SAR Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

Private
MMA Legal Limited
Stok
43-59 Princes Street
Stockport
SK1 1RY

Date: 21 May 2026
Your Ref: 100417
Ref: SAR / ACCESS /CD
Enquiries to: Catrina
Direct Line: 0141 201 3381
Email: catrina.doogan@nhs.scot

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: THERESA SINCLAIR DOB: 13/08/1963

Thank you for your recent request 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:

GLASGOW ROYAL INFIRMARY RECORDS
STOBHILL 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:

Yours sincerely

SAR Team

ELECTRONIC PATIENT RECORDS

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

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☑
WEST MARC	☐
LABS	☐

LUNG CANCER MDT FORM - v26		North Glasgow		REFERRER	IP		
DISCUSSION TYPE	Treatment decision	NUMBER	2	PATH REQ	N	IMAGE REVIEW	Y	SMOKING STATUS	Current smoker

SURNAME	Sinclair	CHI	1308636407	POSTCODE	G66 7DA	REFERRAL DATE	03/06/2024	CONS	Dr Maclay
FORENAME	Theresa	DOB	13/08/1963	AGE	62	MDT DATE	15/05/2026 711	PRESENTER	Dr Maclay

MAIN SYMPTOMS	CO MORBIDITY	PREV CANCER
AAU 2024, Interval CTs since.	Obesity, diabetes, COPD, AAF,	

LUNG FUNCTION				FITNESS			
FEV1	1.2 L	56 %		CFS		PS	2
FEV1/FVC		63 %		6MWT		MRC	4
TLCO		64 %		VO2 Max		STAIRS	
DATE	08/04/2026						

IMAGING	CT DATE	20/03/2026	655	PET DATE	23/04/2026	##	CT/MRI HEAD DATE	30/04/2026	##	BRAIN IMAGING

Intensely FDG avid right apical nodule and left apical nodule highly suspicious of malignancy. Suspicious intensely FDG avid APW node. Right hilar, subcarinal right lower paratracheal node - nonspecific but may be benign. No evidence of distant metastasis. GGO in RUL and LLL may be lowgrade adenocarcinoma spectrum lesions - for follow-up CT.

INVASIVE STAGING

NECK	1	2	3	4	7	8	9	10	11	12	ADR	TUM
L												
R												
other												

DIAGNOSTIC PROCEDURES				PATHOLOGY	PDL1		ROS1	ALK			cT	1a
EBUS/EUS-B staging	DATE	11/05/2026	707								N	2a
	DATE			SUB TYPE		%	EGFR	KRAS	BRAF		M	0
	DATE										STAGE	IIB

SYNCH PRIMARIES (X)	X	1ST SITE	LUL	2ND SITE	RUL	PATHOLOGY - 2ND PRIMARY	PDL1		ROS1	ALK			cT	1b
													N	0
MULTIFOCAL (X)		RUL	RML	RLL	LUL	LLL	SUB TYPE		%	EGFR	KRAS	BRAF	M	0
													STAGE	IA2

REASON FOR DISCUSSION

Review path and confirm treatment plan. Mo reviewed - Not sure would manage LULobectomy and not suitable for segmentectomy. May be suitbale for surgery on right side.

PREVIOUS MDT OUTCOME — Date 24/04/2026

Awaiting PET report. Has COPD and is not overly fit. FDG avid left sided station 5 node very suspicious. Unclear that the optimal treatment will be possible. /// Discussion considered surgery to left with adjuvant treatment as likely N2 disease and RT to right side. Dr Maclay to assess patient in clinic and consider options. Staging EBUS. Brain scan.

MDT COMMENT

MDT RECOMMENDATION

Rediscuss next week with pathology.

REASON NO PRETREATMENT PATHOLOGY

PATIENT UNDERSTANDING

CLINICAL TRIAL

PLANNED TREATMENT

ACTUAL TREATMENT

OPA		CNS	Aggie Mackay

Present at MDT - Chair: Dr Farley. Respiratory: Dr Maclay, Dr Farley, Dr Rooney, Dr Cotton, Victoria Halliday, Chanel Sweeney. Oncology: Dr Steele, Dr Lumsden, Dr Ashton. Surgeon: Mr Asif. Radiology: Dr Thomson, Dr Curle. Nuclear Med: Dr Han. Pathology: None. Palliative Care: Dr Ferguson. MDT Coordinator: Ewan Brown

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Department: Respiratory Department
Contact Tel: 0141 451 5358
Enquiries to: ruth.scoular@nhs.scot

Letter Date: 28/04/2026
Reference: JM/RS
Dictated Date: 24/04/2026
Transcribed Date: 27/04/2026

Mr M Asif
Golden Jubilee National Hospital
Beardmore Street
Clydebank
G81

Dear Mo,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Problems:

1. Left upper lobe T1a N2 radiological diagnosis of lung cancer (station 5 node) 2

2. Right upper lobe synchronous T1b N0 radiological diagnosis of lung cancer

3. Multifocal ground glass changes

4. Obesity

5. Performance status 2 at best, mostly in the house, struggles with stairs and walking up hills, MRC dyspnoea grade 4

6. COPD – FEV1 1.2 litres, 56%; gas transfer 64%

7. Diabetes

8. AF – on Apixaban, Digoxin and Bisoprolol

Plan:

1. Refer for consideration of surgery to the left side followed by SABR to the right side

2. Alternative would be radiotherapy to both sides

3. Unsuitable for neoadjuvant treatment to left side as it is not possible to have pre operative tissue diagnosis

4. MRI of brain

I would be grateful for your help with this lady whom I reviewed in my respiratory clinic on 24th April 2026. She was already referred for prehab at the surgical clinic. We discussed her at MDT prior to clinic. She is a complex case. She has 2 lung lesions. The left upper lobe lesion was visible as a tiny ditzel on a previous CT scan. It is now sub centimetre but FDG avid and very suspicious for a lung cancer. As well as this there is a station 5 lymph node adjacent to the aorta which is very suspicious. At MDT it was not felt that radiotherapy was a good option for this. We are unable to get a tissue diagnosis on the left side and as such the plan was to consider going straight for surgery and thereafter considering adjuvant treatment depending on the surgical stage.

In addition she has a right sided lung lesion. This has also grown in size and is FDG avid and considered to be a synchronous primary. Although this is slightly larger than the left sided lesion there is no nodal involvement. As such the focus should be the left side. This would be amenable to either surgery or SABR technically.

I already referred this lady for prehabilitation because she is not overly healthy in terms of her lifestyle. Her functional status is determined by her obesity and diabetes along with COPD. She has reduced her smoking.

She has a prominent right paratracheal node and I will sample this at staging EBUS. I have also booked an MRI scan of her brain. I think it would be beneficial for you to assess her and decide if surgery is an option for her at all. If you think it is we can proceed in that fashion assuming that the EBUS shows that the N3 node we are planning to sample is negative. However if you deem she will never be suitable for surgery we would need to think of other options.

I am grateful for your help with this lady's case.

Yours sincerely

Dr J Maclay

Consultant in Respiratory Medicine

Electronically Signed: Dr John Maclay, Consultant

cc.

LUNG CANCER MDT FORM - v26			North Glasgow		REFERRER	IP			
DISCUSSION TYPE	Treatment decision	NUMBER	1	PATH REQ	N	IMAGE REVIEW	Y	SMOKING STATUS	Current smoker

SURNAME	Sinclair	CHI	1308636407	POSTCODE	G66 7DA	REFERRAL DATE	03/06/2024	CONS	Dr Maclay
FORENAME	Theresa	DOB	13/08/1963	AGE	62	MDT DATE	24/04/2026	690 PRESENTER	Dr Maclay

MAIN SYMPTOMS	CO MORBIDITY	PREV CANCER
AAU 2024, Interval CTs since.	Obesity, diabetes, COPD, AAF,	

LUNG FUNCTION			FITNESS		
FEV1	1.2 L	56 %	CFS		PS 2
FEV1/FVC		63 %	6MWT		MRC 4
TLCO		64 %	VO2 Max		STAIRS
DATE	08/04/2026				

IMAGING	CT DATE	20/03/2026	655	PET DATE	23/04/2026	##	CT/MRI HEAD DATE		BRAIN IMAGING

Increase in size of 12mm RUL apical nodule, concerning for malignancy.
New indeterminate 8mm nodular soft tissue lesion at the left upper lobe apex anteriorly.

INVASIVE STAGING

NECK	1	2	3	4	7	8	9	10	11	12	ADR	TUM
L												
R												
other												

DIAGNOSTIC PROCEDURES		PATHOLOGY	PDL1	ROS1	ALK	cT	1a
	DATE					N	2a
	DATE	SUB TYPE	%	EGFR	KRAS	BRAF	M	0
	DATE					STAGE	IIB

SYNCH PRIMARIES (X)	X	1ST SITE	LUL	2ND SITE	RUL	PATHOLOGY - 2ND PRIMARY	PDL1	ROS1	ALK	cT	1b
										N	0

MULTIFOCAL (X)		RUL	RML	RLL	LUL	LLL	SUB TYPE	%	EGFR	KRAS	BRAF	M	0
												STAGE	IA2

REASON FOR DISCUSSION

Review imaging, consider treatment

REASON NO PRETREATMENT PATHOLOGY

PATIENT UNDERSTANDING

PREVIOUS MDT OUTCOME — Date

CLINICAL TRIAL

MDT COMMENT

Awaiting PET report. Has COPD and is not overly fit. FDG avid left sided station 5 node very suspicious. Unclear that the optimal treatment will be possible.

PLANNED TREATMENT

MDT RECOMMENDATION

Discussion considered surgery to left with adjuvant treatment as likely N2 disease and RT to right side. Dr Maclay to assess patient in clinic and consider options. Staging EBUS. Brain scan.

ACTUAL TREATMENT

OPA	24/04/2026 JM	CNS	Aggie Mackay

Present at MDT - Chair: Dr Farley. Respiratory: Dr van der Horst, Dr Maclay, Dr Farley, Dr Rooney, Dr Cotton, Victoria Halliday, Chanel Sweeney. Oncology: Dr Steele, Dr Lumsden, Dr Ashton, Dr Duncan. Surgeon: Mr Asif. Radiology: Dr Noble, Dr R MacDuff, Dr Thomson, Dr Curle. Nuclear Med: Dr Han. Pathology: Dr E MacDuff. Palliative Care: None. MDT Coordinator: Ewan Brown

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	Respiratory Department
Contact Tel:	0141 451 5358
Enquiries to:	ruth.scoular@nhs.scot
Letter Date:	27/03/2026
Reference:	JM/RS
Dictated Date:	31/03/2026
Transcribed Date:	31/03/2026

Dear Dr. RM Wilson,

Theresa Sinclair; D.O.B: 13 Aug 1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Attendance: Specialty - Respiratory Medicine; Clinic - GRJMRE9-DR MACLAY URGENT RETURN CLINIC FRI AM
Date and Time of Appointment - 27/03/2026 12:00

Follow Up: Dr Maclay's Clinic 24th April 2026

Clinical Comments:
Problems:

1. Growing right upper lobe nodule, suspicious for malignancy

2. Left upper lobe abnormality also increasing in size

3. Multi focal ground glass changes

4. Obesity

5. Performance status 2 at best, mostly in the house, struggles with stairs and walking up hills, MRC dyspnoea grade 4

6. Previous diagnosis of COPD

7. Diabetes

8. AAF – on Apixaban, Digoxin and Bisoprolol

9. Previous restrictive lung function – likely related to obesity – FEV1 1.3 litres 60% predicted, gas transfer 67%

Plan:

1. PET scan

2. Refer for prehab

3. Update pulmonary function tests

4. Consider treatment thereafter

I reviewed Mrs Sinclair with her family in my respiratory clinic on 27th March 2026. She had a 1 year interval CT scan to follow up some lung nodules. There is a nodule in her right upper lobe which looks suspicious for lung cancer given its rate of growth. As such we have arranged for her to have a PET scan to investigate this further. She has a number of other abnormalities within her lungs which could represent low grade neoplastic lesions although these have not changed on follow up except a left upper lobe nodule which is certainly more prominent although it remains small.

Given the suspicion this represents cancer I will update her pulmonary function tests and I have referred her to the Golden Jubilee National Hospital pulmonary rehab service as I feel her condition could be better than it is currently. However she does have a number of other comorbidities. I will see her back with the results of this in due course.

Yours sincerely

Dr J Maclay

Consultant in Respiratory Medicine

Electronically Signed: Dr John Maclay, Consultant

cc.

Immediate Discharge Letter - Amendments

This version of the document supersedes earlier versions.

Additional Information: Brian CHOO-KANG, 04-Mar-2026 13:32
FINAL DISCHARGE COMMENTS

As per IDL

B Choo-Kang
Consultant

Immediate Discharge Letter

NHS Greater Glasgow and Clyde

Highly Sensitive: No
Consent for Sharing Withheld: No

ROSALYN WILSONLennoxtown Medical Practice,Lennoxtown Hub,46 Main Street, Lennoxtown, G66 7JJ

Main Switchboard:
Date of Completion: 22-Feb-2026

Dear ROSALYN WILSON,

Name	CHI	DoB	Address
Theresa Sinclair	**1308636407**	**13-Aug-1963**	**90a Main Street, Lennoxtown, Glasgow, G66 7DA**

Admitted	Type	Discharged	Destination
09-Feb-2026 01:13	IP	22-Feb-2026	

Specialty	Consultant	Ward	Telephone
Respiratory Medicine	Choo-Kang	GRI Ward 7-16 Respiratory-General Medicine	

Primary Diagnosis
There is no data to display.

Secondary Diagnosis
There is no data to display.

Significant Operations / Procedures:
There is no data to display.

Last Discharge Review: Dearbhail Killoran (Dearbhail Killoran - Foundation Year 1) on 21 Feb 2026 10:18

Discharge Medication:

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
.Compliance Aid - Dosette	Route unspecified	Lennoxtown Pharmacy: 01360 312 458 NKDA	Yes				Added
Allopurinol 100 mg Tablets	oral	ONE TO BE TAKEN EACH DAY,	Yes			Y	
Apixaban 5mg tablets	oral	1 tablet twice daily	Yes				Added
Bisoprolol 3.75mg tablets	oral	1 tablet once daily	Yes		**Dispensing Details:** 7x1.25mg, 7x2.5mg		Added
Colecalciferol 1,000unit tablets	oral	ONE DAILY,	Yes			Y	
Cyanocobalamin 100microgram tablets	oral	1 Tab Daily,	Yes		**Dispensing Details:** 14x50mcg	Y	
Diazepam 2 mg Tablets	oral	ONE TAB TWICE DAILY. DISP WEEKLY ON WEDNESDAY,	Yes			Y	
Digoxin 125microgram tablets	oral	1 tablet once daily , Total dose 187.5mg OD	Yes				Added
Digoxin 62.5microgram tablets	oral	1 tablet once daily , Total dose 187.5mg OD	Yes				Added
Dihydrocodeine 30mg tablets	oral	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY,				Y	
Fluoxetine Hydrochloride 20 mg Capsules	oral	2 DAILY,	Yes			Y	
Furosemide 20 mg Tablets	oral	ONE AT LUNCH TIME,	Yes			Y	
Glyceryl trinitrate 400micrograms/dose pump sublingual spray	sublingual	SPRAY ONE OR TWO DOSES UNDER THE TONGUE WHEN REQUIRED FOR CHEST PAIN AND THEN CLOSE MOUTH,				Y	
Isosorbide mononitrate 25mg modified-release capsules	oral	ONE TO BE TAKEN EACH DAY,	Yes			Y	
Metformin 500mg modified-release tablets	oral	ONE TO BE TAKEN TWICE DAILY-DISPENSE WEEKLY	Yes			Y	Amended

Active Drug Name	Route	Dose	Disp	Reason	Further Details	ECS	Since Admission
Mirtazapine 15 mg Tablets	oral	ONE TO BE TAKEN AT NIGHT,	Yes			Y	
Nicotine 21mg/24hours transdermal patches	subcutaneous	1 patch once daily	Yes				Added
Omeprazole 20 mg Capsules (Gastro-Resistant)	oral	ONE TO BE TAKEN EACH DAY,	Yes			Y	
Paracetamol 500 mg Tablets	oral	when required TAKE TWO FOUR TIMES DAILY,				Y	
Peppermint oil 0.2ml gastro-resistant capsules	oral	ONE TO BE TAKEN THREE TIMES A DAY BEFORE FOOD,	Yes			Y	
Pregabalin 75 mg Capsules	oral	ONE TWICE DAILY IN THE MORNING AND ONE AT TEA TIME,	Yes			Y	
Salbutamol 100 micrograms/ puff Cfc-free inhaler	oral	2 PUFFS AS REQUIRED,				Y	
Simvastatin 40 mg Tablets	oral	ONE TO BE TAKEN AT NIGHT,	Yes			Y	
Thiamine 50 mg Tablets	oral	ONE TO BE TAKEN FOUR TIMES A DAY,	Yes			Y	
Trelegy Ellipta 92micrograms/ dose / 55micrograms/dose / 22micrograms/dose dry powder inhaler (GlaxoSmithKline UK Ltd)	inhalation	ONE PUFF TO BE USED ONCE DAILY,				Y	

"Added" means this medicine was added to the Clinical Portal record after admission. It does not necessarily mean this medicine was started by the hospital.

Dispensing Comments
.

Withheld Medication:

Date	Withheld Drug Name	Route	Dose	Note	Withheld Reason
2026-02-21	Ramipril 2.5 mg Capsules	oral	ONE TO BE TAKEN EACH DAY,		BP controlled without

Stopped Medication:

Date	Stopped Drug Name	Route	Dose	Note	Stopped Reason
2026-02-20	Amitriptyline Hydrochloride 10 mg Tablets	oral	TWO AT NIGHT,		Course completed
2026-02-20	Aspirin 75 mg Dispersible tablets	oral	ONE TO BE TAKEN EACH DAY,		Course completed
2026-02-20	Bisoprolol Fumarate 1.25 mg Tablets	oral	ONE TO BE TAKEN EACH DAY,		Dose increased
2026-02-20	Furosemide 40 mg Tablets	oral	ONE TO BE TAKEN EACH MORNING,		Course completed

Reason for Admission and Presenting Complaints	Admission Category
No data available	No data available

Clinical Comments:

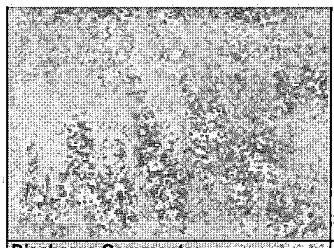
Dear Doctor,

Ms Sinclair was admitted to GRI on 08/02

Issues
1. CAP and exacerbation of COPD
- improved with abx
2. T2RF
- required short time on NIV
- ABGs prior to admission showed no CO_2 retention on air
3. New AF - anticoagulated with apixaban
4. Mild AKI - improved

A DNAR was in place during this admission.

