with redness/pressure damage and for those at risk.

S Skin Inspection	S Surface	K Keep Moving	I Incontinence/ Moisture	N Nutrition	S Self Management/ Shared Care
Check: • Pressure areas ____ hourly • Skin under medical devices ____ hourly • Specify medical devices used	Specify: 1. Mattress 2. Cushion 3. Detail additional pressure redistributing equipment	1. Reposition ____ hourly in bed / chair 2. Overnight patient/carer has agreed to repositioning ____ hourly 3. Specify any manual handling equipment used	1. Skin Care to be carried out ____ hourly 2. Specify products required for increased moisture/continence management:	1. Optimise nutrition and hydration 2. Refer to MUST	1. Discuss and agree plan with patient/family/carer YES / NO 2. Prevent Pressure Ulcers" leaflet given to patient/family/carer YES / NO

Patient name

Patient CHI

or use sticker

4AT assessment - for delirium and cognitive impairment

(1) ALERTNESS This includes patients who may be markedly drowsy (eg. difficult to rouse and/or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep, attempt to wake with speech or gentle touch on shoulder. Ask the patient to state their name and address to assist rating.		Circle Score
Normal (alert, but not agitated, through assessment)		0
Mild sleepiness (<10 secs) after waking, then normal		0
Clearly abnormal		4
(2) AMT4 Age, date of birth, place (name of the hospital/building), current year.		
No mistakes		0
1 mistake		1
2 or more mistakes/untestable		2
(3) ATTENTION Ask the patient: "Please tell me the months of the year in backwards order, starting at December." To assist initial understanding one prompt of "what is the month before December?" is permitted.		
wAchieves 7 months or more correctly		0
Starts but scores <7 months / refuses to start		1
Unstable (cannot start, unwell, drowsy, inattentive)		2
(4) ACUTE CHANGE OR FLUCTUATING COURSE Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg. paranoia, hallucinations) arising over the last 2 weeks and still evident in last 24hrs.		
No		0
Yes		4
4 or more possible delirium + /- cognitive impairment 1-3 possible cognitive impairment 0 delirium or severe cognitive impairment unlikely (but delirium still possible if (4) information incomplete)		TOTAL

Frailty Assessment Tool

(Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?		circle Y or N	
F	Functional impairment (new or worsening) eg difficulty with self care	Y	N
R	Resident in a care home	Y	N
A	Altered mental state such as delirium or dementia (4AT Assessment)	Y	N
I	Immobility/instability decline in mobility, difficulty mobilising without help, fall leading to presentation	Y	N
L	Living at home with support on a daily basis (homecare, one visit or more per day)	Y	N
If YES to any of the criteria in Step 1 move to Step 2			
Step 2 Would this person be better managed by another speciality team at present?		circle Y or N	
Clear need for other specialty input eg exacerbation of known long-term condition such as COPD		Y	N
Need for HDU/ITU (including non-invasive ventilation)		Y	N
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		Y	N
Head injury with loss of consciousness		Y	N
Acute abdominal pain/ surgical presentation		Y	N
Upper GI Bleed		Y	N
Chest pain with suspected acute coronary syndrome		Y	N
Trauma with suspected fracture		Y	N
Are any of the criteria met?			
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.			
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.			



LOGAN

Georgina.

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954.

E

use sticker

G13 4NA



Nursing notes - ongoing care

[illegible]

Queen Elizabeth University Hospital



CHI: 1908546042

Total Att: 20

12 Mth Att: 2

Title: MRS

LOGAN

Georgina

DOB 19/08/1954

Age: 66y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: DF Spence
0141 212 7082

Attendance Date: 26/08/2020

Arrival Time: 16:10

Registration Time: 16:10

Date of Incident: 26/08/2020

Major Incident Desc:

Reason for Attendance: gen unwell urine retenion

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 26/08/2020 16:14

Nurse name: Nurse Claire Ferry

Temp	35.7	C
HR	89	bpm
BP	101/60	mmHg
MAP	73.67	mmHg
RR	19	bpm
SpO2	97	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "likley urine rention/ infection. refused by urology. transfer from ae. n&v. "

cons aware. *df*

Patient ID label

Date	Emergency Department Notes		
	Ambulance Proforma reviewed Yes / No		Seen by (Doctor)
	Time seen		

Patient ID label



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List	
	NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature:	Designation:	Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Seen By: T Foley

Print: FY2

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint 66 ♀	'Retention'
History of presenting complaint ? 2° retention/ Constipation ? 2° Abx Gd/c on Cipro from urology No vomiting today.	Stented in urology for Ⓛ proximal ureteric stone ↳ Some Haematuria since Felt unwell 25/8 Nausea + vomiting ↳ Vomiting +++ blood, food only. Pulling small volumes Haematuria yesterday today dipstick only. Constipated ~ 1/52 → BO today small motion, soft. Since stent visible o recent takeover of o pain → groin o dysuria o AP Lower abd. discomfort

Past Medical History / Review of portal		
Asthma	Diverticulosis	Restless legs
AF	IBS	
Chronic back pain	Pericarditis - 2019	

Systemic Enquiry	
o Coughs	* Felt hot + shivery } a pyrexial. @ 17 Not in hospital.
o SOB	



1908546042

LOGAN

Georgina

F
19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

1. Patient/Relative/Carer 2. GP Phone call 3. GP letter/summary 4. Repeat Prescription 5. Patient own drugs 6. Com. Pharmacist 7. GP letter/summary 8. Repeat Prescription

MEDICINES RECONCILIATION - Acceptable to staple fully completed Emed Rec

Source of medication history
(>1 source preferred)☒ Patient/Relative/carer☐ GP Phone call☒ ECS☒ Patient own drugs☐ Com. Pharmacist☐ GP letter/summary☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr/complete)				Comments Reason for alteration
Name	Dose	Freq	Continue	Amend	Withhold	Stop	
✓ AMITRIPTYLINE	75mg	Nchte					
✓ Buter	30micg	Every 7 days					transdermal
✓ Sertraline	50mg	OD					
✓ Pregabalin	300mg	BD					
✓ Simvastatin	40mg	Nchte					Ab stopped
✓ Methocarbamol	750mg	QDS					
✓ Bisoprolol	2.5mg	OD					
✓ HYOSCINE	20mg	TDS					
✓ Lansoprazole	15mg	OD					
✓ Octasa MR	1.2g	BD					Me salazine
✓ Edoxaban	60mg	OD					
✓ Salofalk foam	1app	Nchte					1g/app
✓ Symbicort 200/6	T	BD					
✓ Salbutamol	II	PRN					Where
✓ Ralvo	700mg	tid					Plaster 12h on/12h off
✓ Ropinirole	250mg	Nchte					500mg
✓ Shortec	10mg	BD					PRN
✓ Diclofenac 1.16% gel	1app	TDS					PRN

Allergies

List any over-the-counter or alternative medicines

FUDRA.

Do medicines need further clarification? ☐ Yes ☐ No

List collected by:

Plan approved by:

Designation:

Date:

Designation:

Date:

Pharmacy review

Comments

Compliance aid:

☐ Yes ☐ No

Community pharmacist

Phone

Reviewed by:

Designation:

Date:



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

1. CONTAINS SENSITIVE INFORMATION 2. THIS DOCUMENT IS NOT TO BE RELEASED OUTSIDE THE NHS SYSTEM

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☒ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Nil.

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

Lives with husband (separated) } managing @
Normally stays alone } Home

General Examination

Temp: 35.5

RR: 18

Pulse: 88

CBG:

SpO₂: 97%

Weight:

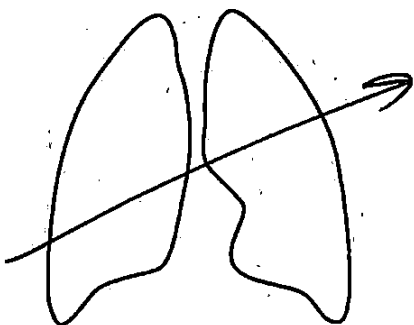
BP: 100/60

Urinalysis:

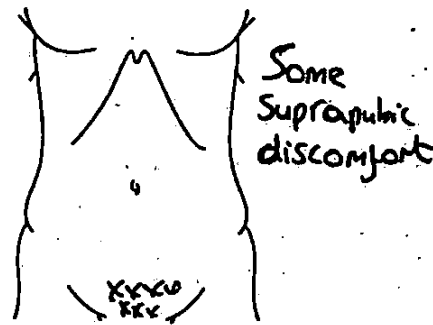
General Appearance:

Looking well
(chatty)

Respiratory



Gastrointestinal System



Cardiovascular

HS 1+1

HR feels Regular

° leg swelling.

Locomotor

Grossly (N)



LOGAN.

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13'4NA

המחיר הממוצע של המכשיר הוא 1,200 ש"ח, ויש לו מחיר מינימלי של 1,000 ש"ח. המחיר הממוצע של המכשיר הוא 1,200 ש"ח, ויש לו מחיר מינימלי של 1,000 ש"ח.

GCS/15

E: /4

M: /6

V: /5

AMT 4 = age, DOB, place, year

AMT score. ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

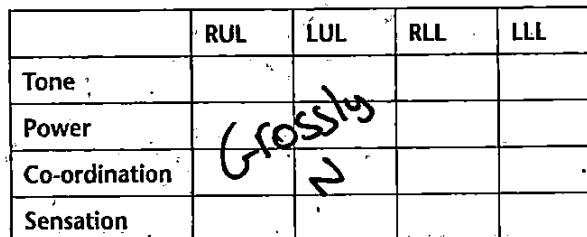
Pupils/fundoscopy:

Cerebellar and extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



Plantars: R L

Skin/Other

N/a.



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

A SCOTTISH HEALTH CARE TRUST (SCOTTISH HEALTH CARE TRUST) LIMITED

Key Results

CXR

ECG

(Differential) diagnosis

Retention

2° Constipation

UTI Seems unlikely

↳ Had recent course cipro.

NEWS ☒Red Flag ☐Sepsis ☐CURB 65 ☐

Management Plan

Bladder scan +/- Catheter → Refer
urology.

MSSU

Dipstick

Laxatives

If Staying in → kordex.

d/w → Alshanti
urology. Will come
+ see.Happy to
accept both.
patient's
many thanks.☐ Thromboprophylaxis assessed☐ Medicine Reconciliation☐ 4AT/TIME☐ Antimicrobial

Signature:

PRINT NAME TFoley

PRINT GRADE FY2.

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

M. GULON, (72 UNCLIN) 26/1/16
2040pm

- 11F

- L stroke 20/18

- today severe central pain, similar to stroke but not as bad

- few episodes of vomiting

- felt congested + passing small volumes of urine

- since arrival; pain better

- moved back

patient v vitals 21/1/16: no grunting
@ on oral O₂

- EKG

-/-, low wall

soft non-tender, no tenderness

Shedden son: 6m/1

pmu + 0.4
as documented

also

CAP 16

25/1/16 (7)

WBC 10.

ing. skin pain - improved
- sepsis - well

① @ what level 21/02 as
planned.

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETEDIs the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days☐ Yes☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive	
Age > 60	Hormone replacement therapy	
Dehydration	Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophilia	Critical care admission	
BMI >30	Varicose veins with phlebitis	
Personal/1st degree relative history of VTE	Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture		

☐ Yes☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia <75 x10 ⁹ /l	
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR >2	Uncontrolled hypertension (>230/120)	
Acute stroke	Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic		
Other - Document		

☐ No☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A

(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by: _____

Date: _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	()								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 - 10 Female: 1 - 12								
CRP	<10								
Troponin hs.I	Male: 0 - 34 Female: 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 - 2.0								

Patient



1908546042

LOGAN

Georgina

F
19/08/1954

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO₂:

FiO₂:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

[illegible]



1908546042

'LOGAN

F

19/08/1954

Date: Time

[illegible]

Patient ID label

Continuation Sheet

Date: Time

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.



1000610040

Georgina

19/08/1954

Date: Time

[illegible]

Patient ID label

Done/Time

[illegible][illegible]

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle								Time Ready to Depart		
1. Admission		2. Discharge		3. Refer to G.P.		4. Transfer to other hospital (see below)		Discharge Time		
5. Died		6. Refer to O.P. Clinic (see below)		7. Irregular Discharge		8. D.O.A.				
Ward No. (If admitted)				Transfer to Hospital				Consultant (if admitted)		
Outpatient clinic specialty							Admission or specialty clinic consultant			
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify		



1908546042

LOGAN

Georgina

F

19/08/1954



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Registration Details - Patient No: 7881

Personal details...		Address details...	
Sex	F	Postcode	G13 4NA
Surname	Logan	House Name Flat No	
Title	Mrs	No and Street	17 Sollas Place
Birth Surname		Village	
Forenames	Georgina	Town	Glasgow
Calling Name	Georgina	County	
Previous Surname	Logan		
Date of Birth	19/08/1954		
DOB			
Marital Status			
Ethnic Origin			

HA/HB Details...		Contact details...	
Health Board	Greater Glasgow	Home Tel No	sister 952 3728
Registered GP	Dr Desmond Spence	Work Tel No	952 5847
Usual GP	Dr Desmond Spence	Mobile Tel No	0777 440 0790
Residential Inst		E Mail Address	
Branch Surgery			
CHI Number	1908546042		
NHS Number			

Practice Information...		Distances	
Dispensing		Rural Mileage	
Hospital Number		Blocked Special	
Records At		Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	12/09/2016		

AMS/CMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
Pharmacy Details	Willis Pharmacy-1566 Dumbarton Road, Scotstoun, Glasgow, (G14 9DB) - 0141 959 2551 (Org Id - 1605)		
Item Collected Check	Yes		
CMS Suitability Status	-1		
CMS Registration Status	2		

Medical Record

Problems

Active Problems		Authorised By	Code
17/08/2020	Endoscopic insertion of ureteric stent (Left)	Mr Todd	7B1A1
17/08/2020	Calculus of ureter	Miss Gray	K121
02/04/2020	H/O: depression Currently on Depression Meds	Mrs Nicol	1465
17/01/2020	Magnetic resonance imaging Degenerative change, minor root compression, no cauda equina	Dr Adair	569-2
01/12/2019	[D]Abdominal pain unspecified, admitted	Miss Martin	R090
21/11/2019	Radiculopathy suspected diagnoses	Mr Andrews	EGTON436
18/07/2019	Atrial fibrillation	Ms Henry	G5730

13/01/2017	H/O amphetamine misuse	Dr Adair	1T4
2010	Irritable bowel syndrome episodic diarrhoea on Octasa	Dr Adair	J521-1
2010	Diverticulosis	Dr Adair	J510
17/11/2004	Asthma	Mrs Connell	H33

Past Problems	Authorised By	Code
2010 Cholecystectomy NEC	Dr Adair	78102-1
12/2009 Primary lumbar discectomy Failed, no benefit from subsequent caudal block	Dr Adair	7J32

Due Diary Entries	Authorised By	Code
25/08/2021 Medication review	Dr Byford	8B314
05/08/2021 Patient "recall" admin. NOS	Ms McGhee	9O4Z.
28/05/2021 Key information summary review date	Ms Mitten	EMISNQKE7
01/12/2020 Near-patient testing - enhanced services administration	Mrs MacConnacher	9kD

Overdue Diary Entries	Authorised By	Code
02/04/2020 Asthma annual review OVERDUE	Mrs Hopkin	66YJ.
19/08/2019 Influenza vaccination OVERDUE	Dr Weir	65E..
18/08/2019 No response to bowel cancer screening programme invitation OVERDUE	Mrs McIntyre	9Ow2.
Bowel Cancer Screening Exclusion		
09/04/2019 Asthma follow-up OVERDUE	Mrs Hopkin	66YK.

Alerts	Authorised By	Code
21/02/2018 Alert ONLY TO SEE GP FOR ISSUES OF ADDITIONAL ANALGESIA/MEDICATION REQUESTS	Mrs McIntyre	EMISALERT
24/04/2017 Alert PLEASE SEE LAST PAIN CLINIC LETTER	Ms Dempsey	EMISALERT

Drug Allergies	Authorised By	Code
None		

Non Drug Allergies	Authorised By	Code
None		

Health Status

18/07/2012	Cervical smear result Cervical smear: negative
03/06/2020	Height 147 cm
03/06/2020	Weight 74 Kg
03/06/2020	Body Mass Index 34.24 kg/m2
03/06/2020	Blood pressure reading 125/75 mm Hg
16/07/2019	Blood pressure reading O/E - BP reading
10/04/2019	Smoking Status Never smoked tobacco
03/05/2013	FH: Ischaemic heart dis. <60
03/05/2013	FH: Ischaemic heart dis. >60


 1908546042
 F
 19/08/1954
 G13 4NA
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire

Consultations
26/08/2020 Mr Archie McCorkell at Barclay Victoria Park Medical Practice

Comment
 TC with Georgina today. Note was discharged on 22/8/20 following diagnosis of ureteric stone & ureteric stent placed. Following discharge exp some abdominal pain & frank haematuria then retention?. Called OOH & Ambulance sent to the house. Claimed felt slightly better when ambulance arrived however did not want to go back into hospital. Signed refusal & advised crew would contact GP. Georgina claimed is now feeling alot better. Is now passing clear urine with

abdominal pain subsided. Is now taking fluids & managed to eat something today as had not eaten for several days. No nausea/vom, was previously feversh? had been taking Paracetamol regular, note Temp with Amb crew was 36.9 & HR 114. Georgina claimed is feeling much better & would contact the practice should she have any further concerns.

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
19/08/1954
G13 4NA

25/08/2020	<u>Mrs Kirstin MacConnacher at Data Entry</u>
History	Post hospital dischrge med reconciliation with medical notes IDL received, patient admitted to QEH17/8 - 22/87 with left sided loin to groin pain. Uretic stone. Uretic stent has been placed. To complete 7 day Ciprifloxacin course. RCOUline Urology MDT stone referral made. Meds rec completed, no changes to repeat medications.
Comment	Medication review done by pharmacist
Additional	
25/08/2020	<u>Dr David Byford at Acute Scripts</u>
Comment	Special Request- ralvo. Allow to continue.
25/08/2020	<u>Dr David Byford at Telephone Consultation</u>
History	Note recent admission with left ureteric colic secondary to stone, stent inserted and awaiting follow up at stone clinic. Reports recurrence of frank haematuria today, which had settled prior to admission. No back pain today so far (did have yesterday). Still on course of cipro.
Comment	Advised the haematuria will be secondary to the stone itself causing local trauma. Plan - monitor and after antibiotic course completed, hand in sample to ensure no residual infection. Also requests some more shortec. Script issued.
Test Request	Midstream Urine (C&S) - Requested
Additional	Medication review done
17/08/2020	<u>Ms Gillian Henry at Barclay Victoria Park Medical Practice</u>
History	Telephone consult due to Covid 19 lockdown back pain and abd pain Left iliac fossa pain very painful to walk vomiting +++ no blood in vomit or stool soft stools. Cry with pain very distressed panting due to discomfort- advised to atyend QE for assessment , finishing sentences.

Medication

Current				
Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
24/07/2020	Dioralyte Oral powder (blackcurrant) DISSOLVE ONE SACHET IN 200ML WATER AND TAKE AS DIRECTED 6 sachet	24/07/2020P	Ms Wilma Mitten	ACUTE
21/07/2020	Ropinirole Hydrochloride Tablets 250 micrograms ONE AT NIGHT- INCREASED TO 2 AT NIGHT IF TOLERATED AND REQUIRED 56 tablet	21/07/2020P	Ms Wilma Mitten	ACUTE
30/04/2020	Ralvo Medicated Plaster 700 mg 12 HOURS ON 12 HOURS OFF 30 PLASTER	25/08/2020P	Dr Desmond Spence	ACUTE
17/07/2019	Shortec Capsules 10 mg ONE TO BE TAKEN TWICE DAILY WHEN REQUIRED 56 CAPSULE	25/08/2020P	Dr Desmond Spence	ACUTE
17/07/2019	Edoxaban Tablets 60 mg ONE TO BE TAKEN EACH DAY 28 tablet	24/08/2020P	Dr Desmond Spence	REPEAT
03/06/2019	Octasa Mr Gastro-resistant Tablets 400 mg TAKE THREE TABLETS TWO TIMES DAILY 168 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
20/03/2019	Lansoprazole Capsules (Gastro-Resistant) 15 mg ONE TO BE TAKEN EACH DAY 28 CAPSULE	24/08/2020P	Dr Desmond Spence	REPEAT
06/02/2019	Hyoscine Butylbromide Tablets 10 mg TAKE 2 TABS THREE TIMES DAILY 168 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
08/11/2018	Prochlorperazine Maleate Tablets 5 mg 1 TAB 3 TIMES DAILY 60 tablet	30/04/2020P	Dr Desmond Spence	REPEAT
28/08/2018	Bisoprolol Fumarate Tablets 2.5 mg ONE TO BE TAKEN EACH DAY 28 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
13/06/2018	ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY 60 sachet	14/10/2019P	Dr Desmond Spence	REPEAT
09/05/2018	Amitriptyline Hydrochloride Tablets 25 mg ONE TO BE TAKEN IN THE EVENING IN ADDITION TO 50MG DOSE. TOTAL DAILY DOSE 75MG. DISPENSE WEEKLY. 28 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
04/05/2018	Diclofenac Diethylammonium Gel 1.16 % APPLY 3 TIMES DAILY IF REQUIRED 100 gram	24/08/2020P	Dr Desmond Spence	REPEAT
	Butec Transdermal patches 20 micrograms/hour APPLY ONE PATCH EVERY SEVEN DAYS IN			

Chas. Allen
Spec. 967.