Medication changes

	- apixaban started and aspirin stopped - bisoprolol increased and digoxin added for rate control - amitriptyline stopped as on pregabalin - furosemide reduced to 20mg due to renal function - ramipril held due to renal function - now improved but BP controlled without - metformin withheld during admission, restarted on reduced dose, please review in community need for re titration clinically indicated Many thanks, Ward 7-16 GRI
Discharge Comments:	
Follow Up:	No n/a
Results Awaited:	No
Pharmacist Comments:	
Final Discharge Letter to Follow:	No

Yours sincerely,

Dearbhail KILLORAN

Prescription Review
Medications reviewed by pharmacist: Caitlin Shaw (Pharmacist)
Checked by: Chantelle BOYLE (student pharmacy technician)
Discharged by: Dearbhail KILLORAN (Foundation Year 1)

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 25/06/2025

Consultant: Dr Daniel Rodgers

RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Dear RM Wilson

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **10/06/2025 at 18:51 hrs.** Departed on: **10/06/2025 at 22:02 hrs.**
Discharge Type: **04a - Incomplete: left before assessment completed** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
SELF - low viral risk c/o unstable angina with wakened by chest pains earlier d/w Dr Rogers

Nursing Assessment:
X2 episodes of central chest pains, relieved with GTN today. pain free in triage, rct course of abx for chest infection. ? unstable angina

Investigations in ED:

1. XR Chest	**2. Coagulation screen**	**3. Urea and Electrolytes**
4. Glucose	**5. LFT**	**6. CRP**
7. Full Blood Count	**8. Troponin I hs**	**9. Chol / Triglyceride**

Diagnosis:

Diagnosis	Side	Site
Person With Feared Complaint In Whom No Diagnosis Is Made		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

Theresa Sinclair attended the assessment unit but did not wait to be assessed. I note her blood tests showed a troponin I of <4 and mildly elevated CRP and WCC.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Christine Aiken
Consultant

Copies to:

1. RM Wilson (GP)

School Address:

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Respiratory Department
0141 451 5358
ruth.scoular@nhs.scot

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	
Contact Tel:	
Enquiries to:	
Letter Date:	24/04/2025
Reference:	JM/RS
Dictated Date:	24/04/2025
Transcribed Date:	24/04/2025

Dear Dr. RM Wilson,

Theresa Sinclair; D.O.B: 13 Aug 1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Attendance: Specialty - Respiratory Medicine; Clinic - GRJMRE8-DR MACLAY RESP THU PM
Date and Time of Appointment - 24/04/2025 16:16

Clinical Comments:
Problems:

1. Multifocal changes on CT scan – solid, subsolid and cystic abnormalities – no change on 3 month interval CT scan 1. COPD: PFTs 14/6/24: FVC 1.52 58% FEV1 48% 1.06, FEV1/FVC 70%

2. Previous substance misuse

3. Angina

4. Current smoker

Plan:

1. 1 year interval CT scan

I carried out a telephone consultation with Mrs Sinclair from my respiratory clinic on 24th April 2025. I am pleased to report the multiple changes on her CT scan are static over the last year. I suggested we do a further CT scan in one year.

Yours sincerely

Dr J Maclay

Consultant in Respiratory Medicine

Electronically Signed: Dr John Maclay, Consultant

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard: 0141 211 4000
Department: Respiratory Department
Contact Tel: 0141 451 5358
Enquiries to: ruth.scoular@ggc.scot.nhs.uk
Letter Date: 12/09/2024
Reference: JM/RS
Dictated Date: 13/09/2024
Transcribed Date: 17/09/2024

Dear Dr. RM Wilson,

Theresa Sinclair; D.O.B: 13 Aug 1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Attendance: Specialty - Respiratory Medicine; Clinic - GRJMRE8-DR MACLAY RESP THU PM
Date and Time of Appointment - 12/09/2024 14:50

Follow Up: Dr Maclay's Clinic 20th March 2025

Clinical Comments:
Problems:

1. Multifocal changes on CT scan – solid, subsolid and cystic abnormalities – no change on 3 month interval CT scan

1. COPD: PFTs 14/6/24: FVC 1.52 58% FEV1 48% 1.06, FEV1/FVC 70%

2. Previous substance misuse

3. Angina

4. Current smoker

Plan:

6 month interval CT scan

I carried out a telephone consultation with Mrs Sinclair from my respiratory clinic on 12th September 2024. Her CT scan has not evolved in the last 3 months with all abnormalities remaining static. The aetiology remains unclear. There is no definite evidence of malignancy here. The cystic abnormality in her right upper lobe is thin walled and has not changed. As you know she had previous lung function tests which showed a restrictive defect. However her FVC lasted less than 2 seconds, but there was evidence of scalloping of the full volume loop which would be consistent with airflow obstruction had she not terminated her expiration early. This would be consistent with the emphysema that we see on CT and the reduced gas transfer. As such I think she should be treated as having COPD and I see she is already on an Anoro Ellipta.

I do think we should keep an eye on the abnormalities on her CT scan and I have scheduled another CT scan for 6 months.

Yours sincerely

Dr J Maclay

Consultant in Respiratory Medicine

Electronically Signed: Dr John Maclay, Consultant

cc.

Clinical letter - GP: Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: MSK physiotherapy
Kirkintilloch Health and Care Centre
Contact Tel:
Enquiries to:

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Letter Date: 29/08/2024
Reference:
Dictated Date: 04/07/2024
Transcribed Date: 04/07/2024

Dear Dr. RM Wilson ,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

GP Action Required: Nil

Presenting Condition: (L) sided low back pain and sciatica

Physiotherapy Comments: Theresa presented to me with a 3 months history of low back and leg pain. it has been improving steadily in recent weeks after beginning her pain medication and she now has no activity limitations in ADL. We have started a walking program. She is in the process of getting her lungs investigated for more sinister pathology and wanted to trial self management of her pain at this stage.

Onset of symptoms - 3 months

Mechanism of onset - unknown

Treatment - The patient was provided w/ a progressive mobilisation-strengthening programme, education on condition and advised on an active approach to improvement.

Discharge Outcome:

The patient completed a course of treatment and symptoms are now:

- Improved.

The patient has an exercise programme to continue with self management.

The patient was advised to contact us if further help was required and have not.

Yours sincerely

Connor Parke

Physiotherapist

connor.parke@ggc.scot.nhs.uk

Electronically Signed: Physiotherapist Connor Parke, Physiotherapist

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	Respiratory
Contact Tel:	0141 451 5358
Enquiries to:	ruth.scoular@ggc.scot.nhs.uk
Letter Date:	13/06/2024
Reference:	CF/SS
Dictated Date:	13/06/2024
Transcribed Date:	18/06/2024

Dear Dr. RM Wilson,

Theresa Sinclair; D.O.B: 13 Aug 1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Attendance: Specialty - Respiratory Medicine; Clinic - GRJMRE8-DR MACLAY RESP THU PM
Date and Time of Appointment - 13/06/2024 14:15

Requested Out-patient Investigations:
PFTs and CT

Follow Up: Telephone Consultation Dr Maclay's clinic

Clinical Comments:

I had the pleasure of reviewing Miss Sinclair in the respiratory outpatient clinic.

Past medical history:

1. COPD: PFTs 14/6/24: FVC 1.52 58% FEV1 48% 1.06, FEV1/FVC 70%

2. Previous substance misuse

3. Angina

4. current smoker

She is a 60 year old lady who was referred to ourselves from the acute assessment unit after an abnormality was found in her CT thorax. She had these investigation on the background of a suspicious chest x-ray in the middle April.

Her CT scan has demonstrated multiple semi-solid and ground glass nodules in both lungs with a possible pneumatocoele in the right hilum. In clinic today, she describes an improvement in her cough and sputum. Her sputum culture did come back with haemophilus influenzae which was sensitive to the antibiotics she received.

She describes shortness of breath after walking 50m and would manage 1 flight stairs without stopping. She is coping at home but does struggle with activities of daily living due to her breathing. She denies any haemoptysis, weight loss, chest pain/wheeze or ankle swelling. She does describe some occasional night sweats. She is an active smoker of 20 a day with a 50 pack year history but is keen to stop and she has remained abstinent from alcohol for the past 7 years.

Her pulmonary function tests have demonstrated a reduced FEV1 and FVC with a ratio in keeping with a restrictive defect however, her FEV1%VC was reduced in keeping with airflow obstruction. There were no CT changes in keeping with fibrotic lung disease.

I have explained to Ms Sinclair today that there are some changes in her CT scan which maybe inflammatory in nature but are also possibly concerning for malignancy. In this regard, we are going to do a repeat CT scan in 3 months time along with full PFTs to further assess this restrictive defect. We will make a telephone consult with her after these results to further discuss and advise on future imaging at that time.

Miss Sinclair is keen to discuss smoking cessation but was happy to go to her local chemist for this.

Kind Regards

Dr C. Findlay

IMT1

Electronically Signed: Dr Caitlin Findlay, Doctor

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Respiratory Medicine NPC General – ACUTE STAFF ONLY	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Urgent - Suspected Cancer
Date of referral 03-Jun-2024 **Date sent** 03-Jun-2024

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main Street
Lennoxtown
Glasgow
G66 7DA

Contact number(s)

Voice: 07754676886
Voice: 07754676886

101033229399D | Unique Care Pathway Number: 101033229399D

REGISTERED GP DETAILS

Name	Dr RM Wilson		
GMC code	-	GP code	-
Practice name	Lennoxtown Medical Practice		
Practice code	-		

Practice address

Contact number(s)
-

REFERRING HCP DETAILS

HCP Name	PaulineGrose
HCP code	4603359
HCP Position	Consultant Acute Medicine
Organisation name	Acute Medicine Acute North Sector (GG&C)

Organisation address

SCI Gateway Virtual Location
Contact number(s)
-

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Urgent USOC

Comment: Urgent Suspicion of Cancer.
I would be grateful for your opinion on this 60 year old lady. She was referred to the Assessment Unit in April of this year with a persistent cough and progressive breathlessness. A chest x-ray at the time was suspicious and as such she proceeded on to a CT chest and abdomen with contrast which was performed on the 23rd May 2024.
The formal report of this suggests the presence of multiple semi-solid and ground glass nodules in both lungs with an uncertain aetiology including potential malignancy.
Past medical history: this lady has a background of COPD, Angina, Previous Drug and Alcohol Dependency and is a longterm smoker.
I would be grateful for your further assessment and investigation as required.
Many thanks
Yours sincerely
Dr Pauline Grose
Consultant Physician Acute Medicine
Electronically Signed: Dr Pauline Grose, Consultant
cc. Dr RM Wilson:
Lennoxtown Medical Practice:
46 Main Street:
Lennoxtown:
G66 7JJ:

Reason for referral

Care type requested: Out Patient

Expected outcome: Investigate

Past medical history

Current medication (Active Repeat medication issued within the last 12 months)

No current medications recorded

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information
Administrative information

Is patient aware they are being referred under a suspicion of cancer pathway?:No - I understand I will need to inform patient of any change to referral status after vetting.

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Consultant
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Referral letter:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

URGENT USOC
Respiratory Consultants
Respiratory Department
Glasgow Royal Infirmary

Main Switchboard: 0141 211 4000
Department: Acute Assessment Unit
Contact Tel: 0141 201 6655
Enquiries to: Megan Kelly
Letter Date: 03/06/2024
Reference: PG/NR
Dictated Date: 03/06/2024
Transcribed Date: 03/06/2024

Dear Respiratory Team,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Urgent Suspicion of Cancer.

I would be grateful for your opinion on this 60 year old lady. She was referred to the Assessment Unit in April of this year with a persistent cough and progressive breathlessness. A chest x-ray at the time was suspicious and as such she proceeded on to a CT chest and abdomen with contrast which was performed on the 23rd May 2024.

The formal report of this suggests the presence of multiple semi-solid and ground glass nodules in both lungs with an uncertain aetiology including potential malignancy.

Past medical history: this lady has a background of COPD, Angina, Previous Drug and Alcohol Dependency and is a longterm smoker.

I would be grateful for your further assessment and investigation as required.

Many thanks

Yours sincerely

Dr Pauline Grose

Consultant Physician Acute Medicine

Electronically Signed: Dr Pauline Grose, Consultant

cc. Dr RM Wilson:
Lennoxtown Medical Practice:
46 Main Street:
Lennoxtown:
G66 7JJ:

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Theresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Main Switchboard:	0141 211 4000
Department:	Acute Assessment Unit
Contact Tel:	0141 201 6655
Enquiries to:	Megan Kelly
Letter Date:	03/06/2024
Reference:	PG/NR
Dictated Date:	03/06/2024
Transcribed Date:	03/06/2024

Dear Ms Sinclair,

Thank you for attending for your recent CT scan. This shows some changes in both lungs which may be due to your previous diagnosis of COPD but which may require further investigation. As such I have referred you to my colleagues in Respiratory Medicine who should be in contact regarding appropriate follow-up in the near future.

Many thanks

Yours sincerely

Dr Pauline Grose

Consultant Physician Acute Medicine

Electronically Signed: Dr Pauline Grose, Consultant

cc.

Letter to Patient:

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: Acute Medicine
Contact Tel: 0141 201 6655
Enquiries to: Megan Kelly
Letter Date: 25/04/2024
Reference: CA/MK
Dictated Date: 22/04/2024
Transcribed Date: 22/04/2024

Theresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Dear Ms Sinclair,

Following your recent attendance to the Acute Assessment Unit, your chest x-ray has been reported as showing some changes which may be consistent with infection and a CT has been recommended to further investigate this.

You should hear directly from the x-ray department and the results of this CT will be forwarded once it is available.

Should you have any questions regarding this, please contact us on the above number.

Yours sincerely,

Dr Christine Aiken

Consultant Physician Acute Medicine

Electronically Signed: Dr Christine Aiken, Consultant

cc. Dr R Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 12/04/2024

Consultant: Dr Christine Aiken

RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Dear RM Wilson

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **11/04/2024 at 19:48 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
***SELF* PC- ? NEW FAST AF. HX- COPD, SMOKER.**

Nursing Assessment:
PC: Sob , pain in back, ?NEW AF. BG: copd + smoker, arthritis, angina , high blood pressure and cholesterol.

Investigations in ED:

1. Full Blood Count	**2. Coagulation screen**	**3. Urea and Electrolytes**
4. Glucose	**5. LFT**	**6. Bone Profile**
7. CRP	**8. Thyroid function tests**	**9. Magnesium**
10. Bone Profile	**11. Blood Film**	**12. XR Chest**

Diagnosis:

Diagnosis	Side	Site
Unspecified Acute Lower Respiratory Infection		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Any medication dispensed or changed is recorded in this letter in the free text below**

Clinician Notes:

Dear colleague, I reviewed Theresa Sinclair, 60 years old lady, at AUU. She was referred for possible symptomatic AF/ LRTI, months worsening SOB, worse last few days on exertion. Green sputum. Feverish. Sweating (long-term). Also irregular rhythm noticed on examination in GP practice. Theresa says that she is long-term SOB on exertion, but recently is more SOB. She says that has a long-term cough, now greenish. She denies any wheeziness. Denies chest pain, palpitations. She told me that she was dizzy in the morning with headache (frontal). No vision change. She told me that she has been prescribed analgesia dihydrocodeine 1 month ago for her hip and knee pain, however it made her constipated and she stopped taking the dihydrocodeine. Today was in pain, especially her low back pain, knee pain – managed as arthritis. Pain settled after taking paracetamol at AAU. BG: COPD, angina, drug overdose, depression, alcohol dependence – 7 years abstinent Smoker – 20/day ECG- normal sinus rhythm, observations normal. Pulse – 70, BP -130/75. RR 15, sp02 – 96. Chest x-ray – R sided consolidation. Bloods – CRP 23, WCC 14.9, Neu 7.9, other normal. Full examination – Respiratory crackles R middle zone. No wheeze. Otherwise normal. Mrs Sinclair was discharged with antibiotics for LRTI. No follow-up needed. If paracetamol not effective and needs to take dihydrocodeine, to contact her GP for laxatives. Happy to be discharged. Kind regards, Marketa Baldrianova GPST1

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Marketa Baldrianova
Doctor

Copies to:

1. RM Wilson (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 23/11/2022

Consultant: Dr Colin Bell

O Amin
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Dear O Amin

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **22/11/2022 at 18:26 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
self- low risk covid/flu Increased episodes of anginal pains, unrelieved with GTN. Fee ling breathless and sweaty at time of onset.

Nursing Assessment:
NEWS 2, COVID POSITIVE 3/52, ? ACS, X2 episodes of central chest pain, used GTN, chest heaviness after GTN, SOB, Sweaty, non radiating , leg pain, Chest discomfort at triage

Investigations in ED:

1. Coagulation screen	**2. Urea and Electrolytes**	**3. Glucose**
4. LFT	**5. CRP**	**6. Chol / Triglyceride**
7. Full Blood Count	**8. Troponin I hs**	**9. Blood Film**
10. XR Chest		

Diagnosis:

Diagnosis	Side	Site
Angina Pectoris, Unspecified		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **Please see Clinician Notes**

Clinician Notes:

COPD- still smokes. Angina. Prev alcohol excess but states abstinent now. Recent covid-19 infection 3 weeks ago and sputum culture Oct 22 positive H. influenzae. Yesterday while walking along the street: central chest pain relieved by GTN lasted about 10 mins, 2nd episode in evening while running after grandkids- dulled by GTN but did last for about 2 hours. Pain free since, states not been bothered by chest pain since RACP clinic assessment review in 2015 but then says does get pains sometimes but quite vague about this. o.e well and pain free. NEWS 0. wheeze throughout. Results: CXR clear. ECG SR 81bpm. Bloods Hb 121, WCC 17.4, U&Es normal, CRP 9. Trop <4 Imp: Anginal episode but no recent history of increasing angina in background. Recent covid-19 infection/ LRTI. Discharged home with Anoro Ellipta (seen by respiratory CNS and advised to step up inhaled therapy). Smoking cessation advice given, worsening advice to reattend if chest pain recurs. If ongoing anginal episodes and increasing in frequency- refer cardiology/RACP

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Ann Loo
Doctor

Copies to:

1. O Amin (GP)

School Address:

Clinical letter - GP: Initial Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Main Switchboard: 0141 211 4000
Department: Community Dietitians
Springburn Health Centre
Contact Tel: 0141 232 9101
Enquiries to: Pamela Sockalingam
Letter Date: 24/01/2020
Reference: PS
Dictated Date: 24/01/2020
Transcribed Date: 24/01/2020

Dr. CJ Taylor
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Dear Dr Taylor,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Thank you for referring this patient for dietary advice for Irritable Bowel Syndrome.