Pr 18

Pr 08 Day

Pr 12 Mon

ext < 1 sec

9/10 12/2/62

Also 30 ft, Glenora, Glenora

popable black, guarding 38 region

130 redwood

I would be grateful for fresh specimens
of the pt.

Yours sincerely
W. Allen

Am 6 May - 6750231

26/07/2017	ADDITION TO 10MCG TOTAL 30MCG/ REMOVE OLD PATCH-DISPENSE WEEKLY 4 PATCH	24/08/2020P	Dr Desmond Spence REPEAT
17/02/2017	Symbicort Turbohaler 200/6 micrograms/inhalation ONE PUFF TO BE INHALED TWICE A DAY 1*1 INHALER	17/04/2020P	Dr Desmond Spence REPEAT
31/01/2017	Amitriptyline Hydrochloride Tablets 50 mg 1 TABS AT EVENING WEEKLY UPLIFT 28 TABLET	24/08/2020P	Dr Desmond Spence REPEAT
19/05/2014	Salofalk Foam Rectal foam 1 gram/application, 80g (14 dose) canister ONE APPLICATION AT NIGHT 14 CANISTER	03/06/2020P	Ms Wilma Mitten REPEAT
01/04/2014	Sertraline Hydrochloride Tablets 50 mg ONE TO BE TAKEN EACH DAY 28 tablet	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Methocarbamol Tablets 750 mg 1 TABS 4 TIMES DAILY 112 TABLET	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Peptac Liquid (aniseed) 10 ML 3 TIMES DAILY 500 ML	14/10/2019P	Dr Desmond Spence REPEAT
09/07/2012	Pregabalin Capsules 300 mg 1 CAP TWICE DAILY 56 capsule	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Salbutamol Cfc-free Inhaler 100 micrograms/puff ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY 1*1 INHALER	06/04/2020P	Dr Desmond Spence REPEAT
09/07/2012	Simvastatin Tablets 40 mg ONE TO BE TAKEN AT NIGHT 28 TABLET	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Capsaicin Cream 0.025 % APPLY 3 TIMES DAILY 45 gram	24/07/2020P	Dr Desmond Spence REPEAT


 1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 F
 19/08/1954
 G13 4NA

Thank you for seeing
this 66 year old lady. It was previously
admitted with a ureter stone & stenosis.

She was discharged with Abx on the 22/8/20.

Since discharge she has been exp nausea/vom, fevers
& passing very little urine with episodes of frank
haematuria. She had called QoH on 25/8/20 &
was later seen by SAS however declined admission.
Today awake & though was feeling better however
come lunchtime exp further episodes of nausea/vom &
continues to pass only small amounts of urine.

Ole today, was lying on the couch with
bileus vomit in basin, could only pass 5-10 mls
of urine, concentrated & +ve for leucocytes, protein
& blood+++ (microscopic). Also severely tender

suprapubic, guarding, dull bladder, palpable bladder.

Bo Normal, describe chronic prostatitis, no chest pain
no rectal exam, small.

PHO,

8/25/2020

Incident Number: CR006750231

Patient Information

GEORGINA LOGAN

Age/Gender: 66y Old Female

Address: 17 SOLLAS PLACE YOKER GLASGOW, G13 4NA

DOB: 19/08/1954

CHI: 190854042

Ethnicity: White Scottish

Date: 26/08/2020

Incident Number: CR006750231

Incident Type: URG

Incident Location: 17 SOLLAS PLACE
YOKER GLASGOW, G13
4NA

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F 19/08/1954

G13 4NA

Presenting Complaint

GENERALLY UNWELL

Additional Comments

G.P URGENT CALL FOR THIS VERY PLEASANT LADY SEEN AT HOME TODAY. PRESENTING WITH NAUSEA/VOMITING, PASSING VERY LITTLE URINE WITH EPISODES OF FRANK HAEMATURIA. O/E GUARDING ABDO, OBVIOUS DISTENSION, PALPABLE BLADDER... JUST 1/52 HAD ENDOSCOPIC INSERTION OF URETERIC STENT. G.P IMP ?? RETENTION. MANY THANKS.

PATIENT ASSESSMENT

AVPU	Alert	<C>
A	Clear	
B	Breathing Adequately	Yes
	Respiratory Rate	16
	SPO2	97
	Oxygen Given	No
C	Pulse Rate	BP
	99	139/78
	Rhythm	Arm
	Irr	Right
	Cap Refill	Central/Peripheral
	<=2 Secs	Central
	ECG Rhythm	ECG
	AF	3 Lead
D	GCS	Eyes
	15	Spontaneously (4)
	Voice	Motor
	Orientated (5)	Obeys Commands (6)
	PEARL	Yes
E		

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:21	99	16	139/78	97	<=2 Secs	15	Alert		36.7		AF				E002340X

NEWS

Time	Clinical Risk	NEWS
14:21	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	3

HISTORY

AMPLE

Allergies	None
Medication	POLYMEDS INCL EDOXABAN, ROPINIROLE HYDROCHLORIDE, SHORTEC, BISOPROLOL, AMITRIPTYLINE, PREGABALIN
Past Medical History	Angina, Asthma, KNOWN AF, DEPRESSION, URETERIC STENT INSERTION 1/52 AGO, IBS
Last Eaten	>4 Hours Ago

CLOSE RECORD

Treatment On Scene	Non Emergency
--------------------	---------------

Conveyance

Transport To Hospital	Normal driving	Pre Alert	No
-----------------------	----------------	-----------	----

INCIDENT LOG

Time Call Received	13:03	Allocated	13:23	Mobile	13:26
--------------------	-------	-----------	-------	--------	-------

8/26/2020

Incident Number: CR006750231

First Resource On Scene:	Crew On Scene	14:26	Crew Left Scene	14:33
Crew At Hosp	Receiving Hospital	QUEEN ELIZABETH UNIVERSITY HOSPITAL	Clear Time	
Crew ID	Crew Grade	Driver		
E9886098	Student Technician Level 4	YES		
E002340X	Ambulance Technician	NO		



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

My Admission Record

7



N
A: 1908546042
— LOGAN F
— Georgina 19/08/1954
— 17 SOLLAS PLACE
D: KNIGHTSWOOD
C: Glasgow, Lanarkshire
Af G13 4NA

Hospital: QUEEN Ward: 1AU
Date of Admission: 26/8/20 Time: 1635
Information obtained from: Name:

Patient ☒ Relative ☐ Other ☐

Preferred Name:

Age: 66 Telephone Number:
Consultant:

P L arm.

Communication

What is your first language? English

Do you require an interpreter? Yes ☐ No ☒

If yes, provide details of arrangements made

Do you use British Sign Language (BSL)? Yes ☐ No ☒

Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who

Preferred first contact

Name: George
Relationship: husband
Address: AIA

Telephone: 07437 685 618

Is this person aware of your admission?

Yes ☒ No ☐

Can we share information with this person?

Yes ☒ No ☐

Preferred second contact

Name:
Relationship:
Address:

Telephone:

Is this person aware of your admission?

Yes ☐ No ☐

Can we share information with this person?

Yes ☐ No ☐

Presenting Complaint / Diagnosis

Retention

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☒

Relevant past medical history

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☐ If yes, Who asked for a copy?

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

N:

Ac

1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Do Glasgow, Lanarkshire

CH

Affix patient ID label

19/08/1954

G13 4NA

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

2. Received holiday dialysis outside Scotland?

3. Been told that you have CPE?

4. Been in close contact with a person with CPE?

If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

and inform the IPCT

Yes

No

☐☒☐☒☐☒☐☒☐☒**MRSA Screening**

Will the patient be an inpatient for more than 23 hours?

If **YES** complete the following section

1. Have you ever been told that you have MRSA?

2. Have you been admitted from another hospital/ residential setting or care home?

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes

No

Unsure

☒☐☐☐☒☐☐☒☐☐☒☐☐☒☐☐☒☐☐☒☐☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

If **YES** inform the IPCT ☐

Yes

No

Unsure

☐☒☐

Name: _____
 Ad:  _____
 1908546042 _____
 LOGAN _____ F _____
 Georgina 19/08/1954 _____
 Do: 17 SOLLAS PLACE _____
 CH KNIGHTSWOOD _____
 Glasgow, Lanarkshire _____
 Affi G13 4NA _____

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☐ when did you stop? _____

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): *cmclaughlin*

Signature: *cmclaughlin*

Designation: *SN*

Date: *26/8/20*

My Assessment Record

Name: _____

 1908546042 F
 LOGAN. 19/08/1954
 Georgina.
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA
 Label

1. Breathing and Circulation			
Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina	✓	✓	
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			
2. Communication			
	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____		✓	

Name: _____
 1908546042
 - LOGAN F
 - Georgina 19/08/1954
 D 17 SOLLAS PLACE
 C KNIGHTSWOOD
 Glasgow, Lanarkshire G13 4NA
 AI

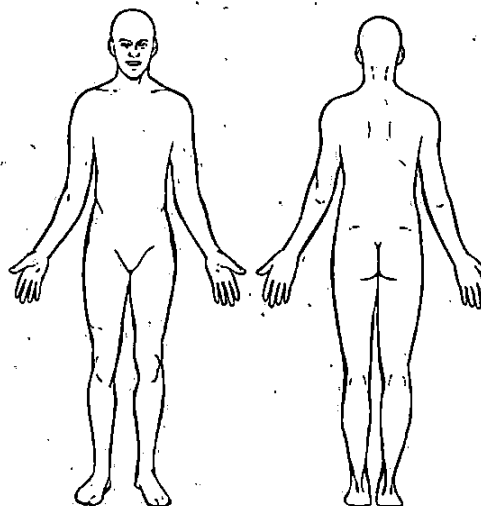
3. Senses

Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☒ Reading ☐ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?		/	
Do you have your lenses with you?		/	
Do you wear a prosthesis?		/	
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?		✓	

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



**N.B. Complete generic pain assessment chart.
 If unable to self report complete Abbey
 Pain Scale.**

Can you describe any chronic pain that you have?

What makes the pain better?



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

Annex patient ID 10001

4. Cognitive Status**THINK DELIRIUM**

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

no

What do you like to eat and drink?

Varied diet

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓	 1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			Assessment of the patient's hydration and nutrition needs
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems		✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention	✓		

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name:  1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire 19/08/1954 G13 4NA
Haematuria			
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

27/8/20

How often in a day/week do you have a bowel movement? Per day Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☒

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			
Constipated	✓		
Diarrhoea / loose stools		✓	
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

N  _____
 Ac 1908546042 _____
 — LOGAN _____ F _____
 — Georgina _____ 19/08/1954 _____
 — 17 SOLLAS PLACE _____
 Dc KNIGHTSWOOD _____
 Cf Glasgow, Lanarkshire _____
 G13 4NA _____
 Affix patient ID label

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?	✓		top set
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?		✓	
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare



Wound Care	Yes ✓	No ✓	Name: _____ A:  1908546042 — LOGAN F — Georgina 19/08/1954 D: 17 SOLLAS PLACE KNIGHTSWOOD Cl Glasgow, Lanarkshire Af: G13 4NA
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent.			
Unsteady when walking			
Do you use a mobility aid	Yes ☒	No ☐	
Do you have your mobility aid with you? <i>Stick</i>	Yes ☐	No ☒	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	



Name: _____
 Ad:  _____
 1908546042
 LOGAN F
 Georgina 19/08/1954
 17 SOLLAS PLACE
 Do: KNIGHTSWOOD
 CHI: Glasgow, Lanarkshire
 Affi: G13 4NA

11. Social Circumstances

Do you:

Live alone ☐

Live with family/ friend/ other ☒

Live in a nursing home ☐

Live in a care home ☐

Live in residential supported care ☐

Live in student accommodation ☐

Live in 'homeless' accommodation ☐

Have no fixed abode ☐

Other please specify ☐

Dependants

Yes
✓

No
✓

Do you have any dependants?

Do you support anyone (e.g. partner, children, relatives, animals)?

Do they need support from someone else whilst you are in hospital?

Would someone else be able to provide this support when you are in hospital?
 If yes, who?

If no support available, contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

Yes
✓

No
✓

Do you have support from social work, social services or a care package?

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

no

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

no

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed

Yes ☐ N/A ☒

Name: _____
 Ac:  _____
 1908546042 _____
 LOGAN _____
 — Georgina _____
 Dc 17 SOLLAS PLACE _____
 CH KNIGHTSWOOD _____
 CH Glasgow, Lanarkshire _____
 Affi _____
 19/08/1954 _____
 G13 4NA _____

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
 (please tick) Yes ☐ No ☐

 1908546042		
A	LOGAN	F
	Georgina	19/08/1954
	17 SOLLAS PLACE	
	KNIGHTSWOOD	
	Glasgow, Lanarkshire	
	G13 4NA	
C		
Affix patient ID label		

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☐

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐

Unemployed ☐

Self-employed ☐

Retired ☐

Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____ / ____ / ____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ____ / ____ / ____



1906546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Risk Assessments/Other Documentation

Cni.

Affix patient ID label

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
26/8/20 16:45	Patient admitted from home. Mobile independently. Alert and orientated.	
	Awaits medical r/v	
18:30	Patient passed urine	
	Bladder scan shows 5mb only	

Name: _____
 Add:  _____
 1908546042
 _____ LOGAN F _____
 _____ Georgina 19/08/1954 _____
 DoB _____
 CHI: _____
 Affix _____

Clinical Notes (cont.)

[illegible]

F
19/08/1954

Clinical Notes (cont.)

[illegible]

NEWS – National Early Warning Score



Name	
Address	1908546042 LOGAN F 4 Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA
CHI No.	
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score					
	3	2	1	0	1	2
Respiration Rate	≤8		9-11	12-20		21-24
Oxygen Saturations	≤91	92-93	94-95	≥96		≥25
Any Supplemental Oxygen		Yes		No		
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°
Pulse	≤40		41-50	51-90	91-110	111-130
Systolic BP	≤90	91-100	101-110	111-219		≥220
Conscious Level				A		V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE: 8/14/28	TIME: 16:28	NEW: 0 1
Resp. Rate Mark: •	35 30 25 20 15 10 5 0	
SpO ₂ (Enter Value)	94-95 92-93 90-91 88-89 86-87 84-85 82-83 80-81 78-79 76-77 74-75 72-73 70-71 68-69 66-67 64-65 62-63 60-61 58-59 56-57 54-55 52-53 50-51 48-49 46-47 44-45 42-43 40-41 38-39 36-37 34-35 32-33 30-31 28-29 26-27 24-25 22-23 20-21 18-19 16-17 14-15 12-13 10-11 8-9 6-7 4-5 2-3 0-1	
Any Suppl O ₂	RA RA	
Temp. Mark: X	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35° 34.5° 34° 33.5° 33° 32.5° 32° 31.5° 31° 30.5° 30° 29.5° 29° 28.5° 28° 27.5° 27° 26.5° 26° 25.5° 25° 24.5° 24° 23.5° 23° 22.5° 22° 21.5° 21° 20.5° 20° 19.5° 19° 18.5° 18° 17.5° 17° 16.5° 16° 15.5° 15° 14.5° 14° 13.5° 13° 12.5° 12° 11.5° 11° 10.5° 10° 9.5° 9° 8.5° 8° 7.5° 7° 6.5° 6° 5.5° 5° 4.5° 4° 3.5° 3° 2.5° 2° 1.5° 1° 0.5° 0°	
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	
Blood Pressure Mark: ◇	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0	
NEWS SCORE using Systolic BP	113 110 100 90 80 70 60 50 40 30 20 10 0	
Conscious Level Mark: •	Alert Verbal Pain Unresp	
Total NEWS (with all obs)	2.0	
BMI	X	
Pain	4/4 2/10	
Nausea	0/3 0	
Urine output	NPV	
Obs due	8/15/28	
Initials	RG	

[illegible]

NHSGGC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT



1908546042
LOGAN
Georgina

19/08/1954



Patient Name:

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	26/8						
		TIME	16:30						
		WARD	190						
		HOSPITAL	Q204						
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?								
2	Has the patient requested the use of bedrails?								
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?								
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A - Risk of falling from the bed								
	B - Risk of rolling from the bed								
	C - Risk of slipping from the bed								
	D - Risk of sliding from the bed								
	E - Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date	26/8							
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

**B. If bedrails are to be used, please consider the following:-
Is patient:-**

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

D. Record keeping:-**All of the following should be recorded:-**

- Date and time of assessment
- Bedrail information leaflet given to patient and/or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

Date: 26/8/20

1. Signed [Signature] Name cmclaughlin Designation (5)
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

G13 4NA

USE FOLLOWING CODES:

Y = Yes · N = No · NA = Not applicable · NT = No Thanks · S = Sleeping · O = Off the ward · I = Independent

[illegible]

Attach Addressograph Label



1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

[illegible]



1908546042

LOGAN

Georgina

F
19/08/1954**FALLS RISK ASSESSMENT****To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward****GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS**Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 190	Ward:	Ward:	Ward:	Ward:
	Date: 26/8	Date:	Date:	Date:	Date:
	Time: 16:45	Time:	Time:	Time:	Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Indep				
2. Check walking aid (if required) is in reach and in use. Stick	@ home				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	yes				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	yes				
5. If glasses are worn, check they are available and in use.	yes				
6. If hearing aid/s are worn, check they are working and in use.	na				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			/								
2. Does the patient have cognitive impairment or a possible delirium?			/								
3. Does the patient attempt to walk alone although unsteady or unsafe?			/								
4. Does the patient or their relative have a fear or anxiety of the patient falling?			/								
5. Based on your clinical judgement, is this patient at high risk of falling?			/								
Signature of nurse completing assessment / update											

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
-------------------------	-------------------------	-------------------------	-------------------------	-------------------------

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.
(Patient care plan 8)

Assess if a low bed is required
(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.
(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.
(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete / Document 4AT – follow THINK DELIRIUM guidelines.
(Patient care plan 4)

Document continence problems and link to care rounding
(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.
(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.
(Patient care plan -negotiated care)

Update the ward team of the patient's mobility status.
(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.
(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.
(If appropriate)

Signature of nurse completing interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN



1908546042

LOGAN

Georgina

19/08/1954

F

Patient) Moving and Handling Assessment Form

Pers: KNIGHTSWOOD Nam: Glasgow, Lanarkshire G13 4NA		Named Nurse:	Person is totally independent (tick here and go to date box)	☒																				
1. Body Build																								
Weight Height		Problems with comprehension, behaviour, co-operation (specify):																						
Kg BMI		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):																						
Risk of Falls: Yes ☐ No ☐																								
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)																								
Hoist	Standaid	Walking Aid	Assistance	Supervision Independent																				
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:																				
Sling type																								
Sling Size																								
3. Toileting																								
Hoist	Standaid	Walking Aid	Assistance	Supervision Independent																				
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:																				
4. Move on / off bed pan																								
Hoist	Manoeuvre	Assistance	Supervision	N/A																				
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:																					
	Monkey pole																							
	Independent bridging																							
5. Move up / down bed																								
Hoist	Handling Aids	Assistance	Supervision	Independent																				
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:																					
	Monkey pole																							
	Rope ladder																							
6. Lateral Transfer to / from trolley / bed																								
Hoist	Handling Aids	Assistance	Supervision	Independent																				
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):																					
	Other (Please specify)																							
7. Sit up over side of bed																								
	Bed Rest	Assistance	Supervision	Independent																				
		People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):																					
8. Into Bath or Shower																								
Equipment	Handling Aid	Assistance	Supervision	Independent																				
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):																					
Variable / Fixed height bath	Shower trolley																							
Bed bath	Bathing hoist (eg Alenti)																							
9. Walking																								
No Walking	Walking Aid	Assistance	Supervision	Independent																				
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)																					
10. Other Instructions / Observations / Equipment Used																								
<table border="1"> <thead> <tr> <th></th> <th>1st Assessment</th> <th>2nd Assessment</th> <th>3rd Assessment</th> </tr> </thead> <tbody> <tr> <td>Recording Symbol:</td> <td>/ Forward slash</td> <td>X Where a forward slash exists, add a back slash to make a cross</td> <td>* Where a slash or cross exists add slashes to make a star</td> </tr> <tr> <td>Date Assessed:</td> <td colspan="2">26/8/20</td> <td></td> </tr> <tr> <td>Assessor's signature:</td> <td colspan="2">16.50</td> <td></td> </tr> <tr> <td>Proposed Review date:</td> <td colspan="2"></td> <td></td> </tr> </tbody> </table>						1st Assessment	2nd Assessment	3rd Assessment	Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star	Date Assessed:	26/8/20			Assessor's signature:	16.50			Proposed Review date:			
	1st Assessment	2nd Assessment	3rd Assessment																					
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star																					
Date Assessed:	26/8/20																							
Assessor's signature:	16.50																							
Proposed Review date:																								

Continuation Sheet

1. General Information (Only complete this section if changed from over page)									
Body Build		Problems with comprehension, behaviour, co-operation (specify):							
Weight	Height								
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):							
BMI									
Risk of Falls: Yes ☐ No ☐									
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
Model		Aid Type	People: 1	2	≥3	Additional Information / Equipment:			
Sling type									
Sling Size									
3. Toileting									
Hoist	Standaid	Walking Aid	Assistance			Supervision		Independent	
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1	2	≥3	Additional Information:			
4. Move on / off bed pan									
Hoist	Manoeuvre	Assistance			Supervision		N / A		
See No 2 Sit to Stand Transfers for details		Roll patient	People: 1	2	≥3	Additional Information:			
		Monkey pole							
		Person bridges							
5. Move up / down bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		Sliding sheets	People: 1	2	≥3	Additional Information:			
		Monkey pole							
		Rope ladder							
6. Lateral Transfer to / from trolley / bed									
Hoist	Handling Aids	Assistance			Supervision		Independent		
See No 2 Sit to Stand Transfers for details		Rigid Transfer Board	People: 1	2	≥3	Additional Information / Equipment (eg sliding sheets):			
		Other (Please specify)							
7. Sit up over side of bed									
Bed Rest		Assistance			Supervision		Independent		
		People: 1	2	≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):				
8. Into Bath or Shower									
Equipment	Handling Aid	Assistance			Supervision		Independent		
Shower	Shower chair	People: 1	2	≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):				
Variable / Fixed height bath	Shower trolley								
Bed bath	Bathing hoist (eg Arent)								
9. Walking									
No Walking	Walking Aid	Assistance			Supervision		Independent		
see 'sit to stand transfers'		People: 1	2	≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)				
10. Other Instructions / Observations / Equipment Used									
		4 th Assessment			5 th Assessment		6 th Assessment		
Recording Symbol:		/ Forward slash			X Where a forward slash exists, add a back slash to make a cross		* Where a slash or cross exists, add slashes to make a star		
Date Assessed:									
Assessor's signature:									
Proposed Review date:									

Adult Peripheral Vascular Cannula

Insertion and Maintenance
Care Plan

1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

CHI: _____

Address: _____

Hospital: _____



Insertion criteria

G13 4NA

Action at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐Resuscitation/Chest Pain ☐IV Drugs ☐Fluids ☒Transfusion ☐

PVC inserted: Day 0	Date: <u>26/8/20</u> Hospital: <u>Queen</u>
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ (A) Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☒ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ____/____/____	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ____/____/____ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ____/____/____

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess.

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: QEUM Ward: IAU	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
1 Pressure Damage Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.		

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
26/8/20	16:45	n	n	n	n	n	low	4 hrly	CM
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.



NHS
Greater Glasgow
and Clyde

Attach Addressograph

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for Increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: - Pressure areas _____ hourly. - Skin under medical devices _____ hourly. - Specify medical devices used:	Specify: - Mattress: - Cushion: - Detail additional pressure redistributing equipment:	- Reposition _____ hourly in bed and chair. - Overnight patient / carer has agreed to repositioning _____ hourly - Specify any manual handling equipment used:	- Skin care to be carried out _____ hourly. - Specify products required for increased moisture / continence management:	- Optimise nutrition and hydration. - Refer to MUST	- Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

Parenteral Drugs: Regular Prescription					DATE													1908545042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA		19/08/1954	F	Patient's Own Medicine	
					MONTH																		
BEFORE ADMISSION ☐	D	DRUG			STOPPED DATE: INITIALS:	Other time													For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
		DOSE	ROUTE	DATE		0700-0900																	
		PRESCRIBER (PRINT & SIGN)				1200-1400																	
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																	
						2200-2400																	
NEW DOSE ☐	E	DRUG			STOPPED DATE: INITIALS:	Other time													For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
		DOSE	ROUTE	DATE		0700-0900																	
		PRESCRIBER (PRINT & SIGN)				1200-1400																	
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																	
						2200-2400																	
NEW DOSE ☐	F	DRUG			STOPPED DATE: INITIALS:	Other time													For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
		DOSE	ROUTE	DATE		0700-0900																	
		PRESCRIBER (PRINT & SIGN)				1200-1400																	
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																	
						2200-2400																	
NEW MEDICATION ☐	G	DRUG			STOPPED DATE: INITIALS:	Other time													For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
		DOSE	ROUTE	DATE		0700-0900																	
		PRESCRIBER (PRINT & SIGN)				1200-1400																	
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800																	
						2200-2400																	

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.



Oral and Other Drugs: Regular Prescription				DATE													Patient's Own Medicine
				MONTH													
BEFORE ADMISSION ☒	H	DRUG AMITRIPTYLINE	DATE 26/8	Other time													For Use Y/N
NEW DOSE ☐	DOSE 50mg	ROUTE O	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) AQZ		STOPPED DATE	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☒	J	DRUG AMITRIPTYLINE	DATE 26/8	Other time													For Use Y/N
NEW DOSE ☐	DOSE 75mg	ROUTE O	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) AQZ		STOPPED DATE	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☒	K	DRUG BUTECH	DATE 26/8	Other time													For Use Y/N
NEW DOSE ☐	DOSE 30 MICROGRAM	ROUTE TDP	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) AQZ		STOPPED DATE	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY EVERY 7 DAYS CHANGE				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☒	L	DRUG SERTRALINE	DATE 26/8	Other time													For Use Y/N
NEW DOSE ☐	DOSE 50mg	ROUTE O	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) AQZ		STOPPED DATE	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription				DATE													Patient's Own Medicine		
				MONTH															
BEFORE ADMISSION ☒	M	DRUG PREGABALIN		DATE	26													1908546042	
NEW DOSE ☐		DOSE 300mg	ROUTE 0	DATE 26/8	1200-1400													LOGAN	19/08/1954
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) ARL		STOPPED INITIALS:	1600-1800													Georgina	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	2000-2400													17 SOLLAS PLACE	
																		KNIGHTSWOOD	
																		Glasgow, Lanarkshire	G13 4NA
BEFORE ADMISSION ☒	N	DRUG SIMVASTATIN		DATE															
NEW DOSE ☐		DOSE 40mg	ROUTE 0	DATE 26/8	1200-1400														
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) ARL		STOPPED INITIALS:	1600-1800														
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	2000-2400														
BEFORE ADMISSION ☒	P	DRUG METHOCARBAMOL		DATE															
NEW DOSE ☐		DOSE 750mg	ROUTE 0	DATE 26/8	1200-1400														
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) ARL		STOPPED INITIALS:	1600-1800														
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	2000-2400														
BEFORE ADMISSION ☒	R	DRUG Bupropion		DATE															
NEW DOSE ☐		DOSE 2.5mg	ROUTE 0	DATE 26/8	1200-1400														
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) ARL		STOPPED INITIALS:	1600-1800														
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	2000-2400														

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription			DATE MONTH	25	6													Patient's Own Medicine			
BEFORE ADMISSION ☒	S	DRUG HYDROSCINE	Other time 0700-0800	1200-1400	1600-1800	2000-2400	Other time	13													For Use Y/N
NEW DOSE ☐	DOSE 20mg	ROUTE O	DATE 26/8	1200-1400	1600-1800	2000-2400	Other time	13													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) Azz		INITIALS:													Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Assessed by						
															Ordered from Pharm						
BEFORE ADMISSION ☒	T	DRUG LANCOPRAZOLE	Other time 0700-0900	1200-1400	1600-1800	2200-2400	Other time														For Use Y/N
NEW DOSE ☐	DOSE 15mg	ROUTE O	DATE 26/8	1200-1400	1600-1800	2200-2400	Other time														Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) Azz		INITIALS:													Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Assessed by						
															Ordered from Pharm						
BEFORE ADMISSION ☒	V	DRUG OCASA MR	Other time 0700-0900	1200-1400	1600-1800	2000-2400	Other time	13													For Use Y/N
NEW DOSE ☐	DOSE 1.2g	ROUTE O	DATE 26/8	1200-1400	1600-1800	2000-2400	Other time	13													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) Azz		INITIALS:													Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Assessed by						
															Ordered from Pharm						
BEFORE ADMISSION ☒	W	DRUG EDOXABAN	Other time 0700-0900	1200-1400	1600-1800	2200-2400	Other time														For Use Y/N
NEW DOSE ☐	DOSE 60mg	ROUTE O	DATE 26/8	1200-1400	1600-1800	2200-2400	Other time														Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) Azz		INITIALS:													Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															Assessed by						
															Ordered from Pharm						

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription				DATE MONTH													Patient's Own Medicine		
BEFORE ADMISSION ☒	CC	DRUG SHORTEC		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:													Qty:	
		10mg		0	26/8	1200-1400													Date:
		PRESCRIBER (PRINT & SIGN) ASR		STOPPED INITIALS:	1600-1800													Assessed by:	
NEW DOSE ☐				Other time													Ordered from Pharm.		
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															
BEFORE ADMISSION ☐	DD	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:													Qty:	
						1200-1400													Date:
		PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:	1600-1800													Assessed by:	
NEW DOSE ☐				Other time													Ordered from Pharm.		
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															
BEFORE ADMISSION ☐	EE	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:													Qty:	
						1200-1400													Date:
		PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:	1600-1800													Assessed by:	
NEW DOSE ☐				Other time													Ordered from Pharm.		
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															
BEFORE ADMISSION ☐	FF	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:													Qty:	
						1200-1400													Date:
		PRESCRIBER (PRINT & SIGN)		STOPPED INITIALS:	1600-1800													Assessed by:	
NEW DOSE ☐				Other time													Ordered from Pharm.		
NEW MEDICATION ☐		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		Other time															

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason



G13 4NA

Oral and Other Drugs: Regular Prescription				DATE → MONTH →	LOGAN Georgina F 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA 19/08/1954												Patient's Own Medicine For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.		
BEFORE ADMISSION ☐	GG	DRUG		Other time													For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.		
NEW DOSE ☐		DOSE	ROUTE	DATE	DATE:	0700-0900													
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)			INITIALS:	1200-1400													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	1600-1800														
				Other time	2200-2400												For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.		
BEFORE ADMISSION ☐	HH	DRUG		Other time														For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
NEW DOSE ☐		DOSE	ROUTE	DATE	DATE:	0700-0900													
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)			INITIALS:	1200-1400													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	1600-1800														
				Other time	2200-2400												For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.		
BEFORE ADMISSION ☐	JJ	DRUG		Other time														For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
NEW DOSE ☐		DOSE	ROUTE	DATE	DATE:	0700-0900													
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)			INITIALS:	1200-1400													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	1600-1800														
				Other time	2200-2400												For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.		
BEFORE ADMISSION ☐	KK	DRUG		Other time														For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
NEW DOSE ☐		DOSE	ROUTE	DATE	DATE:	0700-0900													
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN)			INITIALS:	1200-1400													
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				Other time	1600-1800														
				Other time	2200-2400												For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.		

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

BEFORE ADMINISTRATION ☒	LL DRUG DICLOFENAC GEL			DATE:
DOSE 1 APP	ROUTE TOP	INDICATION PAIN		INITIALS:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN) ABC		MAX.FREQ. 3°	DATE:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY 1-1670 gel			

[illegible]

Patient's Own Medicine	For Use Y/N	Qty:
		Date:
		Assessed by:
	Ordered from Pharm.	
	For Use Y/N	Qty:
		Date:
		Assessed by:
	Ordered from Pharm.	
	For Use Y/N	Qty:
		Date:
		Assessed by:
	Ordered from Pharm.	
	For Use Y/N	Qty:
		Date:
		Assessed by:
	Ordered from Pharm.	

BEFORE ADMISSION	☐			MM	DRUG	SALBUTAMOL		DATE:
NEW DOSE	☐		DOSE	ROUTE	INDICATION		STOPPED	INITIALS:
	☐		2 Puffs	INH	SOB		DATE:	
NEW MEDICATION	☐		PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:	
	☐		ACC			PRN		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY								

[illegible]

BEFORE ADMISSION ☒	DRUG SHORTEC 10mg	DATE: 	
	DOSE 10mg - 20mg	ROUTE O	INDICATION PAIN
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN) ACR	MAX. FREQ. 2°	INITIALS:
NEW MEDICATION ☐	DATE: 		
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

[illegible]

BEFORE ADMISSION ☐	PP		DRUG		DATE:
NEW DOSE ☐	DOSE	ROUTE	INDICATION		STOPPED INITIALS:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

[illegible]

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

[illegible]

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).
 2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).
 3. Print & Sign your full name clearly against each prescription entry.
 4. Time should be recorded in 24hr format e.g. 0600, 1800.
 5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.
 6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.
 7. The following metric unit abbreviations must be used –

Milligram = mg	Gram = g.
Millilitre = ml	Millimoles = mmol
Microgram / Nanogram / Units – Do not abbreviate, write in full	
 8. Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).
 9. The route of administration can be abbreviated using the following -

O = oral	ID = Intradermal
IM = Intramuscular	SL = sublingual
SC = subcutaneous	PR = per rectum
NG = nasogastric	PEG = percutaneous endoscopic gastrostomy
PV = per vagina	RIG = radiologically inserted gastrostomy
PEJ = percutaneous endoscopic jejunostomy	PEJ = percutaneous endoscopic jejunostomy
TOP = topical	ETT = endotracheal
NEB = nebulised	INHAL = inhaled
IV = Intravenous	
- Please note - Intrathecal must be written in full.

FOR NURSES

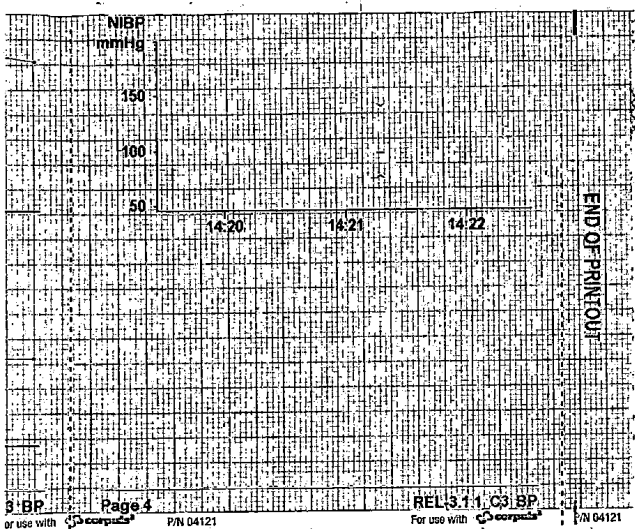
1. The "Once only," "Regular" and "As required" sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.
2. Insert initials in the relevant date column and time row each time a drug is administered.
3. Check that all drugs prescribed at a certain time have been administered.
4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

- | | | | |
|------------------------|--|---|---------------------------------------|
| ③ Patient refused | ⑦ Patient asleep | ⑪ Unable to swallow | ⑭ Other - Record in nursing notes |
| ④ Drug not available | ⑧ Time varied on doctor's instructions | ⑫ No intravenous access | ⑮ Prescription clarification required |
| ⑤ Nil by mouth/fasting | ⑨ Dose withheld on doctor's instructions | ⑬ Patient Self-Administration of Medicine | |
| ⑥ Patient unavailable | ⑩ Nausea/vomiting | | |

corpus TREND		0002151	Time	HR /min	SpO2 %	PR /min	CO2 kPa	NIBP mmHg	SpO2 %	Page 3	REL 3.1.1 C3 BP	PN 04121	For use with CCE 2014	Page 2	REL 3.1.1 C3 BP	PN 04121	For use with CCE 2014	Page 1	REL 3.1.1 C3 BP	PN 04121	For use with CCE 2014
Mission: 20200826131826		Printout: 14:22																			
Mission start: 26.08.2020 14:18 UTC+01:00																					
Patient		Case No.																			
ID		Weight																			
Date of birth (Age)																					
Sex																					
Height																					
HR /min		NIBP																			
CO2 - kPa		RR - /min																			
SpO2 - %		PR - /min																			
PI 0.8%																					
Device		0002151																			
Radio																					
Medical team		07920246799																			
Callback phone																					
EGG filter 0.67 - 20 Hz		Main filter 50 Hz																			

1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/195
 F
 G13 4NA



Queen Elizabeth University Hospital



CHI: 1908546042

Total Att: 20

12 Mth Att: 2

Title: MRS

LOGAN

Georgina

DOB 19/08/1954

Age: 66y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: DF Spence
0141 212 7082

Attendance Date: 26/08/2020

Arrival Time: 16:10

Registration Time: 16:10

Date of Incident: 26/08/2020

Major Incident Desc:

Reason for Attendance: gen unwell urine retenion

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 26/08/2020 16:14

Nurse name: Nurse Claire Ferry

Temp	35.7	C
HR	89	bpm
BP	101/60	mmHg
MAP	73.67	mmHg
RR	19	bpm
SpO2	97	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils Right	Pupils Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "likley urine rention/ infection. refused by urology. transfer from ae. n&v. "

cons aware. *df*

Patient ID label

Date	Emergency Department Notes		
	Ambulance Proforma reviewed	Yes / No	Seen by (Doctor)
	Time seen		

Patient ID label



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

	NEWS	☐	0-7
	RED FLAG	☐	(Tick)
	SEPSIS	☐	
	CURB 65	☐	

Done/ completed	Immediate Managment Plan

Signature:	Designation:	Page No:

PLEASE DO NOT WRITE HERE



1908546042

LOGAN

Georgina

F
19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Seen By: T Foley

Print: FY2

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint 66 ♀	'Retention'
History of presenting complaint ? 2° retention/ Constipation ? 2° Abx Gd/c on Cipro from urology No vomiting today.	Stented in urology for Ⓛ proximal ureteric stone ↳ Some Haematuria since Felt unwell 25/8 Nausea + vomiting ↳ Vomiting + blood, food only. Pulling small volumes Haematuria yesterday today dipstick only. Constipated ~ 1/52 → BO today small motion, soft. Since stent visible ↳ dysuria ↳ AP ↳ groin pain ↳ Lower abdo discomfort

Past Medical History / Review of portal

Asthma	Diverticulosis	Restless legs
AF	IBS	
Chronic back pain	Pericarditis - 2019	

Systemic Enquiry

° Coughs	* Felt hot + shivery @ 17 Not in hospital.	} a pyrexial.
° SOB		



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

G13 4NA

MEDICINES RECONCILIATION – Acceptable to staple fully completed Emed Rec

Source of medication history

☒ Patient/Relative/carer☐ GP Phone call☒ ECS

(>1 source preferred)

☒ Patient own drugs☐ Com. Pharmacist☐ GP letter/summary☐ Repeat Prescription

Other (please specify)

Admission Medicines			Plan for Medicines (Dr complete)				Comments
Name	Dose	Freq	Continue	Amend	Withhold	Stop	Reason for alteration
✓ AMITRIPTYLINE	75mg	Norte					
✓ Butec	30micg	Every 7 days					transdermal
✓ Sertraline	50mg	OD					
✓ Pregabalin	300mg	BD					
✓ Simvastatin	40mg	Norte					At stopped
✓ Methocarbamol	750mg	QDS					
✓ Bisoprolol	2.5mg	OD					
✓ HYOSCINE	20mg	TDS					
✓ Lansoprazole	15mg	OD					
✓ Octasa MR	1.2g	BD					Mealsalzone
✓ Edoxaban	60mg	OD					
✓ Salofalk foam	1app	Norte					1g/app
✓ Symbicort 200/6	T	BD					
✓ Salbutamol	II	PRN					Where
✓ Ralvo	700mg	12hr OD					Plaster 12h on/12h off
✓ Ropinirole	250mg	Norte					500mg
✓ Shortec	10mg	BD					PRN
✓ Diclofenac 1.16% gel	1app	TDS					PRN

Allergies

List any over-the-counter or alternative medicines

No DRUGS.

Do medicines need further clarification? ☐ Yes ☐ No

List collected by :

Plan approved by :

Designation :

Date :

Designation :

Date :

Pharmacy review

Comments

Compliance aid :

☐ Yes ☐ No

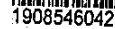
Community pharmacist

Phone

Reviewed by :

Designation :

Date :



19/08/1954

G13 4NA

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☒ Never smoked

Alcohol History

Units/week

FAST score if excess

Nil.

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

Lives with husband (separated) } managing @
Normally stays alone } Home

General Appearance:

Temp: 35.5

RR: 18

Pulse: 88

CBG:

SpO₂: 97%

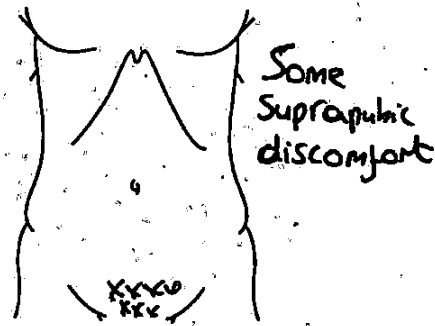
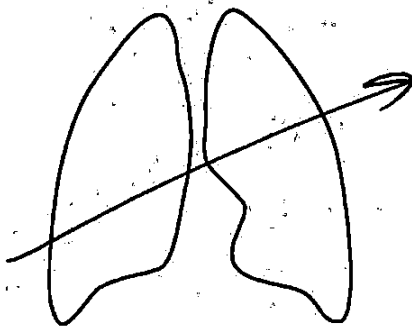
Weight:

BP: 100/60

Urinalysis:

Looking well
Chatty.

Gastrointestinal System



Locomotor

HS 1411

HR feels Regular
° leg swelling.

Grossly (N)



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

A PATIENT'S RECORD MUST BE KEPT IN A SECURE PLACE AND NOT BE LOANED OUT OR GIVEN TO ANYONE OTHER THAN THE PATIENT

Neurological system

GCS 15

E: /4

M: /6

V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

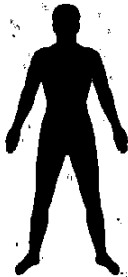
Pupils/funduscopy:

Cerebellar and
extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power	Grossly N			
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

N/a



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

A FORMERLY USED FOR PATIENTS WITH A HISTORY OF ALLERGY TO DRUGS AND FOODS

Key Results

CXR

ECG

(Differential) diagnosis

Retention
2^o Constipation
UTI Seems unlikely
↳ Had recent course apro.