She attended Kirkintilloch clinic as arranged on 23/1/2020

Height: 1.54 Weight: 73.7 kg BMI: 31.1 kg/m²

Dietary assessment showed Theresa has an irregular meal pattern. Her diet is rich in extrinsic sugar, high in fat and low in dietary fibre. Theresa misses breakfast and lunch every day and has a take away meal 4 times per week. She reports having 20 cups of tea daily with 2 sugars in each one and 4 cans red bull energy drink daily. She reported her IBS symptoms are mainly diarrhoea, abdominal pain and bloating. She has type 5 stools and her bowels open twice daily

She was given information and advice for Irritable Bowel Syndrome - diarrhoea, and agreed the following goals:

1. Have regular meals and snacks. Include a breakfast, agreed cornflakes with chopped banana and semi skimmed milk as an idea. Agreed lunch ideas eg soup and a roll or sandwich.

2. Avoid eating for up to 3 hours before bed.

3. Aim 5 portions fruit and veg / day

4. Reduce fat intake by cutting out take away meals and making homemade meals agreed some ideas of easy to make meals. Cut out crisps, agreed alternatives.

5. Limit cups of tea to 2 daily, rather than 20 / day.

6. Cut out red bull energy drinks and replace with water. Aim 1.5 - 2 Litres sugar free water based fluids daily.

Gave written information ndr "IBS dietary advice"

I have arranged a review appointment at clinic on 23/4/20 at 11.15 am

Electronically Signed: ,

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. CJ Taylor
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	Podiatry
Contact Tel:	0141 531 6713
Enquiries to:	
Letter Date:	22/01/2020
Reference:	
Dictated Date:	22/01/2020
Transcribed Date:	22/01/2020

Dear Dr. CJ Taylor,

Theresa Sinclair; D.O.B: 13 Aug 1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Attendance: Specialty - Podiatry; Clinic - SBGNSR156-PODIATRY NAIL SURGERY WEDNESDAY
Date and Time of Appointment - 22/01/2020 10:00

Clinical Comments:
Total nail avulsion was carried out with phenolisation on L1st. Advice was given on self-management of the wound.

We have not made plans for further follow-up, however the patient is aware to contact us for review as required. Local anaesthetic documents scanned.

Lindsay-Ann Mermagen Podiatrist

Electronically Signed: ,

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. CJ Taylor
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	Community podiatry
Contact Tel:	0141 304 7430
Enquiries to:	Donna Ann Bodel
Letter Date:	06/01/2020
Reference:	
Dictated Date:	06/01/2020
Transcribed Date:	06/01/2020

Dear Dr. CJ Taylor,

Theresa Sinclair; D.O.B: 13 Aug 1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Attendance: Specialty - Podiatry; Clinic - KHP2R112-GENERAL PODIATRY 2 MONDAY
Date and Time of Appointment - 06/01/2020 09:15

Clinical Comments:
Theresa attended community podiatry new patient appointment.

S Had both 1st nails off some years previous. Left 1st has regrown, causing discomfort. Wish revision procedure.

O Left 1st onychauxis, involuted.

A Discussed risk versus benefit of total nail avulsion with phenolisation.

Health check list completed. Meds include Ramipril, simvastatin, 75mg Aspirin, inhalers for COPD, Fluoxetine, omeprazole.

Onward referral to nail surgery.

Donna Ann Bodel

Band 5 Podiatrist.

Electronically Signed: ,

cc.

Clinical letter - GP: Discharge letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	Springburn Community Dietetics
Contact Tel:	0141 232 9101
Enquiries to:	Springburn Community Dietetics
Letter Date:	14/02/2019
Reference:	EM
Dictated Date:	14/02/2019
Transcribed Date:	14/02/2019

Dear Dr Wilson,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Thank you for referring the above patient for dietary advice for IBS dietary advice.

Patient attended initial dietetic assessment on 07/08/2019. She was given first line IBS dietary advice, with supporting literature provided.
Unfortunately she did not attend for her review appointment on 4th December 2018. She was discharged from our service on 18/12/2019.

Reason for discharge: Non-attendance for review appointment.

Yours sincerely

Elizabeth Murphy (RD)

Community Dietitian

Electronically Signed: ,

cc.

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 02/04/2017

Consultant: Dr Samantha Perry

RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Dear RM Wilson

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **02/04/2017 at 01:24 hrs.** Departed on: **02/04/2017 at 06:18 hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
fall

Nursing Assessment:
pt fell 5ft from step ladder, collared & immobilised. On Scoop. Intoxicated, daughter present. C/o back pain. Unco-operative in triage

Investigations in ED:
1. CT Head

Diagnosis:

Diagnosis	Side	Site
Superficial injury of scalp		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

fell from 5 step stepladder. struck head - LOC. brought in by daughter, intoxicated. CT head NAD, C spine clinically clear discharged with daughters to observe

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Christopher Lowry
Doctor

Copies to:

1. RM Wilson (GP)

School Address:

Final Discharge Letter

NHS
Greater Glasgow and Clyde

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
0141 211 4000

Dr. RM Wilson
Lennoxtown Medical Practice
Health Clinic
Main Street
Lennoxtown
G66 7DD

Main Switchboard:
Department:
Contact Tel:
Enquiries to: mary.mcloone@ggc.scot.nhs.uk
Letter Date: 28/10/2015
Reference:
Dictated Date: 13/10/2015
Transcribed Date:

Dear Dr. RM Wilson,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Admission: Specialty - General Medicine; Ward - GRI Ward 50 MR Respiratory
Consultant - Dr Brian Neilly; Date of Admission - 12/10/2015
Date of Discharge - 13/10/2015; Discharged to - Private Residence - no additional detail added

Follow Up: None

Clinical Comments:
Ms Sinclair was admitted to Ward 50 GRI intoxicated with pain in her neck and back, a headache and bruising on her chin.
On admission her bloods, obs and examination were unremarkable. She was treated as per GMAWS with diazepam and given pabrinex. The day after admission she was reviewed and found to be well, not scoring on GMAWS and her obs were stable. We note she has follow up with CAT on 15/10. We have discharged her home on thiamine and made no changes to her pre-admission medications.
Kind regards,
Dr Elspeth Murray
FY1
FINAL COMMENTS
Nil to add.
Dr Douglas Cowan Consultant

Electronically Signed: Dr Douglas Cowan, Consultant

cc. n/a

Sinclair Theresa CHI: 1308636407

Immediate Discharge Letter

NHS
Greater Glasgow and Clyde

Highly Sensitive: No Consent for Sharing Withheld: No
This letter supersedes previous version of 13 Oct 2015 12:52

Dr. RM Wilson
Lennoxtown Medical Practice
Health Clinic
Main Street
Lennoxtown
G66 7DD

Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Date of Completion: 13/10/2015

Dear Dr RM Wilson,

Name	CHI	DoB	Address
Theresa Sinclair	1308636407	13/08/1963	90a Main Street Glasgow G66 7DA

Admitted	Type	Discharged	Destination
12/10/2015 11:07	In Patient	13/10/2015	Private Residence - living alone

Specialty	Consultant	Ward	Telephone
General Medicine	Dr Brian Neilly	GRI Ward 50 MR Respiratory	0141 211 4204 / 0141 211 4205

Reason for Admission and Presenting Complaints	Admission Category
	Admission for treatment - Where the patient is expected to be treated for a diagnosed condition not otherwise specified

Diagnosis	Site	Side

Date	Procedures/Interventions/Operations

Clinical Comments:

Dear Doctor,
Ms Sinclair was admitted to Ward 50 GRI intoxicated with pain in her neck and back, a headache and bruising on her chin.
On admission her bloods, obs and examination were unremarkable. She was treated as per GMAWS with diazepam and given pabrinex. The day after admission she was reviewed and found to be well, not scoring on GMAWS and her obs were stable. We note she has follow up with CAT on 15/10. We have discharged her home on thiamine and made no changes to her pre-admission medications.
Kind regards,
Dr Elspeth Murray
FY1

Treatments: None recorded.

Follow-up arranged: None

Planned Outpatient Investigations: None

Final Discharge letter to follow: Yes

Medication Info:

Allergies:

Height: cm **Weight:** kg

Discharge Medication:

Medicine	Route	Dose	UOM	Frequency	Duration	Pharmacy Comment
Thiamine Hydrochloride Tablets	Oral	100	mg	THREE Times a Day	Indefinite	Please supply

New Medication Started: Thiamine

Medication Comment: Diazepam weekly dispense from Lennoxtown pharmacy EG 13/10/15

Discontinued Medication:

Drug Name	Dose	UOM	Reason

Yours sincerely,
Dr Elspeth Murray
Doctor

cc. 1. n/a

Prescription Review
Medications Reviewed by Pharmacist: ,
Dispensed Medications Checked by Pharmacy: ,
Nurse discharging patient: Elspeth Murray, Doctor

NHS Greater Glasgow & Clyde
Rapid Access Chest Pain Service

Dr. Rosalyn Wilson
Dr James Henderson & Dr Rosalyn Wil
Campsie Surgery, Lennoxtown Clinic
G66 7DA

Printed on: 15/07/2015

Dear Dr. Rosalyn Wilson,

Re: THERESA SINCLAIR (CHI 1308636407). 90A Main St Lennoxtown Glasgow G 667DA

Your patient was seen at the Rapid Access Chest Pain Clinic on 15/07/2015 at The Glasgow Royal Infirmary.

Presenting History

New onset of symptoms within last 4 weeks.

Presenting Notes Difficult consultation today, consummed a large quantity of alcohol last night, long standing history of alcohol excess, however does describe typical features, central chest heaviness, exertional, relieved by GTN spray, prescribed by yourself, 3 week history with 3 - 4 episodes, all exertional. Friend, christine, present throughout the consultation.

Relevant Past Medical History

None.
Patients father had CHD at <55 years of age; brother had CHD at <55 years of age; sister had CHD at <65 years of age.
current smoker, alcohol excess.

Investigations

ECG
Heart Rate: 88 (bpm)
Sinus rhythm.
Normal conduction.
Non Ischaemic.

ETT
ETT Done.
Inadequate test.
Protocol: Bruce.
Exercise limiting angina.
Ex. Time: 00:58.
Symptom Positive.

Reason(s) for Stopping
Angina, back pain

Clinical Findings

BP (mmHg) 130/91

Smoking Status Current Smoker

Diagnosis and Recomendations

Outcome: New onset angina
Anti-anginals: Commence according to GGC CHD Management guideline (attached)
Secondary prevention: Commence aspirin 75mgs,(PPI cover due to alcohol excess)Bisoprolol 2.5mg , Ramipril 2.5mg and Simvastatin 40mg unless contraindicated, and uptitrate to optimal dose or maximum tolerated as in GGC CHD Management guideline.
Risk Factor Management: Please manage cholesterol and blood pressure in line with GGC Guidelines. Consider smoking cessation, physical activity levels, alcohol consumption and weight management
No OP review: No Op review or further investigations required but if you have further concerns please consider referral to cardiology out-patients.

Additional discharge comments: New onset of angina in view of typical features, ETT unhelpfull due to low workload, initially stopped due to back pain, however then changed it to chest heaviness when asked to describe the back pain, no ECG changes but very low workload.

Difficult consultation today, unsure how much she took on board despite her friend being present, not keen for any further investigations but has agreed to commence additional medication as recommended above.

No routine follow up arranged if symptoms change or progress despite the medication please re-refer.

Lifestyle, GTN spray and chest pain management advice provided.

Yours Sincerely,

Wenda Crawford
Advanced Nurse Practitioner
Rapid Access Chest Pain Service

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 28/06/2014

Consultant: Dr Claire Fitzpatrick

RM Wilson
Lennoxtown Medical Practice
Health Clinic
Main Street
Lennoxtown
Glasgow
G66 7DD

Dear RM Wilson

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **28/06/2014 at 02:55 hrs.** Departed on: **28/06/2014 at 06:16 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
right shoulder / elbow injury

Nursing Assessment:

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Superficial injury of elbow	**Right**	**Elbow**

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Patient fell in street tonight, landing on right elbow. Superficiacl abrasions to extensor surface, ful range of movement, no acute bony injury seen on xray of right elbow. Alert and orientated, small bruise to right hairline, no neurological red flag signs or symptoms. Broad arm sling applied and discharged home with head injury advice leaflet.

Followup : **none**

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Victoria McWhinnie
Doctor

Copies to:

1. RM Wilson (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 16/11/2013

Consultant: Dr Claire Fitzpatrick

RM Wilson
Dr Rosalyn Wilson & Dr Christopher
Campsie Surgery lennoxtown clinic
103 Main Street
Lennoxtown
Glasgow
G66 7DA

Dear RM Wilson

Re: **Sinclair Teresa** DOB: **13/08/1963** CHI: **1308636407**
908 Main Street
Glasgow G66 7DB

Attended on: **16/11/2013 at 04:13 hrs.** Departed on: **at hrs.**
Discharge Type: **01b - Discharge with follow up by primary care team** Destination: **Private residence**
Previous ED Attendance in last 12 months: **2**

Presenting complaint
shoulder pain

Nursing Assessment:
patient drinking alcohol tonight claims to have been assualted claims injured left shoulder and elbow noobvious inj/deformity

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Sprain and strain of shoulder joint		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
muhammad mahmood
Doctor

Copies to:

1. RM Wilson (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
Lanarkshire
G31 2ER

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 28/08/2013

Consultant: Dr Claire Fitzpatrick

RM Wilson
Dr Rosalyn Wilson & Dr Christopher
Campsie Surgery lennoxtown clinic
103 Main Street
Lennoxtown
Glasgow
G66 7DA

Dear RM Wilson

Re: **Sinclair Teresa** DOB: **13/08/1963** CHI: **1308636407**
908 Main Street
Glasgow G66 7DB

Attended on: **24/08/2013 at 04:06 hrs.** Departed on: **24/08/2013 at 08:50 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **0**

Presenting complaint
back problem

Nursing Assessment:
c/o lower back pain for ages, has been drinking, states in a lot of pain but doesn't take analgesia as she doesn't want to get addicted. states sometimes has pain in lungs. pmh ibs.

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
Low back pain		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Attended intoxicated, drinking wine in the department. Complaining of chronic back pain. Nil new Sx reported from patient, normal lower limb examination. Advised to see GP for physio referral, pt not wanting analgesia.

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Julia Park
Doctor

Copies to:

1. RM Wilson (GP)

School Address:

NHS
Greater Glasgow and Clyde

DEPARTMENT OF GYNAECOLOGY

Dr S Mathew

GLASOW ROYAL INFIRMARY
CASTLE STREET
GLASGOW, G4 OSF

TEL NO: 211 4000

Dr J H Kennedy Dr H Lyall
Dr A M Mathers Dr R Jamieson
Dr R W S Yates Dr P Owen
Dr M. Perera Dr. M. Rodger
Dr J E Norman Dr. M. Deeny

Enquires: Catherine Donaghy (Secretary)
Direct: 0141 211 4755
Fax: 0141 800 1973
E-Mail: Catherine.Donaghy@northglasgow.scot.nhs.uk

Clinic &
Dictated 30/08/2009
Typed 01/09/2009
Your Ref
Our Ref SM/MC

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CHI: 1308636407 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Thank you for referring this 46 year old lady to my Gynaecology Clinic today. She is a para 4 who was referred with a history suggestive of heavy periods. She says her periods last for up to seven days and are quite heavy with dysmenorrhoea. She has had three normal deliveries and a forceps delivery in the past and was sterilised about 8 years ago. Her last smear was negative. There are no bowel or bladder disturbances.

On examination her cervix was hypertrophic, anteverted and parous size and mobile. There was no adnexal mass felt. I have carried out a Pipelle endometrial biopsy and we discussed a Mirena IUS insertion which she was keen to get done today. I have inserted a Mirena IUS under aseptic precautions without any complications. I have suggested we will review her in four months' time and in case she is well and does not want to see us she can always call and cancel the appointment.

Yours sincerely

Dr Sarju Mathew
Consultant Gynaecologist & Obstetrician

NHS
Greater Glasgow and Clyde

DEPARTMENT OF GYNAECOLOGY

Dr S Mathew

GLASOW ROYAL INFIRMARY
CASTLE STREET
GLASGOW, G4 OSF

TEL NO: 211 4000

Dr J H Kennedy Dr H Lyall
Dr A M Mathers Dr R Jamieson
Dr R W S Yates Dr P Owen
Dr M. Perera Dr. M. Rodger
Dr J E Norman Dr. M. Deeny

Enquires: Catherine Donaghy (Secretary)
Direct: 0141 211 4755
Fax: 0141 800 1973
E-Mail: Catherine.Donaghy@northglasgow.scot.nhs.uk

Clinic &
Dictated: 06/07/2009
Typed 08/07/2009
Our Ref SM/CK

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CHI: 1308636407 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

This lady has failed to attend our clinic and another appointment has been sent.

Yours sincerely

Dr Sarju Mathew
Consultant Gynaecologist & Obstetrician

Ward 33
Royal Infirmary
Castle Street
Glasgow G4 0SF
Switchboard 0141 211 4000

Secretary: Catherine Donaghy
Direct Line: 0141 211 4755
Fax Number: 0141 800 1973
catherine.donaghy@ggc.scot.nhs.uk

Ref: SM /CD/23004807E
CHI: 1308636407
DATE: 09/10/09

DEPARTMENT OF GYNAECOLOGY

DR C BAIN
DR S MATHEW
DR M DEENY
DR A DUNCAN
DR R JAMIESON
DR S WONG
PROF M LUMSDEN
DR A MATHERS
DR P OWEN
DR M PERERA
DR M RODGER

Teresa Sinclair
90a Main Street,
Lennoxtown,
Glasgow, G66 7DA

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Teresa,

I hope you are well. This is to inform you that the sample of tissue taken from the lining of your womb has been reported as normal which is very reassuring.