NEWS ☒Red Flag ☐Sepsis ☐CURB 65 ☐

Management Plan

Bladder scan +/- Catheter → Refer
urology.

MSSU

Dipstick

Laxatives

If Staying in → kordex.

dlw → Alshanthi
urology. Will come
+ see.

Happy to
accept both.
patient.
Many thanks.

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation☐ 4AT/TIMESignature: 

PRINT NAME T. Foley

PRINT GRADE FY2.

Page:

Resuscitation Decision

Resuscitation status: **FOR RESUSCITATION** / DNA CPR
(please circle)

If DNA CPR → Complete appropriate form

Senior Medical review

M. GULON, (72 UNLOC) 26/1/16
2040pm

- 115

- L stroke 20/18

- today severe (c) chest pain, similar to chest at rest as bad

- few episodes of vomiting

- felt congested + passing small clots of urine

- since arrived; pain better
- moved back- patient v. ill 21/1/16: no greater
- on oral aspirin

- 110

- 115: 115

- pain + 115
- as documented

- soft non-tender, no (un) tender

- 115: 115

- 115

- 115: 115

- 115: 115

- 115: 115

- 115: 115
- 115: 115- 115: 115
- 115: 115☐ Thromboprophylaxis assessed
☐ Antimicrobial☐ Medicine Reconciliation
☐ DNACPR☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETEDIs the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days☐ Yes☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive	
Age > 60	Hormone replacement therapy	
Dehydration	Pregnancy or <6 weeks post partum (seek specialist advice)	
Known thrombophilia	Critical care admission	
BMI >30	Varicose veins with phlebitis	
Personal/1st degree relative history of VTE	Current significant medical condition e.g. infection, inflammation, cardio resp disease	
Hip fracture		

☐ Yes☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder	
Acquired bleeding disorder	Thrombocytopenia <75 x10 ⁹ /l	
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)	
Concurrent use of anticoagulants e.g. warfarin with INR >2	Uncontrolled hypertension (>230/120)	
Acute stroke	Varicose veins	
Recent (<4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic		
Other - Document		

☐ No☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50kg or eGFR <30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180 Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0- 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	()								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1 -10 Female: 1 - 12								
CRP	<10								
Troponin hs I	Male: 0 - 34 Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170- 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 - 2.0								

Patient



1908546042

LOGAN
Georgina

F

19/08/1954

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp: _____

Pulse: _____

BP: _____

SpO₂: _____

FiO₂: _____

RR: _____

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time

Pati



1908546042

LOGAN

Georgina

F

19/08/1954

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: _____ Time: _____

[illegible]



1008516042

Georgina

19/08/1954

Date: Time

[illegible]

Done/ Time

[illegible][illegible]

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle								Time Ready to Depart		
1. Admission		2. Discharge		3. Refer to G.P.		4. Transfer to other hospital (see below)			Discharge Time	
5. Died		6. Refer to O.P. Clinic (see below)		7. Irregular Discharge		8. D.O.A.				
Ward No. (If admitted)				Transfer to Hospital				Consultant (if admitted)		
Outpatient clinic specialty						Admission or specialty clinic consultant				
Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify		





1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F
19/08/1954

G13 4NA

Registration Details - Patient No: 7881

Personal details...		Address details...	
Sex	F	Postcode	G13 4NA
Surname	Logan	House Name Flat No	
Title	Mrs	No and Street	17 Sollas Place
Birth Surname		Village	
Forenames	Georgina	Town	Glasgow
Calling Name	Georgina	County	
Previous Surname	Logan		
Date of Birth	19/08/1954		
DOB			
Marital Status			
Ethnic Origin			

HA/HB Details...		Contact details...	
Health Board	Greater Glasgow	Home Tel No	sister 952 3728
Registered GP	Dr Desmond Spence	Work Tel No	952 5847
Usual GP	Dr Desmond Spence	Mobile Tel No	0777 440 0790
Residential Inst		E Mail Address	
Branch Surgery			
CHI Number	1908546042		
NHS Number			

Practice Information...		Distances	
Dispensing		Rural Mileage	
Hospital Number		Blocked Special	
Records At		Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	12/09/2016		

AMS/CMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
Pharmacy Details	Willis Pharmacy-1566 Dumbarton Road, Scotstoun, Glasgow, (G14 9DB) - 0141 959 2551 (Org Id - 1605)		
Item Collected Check	Yes		
CMS Suitability Status	-1		
CMS Registration Status	2		

Medical Record

Problems

Active Problems		Authorised By	Code
17/08/2020	Endoscopic insertion of ureteric stent (Left)	Mr Todd	7B1A1
17/08/2020	Calculus of ureter	Miss Gray	K121
02/04/2020	H/O: depression Currently on Depression Meds	Mrs Nicol	1465
17/01/2020	Magnetic resonance imaging Degenerative change, minor root compression, no cauda equina	Dr Adair	569-2
01/12/2019	[D]Abdominal pain unspecified, admitted	Miss Martin	R090
21/11/2019	Radiculopathy suspected diagnoses	Mr Andrews	EGTON436
16/07/2019	Atrial fibrillation	Ms Henry	G5730

13/01/2017	H/O amphetamine misuse	Dr Adair	1T4
2010	Irritable bowel syndrome episodic diarrhoea on Octasa	Dr Adair	J521-1
2010	Diverticulosis	Dr Adair	J510
17/11/2004	Asthma	Mrs Connell	H33

Past Problems	Authorised By	Code
2010 Cholecystectomy NEC	Dr Adair	78102-1
12/2009 Primary lumbar discectomy Failed, no benefit from subsequent caudal block	Dr Adair	7J32

Due Diary Entries	Authorised By	Code
25/08/2021 Medication review	Dr Byford	8B314
05/08/2021 Patient "recall" admin. NOS	Ms McGhee	904Z.
28/05/2021 Key information summary review date	Ms Mitten	EMISNQKE7
01/12/2020 Near-patient testing - enhanced services administration	Mrs MacConnacher	9kD

Overdue Diary Entries	Authorised By	Code
02/04/2020 Asthma annual review OVERDUE	Mrs Hopkin	68YJ.
19/08/2019 Influenza vaccination OVERDUE	Dr Weir	65E..
18/08/2019 No response to bowel cancer screening programme invitation OVERDUE	Mrs McIntyre	90w2.
Bowel Cancer Screening Exclusion		
09/04/2019 Asthma follow-up OVERDUE	Mrs Hopkin	66YK.

Alerts	Authorised By	Code
21/02/2018 Alert ONLY TO SEE GP FOR ISSUES OF ADDITIONAL ANALGESIA/MEDICATION REQUESTS	Mrs McIntyre	EMISALERT
24/04/2017 Alert PLEASE SEE LAST PAIN CLINIC LETTER	Ms Dempsey	EMISALERT

Drug Allergies	Authorised By	Code
None		

Non Drug Allergies	Authorised By	Code
None		

Health Status	
18/07/2012	Cervical smear result Cervical smear: negative
03/06/2020	Height 147 cm
03/06/2020	Weight 74 Kg
03/06/2020	Body Mass Index 34.24 kg/m2
03/06/2020	Blood pressure reading 125/75 mm Hg
03/06/2020	Blood pressure reading O/E - BP reading
16/07/2019	Smoking Status Never smoked tobacco
10/04/2019	FH: Ischaemic heart dis. <60
03/05/2013	FH: Ischaemic heart dis. >60
03/05/2013	



Consultations	
26/08/2020	Mr Archie McCorkell at Barclay Victoria Park Medical Practice
Comment	TC with Georgina today. Note was discharged on 22/8/20 following diagnosis of ureteric stone & ureteric stent placed. Following discharge exp some abdominal pain & frank haematuria then retention?. Called OOH & Ambulance sent to the house. Claimed felt slightly better when ambulance arrived however did not want to go back into hospital. Signed refusal & advised crew would contact GP. Georgina claimed is now feeling alot better. Is now passing clear urine with

abdominal pain subsided. Is now taking fluids & managed to eat something today as had not eaten for several days. No nausea/vom, was previously feverish? had been taking Paracetamol regular, note Temp with Amb crew was 36.9 & HR 114. Georgina claimed is feeling much better & would contact the practice should she have any further concerns.

1908546042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
19/08/1954
G13 4NA

25/08/2020	<u>Mrs Kirstin MacConnacher at Data Entry</u>
History	Post hospital discharge med reconciliation with medical notes IDL received, patient admitted to QEH17/8 - 22/87 with left sided loin to groin pain. Uretic stone. Uretic stent has been placed. To complete 7 day Ciprifloxacin course. ROutline Urology MDT stone referral made. Meds rec completed, no changes to repeat medications.
Comment	Medication review done by pharmacist
Additional	
25/08/2020	<u>Dr David Byford at Acute Scripts</u>
Comment	Special Request- ralvo. Allow to continue.
25/08/2020	<u>Dr David Byford at Telephone Consultation</u>
History	Note recent admission with left ureteric colic secondary to stone, stent inserted and awaiting follow up at stone clinic. Reports recurrence of frank haematuria today, which had settled prior to admission. No back pain today so far (did have yesterday). Still on course of cipro.
Comment	Advised the haematuria will be secondary to the stone itself causing local trauma. Plan - monitor and after antibiotic course completed, hand in sample to ensure no residual infection. Also requests some more shortec. Script issued.
Test Request	Midstream Urine (C&S) - Requested
Additional	Medication review done
17/08/2020	<u>Ms Gillian Henry at Barclay Victoria Park Medical Practice</u>
History	Telephone consult due to Covid 19 lockdown back pain and abd pain Left iliac fossa pain very painful to walk vomiting +++ no blood in vomit or stool soft stools. Cry with pain very distressed panting due to discomfort- advised to atyend QE for assessment , finishing sentences.

Medication

Current	Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
	24/07/2020	Dioralyte Oral powder (blackcurrant) DISSOLVE ONE SACHET IN 200ML WATER AND TAKE AS DIRECTED 6 sachet	24/07/2020P	Ms Wilma Mitten	ACUTE
	21/07/2020	Ropinirole Hydrochloride Tablets 250 micrograms ONE AT NIGHT- INCREASED TO 2 AT NIGHT IF TOLERATED AND REQUIRED 56 tablet	21/07/2020P	Ms Wilma Mitten	ACUTE
	30/04/2020	Ralvo Medicated Plaster 700 mg 12 HOURS ON 12 HOURS OFF 30 PLASTER	25/08/2020P	Dr Desmond Spence	ACUTE
	17/07/2019	Shortec Capsules 10 mg ONE TO BE TAKEN TWICE DAILY WHEN REQUIRED 56 CAPSULE	25/08/2020P	Dr Desmond Spence	ACUTE
	17/07/2019	Edoxaban Tablets 60 mg ONE TO BE TAKEN EACH DAY 28 tablet	24/08/2020P	Dr Desmond Spence	REPEAT
	03/06/2019	Octasa Mr Gastro-resistant Tablets 400 mg TAKE THREE TABLETS TWO TIMES DAILY 168 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
	20/03/2019	Lansoprazole Capsules (Gastro-Resistant) 15 mg ONE TO BE TAKEN EACH DAY 28 CAPSULE	24/08/2020P	Dr Desmond Spence	REPEAT
	06/02/2019	Hyoscine Butylbromide Tablets 10 mg TAKE 2 TABS THREE TIMES DAILY 168 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
	08/11/2018	Prochlorperazine Maleate Tablets 5 mg 1 TAB 3 TIMES DAILY 60 tablet	30/04/2020P	Dr Desmond Spence	REPEAT
	28/08/2018	Bisoprolol Fumarate Tablets 2.5 mg ONE TO BE TAKEN EACH DAY 28 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
	13/05/2018	Ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY 60 sachet	14/10/2019P	Dr Desmond Spence	REPEAT
	09/05/2018	Amitriptyline Hydrochloride Tablets 25 mg ONE TO BE TAKEN IN THE EVENING IN ADDITION TO 50MG DOSE. TOTAL DAILY DOSE 75MG. DISPENSE WEEKLY. 28 TABLET	24/08/2020P	Dr Desmond Spence	REPEAT
	04/05/2018	Diclofenac Diethylammonium Gel 1.16 % APPLY 3 TIMES DAILY IF REQUIRED 100 gram	24/08/2020P	Dr Desmond Spence	REPEAT
		Buteac Transdermal patches 20 micrograms/hour APPLY ONE PATCH EVERY SEVEN DAYS IN			

Am6 Ref - 6750231

Yours sincerely
M. M. M.

I would be grateful for fish
of the pt.
cassmann

130 medium

Alca. 30ft, Alca. 30ft, Alca. 30ft
palpable black, guarding 38 region

Alp. 122/62

cat < 1.600

1212 Wm

1108 Day

PR 18

1102 q67

Chur blue

26/07/2017	ADDITION TO 10MCG TOTAL 30MCG/ REMOVE OLD PATCH-DISPENSE WEEKLY 4 PATCH	24/08/2020P	Dr Desmond Spence REPEAT
17/02/2017	Symbicort Turbohaler 200/6 micrograms/inhalation ONE PUFF TO BE INHALED TWICE A DAY 1*1 INHALER	17/04/2020P	Dr Desmond Spence REPEAT
31/01/2017	Amitriptyline Hydrochloride Tablets 50 mg 1 TABS AT EVENING WEEKLY UPLIFT 28 TABLET	24/08/2020P	Dr Desmond Spence REPEAT
19/05/2014	Salofalk Foam Rectal foam 1 gram/application, 80g (14 dose) canister ONE APPLICATION AT NIGHT 14 CANISTER	03/06/2020P	Ms Wilma Mitten REPEAT
01/04/2014	Sertraline Hydrochloride Tablets 50 mg ONE TO BE TAKEN EACH DAY 28 tablet	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Methocarbamol Tablets 750 mg 1 TABS 4 TIMES DAILY 112 TABLET	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Peptac Liquid (antiseed) 10 ML 3 TIMES DAILY 500 ML	14/10/2019P	Dr Desmond Spence REPEAT
09/07/2012	Pregabalin Capsules 300 mg 1 CAP TWICE DAILY 56 capsule	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Salbutamol Cfc-free Inhaler 100 micrograms/puff ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY 1*1 INHALER	06/04/2020P	Dr Desmond Spence REPEAT
09/07/2012	Simvastatin Tablets 40 mg ONE TO BE TAKEN AT NIGHT 28 TABLET	24/08/2020P	Dr Desmond Spence REPEAT
09/07/2012	Capsaicin Cream 0.025 % APPLY 3 TIMES DAILY 45 gram	24/07/2020P	Dr Desmond Spence REPEAT


 1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 G13 4NA

Thank you for seeing
this 66 year old lady. It was previously
admitted with a ureter stone & stent.
She was discharged with Abx on the 22/8/20.
Since discharge she has been exp nausea/vom, fevers
& passing very little urine with episodes of frank
haematuria. She had called GPs on 25/8/20 &
was later seen by SAS however declined admission.

Today another of thought was feeling better however
come lunchtime exp further episodes of nausea/vom &
continues to pass only small amounts of urine.

Ole today, was lying on the couch with
bileous vomit in basin, could only pass 5-10 mls
of urine, concentrated & +ve for leucocytes, protein
& blood ++ (microscopic). Also severely tender
suprapubic area, guarding, dull bladder, palpable bladder.

Bo Normal, describes chronic breathlessness, no chest pain
no rectal tenderness, small.

PHO,

9/26/2020

Incident Number: CR006750231

Patient Information		Date: 26/08/2020	 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA
GEORGINA LOGAN		Incident Number: CR006750231	
Age/Gender: 66y Old Female		Incident Type: URG	
Address: 17 SOLLAS PLACE YOKER GLASGOW, G13 4NA		Incident Location: 17 SOLLAS PLACE YOKER GLASGOW, G13 4NA	
DOB: 19/08/1954			
CHI: 190854042			
Ethnicity: White Scottish			

Presenting Complaint

GENERALLY UNWELL

Additional Comments

G.P URGENT CALL FOR THIS VERY PLEASANT LADY SEEN AT HOME TODAY.. PRESENTING WITH NAUSEA/VOMITING, PASSING VERY LITTLE URINE WITH EPISODES OF FRANK HAEMATURIA. O/E GUARDING ABDO. OBVIOUS DISTENSION, PALPABLE BLADDER... JUST 1/52 HAD ENDOSCOPIC INSERTION OF URETERIC STENT.. G.P IMP ?? RETENTION.. MANY THANKS..

PATIENT ASSESSMENT

AVPU	Alert	<C>	
A	Clear		
B	Breathing Adequately	Yes	Respiratory Rate 16
	Oxygen Given	No	SPO2 97
C	Pulse Rate	BP	Cap Refill
	99	139/78	<=2 Secs
	Rhythm	Arm	ECG Rhythm
	Irr	Right	Central/Peripheral
		Central	3 Lead
D	GCS	Eyes	Voice
	15	Spontaneously (4)	Orients (5)
			Obeyes Commands (6)
E			PEARL
			Yes

Observations

Time	P	RR	BP	SpO2	CR	GCS	AVPU	ETCO2	T	BM	ECG	P(L)	P(R)	PEF	CrewID
14:21	99	16	139/78	97	<=2 Secs	15	Alert		36.7		AF				E002340X

NEWS

Time	Clinical Risk	NEWS
14:21	POTENTIAL Clinical Risk. Patient is likely to require conveyance to hospital.	3

HISTORY**AMPLE**

Allergies	None
Medication	POLYMEDS INCL EDOXABAN, ROPINIROLE HYDROCHLORIDE, SHORTEC, BISOPROLOL, AMITRIPTYLINE, PREGABALIN
Past Medical History	Angina, Asthma, KNOWN AF, DEPRESSION, URETERIC STENT INSERTION 1/52 AGO, IBS
Last Eaten	>4 Hours Ago

CLOSE RECORD

Treatment On Scene Non Emergency

Conveyance

Transport To Hospital Normal driving Pre Alert No

INCIDENT LOG

Time Call Received	13:03	Allocated	13:23	Mobile	13:26
--------------------	-------	-----------	-------	--------	-------

8/28/2020

Incident Number: CR006750231

First Resource On Scene:

Crew On Scene

14:25

Crew Left Scene

14:33

Crew At Hosp

Receiving Hospital

QUEEN ELIZABETH
UNIVERSITY HOSPITAL

Clear Time

Crew ID

Crew Grade

Driver

E9886098

Student Technician Level 4

YES

E002340X

Ambulance Technician

NO



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

F

19/08/1954

G13 4NA

My Admission Record

7



N: _____
 A: 1908546042
 — LOGAN F
 — Georgina 19/08/1954
 — 17 SOLLAS PLACE
 D: KNIGHTSWOOD
 C: Glasgow, Lanarkshire
 Af: _____ G13 4NA

Hospital: QEUH Ward: IAU

Date of Admission: 26/8/20 Time: 1635

Information obtained from: Name: _____

Patient ☒ Relative ☐ Other ☐ _____

Preferred Name:

Age: 60 Telephone Number: _____

Consultant: _____

P.L. arm

Communication

What is your first language? English

Do you require an interpreter? Yes ☐ No ☒

If yes, provide details of arrangements made _____

Do you use British Sign Language (BSL)? Yes ☐ No ☒

Do you need someone to help you to communicate? Yes ☐ No ☒ If yes, who _____

Preferred first contact

Name: George

Relationship: husband

Address: AIA

Telephone: 07437 685 618

Is this person aware of your admission?

Yes ☒ No ☐

Can we share information with this person?

Yes ☒ No ☐

Preferred second contact

Name: _____

Relationship: _____

Address: _____

Telephone: _____

Is this person aware of your admission?

Yes ☐ No ☐

Can we share information with this person?

Yes ☐ No ☐

Presenting Complaint / Diagnosis

Retention

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☒

Relevant past medical history

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☐ If yes, Who asked for a copy? _____

Date they asked for a copy / / Date Obtained / /

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐No ☒**OR**

Does someone have Guardianship?

Yes ☐No ☒If yes, is this for:- Finance ☐ Welfare ☐ Both ☐Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy? _____ Date they asked for a copy ____/____/____ Date Obtained ____/____/____

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

N:

Ac 1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Do Glasgow, Lanarkshire

CH

Affix patient ID label

F
19/08/1954

G13 4NA

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:

1. Been an inpatient in a hospital outside Scotland?

2. Received holiday dialysis outside Scotland?

3. Been told that you have CPE?

4. Been in close contact with a person with CPE?

If the answer is yes to **ANY** of the questions in this section, you must

Isolate the patient in a side room

Obtain Rectal swab marked 'for CPE'

If patient refuses rectal swab, obtain a stool specimen marked 'for CPE'

and inform the IPCT

Yes

No

☐☒☐☒☐☒☐☒☐☒☐☐☐☐☐**MRSA Screening**

Will the patient be an inpatient for more than 23 hours

If **YES** complete the following section

1. Have you ever been told that you have MRSA?

2. Have you been admitted from another hospital/ residential setting or care home?

3. Do you have a wound / skin ulcer or invasive device which you had before admission?

Yes

No

Unsure

☒☐☐☐☒☐☐☒☐☐☒☐☐☒☐☐☒☐☐☒☐If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabsNasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐**Creutzfeldt-Jakob Disease (CJD)**

Have you ever been informed that you are at increased risk of CJD or vCJD?