Yours sincerely

Dr Sarju Mathew
Consultant Gynaecologist & Obstetrician

CHI: 1308636407

Glasgow Royal Infirmary

EOLC

Total Att: **24**

12 Mth Att: **0**

Title: **MS**

SINCLAIR **Theresa**

DOB **13/08/1963** Age: **61y** Sex: **Female**

90a Main Street
Lennoxtown
Glasgow
G66 7DA
07754676886

Next of kin: **JENKINS, Annmarie**
Relationship: **Daughter**
0745333109

GP: **RM Wilson**
01360 327300

Attendance Date: **10/06/2025** Arrival Time: **18:51**

Registration Time: **18:51** Date of Incident: **10/06/2025**

Major Incident Desc:

Reason for Attendance: **SELF - low viral risk c/o unstable angina with wakened by chest pains earlier d/w Dr Rogers**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score: **0**

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **10/06/2025 19:17** Nurse name: **Nurse Nicola OHalloran**

Temp	**36.3**	C
HR	**84**	bpm
BP	**118/67**	mmHg
MAP	**84.00**	mmHg
RR	**16**	bpm
SpO2	**92**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/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: **X2 episodes of central chest pains, relieved with GTN today. pain free in triage, rct course of abx for chest infection. ? unstable angina.**

1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa

Patient ID label

SATA/AAU MEDICATION DOCUMENTATION

NHS Greater Glasgow and Clyde

Once Only Prescriptions

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given

Discharge Medications

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given

Ambulatory Care Unit Nursing Documentation

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

NHS Greater Glasgow and Clyde

Date: 10/6/25 Time: 19-25

Assessment Completed By (PRINT): Donna

Patient preferred name: _____

Interpreter required ☐ Yes ☐ No

Presenting Complaint: Unstable angina, chest Pain

Patient Prep/Investigations (Please tick when completed)

ID Band	☐	Xrays performed	☐ Yes ☐ No
NEWS2 Chart Completed?	☐	CT/CTPA	☐ Yes ☐ No
12 Lead ECG	☐	Height	
Blood samples Obtained	☐ Yes ☐ No	Weight	
IV access	☐ Yes ☐ No Date: _____ Time: _____ Signature: _____	STOPSS Completed?	☐ Yes ☐ No Date: _____ Time: _____ Signature: _____

Urinalysis

Leukocytes		Glucose		Blood	
Nitrites		Protein		PH	
S.G.		Ketones		MSSU/CSU Sent?	
HCG	+VE	-VE		Strip Lot No:	

Record of intentional rounding

Date	Time	Initial	Date	Time	Initial	Date	Time	Initial

Nursing Notes

Date/Time:		Print Name and Signature
10/6/25. 19:50	Pt not attending initally as out for a cigarette. Initialix DR	
	Awaiting medical r/v.	RLSH
21:00	continously leaving dept for cigarettes. Nicaucee.	Dleushield -sanderson
		RLSH Dleushield -sanderson

Pause for Discharge/Transfer

Relatives informed of admission/discharge?	☐ Yes ☐ No	Signed: _____
IV access removed for discharge?	☐ Yes ☐ No	Signed: _____
Own transport?	☐ Yes ☐ No	Signed: _____
Transport arranged?	☐ Yes ☐ No	Signed: _____
Medicines for discharge given and explained	☐ Yes ☐ No	Signed: _____



1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7DA

NHS
Greater Glasgow and Clyde

Hospital GRI

I hereby certify that I am being discharged from this hospital on my own responsibility.

Signed T Sinclair

Witness Queenshields-Sandison

I hereby agree to relieve the Health Board of all responsibility in connection with the discharge of ..... from hospital.

Signed .....

Relationship .....

Address .....

Witness .....

Note: A permanent form of writing instrument should be used in completing this form.

STY5017N

THERESA SINCLAIR

Scottish Ambulance Service

Age/Gender:	61 Years, 9 Months, 28 Days, Female	**Incident Date:**	10/06/2025 17:26:00
DOB:	13/08/1963	**ePCR Number:**	4-2-100625-172605
Address:	90a main streetlennoxtown G66 7DA, 07754676886	**Incident Number:**	CR012140178
CHI Number:	-	**Incident Type:**	EMG
Ethnicity:	White Scottish	**Incident Location:**	

PATIENT INFO

GP And Surgery

Address:	Lennoxtown Medical Practice, Lennoxtown Hub, 46 Main Street, Lennoxtown	**Name:**	Lennoxtown Medical Practice
Postcode:		G66 7JJ	

Next Of Kin

Forename:	megan	**Surname:**	mccarol
Telephone Number:	07894467054	**Relationship To Patient:**	Parent

ADDITIONAL COMMENTS

Presenting Complaint:	gp referal for ? chest pain

Timestamp	Additional Comment	Crew Name
10/06/2025 18:34:00	999 call to a 61yof ? gp referal for ? chest pain. Patient attended gp surgery after experiencing 2 seperate episodes of chest pain when she woke up this morning. Patient self presented at gp surgery where after being seen gp has ? refered patient to aau. O/a patient was back in own property, alert, not c/o any pain or discomfort. O/e full set of obs carried out which are as recorded below. Patient taken to gri	

ACVPU

Options:	Alert

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No

AIRWAY

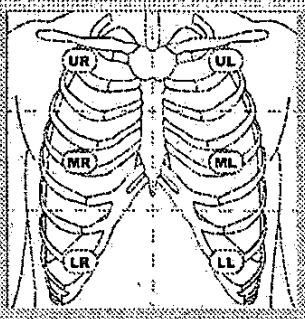
Assessment:	Clear

BREATHING

Breathing Adequately:	Yes	**Initial Respiratory Rate:**	18
Initial SpO2:	92	**Initial SpO2 On Air:**	Yes
Oxygen Given:		No	

Chest Examination

Anterior

Normal Percussion, Normal Breath Sounds, Normal Air Entry	UR		UL	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	MR		ML	Normal Percussion, Normal Breath Sounds, Normal Air Entry
Normal Percussion, Normal Breath Sounds, Normal Air Entry	LR		LL	Normal Percussion, Normal Breath Sounds, Normal Air Entry

CIRCULATION

Pulse Rate:	95	**Rhythm:**	Reg
Most Distal Pulse Found:	Radial	**Cap Refill:**	<=2 Secs
Central Peripheral:	Peripheral	**Arm:**	Right
Systolic Pressure:	127	**Diastolic Pressure:**	78
ECG:		12 Lead	

Rhythm

Rhythm:	Sinus Rhythm

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
10/06/2025 18:10:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

Pupils Equal And Reactive To Light (Pearl):	Yes

Blood Glucose

Blood Sugar Value (MMOL/L):	10

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L|R)	PEF	Crew
10/06/2025 18:11:00	95	18	127/78	92	<=2 Secs	15	Alert			10	Sinus Rhythm			E1011219
10/06/2025 18:11	95	16	117/76	92	<=2 Secs	15	Alert				Sinus Rhythm			E1011219

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
10/06/2025 18:11:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
10/06/2025 18:11	Spontaneously	4	Orientated	5	Obeys Commands	6	15

AMPLE

Allergies:	None

Medication

Medication:	as per ecs

Heart Disease

Disorders:	Hypertension, Angina

Respiratory Disease

Type:	COPD

Diabetes

Type:	Type 2

Other

Other:	goutarthritisdiverticulitis

Last Eaten

Last Eaten:	2 Hours Ago

Events Prior

Events Prior:	gp referal for ? chest pain

SOCIAL HISTORY

General Appearance:	Normal

Occupation

Status:	Retired

Living Arrangement

Mobility	
Patient Mobility:	**Mobile With Assistance**

Communication	
Communication Requirements:	**No Help Required**

Clinical Risks	
Factors:	**None Identified**

Environmental Risks	
Factors:	**None Identified**

ACS

Acute Coronary Syndrome	
Symptoms	**Central Chest Pain, Upper Abdomen**

Associated Symptoms	
Associated Symptoms	**No Associated Symptoms**

MI/STEMI Checklist			
ECG Sent To CCU	**No**	**Discussed ECG With CCU**	**No**
Direct Triage To CCU	**No**	**Patient Thrombolysed**	**No**

CLOSE REPORT

Clinical Response Feedback	
On-Scene Clinical Findings	**Non Emergency**

CONVEYANCE

Transport To Hospital	**Normal Driving**	**Pre-Alert**	**No**

INCIDENT INFORMATION

Dispatch			
Dispatch Code	-	**Dispatch Description**	-

Incident Log

Status Time	Status	Callsign	Reason	Hospital

There are no recorded values.

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E1011219	Ambulance Paramedic (AP)
E9884860	Ambulance Technician (AT)

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1308636407	F
SINCLAIR	13/08/1953
Theresa	
90a Main Street	
Lennoxtown	
Glasgow	
G66 7DA	

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 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:	

Document all actions and interventions

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: .....

Glasgow Coma Scale

Date:
Time:

Eyes	Spontaneously	4
	To sound	3
	To pressure	2
	None	1
	Not testable	NT
Verbal	Orientated	5
	Confused	4
	Words	3
	Sounds	2
	None	1
	Not testable	NT
Motor	Obeys command	6
	Localising pain	5
	Normal flexion	4
	Abnormal flexion	3
	Extension	2
	None	1
	Not testable	NT
TOTAL	(15)	

Pupil reaction and size: s = sluggish, + = reaction, - = no reaction, c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Endotracheal tube or tracheostomy = NT

Always record the best response

Right size:
Right reaction:
Left size:
Left reaction:

Record right (R) and left (L) separately if there is a difference between the two sides

Record right (R) and left (L) separately if there is a difference between the two sides

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

NEWS 2 Key 1 2 3

| | | |

CHI: 1308636407

Glasgow Royal Infirmary

Total Att: 23
12 Mth Att: 0

Title: MS

SINCLAIR **Theresa**

DOB **13/08/1963** Age: **60y** Sex: **Female**

ECG ☒
Bloods ☑

90a Main Street
Lennoxtown
Glasgow
G66 7DA
07754676886

Next of kin: **JENKINS, Annmarie**
Relationship: **Daughter**
0745333109

GP: **RM Wilson**
01360 327300

Attendance Date: **11/04/2024** Arrival Time: **19:48**
Registration Time: **19:48** Date of Incident: **11/04/2024**
Major Incident Desc:

Reason for Attendance: ***SELF* PC- ? NEW FAST AF. HX- COPD, SMOKER.**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:
Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **11/04/2024 20:14** Nurse name: **Nurse Sharlene Smith**

Temp	**35.9**	C
HR	**98**	bpm
BP	**136/85**	mmHg
MAP	**102.00**	mmHg
RR	**16**	bpm
SpO2	**96**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/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: **"PC: Sob , pain in back, ?NEW AF. " "BG: copd + smoker, arthritis, angina , high blood pressure and cholesterol. "**

Patient ID label

1308636407
SINCLAIR
Theresa
F
13/08/1963

SATA/AAU MEDICATION DOCUMENTATION

NHS
Greater Glasgow and Clyde

Once Only Prescriptions

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given
12/4/25	Paracetamol	1g	PO	1255			1255

Discharge Medications

Date	Drug	Dose	Route	Time	Prescriber (Print & Sign)	Given By	Time Given
12/4/25	Amoxicilin	500mg one		TDS	5 days		

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time 12/4/24 Consultant Ward AAU

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

60 O + admitted with symptomatic AF?

2 months Hx of breathlessness, worsened recently with exertion

Green sputum. Sweaty. Feverish.

GP - irregular rhythm - normal rate

Back pain (not mentioned by GP)

SOB = long-term when active/walking.

Today pain/pressure, ? pain ⇒ her ICD has fired + given her 1 shock.

No chest pain. No palpitations. Cough - green. Long-term. Smokes 5mm/sometimes green. Felt feverish last few days. Last few years.

Pain was well to approx. No blood in urine. Pain: stool well. No diarrhoea.

No abdominal pain. →

BG: COPD
angina, arthritis, pain + gout (L), adh. capsulitis of shoulder
drug overdose
depression
alcohol dependence

FH: <60 MI (father, sister), [illegible]
SH: lives alone
Smokes 20/day
Alcohol free - last 7 years.
Allergies - NKDA.

Chest x-ray: pneumonic ? R sided consolidation

ECG: normal sinus rhythm
HR 84

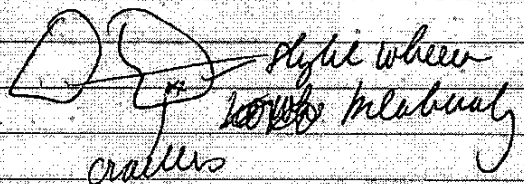
Bloods: CRP 23 ↑ (1)
WCC 14.9 ↑ N/C (2)
Neut 7.9 ↑ clotty screen (3)

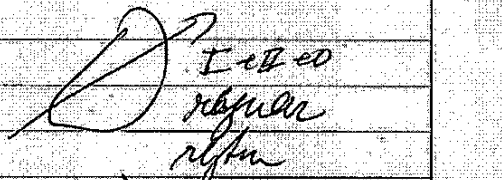
Echo May 2019 - moderate COPD
LFTs Nov 2023 - normal.

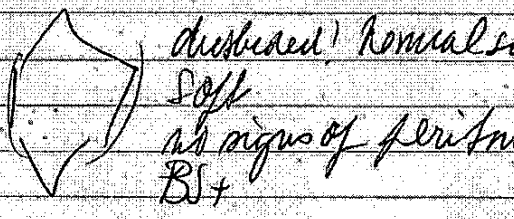
NEWS = 0
Alert, appreciral.

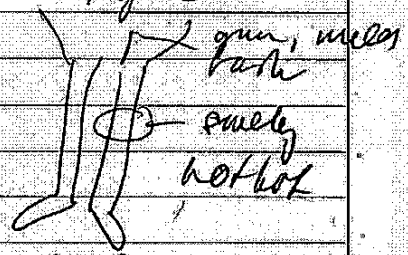
Ward Review

Creamy leg - lower back pain.
Gave pain past hx + swollen knee - just yesterday









Able to elevate both legs 75° C.
Abduction, adduction (2)
ROM & grip strength improved after paracetamol / hot drink + crochet
Mother.

low back pain
→ crossed middle
lower back pain
L4-S1
normal reflexes and sensation

I: antibiotics / pain improved with fluid + rehydration + CRT

P
- urine sample + MSSU (multisystem)
- analgesia
- abx & any meds including patches
- TFTs (mania)
- OP Zoom tape ? D/W as need if agreeable, will write to GP about investigations done.

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients

Non-operative patients

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

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Complete Risk Assessment Result Box.**

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery , spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- **Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES
Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

RAT Medicine & Surgery – TEST OF CHANGE 09

mi • 250744 Version 9_0 • GGC0015

Medicine Reconciliation Form

Source of information: ECS ☑

Patient ☒ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration
✓ Amoxo Clavulin	375mg + 125mg	1	OD	oral				
✓ Peppermint oil		1 cap	TDS (before food)					
✓ Salbutamol cfc	100µg/dose	2 puffs	PRN	inh				
✓ Fluoxetine	20mg	2 T	OD	oral				
✓ Omeprazole	20mg	1 T	OD	oral				
✓ Bisoprolol	1.25mg	1 T	OD	oral				
✓ Isosorbide dinitrate MR	25mg	1 T	OD	oral				
✓ Thiamine	50mg	1 T	QDS	oral				
✓ Glyceryl Trinitrate	400µg	1-2D	when required					
✓ Aspirin	75mg	1 T	OD	oral				
✓ Simvastatin	40mg	1 T	OD	oral				
✓ Ranipril	2.5mg	1 T	OD	oral				
Diazepam	2mg	1 T	BD					
Allergies/adverse events: NKDA								

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review

Check List

VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME

Clinical Notes:

Clinical Notes

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

1308636407
SINCLAIR
Theresa F
90a Main Street 13/08/1963
Lennoxtown
Glasgow
G66 7DA

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital QEU

Patient Preferred Name:

Date: 12/4/24 Time:

Triage Nurse SHARLENE

Transport SAS/Self:

2. Presenting Complaint

SOB
Pain in back

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☑

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
16	96	35·9	98	136 / 85
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15	1			/10

4. Communication

I.D. band on?	Y / N
Relatives present?	Y / N
Relatives / NOK informed?	Y / N
Interpreter required?	Y / N

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 1308636407 SINCLAIR Theresa F
Address: 90a Main Street Lennoxtown Glasgow G66 7DA
DOB: 13/08/1963
CHI Num:

Named Nurse/Team Leader:

Assessment Completed by: Name (PLEASE PRINT) Kirsty

6. Patient Preparation

Prepare patient for examination	☐	IV Cannula (if required)	Y/N
Clothing bag labelled and stored	☐	Blood samples taken	Y/N
GGC RED BAG - with patient	☐	If Yes, list requests	
12 Lead ECG	☑	Cardiac Monitoring	Y/N
X rays performed	☐	Height: Weight:	

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☐	Strip Lot no:

7. Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:
- ☐ IV Fluids
- ☐ IV Drugs
- ☐ Suspected haemorrhage
- ☐ Diagnostic tests

Insertion Date: __/__/__
Insertion Time: ____

Hand hygiene performed immediately before PVC insertion.	☐
Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi permeable dressing used to cover catheter site.	☐
Size/Colour: ____ Insertion site: ____	
Signature: ____	☐

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion:

Insertion Date: __/__/__
Insertion Time: ____

Signature: ____

Hand hygiene performed immediately before insertion.	☐
Aseptic technique maintained throughout insertion procedure and connection to closed drainage.	☐
Urethral meatus cleansed with saline and lubricant used.	☐
Guage: ____ ____ mls in balloon	
N/A @ present	

9. General Safety Precautions to be Undertaken by All Patients

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition

Date: 18/04/20
Time: 03:20

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	NAD
2. Check walking aid (if required) is in reach and in use.	
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	
5. If glasses are worn, check they are available and in use	
6. If hearing aid/s are worn, check they are working and in use.	✓

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Nan
Add 1308636407
SINCLAIR F
Theresa 13/08/1963
DOI 90a Main Street
Lennoxtown
CHI Glasgow
G66 7DA

10. Risk Assessment

If Yes to any of the 5 questions below complete the falls interventional plan. Whether Yes or No, update this assessment in acute wards, or, at the time of a fall or, upon a change in patient's clinical condition.

	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				

11. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / NA	Learning Disabilities	Y / N / NA
Adult Support and Protection	Y / N / NA	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / NA
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / NA	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / NA
Mental Health Triage	Y / N / NA	Infection Risk Roche +/-	Y / N / NA
Has swallow test been carried out?	Y / N / NA	STOPPS completed? Y / N / NA Date_____ Time_____ Sign_____	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / NA	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / NA
FRAILTY SCREENING Completed on Trakcare	Y / N / NA	SUBSTANCE MISUSE FAST SCORE / GMAWS	Y / N / NA

12. Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).	Yes / No

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?	Yes / No
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / No
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / No
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / No
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / No

13. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
12/12/24		EL												

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

1308636407
SINCLAIR F
Theresa 13/08/1963

12/04/24 Patient admitted to M bay 4.
0320 Pt independent mobil.
Bloods, ECG completed on triage.
Obs neurs stable
Pt accepted tea and biscuits.
Had chat.
Aware now for medical review and further plan of care.

12/4/24 Patient reviewed by medic.
0538 Medically fit for D/C.
Plan with GP Mon.
Discussed with patient

EM MAY (GCH)
CC
JW

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Communication with Relatives	Signatures	Time
Next of Kin: Tel:		

Nursing Notes		
Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:_____

Address:_____

DOB:_____

CHI Number:_____

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7	☐	Always	
Snr Dr.:_____ Page no.:_____				
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes; GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC 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	☐	☐	

Document Owner: Pamela Cheung, AAU Team, GRI

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1308636407 F
SINCLAIR - 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7DA

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	**Sp02 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:	

Document all actions and interventions

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 Think Sepsis if Suspicion of Infection	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

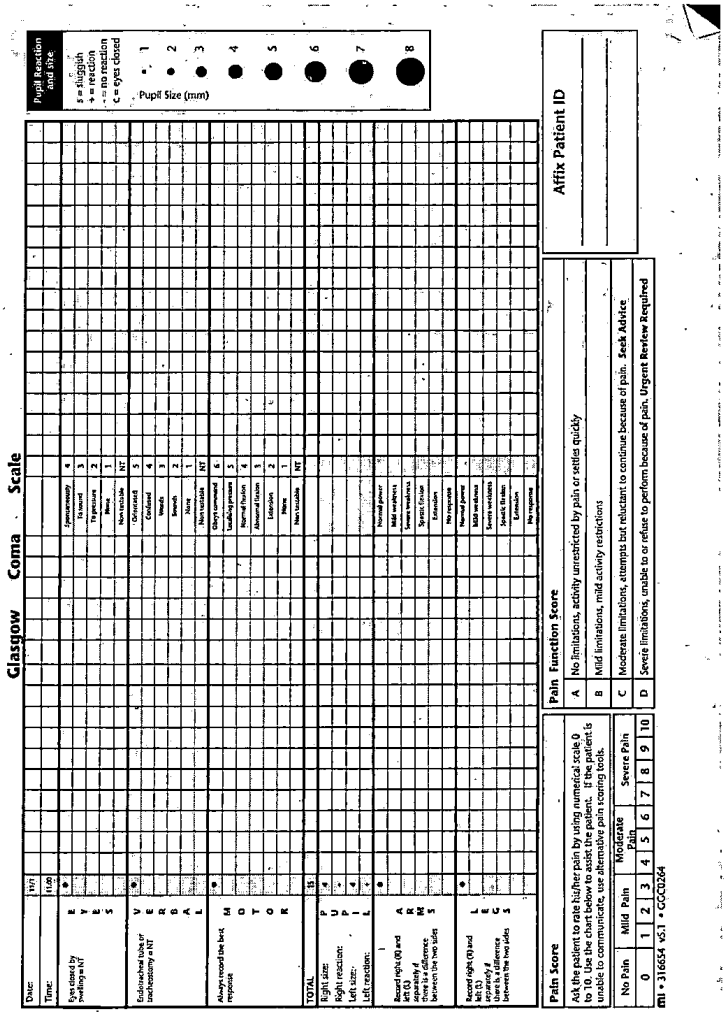
Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....



NEWS 2 Key | 1 | 2 | 3

| | | |

Glasgow Royal Infirmary

CHI: 1308636407

Total Att: 22

12 Mth Att: 0

Title: MS

SINCLAIR

Theresa

DOB 13/08/1963 Age: 59y Sex: Female

90a Main Street
Lennoxtown
Glasgow
G66 7DA
07754676886

Next of kin: JENKINS, TERESA
Relationship: Daughter
078876623809

GP: O Amin
01360 327300

Attendance Date: 22/11/2022 Arrival Time: 18:26

Registration Time: 18:26 Date of Incident: 22/11/2022

Major Incident Desc:

Reason for Attendance: **self- low risk covid/flu Increased episodes of anginal pains, unrelieved with GTN. Feeling breathless and sweaty at time of onset.**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: 03

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **22/11/2022 19:16** Nurse name: **Nurse Aimee Duffy**

Temp	37.2	C
HR	90	bpm
BP	140/80	mmHg
MAP	100.00	mmHg
RR	17	bpm
SpO2	92	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/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: **NEWS 2, COVID POSITIVE 3/52, ? ACS, X2 episodes of central chest pain, used GTN, chest heaviness after GTN, SOB, Sweaty, non radiating , leg pain, Chest discomfort at triage**

1308636407 13/08/1963 SINCLAIR Theresa

1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa

Glasgow Royal Infirmary
Acute Medicine Unit
(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time 23/11/22 0600 Consultant Ward SAFA

Ward Review (Should be completed within 2hrs of transfer from ED) Gillespie IMT2

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
Patient on Bleeders list	☐

sayo
- COPD
- IHD (angina)
- Previous DSH
- Anxiety
- Hypertension

PC Chest pain episodes x 2

HoPC - Episode of chest pain y'day ~ 1200 whilst walking along street - sharp central chest pain then more dull - relieved by GTN ? around 10 mins in total
- 2nd episode ~ 2000 whilst chasing after grandkids - dulled by GTN but persisted (~ 2 hours in total).
- No ↑ SOB from baseline. No pre-syncope / LOC
- No ↑ sputum purulence
- No weight loss, no haemoptysis

Lives alone. Heavy smoker.
Tee total for 5 years.
SOBOE at baseline 2° to COPD

Ix/ U+Es (N) eGFR >90 Trop <4 at 4 hours. Gluc 5.7
LFTs (N) Alb 39 Chol 3.1 Tri 1.2
Hb 121 WCC 17.4 Neut 9.5 Lymph 6.2.

ECG → NSR

cont

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients

Non-operative patients

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

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- **Complete Risk Assessment Result Box.**

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10^9/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery , spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- **Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐*
*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐
Prescribe Enoxaparin at 6pm
[on day of surgery, at the later of either 4h post-op or 6pm]
Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐
If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).
Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

RAT Medicine & Surgery – TEST OF CHANGE 09

mi • 250744 Version 9_0 • GGC0015

Medicine Reconciliation Form

Source of information: ECS ☐

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withold	Stop	continue	Reason for alteration
Allergies/adverse events								

List obtained by _____ Designation _____

Recently altered/discontinued medicines prior to admission and reasons why _____

_____

Compliance aid? Y☐ N☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time _____

Comments

Consultant Review Loo STb AAU

(54) COPD - still smokes
Angina
Prev. OD.
Prev. alcohol excess - states abstinent 5 years.

Recent Covid-19 infection 3 weeks ago.
Yesterday while walking along street: central chest pain relieved by GTN ~ 10 mins. CXR: clear
2nd episode in evening while moving after gardening ⇒ dulled by GTN but lasted ~ 2 hours. Sputum 28/10/22: H. influenzae (S) Amox / Doxy

Bloods: ↓Hb 121
WCC 17.4 CRP 9
U+Es (N) LFTs (N)
Trop c4 Glc 5.7

Pain free since.
States not ~~worsening~~ been bothered by chest pain since Rapid Access Chest pain clinic review in 2015 but then says does get pains sometimes but not severe.

ECG SR 81bpm

O/E: Well, pain free. NEWS 0.
Wheeze throughout.
Calves SNT.

Impression: Anginal episode yesterday but no recent hx of angina
Recent covid-19 infection / LRTI with Rx from GP.

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

Plan:
- D/C home with Anoro Ellipta per Resp CNS.
- Smoking cessation advised - states she has nicotine patches now.
- NO changes to meds at present but suggest to GP for Ktcl re-referral if recurrent angina.

PRINT NAME Loo	STb DESIGNATION
SIGNATURE Loo	23/11/22 11:00 DATE & TIME

Clinical Notes

23/11/22 Respiratory CNS
0835 59 yr old smoker
Spiro Feb 19; Moderate AFO FEV1 68%. FEV1/FVC 64%.
No reversibility.
CXR lungs clear.
Sputum - NAD
Nil eosinophils.
CRP 9
Inhaled therapy: Increase Ellipta OD + SABA PRN
Plan; Would suggest stepping up inhaled therapy to Anoro Ellipta OD (LABA/LAMA)
No other obvious changes to make
Nct ESD.
Advice smoking cessation. C. CARSWELL RCNO 65456

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 1308636407 SINCLAIR Theresa F 13/08/1963
Address: 90a Main Street Lennoxtown Glasgow G66 7DA
DOB:
CHI Nu

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital	Patient Preferred Name:
Date: / Time:	
Triage Nurse	Transport SAS/Self:

2. Presenting Complaint

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☐

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15				/10

4. Communication

I.D. band on?	Y / N
Relatives present?	Y / N
Relatives / NOK informed?	Y / N
Interpreter required?	Y / N

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Nai
Adc 1308636407
SINCLAIR
Theresa
DOI 90a Main Street
Lennoxtown
CHI Glasgow G66 7DA
F
13/08/1963

Named Nurse/Team Leader: _____

Assessment Completed by: Name (PLEASE PRINT) _____

6. Patient Preparation

Prepare patient for examination	☐	IV Cannula (if required)	Y/N
Clothing bag labelled and stored	☐	Blood samples taken	Y/N
GGC RED BAG - with patient	☐	If Yes, list requests	
12 Lead ECG	☐	Cardiac Monitoring	Y/N
X-rays performed	☐	Height: / Weight:	

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☐	Strip Lot no:

7. Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:

☐ IV Fluids

☐ IV Drugs

☐ Suspected haemorrhage

☐ Diagnostic tests

Insertion Date: ___/___/___

Insertion Time: ___:___

Hand hygiene performed immediately before PVC insertion.	☐
Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi permeable dressing used to cover catheter site.	☐
Size/Colour:_____ Insertion site:_____	
Signature:_____	☐

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion:

Insertion Date: ___/___/___

Insertion Time: ___:___

Signature: _____

Hand hygiene performed immediately before insertion.	☐
Aseptic technique maintained throughout insertion procedure and connection to closed drainage.	☐
Urethral meatus cleansed with saline and lubricant used.	
Guage: _____ _____ mls in balloon	☐

9. General Safety Precautions to be Undertaken by All Patients

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition

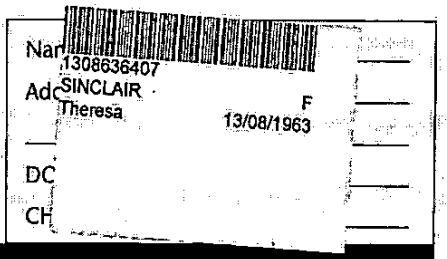
Date: Time:

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	
2. Check walking aid (if required) is in reach and in use.	
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	
5. If glasses are worn, check they are available and in use	
6. If hearing aid/s are worn, check they are working and in use.	

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde



10. Risk Assessment

If Yes to any of the 5 questions below complete the falls interventional plan. Whether Yes or No, update this assessment in acute wards, or, at the time of a fall or, upon a change in patient's clinical condition.

	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				

11. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / NA	Learning Disabilities	Y / N / NA
Adult Support and Protection	Y / N / NA	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / NA
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / NA	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / NA
Mental Health Triage	Y / N / NA	Infection Risk	Y / N / NA
Has swallow test been carried out?	Y / N / NA	STOPPS completed? Y / N / NA Date_____ Time_____ Sign_____	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / NA	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / NA
FRAILTY SCREENING Completed on Trakcare	Y / N / NA	SUBSTANCE MISUSE FAST SCORE / GMAWS	Y / N / NA

12. Pressure Area Assessment

1 Pressure Damage — Does the person have redness and/or existing damage? Yes / No

If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

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

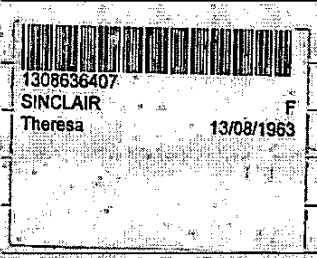
2 Mobility	Does the person require assistance to mobilise?	Yes / No
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / No
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / No
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / No
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / No

13. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.



Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: SINCLAIR Theresa F
Address: 90a Main Street, Lennoxtown, Glasgow, G66 7DA
DOB: 13/08/1963
CHI No: 1308636407

Communication with Relatives		Signatures	
Next of Kin:	Tel:		

Nursing Notes

Date and Time		Print Name and Signature
23/11/22	Patient brought to bay ECG +	
0055	blood? obtained. Returned to waiting area to await Medical review -	NRA BERTON CHARGE NURSE
23/11/22.	transfered to cubicle 17	
0417	NEWS = 1. Noted not rpt since 19:16. (22/11). All inital ix & awaiting ax.	
	Accepted tea/ biscuits and sandwich.	RGSN
0900	Accepted cleansing wipes for a wash. Mobilising to toilet and commode. Accepted a cup of tea. Settled in bed.	
0910	Meds as per kempa. awaits med RV / resp nurse RV otherwise well	
1000	News stable + well	
1125	For home Inhaler Give. No Ax daughter will collect.	

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: _____

Address: _____

_____

DOB: _____

CHI Number: _____

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: _____

Address: _____

_____

DOB: _____

CHI Number: _____

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:_____

Address:_____

_____

DOB:_____

CHI Number:_____

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7	☐	Always	
Snr Dr.:_____ Page no.:_____				
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes; GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC 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	☐	☐	

Document Owner: Pamela Cheung, AAU Team, GRI

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1308536407
SINCLAIR
Af Theresa
F
13/08/1963

	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:	

Document all actions and interventions

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:.....

Glasgow Coma Scale

	Init	Init
Date:		
Time:		
E Eyes closed by swelling = NT	4 Spontaneously 3 To sound 2 To pressure 1 None NT Not testable	
V Endotracheal tube or tracheostomy = NT	5 Orientated 4 Confused 3 Words 2 Sounds 1 None NT Not testable	
M Always record the best response	6 Obey commands 5 Localising pressure 4 Normal flexion 3 Abnormal flexion 2 Extension 1 None NT Not testable	
TOTAL	15	
Right size: Right reaction: Left size: Left reaction:	P Pupil Reaction and Size U s = sluggish P + = responsive I - = non reaction L c = eyes closed	
Record right (R) and left (L) separately if there is a difference between the two sides	A 0 Normal power M 1 Mild weakness B 2 Severe weakness S 3 Spastic flexion 4 Extension 5 No response	
Record right (R) and left (L) separately if there is a difference between the two sides	L 0 Normal power E 1 Mild weakness G 2 Severe weakness S 3 Spastic flexion 4 Extension 5 No response	

Pupil Reaction and Size: s = sluggish; + = responsive; - = non reaction; c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

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

NH • 316654 v5.1 • GCC0264

NEWS 2 Key | 1 | 2 | 3

| | | |

CHI: 1308636407

Glasgow Royal Infirmary

13

Total Att: **21**

12 Mth Att: **0**

Title: **MS**

SINCLAIR **Theresa**

DOB: **13/08/1963** Age: **53y** Sex: **Female**

90a Main Street
Lennoxtown
Glasgow
G66 7DA

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 327300

Attendance Date: **02/04/2017** Arrival Time: **01:24**

Registration Time: **01:24** Date of Incident: **02/04/2017**

Major Incident Desc:

Reason for Attendance: **fall**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **2** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **02/04/2017 01:44** Nurse name: **Nurse Jennifer Little**

Temp		C
HR	**78**	bpm
BP	**123/86**	mmHg
MAP	**98.33**	mmHg
RR	**18**	bpm
SpO2	**98**	%
Oxygen		%

BM	**6.1**	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	
Left	
Right	
Corrected?	