If **YES** inform the IPCT ☐

Yes

No

Unsure

☐☒☐

Name: _____

Ad: _____



1908546042

LOGAN

F

Georgina

19/08/1954

Do: 17 SOLLAS PLACE

CH KNIGHTSWOOD

Glasgow, Lanarkshire

Affi

G13 4NA

Lifestyle

Smoking

Are you a: smoker ☐ ex-smoker ☐ when did you stop? _____

Never smoked ☒

Do you use eCigarettes? Yes ☐ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ____/____/____

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☒

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

Alcohol

Do you drink alcohol? Yes ☐ No ☒

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

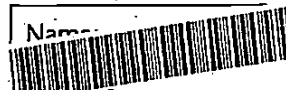
Name (Please PRINT): *cmclaughlin*

Signature: *cmclaughlin*

Designation: *SN*

Date: *26/8/20*

My Assessment Record

Name: _____

 1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 19/08/1954
 F
 G13 4NA
 label

1. Breathing and Circulation			
Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems			
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers	✓	✓	
Oxygen therapy			
Do you have any other symptoms?			
Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina	✓	✓	
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			
2. Communication			
	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team?		✓	
Contact details: _____			

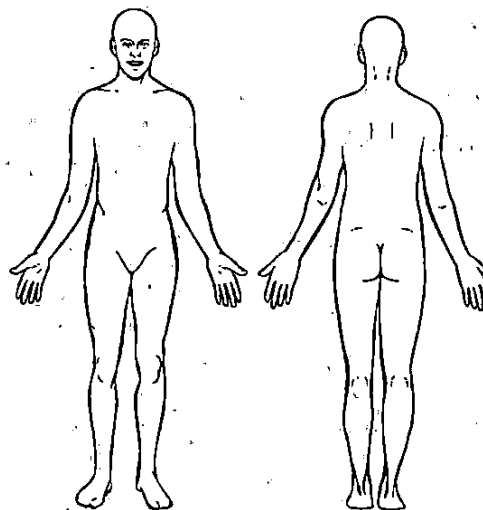
Name: _____
 1908546042 _____
 - LOGAN _____ F
 - Georgina _____ 19/08/1954
 - 17 SOLLAS PLACE _____
 - D KNIGHTSWOOD _____
 - C Glasgow, Lanarkshire _____ G13 4NA
 At _____

B. Senses			
Vision	Yes ✓	No ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		Distance ☒ Reading ☐ Both ☐
Do you wear glasses?	✓		
Do you have your glasses with you?	✓		
Do you wear contact lenses?		/	
Do you have your lenses with you?		/	
Do you wear a prosthesis?		/	
Hearing	Yes ✓	No ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			
Pain	Yes ✓	No ✓	Assessment of the patient's pain
Do you have pain?		/	

Can you describe where and what the pain is like?

Mark current pain on body chart

Have you had treatment / intervention for the pain?



**N.B. Complete generic pain assessment chart.
 If unable to self report complete Abbey
 Pain Scale.**

Can you describe any chronic pain that you have?

What makes the pain better?



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Allix patient ID 1001

4. Cognitive Status**THINK DELIRIUM**

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

no

What do you like to eat and drink?

Varied diet

What do you not like to eat and drink?

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation	Normal for the patient	 1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA
Normal diet and fluids	✓	✓	
Therapeutic diet			
Cultural, ethnic or religious diet			
Texture Modified Diet Please state _____			Assessment of the patient's hydration and nutrition needs
Thickened Fluid Please state _____			
Oral Nutritional supplements Preferred flavour _____			
Enteral Nutrition			
Parenteral Nutrition			
Nil by Mouth			
N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission			
Assistance with eating and drinking	Admission Presentation	Normal for the patient	
Independent (Green)	✓	✓	
Prompting / encouragement / opening packets/cutting up food (Amber)			
Full assistance with eating and drinking (Red)			
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?			
6. Elimination			
Bladder	Admission Presentation	Normal for the patient	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention	✓		

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓	Name:  1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA
Haematuria			F 19/08/1954
Incontinent			

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☒ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ____/____/____

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move?

27/8/20

How often in a day/week do you have a bowel movement? Per day Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ No ☒

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular			
Constipated	✓		
Diarrhoea / loose stools		✓	
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

N  _____
 A 1908546042 _____
 LOGAN _____ F _____
 Georgina 19/08/1954 _____
 17 SOLLAS PLACE _____
 D KNIGHTSWOOD _____
 Glasgow, Lanarkshire _____
 G13 4NA _____
 C _____
 Affix patient ID label

7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			
Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			
Dental work	Yes ✓	No ✓	Description of any dental work
Do you wear dentures?	✓		top set
Do you have your dentures with you?	✓		
Are your dentures a good fit?	✓		
Do you have any other dental work that we need to be aware of?		✓	
Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☒

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ Adult wound assessment and management chart required

N.B If Grade 2 pressure damage on ankle or below refer to Podiatry via TrakCare

Wound Care	Yes ✓	No ✓	Name: _____ A  _____ 1908546042 — LOGAN F _____ — Georgina 19/08/1954 _____ D 17 SOLLAS PLACE _____ C KNIGHTSWOOD _____ Cl Glasgow, Lanarkshire _____ Af G13 4NA _____
Do you have any wounds? N.B. If yes, complete an assessment chart for wound management		✓	

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent			
Unsteady when walking			
Do you use a mobility aid	Yes ☒	No ☐	
Do you have your mobility aid with you? <i>Stick</i>	Yes ☐	No ☒	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?		✓	
Do you do or use anything to help you sleep?		✓	

Name:		
Adc:		
	1908546042	
	LOGAN	F
	Georgina	19/08/1954
Doi:	17 SOLLAS PLACE	
	KNIGHTSWOOD	
CHI:	Glasgow, Lanarkshire	
Affi:	G13 4NA	

11. Social Circumstances

Do you:

- | | |
|---|---|
| Live alone ☐ | Live with family/ friend/ other ☒ |
| Live in a nursing home ☐ | Live in a care home ☐ |
| Live in residential supported care ☐ | Live in student accommodation ☐ |
| Live in 'homeless' accommodation ☐ | Have no fixed abode ☐ |
| Other please specify ☐ | |

Dependants

Yes	No
-----	----

- | | | |
|--|--|-------------------------------------|
| Do you have any dependants? | | ☒ |
| Do you support anyone (e.g. partner, children, relatives, animals)? | | ☒ |
| Do they need support from someone else whilst you are in hospital? | | ☒ |
| Would someone else be able to provide this support when you are in hospital?
If yes, who? | | ☒ |

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services

Yes	No
-----	----

- | | | |
|--|--|-------------------------------------|
| Do you have support from social work, social services or a care package? | | ☒ |
| If yes, please provide details: | | |
| | | |
| If yes, has contact been made to cancel arrangements during admission? | | ☒ |

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

no

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

no

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☒

Healthcare Chaplain informed Yes ☐ N/A ☒

Name: _____
 Ac:  _____
 1908546042 _____ F _____
 LOGAN _____
 Georgina _____ 19/08/1954 _____
 Dc 17 SOLLAS PLACE _____
 CH KNIGHTSWOOD _____
 Glasgow, Lanarkshire _____ G13 4NA _____
 Affi _____

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name:

Contact Details:

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
 (please tick) Yes ☐ No ☐



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

C

Affix patient ID label

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?

Yes ☐ No ☐

Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐Unemployed ☐Self-employed ☐Retired ☐Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

Yes ☐ No ☐ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?

Yes ☐ No ☐ If yes when was patient referred ____/____/____

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?

Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ____/____/____



1908546042

LOGAN

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Risk Assessments/Other Documentation

Cm.

Affix patient ID label

Additional NHSGCC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓				
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
26/8/20 16:45	Patient admitted from home. mobile independently. Alert and orientated.	
	Awaits medical review	
18:30	Patient passed urine	
	Bladder scan shows 5mb only	

19/08/1954

Clinical Notes (cont.)

[illegible]



19/08/1954



NEWS – National Early Warning Score



Name	1908546042
Address	LOGAN F 4 Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA
CHI No.	
DoB	19/08/1954

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score					
	3	2	1	0	1	2
Respiration Rate	≤8		9-11	12-20		≥25
Oxygen Saturations	≤91	92-93	94-95	≥96		
Any Supplemental Oxygen		Yes		No		
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°
Pulse	≤40		41-50	51-90	91-110	≥131
Systolic BP	≤90	91-100	101-110	111-219		≥220
Conscious Level				A		V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE: 10/16/28		TIME: 15:08	DATE:	TIME:	NEW
Resp. Rate	35		35		
Mark: •	25		25		
	20		20		
	12		16		
	8				
SpO ₂	296	97.96	296		
(Enter Value)	94.95		94.95		
Any Suppl O ₂	5.91		5.91		
Room air	%		%		
Temp.	39°		39°		
Mark: X	38.5°		38.5°		
	38°		38°		
	37.5°		37.5°		
	37°		37°		
	36.5°		36.5°		
	36°		36°		
	35.5°		35.5°		
	35°		35°		
Pulse	79		79		
Mark: •	80		80		
	70		70		
	60		60		
	50		50		
	40		40		
	30		30		
	20		20		
	10		10		
	0		0		
Blood Pressure	170		170		
Mark: X	160		160		
	150		150		
	140		140		
	130		130		
	120		120		
	110		110		
	100		100		
	90		90		
	80		80		
	70		70		
	60		60		
	50		50		
NEWS SCORE	120		120		
using Systolic BP	110		110		
	100		100		
	90		90		
	80		80		
	70		70		
	60		60		
	50		50		
Conscious Level	Alert		Alert		
Mark: •	Verbal		Verbal		
	Pain		Pain		
	Unresp		Unresp		
Total NEWS (with all obs)	2	0	2	0	
BM	X		BM		
Pain	4/10		Pain		
Nausea	0/3		Nausea		
Urine output	1000		UO		
Obs due	10/15/28		Obs due		
Initials	RC		Initials		

[illegible]

NHSGGC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrail Guidance (see reverse) and Guidelines for Falls Prevention and Management (Adults).

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

1908546042
LOGAN
Georgina
19/08/1954



Patient Name:

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment		DATE	26/8						
		TIME	16:50						
		WARD	19A						
		HOSPITAL	QEDH						
SECTION ONE - GENERAL									
1	Is the patient likely to fall, roll, slip or slide from the bed?		Y	N	Y	N	Y	N	Y
2	Has the patient requested the use of bedrails?		Y	N	Y	N	Y	N	Y
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO - COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?		Y	N	Y	N	Y	N	Y
4	Is the patient stressed, delirious or restless?		Y	N	Y	N	Y	N	Y
5	Is the patient small in stature?		Y	N	Y	N	Y	N	Y
6	Does the patient have an unusually large or small head that might present an entrapment issue?		Y	N	Y	N	Y	N	Y
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		Y	N	Y	N	Y	N	Y
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION THREE - COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		Y	N	Y	N	Y	N	Y
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition		Y	N	Y	N	Y	N	Y
10	Has the use of bedrails been discussed with relatives/carers?		Y	N	Y	N	Y	N	Y
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		Y	N	Y	N	Y	N	Y
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		Y	N	Y	N	Y	N	Y
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE - See Guidance overleaf									
SECTION FOUR - DECISION MAKING									
13	Will bedrails be used for this patient at the present time?		Y	N	Y	N	Y	N	Y
14	Rationale for use of bedrails: (Please insert code in the box on the right)		Y	N	Y	N	Y	N	Y
	A - Risk of falling from the bed		Y	N	Y	N	Y	N	Y
	B - Risk of rolling from the bed		Y	N	Y	N	Y	N	Y
	C - Risk of slipping from the bed		Y	N	Y	N	Y	N	Y
	D - Risk of sliding from the bed		Y	N	Y	N	Y	N	Y
	E - Patient request		Y	N	Y	N	Y	N	Y
15	Bedrail risk assessment completed by:		Y	N	Y	N	Y	N	Y
16	Bedrails checked by:		Y	N	Y	N	Y	N	Y
17	Date		26/8						
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									

A. Alternatives to bed rails:-

- Move the patient to a more observable area
- Increase patient observation
- Ensure the bed is returned to the lowest height appropriate to the patient needs, after care delivery
- Ensure patient needs are anticipated e.g. drinks are accessible, regular toileting, call bell to hand
- Nursing patient on mattress on the floor should be the last resort, and safety checks should be made for hot pipes, trailing wires, electrical sockets etc
- A generic moving and handling assessment must be carried out for staff caring for patients nursed on mattress on the floor.
- Contact Hospital Falls team for advice where appropriate

C. Safe use and application of bedrails:-

- If bedrail is fitted and there is a gap between the lower rail and the mattress then a bedrail should not be used
- If the gap between the bars on the bedrail is greater than 12cm then a bedrail should not be used
- If the bedrail moves away from the side of the mattress then a bedrail should not be used
- If the gap between the bedrail and the headboard is between 6cm and 25cm then a bedrail should not be used
- If the gap between the bedrail and the footboard is between 6cm and 25cm then a bedrail should not be used
- If the bedrail has not been fitted correctly then the bedrail should not be used
- If the bedrail is not secure then the bedrail should not be used
- If the bedrail is not compatible with the frame it will be fitted to then a bedrail should not be used
- If the bedrail is not in good working order then the bedrail should not be used

**B. If bedrails are to be used, please consider the following:-
Is patient:-**

- Stressed, delirious or restless
- At risk of entrapment
- At risk of climbing over the top of the bed rail
- At risk of being psychologically affected by the use of the bed rail

D. Record keeping:-

All of the following should be recorded:-

- Date and time of assessment
- Bedrail information leaflet given to patient and/or next of kin
- Rationale for decision in care plan or in AWI treatment plan
- Where bedrails are considered appropriate and patient has declined their use
- Any other actions implemented
- Care planning should be reviewed and updated as per record keeping standards

Bedrail risk assessments should be made as follows:-

- On admission
- If patient's condition changes or fall / suspected fall from bed
- Daily/weekly depending on the patient's status

Date: 26/8/20

1. Signed [Signature] Name cmclaughlin Designation (5)
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

*Y = Yes · N = No · NA = Not applicable · NT = No Thanks · S = Sleeping · O = Off the ward · I = Independent

[illegible]

Ward:

G13 4NA

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

NHS
Greater Glasgow
and Clyde

[illegible]



1908546042
LOGAN
Georgina

F
19/08/1954

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission
and on Transfer to Another Ward



GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 1A0	Ward:	Ward:	Ward:	Ward:
	Date: 26/8	Date:	Date:	Date:	Date:
	Time: 16:45	Time:	Time:	Time:	Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Indep				
2. Check walking aid (if required) is in reach and in use. Stick	@home				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	yes				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	yes				
5. If glasses are worn, check they are available and in use.	yes				
6. If hearing aid/s are worn, check they are working and in use.	na				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).

Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.

****ALL patients in older people's wards must have an interventional plan in place (overleaf)****

	Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?			/								
2. Does the patient have cognitive impairment or a possible delirium?			/								
3. Does the patient attempt to walk alone although unsteady or unsafe?			/								
4. Does the patient or their relative have a fear or anxiety of the patient falling?			/								
5. Based on your clinical judgement, is this patient at high risk of falling?			/								
Signature of nurse completing assessment / update											

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

Complete for all patients identified at risk of falling.

Ward:	Ward:	Ward:	Ward:	Ward:
Date:	Date:	Date:	Date:	Date:
Time:	Time:	Time:	Time:	Time:

BED AND SEATING

Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice.

(Patient care plan 8)

Assess if a low bed is required

(Patient care plan 9)

SAFETY

Complete / update bedrails risk assessment if bedrail in use.

(Patient care plan 9)

Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart.

(Patient care plan 9)

If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.

HEALTH

Complete /Document 4AT – follow THINK DELIRIUM guidelines.

(Patient care plan 4)

Document continence problems and link to care rounding

(Patient care plan 6)

Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns.

(Patient care plan 1)

If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.

COMMUNICATION

Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative.

(Patient care plan -negotiated-care)

Update the ward team of the patient's mobility status.

(Patient care plan 8)

Discuss the patient's fall risk at safety briefs and MDT meetings.

(If appropriate)

Consider a referral to the Hospital Falls Service for advice using trackcare.

(If appropriate)

Signature of nurse completing interventional plan / or update

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN



1908546042

LOGAN

Georgina

19/08/1954

Patient) Moving and Handling Assessment Form

Person: KNIGHTSWOOD Name: Glasgow, Lanarkshire G13 4NA		Named Nurse:	Person is totally independent (tick here and go to date box)	☒															
1. Body Build																			
Weight: Kg Height: cm BMI:		Problems with comprehension, behaviour, co-operation (specify):																	
Risk of Falls: Yes ☐ No ☐		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):																	
2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)																			
Hoist	Standaid	Walking Aid	Assistance	Supervision Independent															
Model	Aid Type	People: 1 2 >3	Additional Information / Equipment:																
Sling type																			
Sling Size																			
3. Toileting																			
Hoist	Standaid	Walking Aid	Assistance	Supervision Independent															
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 2 >3	Additional Information:																
4. Move on / off bed pan																			
Hoist	Manoeuvre	Assistance	Supervision	N/A															
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Independent bridging	People: 1 2 >3	Additional Information:																
5. Move up / down bed																			
Hoist	Handling Aids	Assistance	Supervision	Independent															
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1 2 >3	Additional Information:																
6. Lateral Transfer to / from trolley / bed																			
Hoist	Handling Aids	Assistance	Supervision	Independent															
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):																
7. Sit up over side of bed																			
	Bed Rest	Assistance	Supervision	Independent															
		People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):																
8. Into Bath or Shower																			
Equipment	Handling Aid	Assistance	Supervision	Independent															
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):																
Variable / Fixed height bath	Shower trolley																		
Bed bath	Bathing hoist (eg Alenti)																		
9. Walking																			
No Walking	Walking Aid	Assistance	Supervision	Independent															
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)																
10. Other Instructions / Observations / Equipment Used																			
<table border="1"> <thead> <tr> <th>1st Assessment</th> <th>2nd Assessment</th> <th>3rd Assessment</th> </tr> </thead> <tbody> <tr> <td>Recording Symbol: / Forward slash</td> <td>X Where a forward slash exists, add a back slash to make a cross</td> <td>* Where a slash or cross exists add slashes to make a star</td> </tr> <tr> <td>Date Assessed: 26/8/20</td> <td></td> <td></td> </tr> <tr> <td>Assessor's signature: 16.50</td> <td></td> <td></td> </tr> <tr> <td>Proposed Review date:</td> <td></td> <td></td> </tr> </tbody> </table>					1 st Assessment	2 nd Assessment	3 rd Assessment	Recording Symbol: / Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star	Date Assessed: 26/8/20			Assessor's signature: 16.50			Proposed Review date:		
1 st Assessment	2 nd Assessment	3 rd Assessment																	
Recording Symbol: / Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star																	
Date Assessed: 26/8/20																			
Assessor's signature: 16.50																			
Proposed Review date:																			

Continuation Sheet

[illegible]

Adult Peripheral Vascular Canni

Insertion and Maintenance Care Plan



1908546042

LOGAN

Georgina

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

19/08/1954

F

CHI:

Address:

Hospital:



Insertion cr

G13 4NA

Action at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐

Resuscitation/Chest Pain ☐

IV Drugs ☐

Fluids ☒

Transfusion ☐

PVC inserted: Day 0	Date: <u>26/8/20</u> Hospital: <u>QCU</u>
	Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☒ <u>LA</u> Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☒ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☒ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? Diagnostics Resuscitation/ Chest Pain IV Drugs Fluids Transfusion	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P. (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and *S. aureus* bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult: IV* → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature $\leq 37.9^{\circ}\text{C}$, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, *S. aureus* bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abscess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

NO

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

Pressure Ulcer Daily Risk Assessment (PUDRA)

 1908546042 LOGAN F Georgina 19/08/1954 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA	Hospital: QCUH Ward: 1A11	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes
--	--	--

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.
--------------------------	--

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2 Mobility	Does the person require assistance to mobilise?
3 Continence	Does the person have continence issues with urine and/or faeces?
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
26/8/20	16:45	n	n	n	n	n	low	4 hrly	cm
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

NHS
Greater Glasgow
and Clyde

Attach Addressograph

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

MEDICINE

PRESCRIPTION FORM

Hospital Name: QEH

MEDICINES RECONCILIATION				ONCE ONLY AND PREMEDICATION DRUGS							
Medicines Discussed on Admission YES ☐				DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
Date _____ Name (Print) _____											
Discharge Prescription Prepared & Reconciled YES ☐											
Date _____ Name (Print) _____											
Date and time this form prepared:		Sheet No	2nd Prescription in use								
/ / Time: _____		_____	YES ☐ NO ☐								
DOCTOR'S DECLARATION (if required by Local Protocol)											
I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:											

with the following exceptions: _____											
Print & Sign: _____ Date: _____											
COMMUNITY PHARMACY INFORMATION											
Name _____ Tel No. _____											
Address _____											
Compliance Aid Details _____											
Patient consent to share discharge information Y/N _____											
Print & Sign _____											
PATIENT DETAILS				TARGET OXYGEN SATURATIONS							
Hosp:			Height:	Please <u>CIRCLE</u> a target saturation and prescribe oxygen on the Regular Prescription section.				94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)	
DOB:	1908546042 LOGAN 4 Georgina 19/08/195 F		Weight:								
Date	17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire		Surface area:	On Home Oxygen? Yes / No _____ L/min							
Cons	G13 4NA		Ward:								
DATE: ____ / ____ / ____				PRESCRIBER (PRINT & SIGN): _____							

EDOXABAN		DATE: _____			
		MONTH: _____			
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N		RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)			
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N					
SIGNATURE OF ASSESSOR _____					
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N					
Parenteral Drugs : Regular Prescription					
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A DRUG		Other time	Patient's Own Medication For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
	DOSE	ROUTE	DATE		DATE:
	PRESCRIBER (PRINT & SIGN)				INITIALS:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG		Other time	Patient's Own Medication For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
	DOSE	ROUTE	DATE		DATE:
	PRESCRIBER (PRINT & SIGN)				INITIALS:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG		Other time	Patient's Own Medication For Use Y/N Qty: Date: Assessed by: Ordered from Pharm.	
	DOSE	ROUTE	DATE		DATE:
	PRESCRIBER (PRINT & SIGN)				INITIALS:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription				DATE													Patient's Own Medicine		
				MONTH															
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	D	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:														
		PRESCRIBER (PRINT & SIGN)			STOPPED	INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	E	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:														
		PRESCRIBER (PRINT & SIGN)			STOPPED	INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	F	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:														
		PRESCRIBER (PRINT & SIGN)			STOPPED	INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	G	DRUG		Other time													For Use Y/N		
		DOSE	ROUTE	DATE	DATE:														
		PRESCRIBER (PRINT & SIGN)			STOPPED	INITIALS:													
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																	

1908548042
LOGAN
Georgina
17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow, Lanarkshire
G13 4NA
F
19/08/1954

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription				DATE													Patient's Own Medicine
BEFORE ADMISSION ☒	H	DRUG AMITRIPTYLINE	DATE MONTH 8	Other time													For Use Y/N
NEW DOSE ☐	DOSE 50mg	ROUTE O	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) A.R.		STOPPED DATE: INITIALS:	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☒	J	DRUG AMITRIPTYLINE	DATE	Other time													For Use Y/N
NEW DOSE ☐	DOSE 75mg	ROUTE O	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) A.R.		STOPPED DATE: INITIALS:	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☒	K	DRUG BUTEK	DATE	Other time													For Use Y/N
NEW DOSE ☐	DOSE 30 microgram	ROUTE TDP	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) A.R.		STOPPED DATE: INITIALS:	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY every 7 DAYS CHANGE				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													
BEFORE ADMISSION ☒	L	DRUG SERTRALINE	DATE	Other time													For Use Y/N
NEW DOSE ☐	DOSE 50mg	ROUTE O	DATE 26/8	0700-0900													Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) A.R.		STOPPED DATE: INITIALS:	1200-1400													Date:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800													Assessed by:
				2200-2400													Ordered from Pharm.
				Other time													

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription				DATE													 1908546042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA		Patient's Own Medicine
BEFORE ADMISSION ☒	M	DRUG PREGABALIN	DATE 26/8	Other time														For Use Y/N	
NEW DOSE ☐		DOSE 300mg	ROUTE O	DATE 26/8	1200-1400														Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) Azz	STOPPED INITIALS:	1600-1800														Date:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				2000-2400														Assessed by:	
				Other time														Ordered from Pharm.	
BEFORE ADMISSION ☒	N	DRUG SIMVASTATIN	DATE	Other time														For Use Y/N	
NEW DOSE ☐		DOSE 40mg	ROUTE O	DATE 26/8	0700-0900														Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) Azz	STOPPED INITIALS:	1200-1400														Date:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800														Assessed by:	
				2000-2400														Ordered from Pharm.	
				Other time															
BEFORE ADMISSION ☒	P	DRUG METHOCARBAMOL	DATE	Other time														For Use Y/N	
NEW DOSE ☐		DOSE 750mg	ROUTE O	DATE 26/8	0700-0900														Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) Azz	STOPPED INITIALS:	1200-1400														Date:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800														Assessed by:	
				2000-2400														Ordered from Pharm.	
				Other time															
BEFORE ADMISSION ☒	R	DRUG BEOPRISOL	DATE	Other time														For Use Y/N	
NEW DOSE ☐		DOSE 2.5mg	ROUTE O	DATE 26/8	0700-0900														Qty:
NEW MEDICATION ☐		PRESCRIBER (PRINT & SIGN) Azz	STOPPED INITIALS:	1200-1400														Date:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800														Assessed by:	
				2000-2400														Ordered from Pharm.	
				Other time															

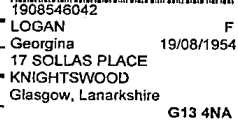
The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription				DATE													 1908546042 'LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA		Patient's Own Medicine						
				MONTH																					
BEFORE ADMISSION ☒	X	DRUG	SALOFALK FORM	Other time	28																				
NEW DOSE ☐		DOSE	1 APP	ROUTE	TDP	DATE	26/8	STOPPED	DATE:	0700-0900															For Use Y/N
NEW MEDICATION ☐		PREScriBER (PRINT & SIGN)	AQQ	INITIALS:	1200-1400															Qty:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800															Date:						
				2200-2400															Assessed by						
				Other time															Ordered from Pharm						
BEFORE ADMISSION ☒	Y	DRUG	SYMBIORCT	Other time																For Use Y/N					
NEW DOSE ☐		DOSE	1 PUFF	ROUTE		DATE		STOPPED	DATE:	0700-0900															Qty:
NEW MEDICATION ☐		PREScriBER (PRINT & SIGN)	AQQ	INITIALS:	1200-1400															Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800															Assessed by						
				2200-2400															Ordered from Pharm						
				Other time																					
BEFORE ADMISSION ☒	AA	DRUG	RALVO	Other time																For Use Y/N					
NEW DOSE ☐		DOSE	700mg	ROUTE	TDP	DATE	26/8	STOPPED	DATE:	0700-0900															Qty:
NEW MEDICATION ☐		PREScriBER (PRINT & SIGN)	AQQ	INITIALS:	1200-1400															Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800															Assessed by						
12h on 12h off				2200-2400															Ordered from Pharm						
				Other time																					
BEFORE ADMISSION ☒	BB	DRUG	ROPINIROLE	Other time																For Use Y/N					
NEW DOSE ☐		DOSE	250MICROG	ROUTE	0	DATE	26/8	STOPPED	DATE:	0700-0900															Qty:
NEW MEDICATION ☐		PREScriBER (PRINT & SIGN)	AQQ	INITIALS:	1200-1400															Date:					
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY				1600-1800															Assessed by						
				2200-2400															Ordered from Pharm						
				Other time																					

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription				DATE													Patient's Own Medicine
				MONTH													
BEFORE ADMISSION ☒	CC	DRUG SHORTEL		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE:													Qty:
			26/8														Date:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN) AGR			INITIALS:													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED													Ordered from Pharm.
				1200-1400													
				1600-1800													
				2200-2400													
				Other time													
BEFORE ADMISSION ☐	DD	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE:													Qty:
																	Date:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			INITIALS:													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED													Ordered from Pharm.
				0700-0900													
				1200-1400													
				1600-1800													
				2200-2400													
				Other time													
BEFORE ADMISSION ☐	EE	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE:													Qty:
																	Date:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			INITIALS:													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED													Ordered from Pharm.
				0700-0900													
				1200-1400													
				1600-1800													
				2200-2400													
				Other time													
BEFORE ADMISSION ☐	FF	DRUG		Other time													For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	DATE	DATE:													Qty:
																	Date:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			INITIALS:													Assessed by:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			STOPPED													Ordered from Pharm.
				0700-0900													
				1200-1400													
				1600-1800													
				2200-2400													
				Other time													

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason



Oral and Other Drugs: Regular Prescription				DATE													Patient's Own Medicine	
				MONTH														
BEFORE ADMISSION ☐	GG DRUG			Other time													Patient's Own Medicine	
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													For Use Y/N	
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			1200-1400													Qty:	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1600-1800													Date:	
				1600-1800													Assessed by:	
				2200-2400													Ordered from Pharm.	
				Other time														
BEFORE ADMISSION ☐	HH DRUG			Other time													For Use Y/N	
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:	
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			1200-1400													Date:	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1600-1800													Assessed by:	
				2200-2400													Ordered from Pharm.	
				Other time														
BEFORE ADMISSION ☐	JJ DRUG			Other time													For Use Y/N	
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:	
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			1200-1400													Date:	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1600-1800													Assessed by:	
				2200-2400													Ordered from Pharm.	
				Other time														
BEFORE ADMISSION ☐	KK DRUG			Other time													For Use Y/N	
NEW DOSE ☐	DOSE	ROUTE	DATE	0700-0900													Qty:	
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)			1200-1400													Date:	
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			1600-1800													Assessed by:	
				2200-2400													Ordered from Pharm.	
				Other time														

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions									
BEFORE ADMISSION ☒	LL	DRUG	DICLOFENAC GEL						
NEW DOSE ☐	DOSE	ROUTE	INDICATION						
	1 App	TOP	PAIN						
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:				
	AECZ		3°						
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									
1-1670 gel									
BEFORE ADMISSION ☒	MM	DRUG	SALBUTAMOL						
NEW DOSE ☐	DOSE	ROUTE	INDICATION						
	2 Puffs	INH	SOB						
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:				
	AECZ		PRN						
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									
BEFORE ADMISSION ☒	NN	DRUG	SHOLTEL 10mg						
NEW DOSE ☐	DOSE	ROUTE	INDICATION						
	10mg - 20mg	O	PAIN						
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:				
	AECZ		2°						
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									
BEFORE ADMISSION ☐	pp	DRUG							
NEW DOSE ☐	DOSE	ROUTE	INDICATION						
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:				
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY									

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Patient's Own Medicine	
For Use Y/N	
Qty:	
Date:	
Assessed by:	
Ordered from Pharm.	
For Use Y/N	
Qty:	
Date:	
Assessed by:	
Ordered from Pharm.	
For Use Y/N	
Qty:	
Date:	
Assessed by:	
Ordered from Pharm.	
For Use Y/N	
Qty:	
Date:	
Assessed by:	
Ordered from Pharm.	

Patient's Own Medicine																	
BEFORE ADMISSION ☐	RR	DRUG		DATE: STOPPED INITIALS:	DATE											For Use Y/N	
		DOSE	ROUTE		INDICATION	TIME											Qty:
		PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DOSE											Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY													Assessed by:		
NEW DOSE ☐	SS	DRUG		DATE: STOPPED INITIALS:	DATE											For Use Y/N	
		DOSE	ROUTE		INDICATION	TIME											Qty:
		PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DOSE											Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY													Assessed by:		
NEW DOSE ☐	TT	DRUG		DATE: STOPPED INITIALS:	DATE											For Use Y/N	
		DOSE	ROUTE		INDICATION	TIME											Qty:
		PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DOSE											Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY													Assessed by:		
NEW DOSE ☐	VV	DRUG		DATE: STOPPED INITIALS:	DATE											For Use Y/N	
		DOSE	ROUTE		INDICATION	TIME											Qty:
		PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DOSE											Date:
		ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY													Assessed by:		

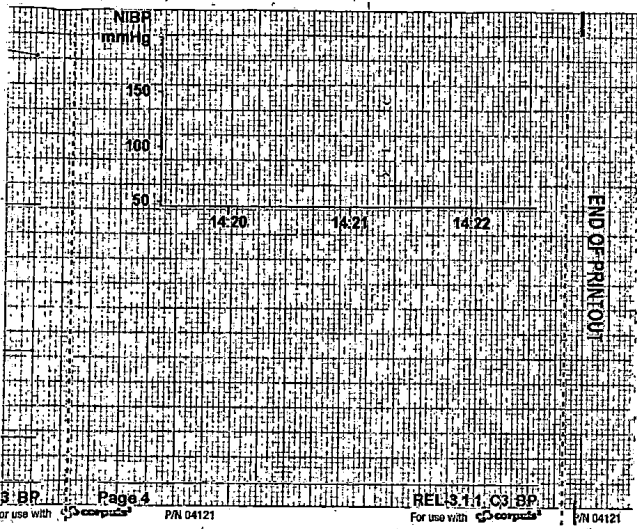
The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

 1908548042 LOGAN Georgina 17 SOLLAS PLACE KNIGHTSWOOD Glasgow, Lanarkshire G13 4NA		Name CHI No
---	--	----------------

Drug Allergies / Sensitivities None Known ☒ Yes ☐ (provide details below)

NKA

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)								Notes for Users
Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.								FOR PRESCRIBERS: 1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline). 2. All prescription entries must be legible and made so as to be indelible (black ink is recommended). 3. Print & Sign your full name clearly against each prescription entry. 4. Time should be recorded in 24hr format e.g. 0600, 1800. 5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason. 6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry. 7. The following metric unit abbreviations must be used - Milligram = mg Gram = g Millilitre = ml Millimoles = mmol Microgram / Nanogram / Units - Do not abbreviate, write in full Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml NOT .5ml). 8. The route of administration can be abbreviated using the following - O = oral ID = intradermal IM = intramuscular SL = sublingual SC = subcutaneous PR = per rectum NG = nasogastric PEG = percutaneous endoscopic gastrostomy PV = per vagina RIG = radiologically inserted gastrostomy NJ = nasojejunosomy PEJ = percutaneous endoscopic jejunostomy TOP = topical ETT = endotracheal NEB = nebulised INHAL = inhaled IV = intravenous Please note - Intrathecal must be written in full.
DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)	FOR NURSES 1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided. 2. Insert initials in the relevant date column and time row each time a drug is administered. 3. Check that all drugs prescribed at a certain time have been administered. 4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.
Codes for Non-Administration of Drugs								
③ Patient refused ④ Drug not available ⑤ Nil by mouth/fasting ⑥ Patient unavailable		⑦ Patient asleep ⑧ Time varied on doctor's instructions ⑨ Dose withheld on doctor's instructions ⑩ Nausea/vomiting		⑪ Unable to swallow ⑫ No intravenous access ⑬ Patient Self-Administration of Medicine		⑭ Other - Record in nursing notes ⑮ Prescription clarification required		





Affix Label



CHI: 1908546042

Queen Elizabeth University Hospital

H

Title: MRS

Total Att: 16

12 Mth Att: 0

LOGAN

Georgina

DOB: 19/08/1954

Age: 64y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
01419523728

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: P Balaji
0141 212 7082

Attendance Date: 10/07/2019

Arrival Time: 05:31

Registration Time: 05:31

Date of Incident: 10/07/2019

Major Incident Desc:

Reason for Attendance: chest pain / vomiting

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 2

Tetanus up to date/fully immunised:

Presenting Complaint: Chest Pain

Observation Date: 10/07/2019 05:37

Nurse name: Nurse Nicola Baxter1

Temp	36.3	C
HR	83	bpm
BP	125/84	mmHg
MAP		mmHg
RR	16	bpm
SpO2	98	%
Oxygen	21	%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: SelfRef:central non radiating chest pain since 4am. Woke from sleep. PMH: angina

Refused GTN - states makes her sick -
accepted GTN @ 0612

Patient ID label

1908546042 19/08/1954

LOGAN Georgia

Emergency Department Notes	Ambulance/Proforma reviewed Yes/No Seen by (Doctor) <u>Hyla James</u> Time seen <u>06:55</u>
----------------------------	--

60 year old female

PE - chest pain

14pc - woke up from bed with chest pain at around 4 am in the morning

Worked x1 - central chest pain, not radiating to arm, no sweating, no palpitation

no dizziness, no collapse, no abdominal pain, no SOB, no exertional symptoms

No focal neurological symptoms.

PMH ① IBD ② Angina ③ chronic back pain

④ Asthma

Medication - aspirin etc

Lives with family

Next non smoker

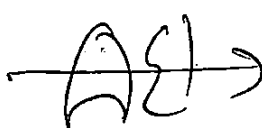
No EPH

6/10 (A) clear

10/8/19

Patient ID label

1908546042

Date .	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	⑧ RR - 16/min SpO₂ - 98% on air  ⑨ HR - 83/min B1 H1 to CBF - 23 sec ⑩ CBF - 15/min  SNT B1 - normal Calver - SNT HEART Score - 3	

Differential Diagnosis/Problem List

① To rule out AET

NEWS

☐

0-7

RED FLAG

☐

(Tick)

SEPSIS

☐

CURB 65

☐

Done/ completed	Immediate Management Plan
	① Bloods Proposed C1
	② E.C.G - no new changes.
	③ Chest X-ray - nil focal.
	④ Analgesia
	Patient is pain free at the moment.
	Observations - normal. Discharged with
	consultant Dr. Jason Long. safety netted
	& discharged home.

Signature:



Designation:

CE

Page No:

PLEASE DO NOT WRITE HERE

In-Patient Admission Notes

Patient ID label

1908546042

Seen By:

Print:

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)

Presenting complaint

History of presenting complaint

Past Medical History / Review of portal

Systemic Enquiry

Patient ID label

1908540042

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☐ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

General Examination

Temp:

RR:

Pulse:

CBG:

SpO₂:

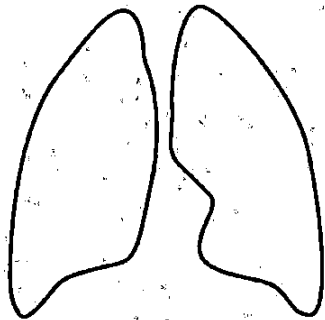
Weight:

BP:

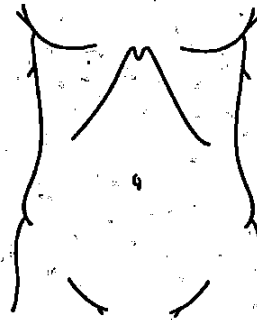
Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

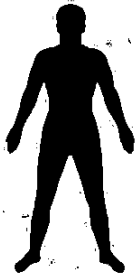
Pupils/fundoscopy:

**Cerebellar and
extrapyramidal:**

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

1908546042

Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME

PRINT GRADE

Page:

Patient ID label

Resuscitation Decision

Resuscitation status: **FOR RESUSCITATION** / **DNA CPR**
(please circle)

If DNA CPR → Complete appropriate form.

Senior Medical review

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation
☐ DNACPR

☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label

1908546042

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETEDIs the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days☐ Yes☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive
Age > 60	Hormone replacement therapy
Dehydration	Pregnancy or < 6 weeks post partum (seek specialist advice)
Known thrombophilia	Critical care admission
BMI ≥ 30	Varicose veins with phlebitis
Personal/1st degree relative history of VTE	Current significant medical condition e.g. infection, inflammation, cardio resp disease
Hip fracture	

☐ Yes☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder
Acquired bleeding disorder	Thrombocytopaenia $< 75 \times 10^9/l$
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)
Concurrent use of anticoagulants e.g. warfarin with INR > 2	Uncontrolled hypertension ($> 230/120$)
Acute stroke	Varicose veins
Recent (< 4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic	
Other - Document	

☐ No☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50 kg or eGFR < 30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A

(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____

Patient ID label

Results

[illegible]

1908546042

Patient ID label

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp:

Pulse:

BP:

SpO₂:

FiO₂:

RR:

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

[illegible]This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Patient ID label

1908546042.