GCS	
Eyes	**4**
Motor	**6**
Verbal	**4**
Total	**14**

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

Nursing Notes: **pt fell 5ft from step ladder, collared & immobilised. On Scoop. Intoxicated, daughter present. C/o back pain. Unco-operative in triage**

1308636407 13/08/1963 SINCLAIR Theresa

1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa

To be Completed by Clinician		
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

Date	**Clinical Notes**		
	Seen By	Time Seen	

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	1308636407 SINCLAIR F
Address	3 Theresa 13/08/1963 90a Main Street Lennoxtown Glasgow
CHI No.	G66 7DA
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

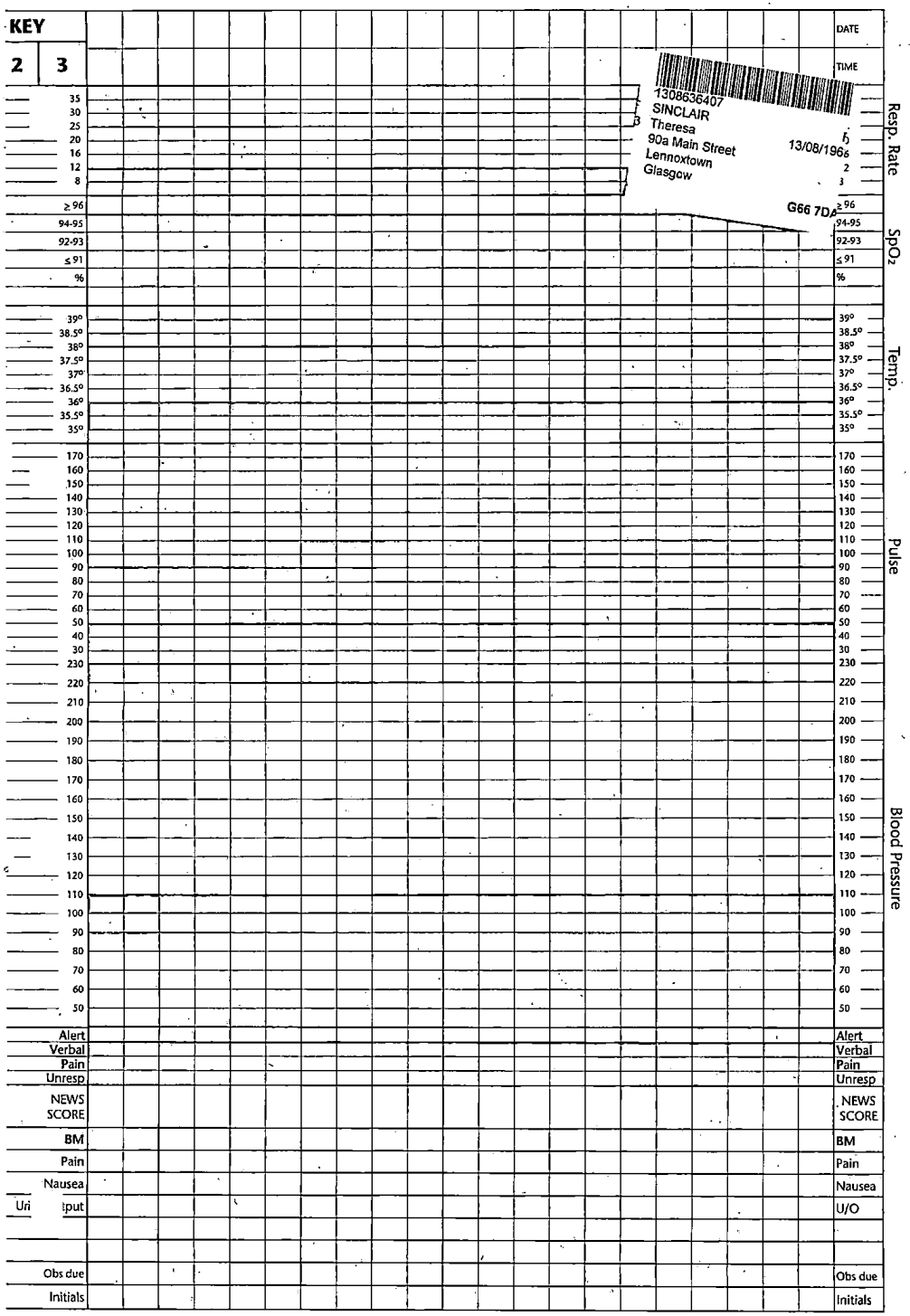
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

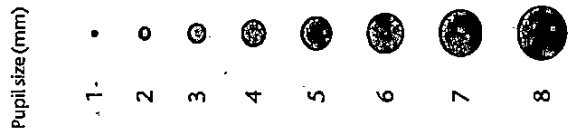
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need 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.

(13) Theresa Sinclair

| | | |


KEY
2
3
DATE
TIME
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
13/08/1986
G66 7DA
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
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

Glasgow Coma Scale



Neurological Observations

Date:				2/4/18																						
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 = T
		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			14																						
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																								
		No response																								
	LEGS	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 (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Emergency Department Nursing Documentation

Presenting Complaint: Fall

Date and Time: 0220, 2/4/17

NHS Greater Glasgow and Clyde

1308636407
SINCLAIR F
3 Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

bel

Named Nurse(s):

Patient preparation (Please tick when completed)	Initials: NB	Communication (Please tick when completed)	Initials: NP
Prepare patient for examination and provide blankets if required	☐	Communication Aids (spectacles / hearing aid)	☒
		Relatives present, who? Daughter	☑
Clothing bagged, labelled and stored under trolley	☒	Relatives / NOK informed	☒
Name-band (if required)	☑	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 *Results:*	☐
Cardiac Monitoring	☐		
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		
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Has Swallow test been carried out?	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	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	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

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

Date and Time		Print Name and Signature
0225, 2/4/17	Made comfortable on trolley, collar and blocks in place, obs recorded NEWS 1, awaiting medical r/v	
0300	patient not tolerating immobilisation keeps trying to get up daughter present who is trying to deescalate situation. Collar still instiv	RBarel SIN
0510	Obs recorded. NEWS 1, collar and blocks removed by doctor, now attending CT scan.	

P Patient Label
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/196:

Nursing Notes and Care Plan

Date and Time		Print Name and Signature

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 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

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							

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
Continence		Clammy /pyrexia	1	65-74	3	Anaemia = Hb < 8	2
Complete/Catheterised	0	Discoloured (brusing/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			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			**Special Risks - Medication**	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart.

cm Scale 0 2 4 6 8 10

ADULT HEAD INJURY ASSESSMENT FORM - GLASGOW ROYAL INFIRMARY

Patient Detail

Name: 1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

DOB:

Doctor: LOWRY
Grade: ST4
Date: 2 / 4 / 17
Time seen: 05 : 30

HISTORY / MECHANISM OF INJURY *SOURCE:* (Patient) (Witnesses) Ambulance / Police

- INTOXICATED
- CLIMBED UP 5 STEPS + FELL DOWN.
- LOC
  VOMITED
  / CONFUSED.
- HAND NOT HELD DOWN

LOC	No	(Yes)	Duration:	
Amnesia: PT	No	<5m	(5-60)	Hrs:
Amnesia: RG	(No)	Duration:		
Headache	(No)	Yes:		
Vomiting	No	freq 2	time	
Alcohol	No	AMOUNT 25 units		
Drugs	(No)	DESCRIBE		
Seizure	(No)	Yes: TIME		

PMH

ALCOHOL XS
DEPRESSION

DH (Aspirin) Clopidogrel NOAC Warfarin: INR=

THIAMINE - OMEPRAZOLE - CODYDRAMOL / LORMIN
- FLUOXETINE - METFORMIN - OLMESARTAN / SIMVASTATIN

TETANUS
Complete
Booster
Uncertain

EXAMINATION

HR	78	BP	123/86	RR	18	BM	6.1	Temp		SaO_2	93	air/O_2

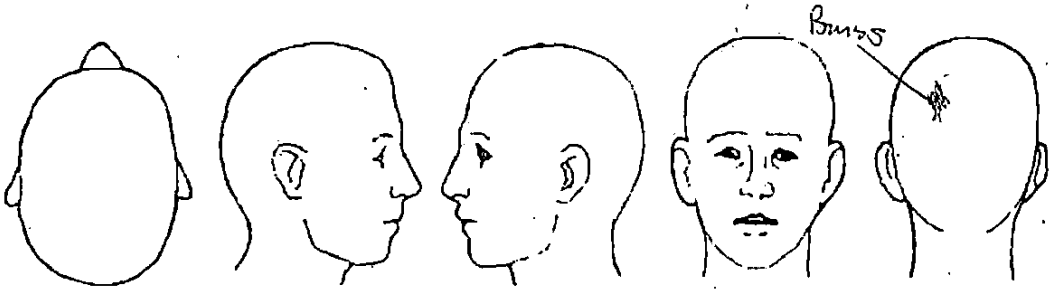
GCS	Description	Score
E	4	/4
M	6	/6
V	4	/5
Total	14	/15

CN I-XII	Normal	Abnormal
	COMMENTS	

	LEFT				RIGHT			
EYES								
	REACTS: Y/N	RO(N)	VA		REACTS: Y/N	RO(N)	VA	
EARS	(Clear)	Wax	Abnormal		(Clear)	Wax	Abnormal	
Limbs upper	(Normal)	Weakness			(Normal)	Weakness		
Limbs lower	(Normal)	Weakness			(Normal)	Weakness		

Speech: (Normal) Abnormal **Balance/Gait:** (OK) unsteady

Face Movement/Sens: (Normal) Abnormal - DESCRIBE



Wound Closure	NONE	GLUE SUTURES [No:] STAPLES [No:]
Skull #	NO	COMMENT
Base of Skull #	NO	COMMENT
Neck Injury	NO	COMMENT

OTHER INJURIES / PROBLEMS	NONE	LISTED ON ED CARD

IMAGING

Immediate CT		NO	YES	Nil Acute COMMENT
CT within 8hrs		NO	YES	
C-Spine	CT	NO		RESULT
	X-ray	NO		RESULT
Other		NO		RESULT,

IMPRESSION

Scalp haematoma

Minor head injury.

TREATMENT

IV Access	NO	YES		REFUSED
Bloods	NO	YES Document on card + significant results here		
Pabrinex	NO	I+II TDS		2x (I+II) TDS
GMAWS	NO	Symptom triggered		Fixed + symptom triggered
Analgesia	NO	Cocodamol	PRN	REGULAR
		Other		

OUTCOME

Home	YES	*NB*: ALCOHOL HIWC SUPERVISION - Wounds	
Admit	46 AAU	65 OTHER	
D/W Neurosurgery	NO	YES	COMMENTS
Specialty Involvement	NO	YES	

Signature

DNA @ 04:55

Glasgow Royal Infirmary

CHI: 1308636407

Total Att: 17

12 Mth Att: 4

Title: **MS**

SINCLAIR **Theresa**

DOB: **13/08/1963** Age: **50y** Sex: **Female**

90a Main Street
Lennoxtown
Glasgow
G66 7DA

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 310357

Attendance Date: **28/06/2014** Arrival Time: **02:52**

Registration Time: **02:52** Date of Incident: **28/06/2014**

Major Incident Desc:

Reason for Attendance: **right shoulder elbow injury**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **28/06/2014 03:05** Nurse name: **Nurse Emma Lindsay**

Temp	36	C
HR	74	bpm
BP	131/76	mmHg
MAP	94.33	mmHg
RR	14	bpm
SpO2	98	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm

Visual Acuity	C	P	F
Left			
Right			
Corrected?			

GCS	
Eyes	
Motor	
Verbal	
Total	

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

Nursing Notes: **pt fell over barrier outside pub tonight. has lac to R elbow, R side of forehead and is c/o shooting pain up R arm.**

1308636407 13/08/1963 SINCLAIR Theresa

1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa

[redacted]

To be Completed by Clinician		
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

Date	Clinical Notes
	Seen By [illegible] Time Seen 0515
28/6/14	50 - ® elbow injury / head injury HPC - Patient drinking heavily tonight. Fell over road barrier landing on ® side / elbow. No LOC, no headache, no vomit. Abrasions to ® elbow. RHD - PMH - Alcohol dependance. Depression SHx - lives c boyfriend (in waiting room) AE Patient smells of alcohol. Alert + orientated. No cspine tenderness or pain a neck movements. Small bruise at ® hairline. No swelling. PERLA. Cranial Nerves II - XII intact. ® ELBOW superficial abrasions to extensor surfaces. Mild swelling. Tender proximal humerus, olecranon. Able to fully flex, extend, supinate, pronate. No bony tenderness ® shoulder. ROM ® shoulder. Distal pulses, sensation normal. Xray: No acute bony injury ® elbow seen. Plan BAS - D/C home c HP advice.

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
CHI No. Glasgow G66 7DA
DoB

	Date	Ward
Admitted	28/06/14	GRI 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.

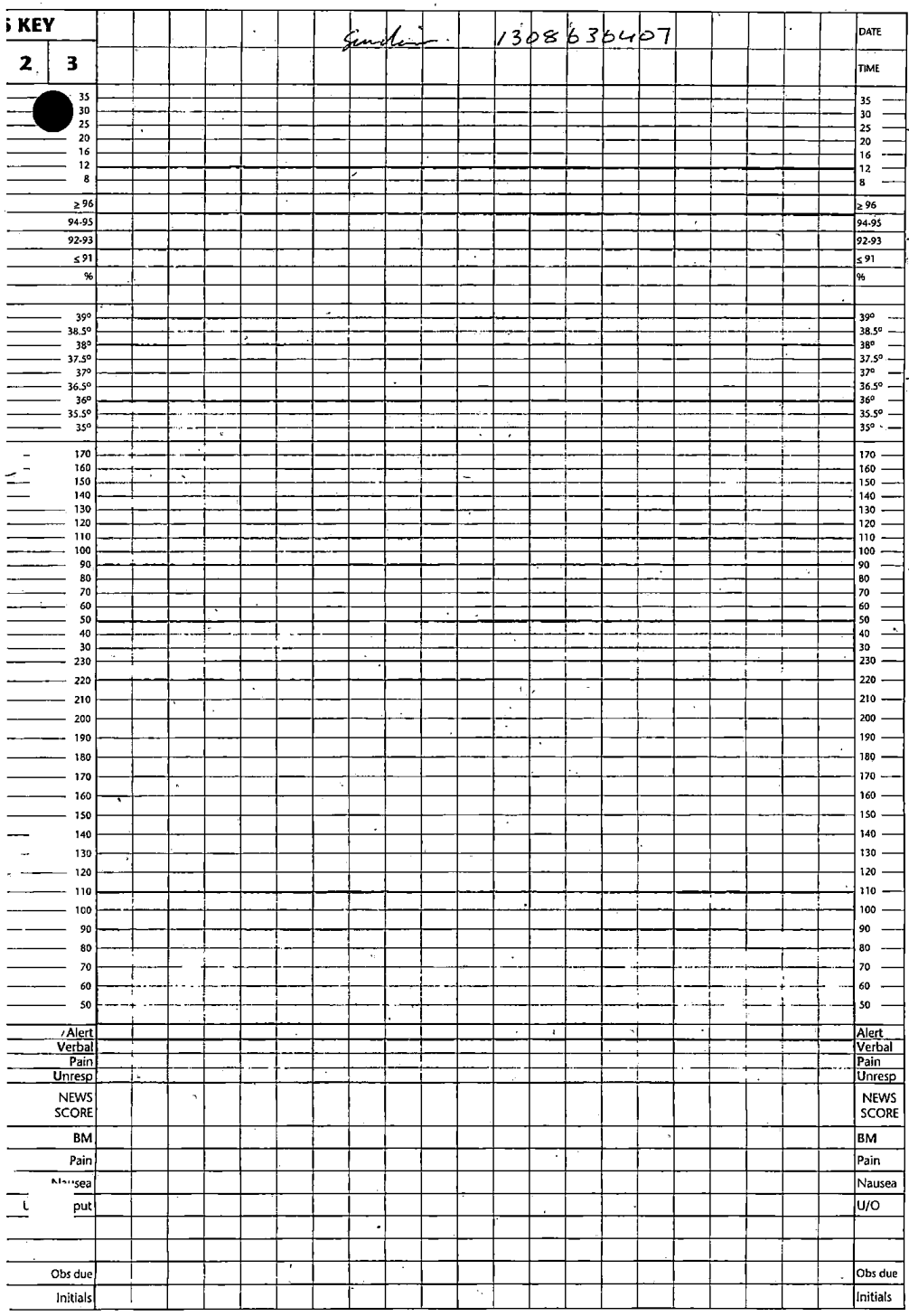
See NEWS Actions Reference Tool for local escalation policy

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.

(11)

Theresa Sinclair

| | | |


KEY
2
3
Smith
1308636407
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
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

Neurological Observations

Date:				20																										
Time:				05																										
COMA SCALE	E Eyes open	Spontaneously	4	4																										Eyes closed by dwelling = C
		To speech	3																											
		To pain	2																											
		None	1																											
	V Best Verbal response	Orientated	5	5																										Endotracheal tube or tracheostomy = T
		Confused	4																											
		Inappropriate words	3																											
		Incomprehensible sounds	2																											
		None	1																											
	M Best motor response	Obeys	6	6																										Usually record the best arm response
		Localises	5																											
		Flexion - withdrawal	4																											
		Flexion - abnormal	3																											
		Extension to pain	2																											
		None	1																											
TOTAL SCORE				15																										
PUPILS	R	Size		4																										+ reacts – no reaction c. eyes closed
		Reaction		+																										
	L	Size		3																										
		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																												
		No response																												
	LEGS	Normal power																												
		Mild weakness																												
		Severe weakness																												
		Spastic flexion																												
		Extension																												
		No response																												

Glasgow Coma Scale

Pupil size (mm)

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8

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 (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261

97339

CHI - 1308636407

E-Pacer PATIENT REPORT

Time 02:32 Date 28/06/2014

PATIENT AND INCIDENT DETAILS

Incident number	CR000408030.001
Name	TERESA SINCLAIR
Age	50 year(s)
Date of birth	13/08/1963
Gender	Female
Incident location	90A MAIN STREET LENNOXTOWN GLASGOW
Incident post code	G66 7DA
Incident type	EMG
Call received	28/06/2014, 01:43
Call passed	28/06/2014, 01:43
Crew mobile	28/06/2014, 01:48
Crew at scene	28/06/2014, 02:00
Crew left scene	28/06/2014, 02:14
Receiving hospital and department	GRIN Glasgow Royal Infirmary

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Slow
Respiratory rate	

CIRCULATION

Pulse rate	Normal
Most peripheral pulse found	Radial
Cap refill rate	

C-SPINE INJURY

Suspicion of CSI	No evidence of C-spine injury

PATIENT CONSENT

Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

AMPDS

Dispatch code	17B01	Fallen with Possibly Dangerous Area Injuries
Final code	17B01	Falls, Possibly Dangerous Area

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
02:00	86	Reg	20	185 / 110	<2 secs	-	6.3	4/10	36.4	96	15	0	7.6	NSR	0
02:15	90	Reg	20	184 / 111	-	-	6.3	4/10	36.4	95	15	1	7.6	NSR	0
	-	-	-	- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia	
Sepsis: UTI	
Sepsis: Other infection	
Sepsis: Abdo pain	
Sepsis: Diarrhoea	
Sepsis: Abdo distension	
Sepsis: Meningitis	
Sepsis: Cellulitis	
Sepsis: Septic arthritis	
Sepsis: Wound infection	
Sepsis: Infected indwelling device	

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	

AMPLE

Allergies	None
Other allergies	
Medication	DIAZAPAM, FLUOXETINE,CODYDRAMOL,MEBEVERINE
Past history	ALCOHOL ABUSE ,DEPRESSION,
Last eaten	>5 hrs
Events prior	FALL IN STREET

EMERGENCY SERVICES ON SCENE

Paramedic	Technician

FINAL OBSERVATION AND COMMENTS

50 YOF FALL IN STREET ,FELL OVER METAL BARRIER IN STREET RIGHT ELBOW / SOULDER PAIN 2/3 ABRASIONS ON ELBOW ALSO SMALL ABASION ON RIGHT SIDE OF HEAD UNSURE IF THIS OLD INJURY.PT BEEN DRINKING VERY INTOXICATED	
Report ID	4f4c746a-72ad-4d57-81ac-de45e02face8