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

1908546042

Continuation Sheet	
Date: Time	

Emergency Department Nursing Documentation



Presenting Complaint: Chest Pain

Date and Time: 18/7/19

Named Nurse(s):			
Patient preparation (Please tick when completed)		Initials:	
Prepare patient for examination and provide blankets if required	☒	Communication (Please tick when completed)	Initials:
Clothing bagged, labelled and stored under trolley	☒	Communication Aids (spectacles / hearing aid)	☐
Name-band (if required)	☐	Relatives present, who?	☐
		Relatives / NOK informed	☐
		Interpreter required	☐
		Telephone interpretation required	☐
Observations and Investigations (Please tick when completed)		Initials:	
Vital Signs recorded on NEWS chart and NEWS score recorded. Record Pain, blood sugar and neuro obs on NEWS chart if appropriate.	☒	IV cannula (if required)	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated	☐
Cardiac Monitoring	☒	Results:	
X-rays performed	☐	HCG specimen if indicated +ve ☐ -ve ☐ Strip Lot no:	☐
Other: please add	☐	Weight:	☐
Screening Tools (Please circle or tick as appropriate)		Initials:	
SEPSIS risk? SIRS Criteria 2 or more and suspicion of infection Sepsis 6 protocol initialise and departmental documentation started	Y / N Y / N	Preliminary Pressure Ulcer Risk Assessment The patient can reposition themselves whilst in the department?	Y / N
AMT 4 (if >65 years) SCORE	/4	There is no reported skin damaged other than presenting trauma?	Y / N
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc). If at risk complete risk assessment	Y / N	The person is fully continent? If NO to any of the above initiate Waterlow risk assessment (within 4 hrs)	Y / N
Mental Health Triage Assessment	Y / N	Waterlow Score If >10 commence Active Care	☐
Child Protection considered (in line with policy)	Y / N	Active Care (clinical judgement) (include all trolley patients at risk of pressure ulcers and all trolley patients in department for >4hrs) Record on Active Care Chart	☐
FAST	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
GMAWS	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐
Has Swallow test been carried out?	Y / N		
Pause for Transfer (Please tick when completed)		Tick when completed	N/A
Relatives Informed		☐	☐
Cannula		☐	☐
Name band		☐	☐
AMT4		☐	☐
NEWS chart NEWS >7 - Name and Page number of senior doctor caring for patient		☐	Always
Prescriptions signed	Infusions	☐	☐
	Drugs	☐	☐
Allergies are recorded (e.g. on Kardex)		☐	☐
Fluids		☐	☐
Two hour plan in place e.g. Fluids, Antibiotics and emergency drugs written up on Kardex		☐	☐
GMAWS		☐	☐
Belongings (including patient's medications)		☐	Always
Bed requested, accepted and ward informed		☐	Always
Notes: medical notes, GP letter, PRF		☐	Always
Investigations	CXR reviewed	☐	
	ECG reviewed	☐	☐
	Bloods sent	☐	☐
	Bloods reviewed	☐	☐
	Patient on O ₂ cylinder checked	☐	☐
	Patients requiring analgesia: sufficient	☐	☐
Notes		Print name	

Patient Addressograph Label

Pause for Discharge (Please tick when completed)	☐ Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula removed	☐	☐	
Relatives aware of discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required and contacted	☐	☐	
SAS transport required and ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Nursing Notes and Care Plan

[illegible]

Patient Addressograph Label

Nursing Notes and Care Plan

[illegible]

Emergency Department - Active Care

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) ½ hour 1 hour 2 hours

Signed Name

USE FOLLOWING CODE:

O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

Time

Patient Addressograph Label

Signed _____ Name _____																				
USE FOLLOWING CODE: O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks						Time														
	1.	PAIN: Assess and address If in pain inform registered nurse Y / N or N/A																		
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (independent)																		
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)																		
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)																		
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B																		
		Chair Assist to walk, stand or tilt (W / ST/ T)																		
I	4.	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine/faeces																		
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N' (consider mouth care)																		
		Encourage the patient to drink? (if appropriate) Y / N / N/A																		
		Food, snack or supplement taken? (if appropriate) Y / N / N/A																		
	6.	ENVIRONMENT: Is the patient able to call for assistance? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?, Y / N																		
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y / N																		
	8.	ESCALATION: Escalate any issues to the Registered Nurse? Y / N/A																		
						Nurse Initials														

Nurse Initials

USE FOLLOWING CODE:

Specialist Pressure Redistributing equipment

Variations

V = Variant
I = Independent
NT = No thanks

☐ Repose Mattress
☐ Moving and handling aids
☐ Other:

Time	No.	Variation
------	-----	-----------

Signed

Waterlow Pressure Area Risk Assessment

Build/Weight		Skin Type/Visual Risk Areas		Sex/Age		Special Risks - Tissue Malnutrition	
Average (BMI 20-24.9)	0	Healthy	0	Male	1	Multiple organ failure/ Terminal cachexia	8
Above Average (BMI 25-29.9)	1	Tissue Paper (thin/fragile)	1	Female	2		
Obese (BMI > 30)	2	Dry (appears flaky)	1	14-49	1	Single organ failure	5
Below Average (BMI < 20)	3	Oedematous (puffy)	1	50-64	2	Peripheral Vascular Disease	5
Contenance		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (bruising/mottled)	2	75-80	4	Smoking	1
Incontinent urine	1			81+	5	Neurological Deficit	
Incontinent faeces	2	Broken (established ulcer)	3	Nutritional Element:		Diabetes/MS/CVA Motor or sensory paraplegia (Max 6)	4-6
Doubly Incontinent (urine and faeces)	3	Mobility		Unplanned weight loss in past 3-6 months < 5% Score 0 5-10% Score 1 > 10% Score 2			
Special Risks – Surgery/Trauma		Fully mobile	0				
On table > 6 hours	8	Restless/Fidgety	1			Special Risks - Medication	
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
On table > 2 hours (up to 48 hrs post op)	5			Bed bound (unconscious/unable to change position/traction)	4		
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days			
Patient's Initial Waterlow Score =			If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart				

NEWS – National Early Warning Score



Name
Address

1908546042
LOGAN
Georgina

19/08/1954

CHI No.
DoB

	Date	Ward
Admitted	10/7/19	ED
Transferred		
Transferred		

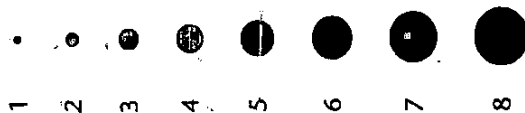
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically-ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.



[illegible]

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

0	= None
1	= Mild (<i>Not distressing – no retching/vomiting</i>)
2	= Moderate (<i>Troublesome – occasional retching/vomiting</i>)
3	= Severe (<i>Distressing – frequent retching/vomiting</i>)

Management Plan and Patient Exclusions

[illegible]

1908546042.

Affix Label



CHI: 1908546042

Queen Elizabeth University Hospital

Total Att: 15

12 Mth Att: 0

Title: MRS

LOGAN

Georgina

DOB: 19/08/1954

Age: 63y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: P Balaji
0141 212 7082

Attendance Date: 29/06/2018

Arrival Time: 13:13

Registration Time: 13:13

Date of Incident: 29/06/2018

Major Incident Desc:

Reason for Attendance: SURGICAL GP - thrombosed haemorrhoids

Affix Label

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 29/06/2018 13:38

Nurse name: Nurse Jennifer Morrison1

Temp	35.9	C
HR	78	bpm
BP	123/71	mmHg
MAP	88.33	mmHg
RR	16	bpm
SpO2	98	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils-Right	Pupils-Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes: "Returned from Spain last night " "unable to eat or drink due to pain "

Patient ID label

Date	Emergency Department Notes		
	Ambulance Proforma reviewed Yes / No	Seen by (Doctor)	Time seen

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List	
	NEWS ☐ 0-7 RED FLAG ☐ (Tick) SEPSIS ☐ CURB 65 ☐

Done/ completed	Immediate Managment Plan

Signature:	Designation:	Page No:

In-Patient Admission Notes

Patient ID label

Seen By:

Print:

Time Seen:

Pg. No:

PRF Reviewed Yes / No

Presenting Complaint(s)	
Presenting complaint	
History of presenting complaint	

Past Medical History / Review of portal	

Systemic Enquiry	

Patient ID label

Social History \ Family History

Smoking History

Ex-smoker/Smoker _____ cpd _____ yrs

☐ Never smoked

Alcohol History

_____ Units/week

FAST score if excess _____

Recreational Drugs

Driving Status

Social Circumstances (home, supports, functional status, occupation, travel)

General Examination

Temp:

RR:

Pulse:

CBG:

SpO₂:

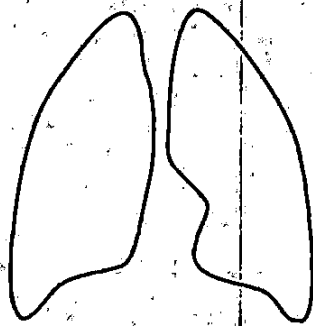
Weight:

BP:

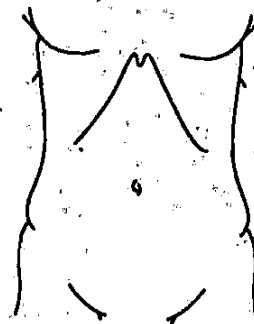
Urinalysis:

General Appearance:

Respiratory



Gastrointestinal System



Cardiovascular

Locomotor

Patient ID label

Neurological system

GCS: /15 E: /4 M: /6 V: /5

AMT 4 = age, DOB, place, year

AMT score ____ /4

Is the patient more confused/drowsy than normal: Y / N
If yes complete 4AT / TIME

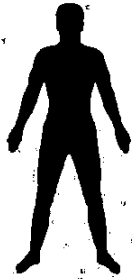
Pupils/fundoscopy:

Cerebellar and
extrapyramidal:

Cranial Nerves:

Neck:

Reflexes:



	RUL	LUL	RLL	LLL
Tone				
Power				
Co-ordination				
Sensation				

Plantars: R L

Skin/Other

Patient ID label

Key Results

CXR

ECG

(Differential) diagnosis

NEWS ☐

Red Flag ☐

Sepsis ☐

CURB 65 ☐

Management Plan

☐ Thromboprophylaxis assessed
☐ Antimicrobial

☐ Medicine Reconciliation

☐ 4AT/TIME

Signature:

PRINT NAME

PRINT GRADE

Page:



1908546042

LOGAN

F

Georgina

19/08/1954

17 SOLLAS PLACE

KNIGHTSWOOD

Glasgow, Lanarkshire

G13 4NA

Resuscitation Decision

Resuscitation status: FOR RESUSCITATION / DNA CPR
(please circle)

If DNA CPR -> Complete appropriate form

Senior Medical review

29/06/19 NAIR - Hand Ray1400

- thrombotic haemorrhoid

- C.D. - Asacol - has loose bowel

- On regular opiates for pain back surgery

- feels systemically well

- changed by Driff name Transfer

- of thrombotic external haemorrhoid

No abscess or necrosis

- Pt happy to try - Instillment + ice ^{compress} ~~patches~~
(not to use ice directly on the skin)

- Instillment provided

- Will return if struggling

(No further medication - writing given)

H. S. NAIR ST4☐ Thromboprophylaxis assessed
☐ Antimicrobial☐ Medicine Reconciliation
☐ DNACPR☐ 4AT/TIME
☐ AWI if appropriate

Sepsis Six

- ☐ Antibiotics within 1 hour
- ☐ Appropriate Cultures
- ☐ Fluids
- ☐ Oxygen
- ☐ Lactate
- ☐ Fluid balance, consider catheter

Patient ID label

Medical patient thromboprophylaxis decision aid – ENSURE BLACK BOX COMPLETEDIs the patient bed-bound or expected to have reduced mobility relative to normal for ≥ 2 days☐ Yes☐ No

Does the patient have any of the following risk factors? Tick if apply

Active cancer or cancer treatment	Use of oestrogen containing contraceptive
Age > 60	Hormone replacement therapy
Dehydration	Pregnancy or < 6 weeks post partum (seek specialist advice)
Known thrombophilia	Critical care admission
BMI > 30	Varicose veins with phlebitis
Personal/1st degree relative history of VTE	Current significant medical condition e.g. infection, inflammation, cardio resp disease
Hip fracture	

☐ Yes☐ No

- No thromboprophylaxis
- Reassess (every 72 hours minimum) and document
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)

Does the patient have any of the following contraindications? Tick if apply

Active bleeding	Untreated inherited bleeding disorder
Acquired bleeding disorder	Thrombocytopaenia $< 75 \times 10^9/l$
Thyroid, spinal, posterior eye or neurosurgery	Other procedure with high bleeding risk (discuss with senior)
Concurrent use of anticoagulants e.g. warfarin with INR > 2	Uncontrolled hypertension ($> 230/120$)
Acute stroke	Varicose veins
Recent (< 4 hours) or expected (within 12 hours) lumbar puncture, epidural or spinal anaesthetic	
Other - Document	

☐ No☐ Yes

- Discuss with senior clinical staff regarding thromboprophylaxis
- Ensure patient informed of how to reduce risk of DVT (see information leaflet)
- Consider mechanical prophylaxis unless contraindicated
- Reassess (every 72 hours minimum) and document

Enoxaparin 40mg (reduce to 20mg if weighs < 50 kg or eGFR < 30)

- Reassess every 72 hours minimum
- Ensure patient informed (see information leaflet)

Patient informed ☐ Yes ☐ N/A
(only n/a if due to cognitive impairment or similar)

If N/A why? _____

Assessed by _____

Date _____

Patient ID label

Results

Date									
Time									
Parameter	Ref Range								
Hb	Male: 130-180, Female: 110-165								
WCC	4.0 - 11.0								
Plts	150 - 450								
MCV	80 - 100								
Neut	2.0 - 7.5								
PT	9.0 - 13.0								
APTT	27.0 - 38.0								
Fibrinogen	1.7 - 4.0								
INR	()								
Thromb T	11-15 secs								
D-Dimer	0 - 250								
Na+	133 - 146								
K+	3.5 - 5.3								
Cl-	95 - 108								
HCO3-	22 - 29								
Urea	2.5 - 7.8								
Creat	40 - 130								
eGFR									
Glucose	3.5 - 6.0								
Protein	60 - 80								
Albumin	35 - 50								
AlkP	30 - 130								
Bil	<20								
ALT	<50								
AST	<40								
GGT	Male: <70 Female: <40								
ESR	Male: 1-10 Female: 1-12								
CRP	<10								
Troponin hs I	Male: 0 - 34, Female 0 - 16								
CK	Male: 40 - 230 Female: 25 - 200								
Corr. Ca++	2.20 - 2.60								
PO4-	0.8 - 1.5								
Mg++	0.70 - 1.00								
Alcohol									
Paracetamol	<100 @4 hr								
Salicylate									
AST	<40								
Amylase	<100								
LDH	170 - 380								
Folate									
B12	200 - 900								
Ferritin	Male: 20 - 300 Female: 15 - 200								
TSH	0.35 - 5.00								
Free T4	9.0 - 21.0								
Digoxin	0.5 - 2.0								

Patient ID label

Post Take Ward Round IAU/ARU

Consultant: _____ Date: _____ Time: _____

Summary

Temp: _____

Pulse: _____

BP: _____

SpO₂: _____

FiO₂: _____

RR: _____

Diagnosis:

Plan:

Recommended Destination: _____

Suitable to board if required ☐ Yes ☐ No

Expected Date of Discharge: _____

Signature: _____

Designation: _____

Bleep Number: _____

Patient ID label

Continuation Sheet

Date: Time:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or printed text on the paper.

Patient ID label

Continuation Sheet	
Date: Time	

Patient ID label

Continuation Sheet

Date: Time:

Blank lined page with horizontal ruling lines.



Continuation Sheet

Date: Time

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or printed text on the paper.

Patient ID label

Nursing Documentation
Done/Time

[illegible]

Once only prescriptions (including tetanus prophylaxis)

[illegible]

Discharge prescription packs

Date Given	Drug (Block Capitals)	Dose	Method of administration	Frequency	Signature	Given by

DISCHARGE CODES: Please Circle	Time Ready to Depart
--------------------------------	----------------------

1. Admission	2. Discharge	3. Refer to G.P.	4. Transfer to other hospital (see below)	Discharge Time
5. Died	6. Refer to O.P. Clinic (see below)	7. Irregular Discharge	8. D.O.A.	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)
------------------------	----------------------	--------------------------

Clinic Referred To	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify
--------------------	----	--------	-----------	-----	---------	----------	---------------	----------------

Registration Details - Patient No: 7881

Personal details...		Address details...	
Sex	F	Postcode	G13 4NA
Surname	Logan	House Name Flat No.	
Title	Mrs	No and Street	17 Sollas Place
Birth Surname		Village	
Forenames	Georgina	Town	Glasgow
Calling Name	Georgina	County	
Previous Surname	Logan		
Date of Birth	19/08/1954		
DOB			
Marital Status			
Ethnic Origin			

HA/HB Details...		Contact details...	
Health Board	Greater Glasgow	Home Tel No	sister 952 3728
Registered GP	Dr Andrew McCall	Work Tel No	952 5847
Usual GP	Dr Andrew McCall	Mobile Tel No	0777 440 0790
Residential Inst.		E Mail Address	
Branch Surgery			
CHI Number	1908546042		
NHS Number			

Practice Information...		Distances	
Dispensing		Rural Mileage	
Hospital Number		Blocked Special	
Records At		Walking Quarters	

Further Information		Upload Consent	
Long/Short stay or Dead		SCI-DC Consent	Implied Consent (default)
Date of registration	12/09/2016		

AMS/CMS Details		ECS (GP Summary) Consent	
AMS Consent	Yes	Patient Consent	Implied Consent (default)
Pharmacy Details	J P Mackie & Co Ltd-145 Spey Road,Bearsden,Glasgow,G61 1LF)(Org Id - 1687)		
Item Collected Check	Yes		
CMS Suitability Status	-1		
CMS Registration Status	2		

Medical Record

Problems

Active Problems		Authorised By	Code
01/04/2014	Advice given about bowel cancer screening programme	Mrs Connell	8CAy
19/11/2013	No response to bowel cancer screening programme invitation	Mrs Connell	9Ow2
17/11/2004	Asthma	Mrs Connell	H33
Past Problems		Authorised By	Code
21/01/2014	Advice given about bowel cancer screening programme	Mrs Connell	8CAy
Duo Diary Entries		Authorised By	Code
19/08/2019	Influenza vaccination	Dr Weir	65E..
10/06/2019	Asthma annual review	Mrs Hopkin	66YJ.
31/01/2019	Medication review	Mrs Artru	8B314
11/07/2018	Asthma follow-up	Mrs Hopkin	66YK.

Overdue Diary Entries		Authorised By	Code
18/08/2017	No response to bowel cancer screening programme invitation OVERDUE	Mrs Hopkin	90w2.
31/01/2017	Bowel Cancer Screening Exclusion	Dr McCull	6A ..
24/08/2016	Patient reviewed OVERDUE 6 weeks	Dr McCull	13Hc.
21/07/2016	Bereavement OVERDUE 3 weeks	Dr McCull	13Ht1
	Domestic stress OVERDUE 2 weeks		

Alerts		Authorised By	Code
11/06/2018	Alert Ask to make Asthma Follow up Appointment Marg H	Mrs Hopkin	EMISALERT
21/02/2018	Alert ONLY TO SEE GP FOR ISSUES OF ADDITIONAL ANALGESIA/MEDICATION REQUESTS	Mrs McIntyre	EMISALERT
24/04/2017	Alert PLEASE SEE LAST PAIN CLINIC LETTER	Ms Dempsey	EMISALERT

Drug Allergies		Authorised By	Code
None			

Non Drug Allergies		Authorised By	Code
None			

Health Status		
18/07/2012		Cervical smear result Cervical smear: negative
17/08/2015		Height 148 cm
17/08/2015		Weight 65.1 Kg
17/08/2015		Body Mass Index 29.72 kg/m2
21/02/2018		Blood pressure reading 0/E - BP reading
21/02/2018		Blood pressure reading 125/75 mm Hg
11/06/2018		Smoking Status Never smoked tobacco
03/05/2013		FH: Ischaemic heart d.s. <60
03/05/2013		FH: Ischaemic heart d.s. >60

Consultations	
29/06/2018 11:47	Dr Cyrus Wilson at Victoria Park Medical Practice
History	2/7 thrombosed external haemorrhoids, severe pain, unable to sit, note h/o fissid, external PR exam, verbal consent, Beth Cameron chaperone, large acutely thrombosed external haemorrhoid, very tender, pt unable to sit down without pain.
Examination	
Comment	1pc surgical receiving - refer surgeons as per NICE guidelines, pt req further shortec for LBP - warned re constipation and worsening of thrombosed pile.
Medication	Shortec Capsules 10 mg 30 capsule ONE CAPSULE AS REQUIRED
13/06/2018 11:33	Mrs Lorraine Cannon at Telephone Consultation
Comment	request for sunscreen, prescription generated as below.
Medication	Sunsense Ultra Lotion SPF 50+ 500 ml APPLY AS A SUNSCREEN AS DIRECTED Sunsense Daily Face Cream SPF 50+ 75 gram APPLY WHEN REQUIRED
13/06/2018	Ms Kirsty MacKenzie at Victoria Park Medical Practice
Comment	TC to willis to adv pt has to stop senna, quinine and butec 10, to start on Tybogat regularly. Also to authorise 3 dosselle box as pt is going on holiday
13/06/2018	Dr Preethy Balaji at Victoria Park Medical Practice
	going on holiday next week and taking meds for same, also having

History constipation, known to have IBS/IBD - on asacol and salofalk, senna causing cramps and spasms. meds review done, has stopped butec patches 10mcg and using 20 only, also keen to stop senna, agreed and replace with lybogel. also discussed quinine as not benefit / stopped. will inform pharmacy going on holiday on 20th - next week. looking for 3 weeks dosette box for this - agreed

Comment

Medication Ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet 60 sachet THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY
Shorice Capsules 10 mg 30 capsule ONE CAPSULE AS REQUIRED
Volumatic Spacer device 1 device USE WITH INHALER

11/06/2018 Mrs Margaret Hopkin at Victoria Park Medical Practice

Comment Opportunistic Asthma Review ----- one for Blood Tests --- Sent as Below on-line NO Cough, Wheezing Taking Symbicort 100/6 x 2 BID --- Inhaler Technique terrible Advised --- Using Salbutamol Once a Day, PFR 310 --- DJ Follow up When Back from Holiday

Problem abdominal Discomfort --- Cramps --- Flare of IBS But C/o Constipation --- taking Sennakot --- advised to See Dr To Review IBS Medication and Blood Results

Social Never smoked tobacco

Follow up Asthma follow-up (11/07/2018)
(diary entry deleted) (Not Known)

Additional Using inhaled steroids - normal dose
Inhaler technique - poor
Asthma not disturbing sleep
Increasing exercise wheeze
Asthma causes daytime symptoms most days
Asthma management plan given
Asthma medication review
Asthma annual review