Glasgow Royal Infirmary

7

CHI: 1308636407

Total Att: 15

12 Mth Att: 2

Title: **MS**

SINCLAIR **Teresa**

DOB: **13/08/1963** Age: **50y** Sex: **Female**

908 Main Street
LENNOXTOWN
Glasgow
Lanarkshire
G66 7DB

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 310357

Attendance Date: **16/11/2013** Arrival Time: **04:13**

Registration Time: **04:13** Date of Incident: **16/11/2013**

Major Incident Desc:

Reason for Attendance: **shoulder pain**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **4** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **16/11/2013 04:24** Nurse name: **Nurse Laura Ann Cunning**

Temp	**36**	C
HR	**96**	bpm
BP	**143/93**	mmHg
MAP	**109.67**	mmHg
RR	**17**	bpm
SpO2	**96**	%
Oxygen		%

BM	**5.2**	mmol/L
PF		l/min
Expected PF		l/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: **patient drinking alcohol tonight claims to have been assualted claims injured left shoulder and elbow noobvious inj/deformity**

1308636407 13/08/1963 SINCLAIR Teresa

1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa

To be Completed by Clinician		
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

Date	Clinical Notes		
16-11-13	Seen By M. Mahmood	5 years old	Time Seen 0630

was drinking alcohol with friends.
Had a fight Someone punched to Shoulder + left arm
no Hx loc or vomiting
C/o Pain left Shoulder + arm

Hx/o - Assault
- Alcohol Excess

Meds - Amoxicillin

O/E P. 96 B.P 143/93 Temp 36 RR 17
GCS 15/15
CVS Exam (N)
Resp Sys (N)
CVS (N)
PR
Chest clear
Good air entry

Left arm + Shoulder
- Good ROM
- no Bruise
- no neurovascular deficit
- Musculoskeletal pain
S.T.E.
(P) - Analgesia
DC Steyed with advice Tetanus

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

CHI - 1308636407

E-Pacer PATIENT REPORT

Time	03:52	Date	16/11/2013

PATIENT AND INCIDENT DETAILS

Incident number	PA004779651.001
Name	THERESA SINCLAIR
Age	50 year(s)
Date of birth	13/08/1963
Gender	Female
Incident location	90A MAIN STREET LENNOXTOWN LENNOXTOWN
Incident post code	G66 7DA
Incident type	EMG
Call received	16/11/2013, 01:34
Call passed	16/11/2013, 03:21
Crew mobile	16/11/2013, 03:21
Crew at scene	16/11/2013, 03:33
Crew left scene	16/11/2013, 03:44
Receiving hospital and department	GRIN Glasgow Royal Infirmary

PRIMARY SURVEY

RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	
CIRCULATION	
Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin texture	Dry

C-SPINE INJURY

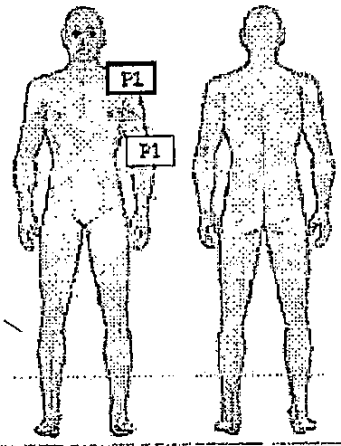
Suspicion of CSI	No evidence of C-spine injury

PATIENT CONSENT

Patient consent	Treatment benefits explained, Risks of condition explained, Risk of refusal explained, Capacity to understand risks and treatment

INJURIES

PAIN	P1. No pain relief provided P2. P3. P4.



AMPDS

Dispatch code	04A01A	Assault with Not Dangerous Proximal Injuries
Final code	30A01	Traumatic Injuries, Not dangerous proximal body area

GCS

Final GCS eye opening	Spontaneous
Final GCS verbal response	Orientated
Final GCS motor response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Pulse rhythm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Pain score	Temp °C	SpO2 %	GCS Total	NEWS	RTS	ECG	Sepsis
03:34	114	Reg	18	134 / 87	<2 secs	-	5.2	2/10	36.2	97	14	2	7.6	Sinus tachy	1
03:46	102	Reg	18	144 / 88	<2 secs	-	-	1/10	-	98	15	-	7.6	Sinus tachy	1
				- / -	-	-	-	-	-	-	-	-	-	-	0

SEPSIS

Sepsis: Pneumonia
Sepsis: UTI
Sepsis: Other infection
Sepsis: Abdo pain
Sepsis: Diarrhoea
Sepsis: Abdo distension
Sepsis: Meningitis
Sepsis: Cellulitis
Sepsis: Septic arthritis
Sepsis: Wound infection
Sepsis: Infected indwelling device

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Other allergies	
Medication	LIST WITH PT
Past history	DEPRESSION.
Last eaten	
Events prior	

EMERGENCY SERVICES ON SCENE

Paramedic	Technician
	Police

FINAL OBSERVATION AND COMMENTS

PC L SHOULDER PAIN HPC 50 Y/O F. PT BEEN DRINKING. C/O L SHOULDER PAIN ? ASSAULT. RELUCTANT TO GIVE FULL ACCOUNT. O/E LYING IN BED. VERBALLY ABUSIVE. ETOH ODOUR. WAVING L ARM C/O PAIN. CHEST: NAD. ABDO: NAD. L SHOULDER/ARM: NO OBVIOUS INJ/DEFORMITY. NO OTHER OBVIOUS INJ.

Report ID	3b92c2eb-28d8-409e-b461-c4dbda2f1895

CHI: 1308636407

Glasgow Royal Infirmary

18

Total Att: **13**

12 Mth Att: **0**

Title: **MS**

SINCLAIR **Teresa**

DOB: **13/08/1963** Age: **50y** Sex: **Female**

908 Main Street
LENNOXTOWN
Glasgow
Lanarkshire
G66 7DB

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 310357

Attendance Date: **24/08/2013** Arrival Time: **04:06**

Registration Time: **04:06** Date of Incident: **24/08/2013**

Major Incident Desc:

Reason for Attendance: **back problem**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **3** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **24/08/2013 04:35** Nurse name: **Nurse Jaime Moffat**

Temp	**36.5**	C
HR	**132**	bpm
BP	**111/82**	mmHg
MAP	**91.67**	mmHg
RR	**20**	bpm
SpO2	**96**	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/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 lower back pain for ages, has been drinking, states in a lot of pain but doesn't take analgesia as she doesn't want to get addicted. states sometimes has pain in lungs. pmh ibs.**

24/8/13 0800 PARK GPST2

50yo ♀ Back pain

Arrived intoxicated +++
Drinking bottle of wine in cubicle. Swearing initially. Not too compliant with examination or history

c/o back pain – several years history
no acute change
initially said that hadn't seen GP in past years for this but then changed story
sounds like has been referred for chronic problems with ?urinary/faecal incontinence
Nil new changes to bowel/bladder
(E) sciatica

Not taking analgesia as says doesn't want to get addicted
Ongoing abdo pain – says has been diagnosed with IBS.

O/E Sp02 96% T36 RR18 HR130 – 120 BP 147/93
Intoxicated ++ GCS 15/15
walking around + steady on feet
Abdo SNT
Generalised tenderness of lumbar spine + across lower back
Power 5/5 both lower legs
(N) sens + reflexes of legs Plantars ↓

Imp/ Chronic LBP

Plan/ D/C home – DNW Dr Balachandran
offered analgesia but pt not wanting
Advised to see GP on monday + consider physio

GPST2

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	1308636407
Address	SINCLAIR F Teresa 13/08/1963 908 Main Street LENNOXTOWN Glasgow, Lanarkshire
CHI No.	G66 7DB
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

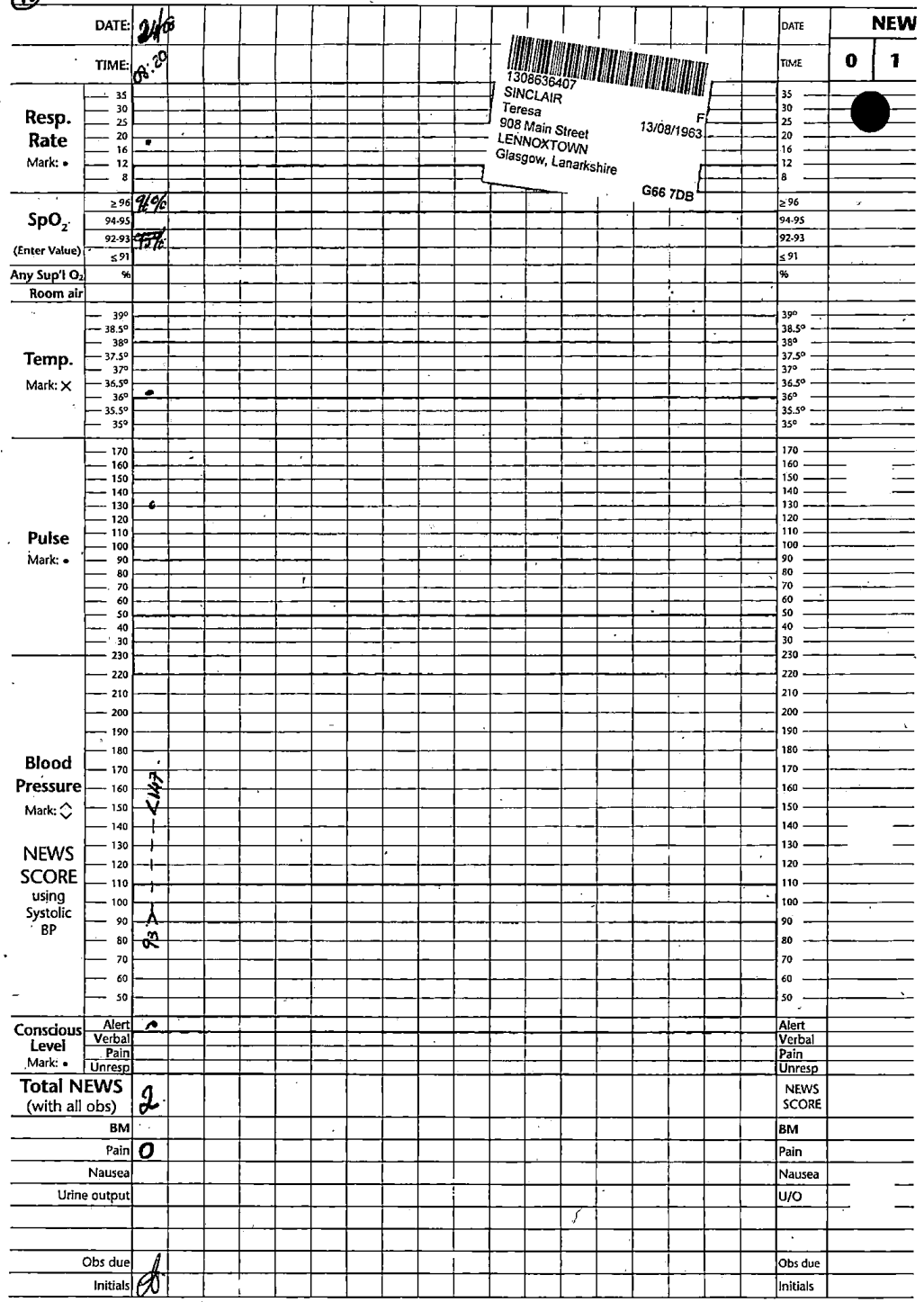
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

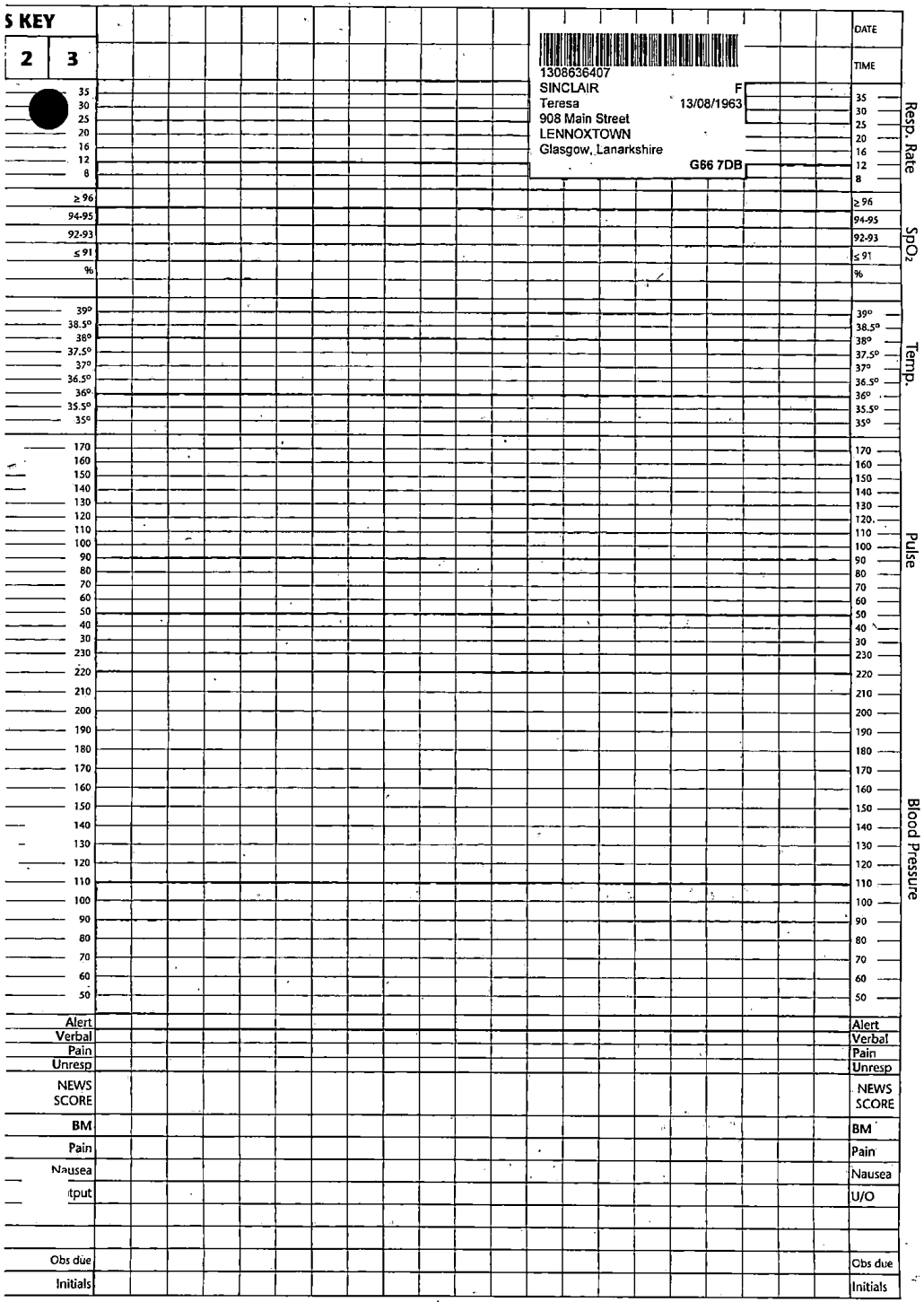
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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.

(18)


DATE: 24/6
TIME: 08:20
1308636407
SINCLAIR
Teresa
908 Main Street
LENNOXTOWN
Glasgow, Lanarkshire
G66 7DB
F
13/08/1963
NEW
0 1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
DATE
TIME
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials


S KEY
2
3
1308636407
SINCLAIR
Teresa
908 Main Street
LENNOXTOWN
Glasgow, Lanarkshire
F
13/08/1963
G66 7DB
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
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

Neurological Observations

| | | |

Accident and Emergency Department
Glasgow Royal Infirmary

.23004807E

A&E No. 12000002763

DNA 3.20 3.30 Removed Coats

3

Surname	SINCLAIR	**Forename**	TERESA	**Title:** MS
Address:	92 MAIN STREET LENNOXTOWN GLASGOW	**Postcode** **Telephone:**	G66 7DB 077866 01685	**CHI No:**1308636407
Date of Birth:	13.08.63	**Sex:**	F	**Age:** 48 yrs

CHI Number: 1308636407

GP Name:	HENDERSON JAMES		
Address:	LENNOXTOWN CLINIC 103 MAIN STREET LENNOXTOWN	**Postcode** **Telephone:**	G66 7DA 01360310357

Next of Kin	TERESA JENKINS		
Relationship:	DAUGHTER		
Address:	275 MAIN STREET LENNOXTOWN GLASGOW	**Postcode** **Telephone:**	G66 7DH 078876623809
Primary Carer:			

Date of Attendance: 13.01.12 02:13
Date of Incident:
Presenting Complaint: ASSAULTED

Triage	ADMITS ALCOHOL. C/O RIGHT HAND NUMBNESS. NO WEAKNESSES. ALSO C/O ABDO DISTENDED. STATES HAS STOPPED DRINKING FOR 6MONTHS AND HAS DRANK TONIGHT.	**Tetanus Cover:** **Allergies:**

P= 124 **BP=** 126/77 **RR=** 18 **Sat=** 96 **BM=**

PF= **GCS=E:** **M:** **V:** **Total:**

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

© iSOFT Group Limited

[redacted]

E-Pacer PATIENT REPORT

Time 02:03 Date 13/01/2012

PATIENT AND INCIDENT DETAILS

Incident number	PA004028/92 001
Name	SINCLAIR THERESA
Address	AS ABOVE
Age	0
Date of birth	13/03/1963
Gender	Female
Incident location	92 MAIN STREET LENNOXTOWN LENNOXTOWN
Incident post code	G66 7DA
Incident type	EMG
Call received	13/01/2012, 01:15
Call passed	13/01/2012, 01:17
Crew mobile	13/01/2012, 01:18
Crew at scene	13/01/2012, 01:26
Crew left scene	13/01/2012, 01:48
Receiving hospital and department	GRIN Glasgow Royal Infirmary

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

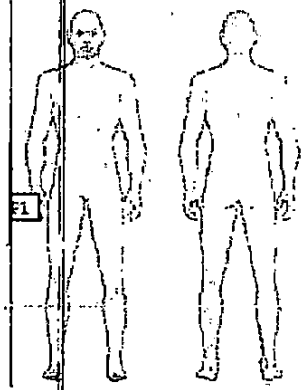
Breathing rate	Normal
Respiratory rate	20

CIRCULATION

Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	>2 secs
Skin colour	Normal

INJURIES

PAIN P1. No pain relief provided; P2.; P3.; P4.