Medication

Current	Date Commenced	Drug Details	Date Last Issue	Authorised By	Type
	13/06/2018	Shorice Capsules 10 mg ONE CAPSULE AS REQUIRED 30 capsule	29/06/2018P	Dr Andrew McCall	ACUTE
	13/06/2018	Volumatic Spacer device USE WITH INHALER 1 device	13/06/2018P	Dr Andrew McCall	ACUTE
	13/06/2018	Sunsense Ultra Lotion SPF 50+ APPLY AS A SUNSCREEN AS DIRECTED 500 ml	13/06/2018P	Dr Andrew McCall	ACUTE
	13/06/2018	Sunsense Daily Face Cream SPF 50+ APPLY WHEN REQUIRED 75 gram	13/06/2018P	Dr Andrew McCall	ACUTE
	08/06/2018	Temazepam Tablets 10 mg 1 TAB NOCTE ONLY IF REQUIRED 7 tablet	08/06/2018P	Dr Andrew McCall	ACUTE
	23/03/2018	Hyoscine Butylbromide Tablets 10 mg 1 OR 2 TABS UP TO 3 X DAILY AS REQUIRED TAPERED REDUCTION 30 WEEKLY 120 tablet	07/06/2018P	Dr Andrew McCall	ACUTE
	13/06/2018	Ispaghula Husk Sugar and Gluten Free Effervescent granules 3.5 grams/sachet THE CONTENTS OF ONE SACHET TO BE TAKEN TWICE A DAY 60 sachet	13/06/2018P	Dr Andrew McCall	REPEAT
	09/05/2018	Amitriptyline Hydrochloride Tablets 25 mg ONE TO BE TAKEN IN THE EVENING IN ADDITION TO 50MG DOSE. TOTAL DAILY DOSE 75MG. DISPENSE WEEKLY 28 TABLET	07/06/2018P	Dr Andrew McCall	REPEAT
	04/05/2018	Diclofenac Diethylammonium Gel 1.16 % APPLY 3 TIMES DAILY IF REQUIRED 100 gram	04/05/2018P	Dr Andrew McCall	REPEAT
	26/07/2017	Butec Transdermal patches 20 micrograms/hour APPLY ONE PATCH EVERY SEVEN DAYS / REMOVE OLD PATCH 4 PATCH	07/06/2018P	Dr Andrew McCall	REPEAT
	17/02/2017	Symbicort Turbohaler 200/6 micrograms/inhalation ONE PUFF TO BE INHALED TWICE A DAY 1:1 INHALER	07/06/2018P	Dr Andrew McCall	REPEAT
	31/01/2017	Amitriptyline Hydrochloride Tablets 50 mg 1 TABS AT NIGHT WEEKLY UPLIFT 28 TABLET	07/06/2018P	Dr Andrew McCall	REPEAT
	19/05/2014	Salofalk Foam Rectal foam 1 gram/application, 80g (14 dose) canister ONE APPLICATION AT NIGHT 14 CANISTER	07/06/2018P	Dr Andrew McCall	REPEAT
	19/05/2014	Asacol Mr Gastro-resistant Tablets 400 mg 3 TABS TWICE DAILY 168 TABLET	07/06/2018P	Dr Andrew McCall	REPEAT
	01/04/2014	Sertraline Hydrochloride Tablets 50 mg ONE TO BE TAKEN EACH DAY 28 tablet	07/06/2018P	Dr Andrew McCall	REPEAT
	09/07/2012	Mollicarbamol Tablets 750 mg 2 TABS 4 TIMES DAILY 224 TABLET	07/06/2018P	Dr Andrew McCall	REPEAT
		Omeprazole Capsules (Gastro-Resistant) 20 mg 2			

09/07/2012	CAPS DAILY 50 CAPSULE	07/06/2018P	Dr Andrew McCall	REPEAT
09/07/2012	Peptac Liquid (aniseed) 10 ML 3 TIMES DAILY 500 ML	07/06/2018P	Dr Andrew McCall	REPEAT
09/07/2012	Pregabalin Capsules 300 mg 1 CAP TWICE DAILY 50 capsule	07/06/2018P	Dr Andrew McCall	REPEAT
09/07/2012	Salbutamol Cfc-free inhaler 100 micrograms/puff ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED UP TO FOUR TIMES A DAY 111 INHALER	07/06/2018P	Dr Andrew McCall	REPEAT
09/07/2012	Simvastatin Tablets 40 mg ONE TO BE TAKEN AT NIGHT 28 TABLET	07/06/2018P	Dr Andrew McCall	REPEAT
09/07/2012	Capsaicin Cream 0.025 % APPLY 3 TIMES DAILY 45 gram	07/06/2018P	Dr Andrew McCall	REPEAT



NEWS – National Early Warning Score



1908546042
 LOGAN
 Georgina
 17 SOLLAS PLACE
 KNIGHTSWOOD
 Glasgow, Lanarkshire
 G13 4NA
 19/08/195

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8	92-93 Yes	9-11	12-20		21-24	≥25
Oxygen Saturations	≤91		94-95	≥96			
Any Supplemental Oxygen				No			
Temperature	≤35.0°	91-100	35.1-36.0°	36.1-38.0°	38.1-39.0°	≥39.1° 111-130	
Pulse	≤40		41-50	51-90	91-110		≥131
Systolic BP	≤90		101-110	111-219			≥220
Conscious Level				A			V, P or U

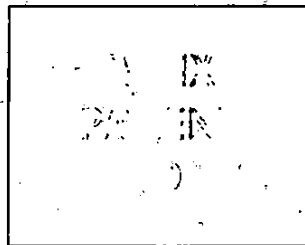
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	- Inform trained nurse. - Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	- Trained Nurse assessment. - Inform medical team caring for the patient. - Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. - Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	- Trained Nurse to assess immediately. - Inform medical team caring for the patient – this should be at least senior medical staff level. - Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. - Consider referral to high dependency or ITU.

DATE: 2/26	NEWS: 0 1
TIME: 13:30	
Resp. Rate Mark: •	35 30 25 20 15 10 5 0
SpO ₂ (Enter Value)	96-95 92-93 89-90 86-87 83-84 80-81 77-78 74-75 71-72 68-69 65-66 62-63 59-60 56-57 53-54 50-51 47-48 44-45 41-42 38-39 35-36 32-33 29-30 26-27 23-24 20-21 17-18 14-15 11-12 8-9 5-6 2-3 0-1
Any Suppl O ₂ Room air	100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%
Temp. Mark: X	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35° 34.5° 34° 33.5° 33° 32.5° 32° 31.5° 31° 30.5° 30° 29.5° 29° 28.5° 28° 27.5° 27° 26.5° 26° 25.5° 25° 24.5° 24° 23.5° 23° 22.5° 22° 21.5° 21° 20.5° 20° 19.5° 19° 18.5° 18° 17.5° 17° 16.5° 16° 15.5° 15° 14.5° 14° 13.5° 13° 12.5° 12° 11.5° 11° 10.5° 10° 9.5° 9° 8.5° 8° 7.5° 7° 6.5° 6° 5.5° 5° 4.5° 4° 3.5° 3° 2.5° 2° 1.5° 1° 0.5° 0°
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10 0
Blood Pressure Mark: ◇	220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50
NEWS SCORE using Systolic BP	13 12 11 10 9 8 7 6 5 4 3 2 1 0
Conscious Level Mark: •	Alert Verbal Pain Unresp
Total NEWS (with all obs)	0
BM	NA
Pain	2
Nausea	0
Urine output	0.2
Obs due	10
Initials	PC

[illegible]

[illegible]

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

0	= None
1	= Mild (<i>Not distressing – no retching/vomiting</i>)
2	= Moderate (<i>Troublesome – occasional retching/vomiting</i>)
3	= Severe (<i>Distressing – frequent retching/vomiting</i>)

[illegible]



CHI: 1908546042

Queen Elizabeth University Hospital

Total Att: 14

12 Mth Att: 1

Title: MRS

LOGAN

Georgina

DOB: 19/08/1954

Age: 61y

Sex: Female

17 SOLLAS PLACE
KNIGHTSWOOD
Glasgow
Lanarkshire
G13 4NA
07774400790

Next of kin: LOGAN, GEORGE
Relationship: Husband
07774400790

GP: PJ Weir
08444 773318

Attendance Date: 10/08/2016

Arrival Time: 09:30

Registration Time: 09:30

Date of Incident: 10/08/2016

Major Incident Desc:

Reason for Attendance: for meds

Nursing Assessment

Alerts: Not Recorded

Allergies: Not Recorded

Pain Score:

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 10/08/2016 09:36

Nurse name: Nurse Nicola Hunter

Temp	35.6	C
HR	82	bpm
BP	126/67	mmHg
MAP	86.67	mmHg
RR	16	bpm
SpO2	100	%
Oxygen		%

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

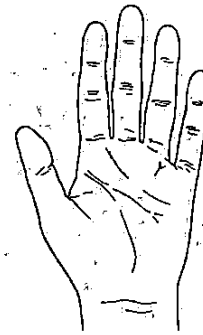
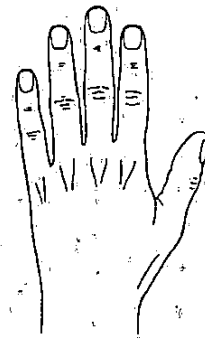
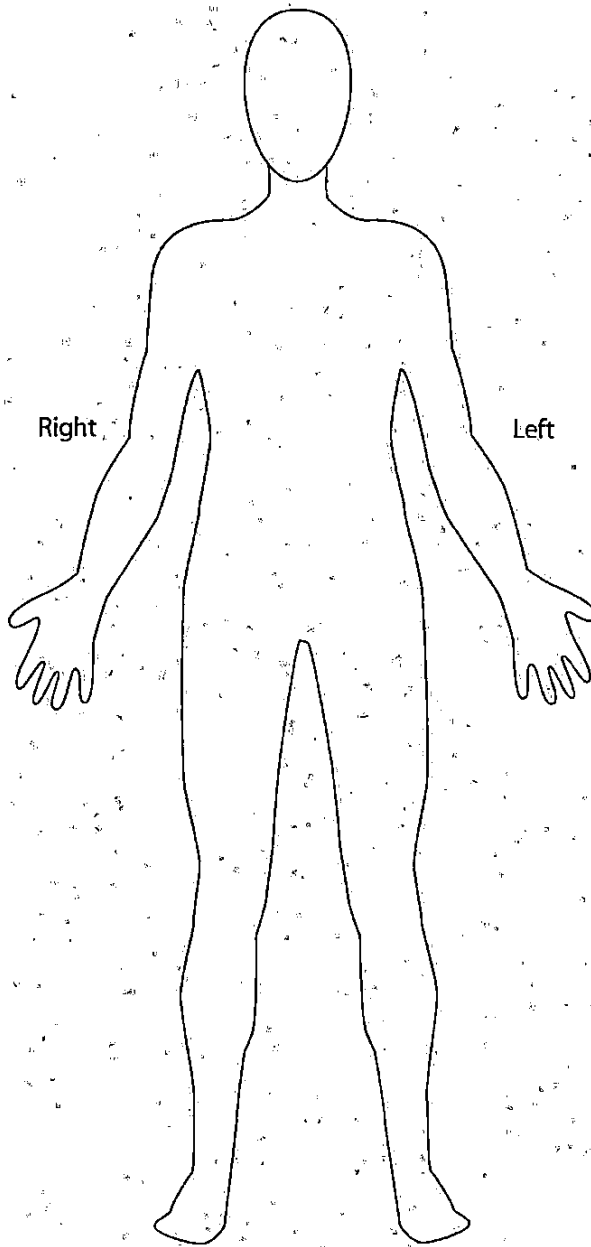
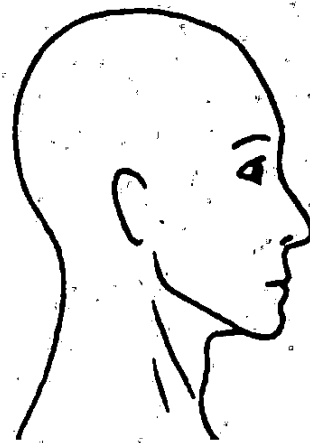
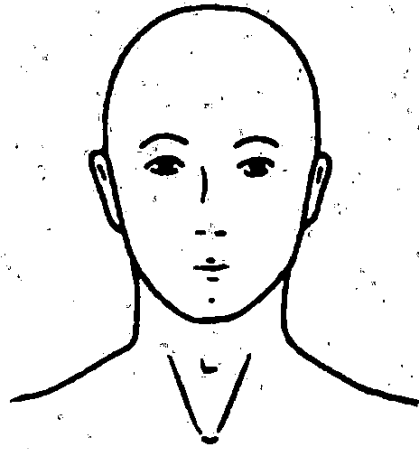
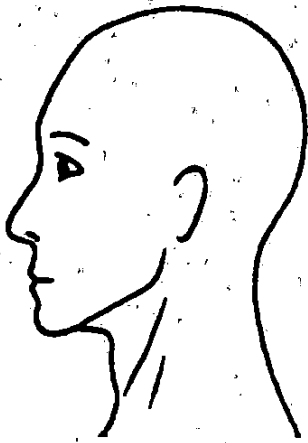
Pupils: Right		Pupils: Left	
Size (mm)		Size (mm)	
Reaction		Reaction	

Nursing Notes: requiring repeat prescription. lady just back from holiday and left meds there.... lady now happy to go to GPs and get rpt prescription... doesn't have particular complaint

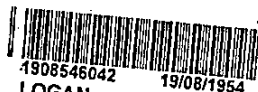
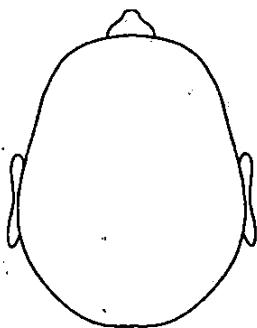
Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen
	 1908546042 19/08/1954 LOGAN Georgina	
Differential Diagnosis/Problem List		
SEWS <input data-bbox="1096 1711 1161 1774" type="checkbox"/> 0-7 RED FLAG <input data-bbox="1096 1785 1161 1848" type="checkbox"/> (Tick) SIRS <input data-bbox="1096 1858 1161 1921" type="checkbox"/> CURB 65 <input data-bbox="1096 1932 1161 1995" type="checkbox"/>		

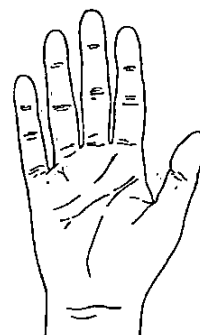
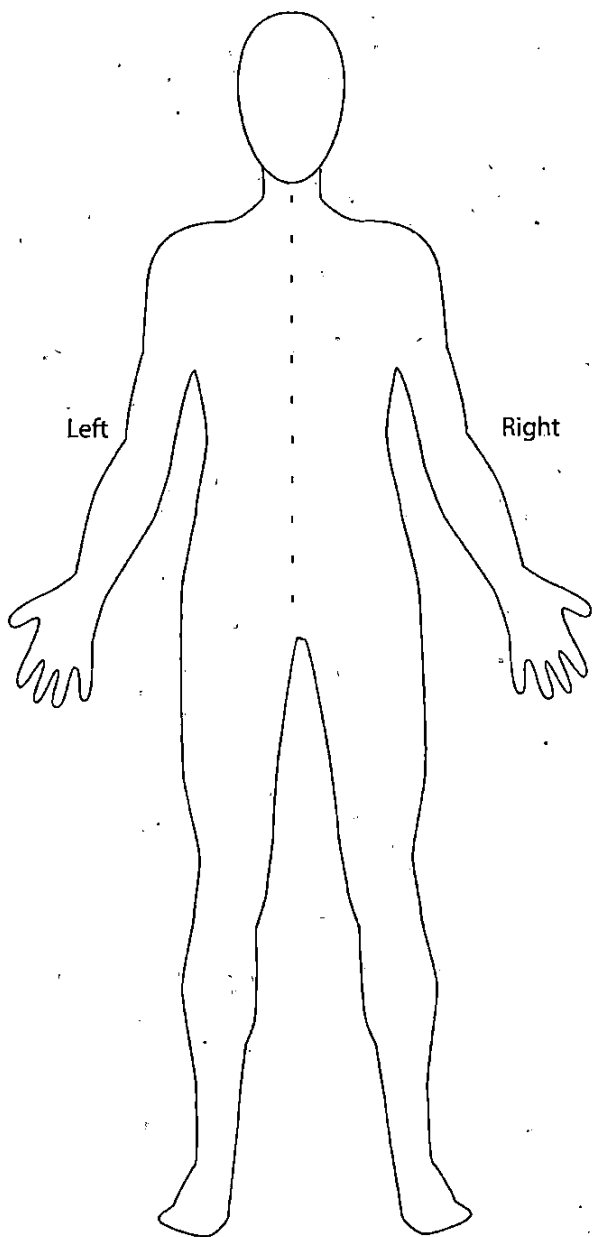
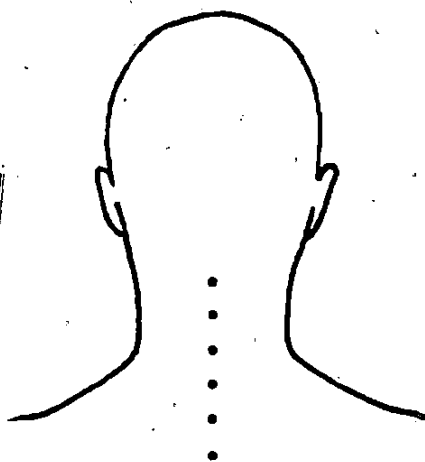
Injuries / Problems



Injuries / Problems



LOGAN
Georgina



Continuation Sheet

Date: Time



1908546042

19/08/1954

LOGAN

Georgina

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature:

Designation:

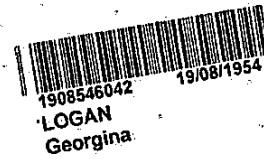
Page No.:

Senior Doctor Review

Please affix patient ID-label here

Seen by (print):

Time seen:



Done/ completed	Continuing Managment Plan

Signature:

Designation:

Page No:

Serial Blood Results									
	Date:								
	Time:								
	Signature:								
Sodium	135 - 146								
Potassium	3.5 - 5.3								
Chloride	95 - 108								
Urea	2.6 - 7.8								
Creatinine	40 - 130								
Estimated GFR									
Bicarbonate	22 - 29								
Glucose	3.5 - 6.0								
CRP	0 - 10								
Magnesium	0.7 - 1.0								
Calcium	2.2 - 2.6								
Calcium Adj	2.2 - 2.6								
Phosphate	0.8 - 1.5								
Cardiac Enzymes & Liver Function Tests	Normal Values								
Troponin	<0.04								
CK	<150								
Amylase	0 - 100								
ALT	0 - 50								
Gamma-GT	0 - 70								
Alk Phos	30 - 130								
Total Bilirubin	0 - 20								
Albumin	35 - 50								
Haematology & Clotting Screen	Normal Values								
White Blood Count	4.0 - 11.0								
Haemoglobin	115 - 165								
Haematocrit	0.370 - 0.470								
MCV	80 - 100								
Platelet Count	150 - 410								
Neutrophils	1.8 - 7.7								
Lymphocytes	1 - 4.8								
Prothrombin Time	9 - 13								
PCT Ratio									
APTT	27 - 38								
APTT ratio	0.8 - 1.2								
Thrombin Time	10 - 16								
TCT Ratio									
Arterial Blood Gas	Normal Values								
H+	36 - 43								
PCO ₂	4.5 - 6								
PO ₂	10.5 - 13.5								
Base excess	+/- 2.5								
Bicarbonate	20 - 28								
FI _{O₂} (Inspired Oxygen)									
Other									

1908546042
LOGAN
Georgina
19/08/1954

Done/ Time

[illegible][illegible][illegible]

DISCHARGE CODES: Please Circle							Time Ready to Depart		
1. Admission		2. Discharge		3. Refer to G.P.		4. Transfer to other hospital (see below)		Discharge Time	
5. Died		6. Refer to O.P. Clinic (see below)		7. Irregular Discharge		8. D.O.A.			
Ward No. (If admitted)				Transfer to Hospital			Consultant (if admitted)		
Outpatient clinic specialty						Admission or specialty clinic consultant			
Clinic Referred to	AE	OP DVT	DME Fails	TIA	Medical	Surgical	First Seizure	Others Specify	



CHI: 1908546042

Queen Elizabeth University Hospital

Title: MRS

Total Att: 34

12 Mth Att: 1

LOGAN

Georgina

DOB: 19/08/1954

Age: 71y

Sex: Female

17 Sollas Place

Next of kin: LOGAN, George

Relationship: Husband

01419523728

Glasgow
Lanarkshire

G13 4NA

01419523728

GP: RP Murphy

0141 212 7082

Attendance Date: 19/01/2026

Arrival Time: 12:49

Registration Time: 12:49

Date of Incident: 19/01/2026

Major Incident Desc:

Reason for Attendance: SURGICAL (OWN) - lower abdominal pain and vomiting ?constipation

Nursing Assessment

Alerts: Not Recorded

Allergies: None Known

Pain Score: 7

Triage Category: 3

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 19/01/2026 13:28

Nurse name: Nurse Heather Lower2

RR	16	bpm
Oxygen		%
Air or O2		
SpO2	98	%
HR	61	bpm
BP	119/99	mmHg
CRT		
MAP	106	mmHg
AVPU		
Temp	35.7	C
EWS Total		

BM		mmol/L
PF		1/min
Expected PF		1/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	
Motor	
Verbal	
Total	

Pupils: Right	Pupils: Left
Size (mm)	Size (mm)
Reaction	Reaction

Nursing Notes:

Patient ID label

Date	Emergency Department Notes		
	Ambulance Proforma reviewed Yes / No		Time seen
	Seen by (Doctor)		

Patient ID label

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Differential Diagnosis/Problem List

	NEWS	☐	0-7
	RED FLAG	☐	(Tick)
	SEPSIS	☐	
	CURB 65	☐	

Done/ completed	Immediate Managment Plan

Signature:	Designation:	Page No:
------------	--------------	----------