AMPDS

Dispatch code	04B03A	Assaulted/Unknown Status/other codes N/A
Final code	04A01	Assault, No Dangerous Injuries

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	% Peak flow	Blood Sugar mmol/l	Temp °C	SpO2 %	GCS Total	RTS	SEWS	ECG	Pain score
:	-	20	- / -	>2 secs	-	-	-	-	:	-	-	-	-

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Dilated	Dilated
Pupil reaction	Normal	Normal

AMPLE

Allergies	Unknown
Other allergies	
Medication	UNKNOWN / 2mg DIAZEPAM
Past history	ALCOHOL PROBLEMS / DEPRESSION ?
Last eaten	
Events prior	PT SAYS SHE WAS ASSAULTED BY NEIGHBOUR AND IS COMPLAINING OF A PAINFUL R ARM THOUGH PT SEEMS TO BE ABLE TO MOVE IT FREELY AND NO OBV SIGN OF INJ PT COMP PINS N NEEDLES ON R HAND . PT IS INTOXICATED AND IS ALSO SAYING SHE HAS BEEN HAVING ABDO PAINS FOR WEEKS AND LOOKS SWOLLEN (POLICE CALL)
Report ID	284e2b92-2e58-40e4-9a17-7b0711a6740e

Review images at MDT

Performed	14-May-2026 09:34	Received	15-May-2026 10:30
Reported	15-May-2026 10:28	Order Number	G107H43535368
Status	Final	Source System	MiSys

Review images at MDT Final
Theresa Sinclair
Review images at Respiratory MDT on 15.05.26 : This is a radiology review report. This report contains information pertinent to the patient's current management and may not document all pathology or incidental non contributory minor abnormality.
It is strongly advised that this report is interpreted in conjunction with the original radiology report for this examination, which may have been performed at another hospital.
In constructing this report, additional clinical information may have been available to the review radiologist that was not available at the time of the original report.

Deferred as pathology is not fully ready.

Reported by: Dr Jennifer Curle and Dr Laura Thomson
Verified by: Dr Jennifer Curle

MRI Head with contrast

Performed	30-Apr-2026 14:00	Received	01-May-2026 15:12
Reported	01-May-2026 15:10	Order Number	G107H43465797
Status	Final	Source System	MiSys

MRI Head with contrast Final
Theresa Sinclair
Clinical History :
Stage 3 lung cancer, left side planned for radical treatment. For completion of staging

MRI Head with contrast :
Axial T2, T2-FLAIR, 3-D pre- and post-contrast T1 sequences.

No space-occupying lesion or abnormal enhancement. Some minor patchy high T2/FLAIR signal in the pons which is non-specific although most likely reflects minor small vessel disease. Otherwise unremarkable appearances of the brain parenchyma, CSF spaces, midline structures, and major intracranial vessel flow voids.

In conclusion, no evidence of intracranial malignancy.

Reported by: Dr Fraser Hendry
Verified by: Dr Fraser Hendry

NM Whole body PET FDG

Performed	23-Apr-2026 13:32	Received	28-Apr-2026 11:56
Reported	28-Apr-2026 11:54	Order Number	G504H43373715
Status	Final	Source System	MiSys

NM Whole body PET FDG Final
Theresa Sinclair
Clinical History :
Multifocal changes. Growing RUL nodule, and LUL nodule. For PET to further characterise.

FDG-PET CT
Technique: FDG-PET from skull base to mid femur with low dose unenhanced CT. Reference made to CT of 20/03/26 and 25/03/25.

Findings:
Intensely FDG avid 12 mm right apical nodule and 8mm left apical nodule highly suspicious of malignancy.
Faint FDG uptake in a GGO in the LLL and RUL - may represent lowgrade adenocarcinoma spectrum lesions.

Intensely FDG avid short axis 8 mm AP W node suspicious of nodal involvement.
Mild - moderately avid right hilar, subcarinal and right lower paratracheal nodes - nonspecific but may be benign.
No FDG avid supraclavicular lymphadenopathy.

FDG uptake of the liver, adrenals, pancreas and spleen is unremarkable.
No evidence of skeletal metastasis.

Conclusions:
Intensely FDG avid right apical nodule and left apical nodule highly suspicious of malignancy.
Suspicious intensely FDG avid APW node.
Right hilar, subcarinal right lower paratracheal node - nonspecific but may be benign.
No evidence of distant metastasis.
GGO in RUL and LLL may be lowgrade adenocarcinoma spectrum lesions - for follow-up CT.
Key images on PACS.

Reported by: Dr Sai Han
Verified by: Dr Sai Han

Review images at MDT

Performed	23-Apr-2026 10:21	Received	24-Apr-2026 09:49
Reported	24-Apr-2026 09:47	Order Number	G107H43459334
Status	Final	Source System	MiSys

Review images at MDT Final
Theresa Sinclair
Review images at Respiratory MDT 24.04.26 : This is a radiology review report. This report contains information pertinent to the patient's current management and may not document all pathology or incidental non contributory minor abnormality.
It is strongly advised that this report is interpreted in conjunction with the original radiology report for this examination, which may have been performed at another hospital.
In constructing this report, additional clinical information may have been available to the review radiologist that was not available at the time of the original report.

Increase in size of 12mm RUL apical nodule, concerning for malignancy. T1bN0M0
New 8mm nodular soft tissue lesion at the left upper lobe apex anteriorly - this is FDG with avid N2 node - T1aN2M0
Staging EBUS and CT brain
Discuss with patient - surgery to left with adjuvant treatment and radiotherapy to the right

Reported by: Dr Ross MacDuff and Dr Colin Noble
Verified by: Dr Ross MacDuff

CT Thorax

Performed	20-Mar-2026 09:06	Received	25-Mar-2026 12:53
Reported	25-Mar-2026 12:51	Order Number	G107H42163260
Status	Final	Source System	MiSys

CT Thorax Final
Theresa Sinclair
Clinical History :

Multiple lung nodules under review - for interval CT scan March 2026 please (1 year)

CT Thorax :
Comparison made with the previous CT dated 25/03/25.

Increase in size and spiculation of the solid right upper lobe apical nodule, now measuring 12mm in maximal diameter compared to 9mm previously. PACS based volume analysis suggests doubling time of 235 days (vol currently 1053mm3 compared with 366mm3 on CT of 25/03/25).
New 8mm nodular soft tissue lesion at the left upper lobe apex anteriorly.
Multiple foci of ground-glass change within both lungs are unchanged, the largest 12mm at the apical left lower lobe. Stable multiloculated right perihilar cyst.
Mild bibasal reticular change.
No pleural fluid.

Slightly enlarged right lower paratracheal node measuring 11mm and the 9mm subcarinal node are unchanged from previous. No new or enlarging thoracic lymphadenopathy.

No gross finding within the imaged upper abdomen, allowing for lack of contrast.
No concerning skeletal lesion.

Conclusion: Increase in size of 12mm RUL apical nodule, concerning for malignancy.
New indeterminate 8mm nodular soft tissue lesion at the left upper lobe apex anteriorly.
Respiratory MDT discussion +/- PET CT recommended.

Reported by: Dr Matthew Thomas Friar (SpR) and Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Chest

Performed	15-Feb-2026 12:45	Received	19-Feb-2026 11:58
Reported	19-Feb-2026 11:56	Order Number	G107H43217287
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

7/7 on NIV and HFNO. CXR previously suggested pneumonitis. For repeat to assess clinical condition

XR Chest :
AP erect film which is compared with the previous films of 12/02/2026 and 24/11/2025 and the CT of 25/03/2025.. The extensive patchy air space shadowing bilaterally on the most recent film has essentially resolved. No new focal lung pathology. There is a preexisting small ill-defined nodule in the right upper zone in keeping with the subsolid lesion seen on CT. I note further CT follow-up is intended . Normal heart and mediastinal contour. No lobar collapse, pneumothorax or pleural effusion. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	12-Feb-2026 07:50	Received	12-Feb-2026 16:17
Reported	12-Feb-2026 16:15	Order Number	G107H43206295
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

62F IECOPD T2RF desturated overnight on 15L TM SpO2 80. urgent CXR

XR Chest :
Portable AP, erect film.

Comparison made to multiple previous films with oldest dated 23/12/24.
Projection precludes cardiomediastinal assessment.
There is evidence of diffuse bilateral mid and lower zone consolidation, which has progressed since radiograph dated 08/02/2026.
No pleural effusion or lobar collapse.
No acute skeletal pathology.

Repeat film is advised in 6-8 weeks after appropriate treatment to ensure resolution.

Reported by: Dr Riya Ghose (SpR) and Dr Jennifer Curle
Verified by: Dr Jennifer Curle

XR Chest

Performed	08-Feb-2026 17:30	Received	12-Feb-2026 10:34
Reported	12-Feb-2026 10:32	Order Number	G107H43190433
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

Severe IECOPD
15L Venturi
widespread wheeze and creps
RR30.
CXR to assess for consolidation please

XR Chest :
There is new patchy air space shadowing in the mid and lower zones when compared with the previous film of 24/11/2025. This is in keeping with a diffuse inflammatory pneumonitis. The small right upper zone opacity persists projected over the anterior aspect of the right second rib . No large areas of focal consolidation. No lobar collapse, pneumothorax or pleural effusion. No evidence of cardiac failure. Normal heart and mediastinal contour. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Chest

Performed	10-Jun-2025 20:08	Received	31-Jul-2025 16:42
Reported	31-Jul-2025 16:40	Order Number	G107H42334794
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

central chest pain relieved by GTN ?ACS. please exclude cardiomegaly or effusions

XR Chest :
PA radiograph. Reference made to the radiograph of 23/12/2024 and CT thorax dated 25/03/2025.

Normal heart size and cardiomediastinal contours. The lungs are clear with no focal pulmonary pathology. No pleural effusion or pneumothorax. The imaged bony thorax is unremarkable.

Reported by: Dr Gemma McGivern
Verified by: Dr Gemma McGivern

CT Thorax

Performed	25-Mar-2025 16:56	Received	22-Apr-2025 15:58
Reported	22-Apr-2025 15:54	Order Number	G107H41377336
Status	Final	Source System	MiSys

CT Thorax Final
Theresa Sinclair
SEE REPORT FOR CLINICAL INFORMATION

Examination Dated: 25/03/2025 16:56

Title & Technique: CT Thorax

Clinical Details: Multiple lung nodules under review - for interval CT scan March 2025 please (6/12)

(Information via Order Comms)

Findings:

Comparison is made with previous scan dated 25/09/24.

To alleviate the angle change limitation, I made comparison of nodules in sagittal plane.
Approx.. 9mm sized ground glass nodule in apical segment of left lower lobe appears stable.
Branching, angulated thick linear nodule in right upper lobe is difficult to quantify due to its shape, but largely appears stable.
Also, faint 4mm sized anterior subpleural and lateral peripheral nodules in right upper lobe are unchanged. Focal spiculated ground glass nodular appearance adjacent to air cyst / bulla in right upper lobe is stable.
Stable right lower lobe calcified granuloma.
No newer nodules are seen.
No mediastinal lymphadenopathy or pleural effusion is seen.
No bone destruction evident.

Conclusion:
Stable indeterminate lung nodules. Surveillance suggested as per local protocol.

4Ways Reporting Radiologist: Swati Shah - GMC 7481162 on 22/04/2025 15:54
This report is intended to be read by medically qualified professionals; any patient concerns or decisions regarding medical treatment arising from its contents should be discussed with the patients's doctor or referring clinician.

Reported by: Dr Swati Shah
Verified by: Dr Swati Shah

CT Thorax abdomen pelvis with contrast

Performed	25-Sep-2024 11:16	Received	26-Sep-2024 08:44
Reported	26-Sep-2024 08:42	Order Number	G504H41311963
Status	Final	Source System	MiSys

CT Thorax abdomen pelvis with contrast Final
Theresa Sinclair
Clinical History :

Suspicion of cancer but with no obvious localising features? : Yes
Do any signs, symptoms or investigations (including CXR and FBC) suggest malignancy in a specific system or alternative diagnosis? : No
Intractable back pain L sided abdominal pain tender over L2-L4 vertebrae, this lady had CT scan suspicious of lung malignancy in may'24 and has app for repeat CT chest at Gartnaval hosp on 5/9/24, she has 2weeks of intractable low back pain with tenderness over Lumbar vertebrae ? meta disease, would you be able to extend CT to abdomen and pelvis and lumbar spine please at same app?

CT Thorax abdomen pelvis with contrast :
Comparison made with the previous CT dated 23/05/2024. Note is made of the previous CT dated 05/09/2024.

Unchanged 9 mm right apical nodule. Other foci of ground-glass change within both lungs are also unchanged. No new significant pulmonary nodule or central endobronchial lesion. Slightly enlarged right lower paratracheal node measuring 11 mm and prominent 9 mm subcarinal node are unchanged from previous. No other mediastinal, hilar or axillary lymphadenopathy.

The solid upper abdominal organs appear unremarkable. Unremarkable gallbladder and nondilated biliary tree. No gross focal oesophageal or gastric abnormality. Uncomplicated mild sigmoid diverticulosis. The remainder of the unprepared bowel loops appear grossly normal. No abdominal or pelvic lymphadenopathy. Sterilisation clips.

Mild degenerative changes at the L2/L3 level. No significant bony abnormality.

Impression:
Unchanged intrathoracic appearances. No definite evidence of malignancy.

Reported by: Dr V-Liem Soon and None
Verified by: Dr V-Liem Soon

CT Thorax

Performed	05-Sep-2024 17:08	Received	11-Oct-2024 08:38
Reported	11-Oct-2024 08:35	Order Number	G107H41056687
Status	Final	Source System	MiSys

CT Thorax Final
Theresa Sinclair
Clinical History: for 3 month interval CT thorax: multiple semi-solid/ground glass opacities in both lungs. Active smoker. interval CT to monitor: inflammation vs malignancy

05/09/2024, 17:08, CT Thorax

CT Thorax:

Non-contrast study. Reference has been made to the previous study from May 2024.

If you see nodule within the right apex remains unchanged. Groundglass opacities within the right upper lobe and subpleural apical segment of the left lower lobe also remains stable. There is no new significant pulmonary nodule or consolidation. No pleural or pericardial effusion. There are no size significant mediastinal lymph nodes.

Conclusion:
Stable right upper lobe nodule and bilateral groundglass opacities.

Dr. Rumman Ahmed FRCR EBIR
Consultant Radiologist
GMC: 7138298
Axon Diagnostics
clinicalqueries@axondiagnostics.com

Reported by: AXON Reporting
Verified by: AXON Reporting

CT Thorax and abdomen with contrast

Performed	23-May-2024 13:28	Received	30-May-2024 00:02
Reported	30-May-2024 00:00	Order Number	G107H40862502
Status	Final	Source System	MiSys

CT Thorax and abdomen with contrast Final
Theresa Sinclair
Clinical History :
CXR 12/4/24 reported as impression of cavitating opacity in right mid zone with patchy air space opacity in left midzone. CT thorax to assess for underlying malignancy

Comparison: No previous CT imaging is available for comparison.

Findings:

Thoraxâ€"
The multiple bilateral nodules that are probably predominantly groundglass but some have a solid component. Such as that on image 50 series 4 which has an 8 mm solid component and overall 11 mm in size.
Further groundglass nodule measuring 1.8 cm noted on image 99 series 4 and adjacent to this and the right hilum is a pneumatocoele measuring 3.4 x 2.5 cm. It is uncertain if this is related to the semi solid nodule as there has no clear soft tissue or groundglass component.
1.3 cm groundglass nodule in the apex of the left lower lobe image 134 series 4.

Abdomenâ€"unremarkable appearances of the liver, kidneys, adrenals, spleen, pancreas and partially imaged bowel.

Skeletal review is negative.

Conclusion/recommendations: Multiple semi solid and groundglass nodules both lungs as described with a pneumatocoele on the right hilum which may be associated with one of the nodules but otherwise has no clear solid or groundglass component. **The differential remains wide presentation and a respiratory opinion is advised to enact appropriate followup for potential malignancy**

Medica Red Flag

Dr Rhys Llewelyn. Consultant Radiologist, Medica Reporting Ltd

GMC: 6104892

If you are a clinician and have a query on this report, please call Medica on 01424 377 901 or email clinical@medicagroup.co.uk

Reported by: Dr Rhys Llewelyn
Verified by: Dr Rhys Llewelyn

XR Chest

Performed	12-Apr-2024 02:22	Received	18-Apr-2024 17:44
Reported	18-Apr-2024 17:42	Order Number	G107H40826505
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

60F short of breath ?consolidation ?PTX

XR Chest :
PA erect chest radiograph. Comparison made to previous imaging 8/1/24.

Normal heart size and cardiomediastinal contours. Pulmonary appearances are suggestive of underlying emphysema. There is impression of a cavitating opacity within the right mid zone. Patchy air space opacity in the left mid zone. Whilst appearances could be infective or inflammatory in aetiology, respiratory referral with a view to CT of the thorax is advised.

Tracked report.

Reported by: Dr Sean Morrison (SpR) and Dr Gemma McGivern
Verified by: Dr Gemma McGivern

XR Chest

Performed	23-Nov-2022 07:26	Received	23-Nov-2022 09:26
Reported	23-Nov-2022 09:24	Order Number	G107H39081960
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

Presents with chest pain. Recent covid 19 3 weeks ago. COPD, angina. ?consolidation ?PTX

XR Chest :

The heart is not enlarged and mediastinal contours are normal. Lungs clear with no change comparing to 13/9/22,

Reported by: Dr Giles Roditi
Verified by: Dr Giles Roditi

CT Head

Performed	02-Apr-2017 05:15	Received	02-Apr-2017 11:40
Reported	02-Apr-2017 06:08	Order Number	G107H32505207
Status	Final	Source System	MiSys

CT Head Final
Theresa Sinclair
Clinical History :
fall from 5ft - LOC and vomiting, remains GCS 14 after 4 hrs

CT Head :
Noncontrast volume acquisition of the head. Comparison made with the CT of 12/10/2015.

No evidence of an acute infarct, space-occupying lesion or intra or extra-axial haemorrhage.

Grossly unremarkable appearance of the brain parenchyma. Normal midline structures and cranio-cervical junction. Patent ventricular system. The skull vault is intact and the visualised sinuses are clear. There is some soft tissue swelling over both orbits but the globes look intact.

Conclusion: No acute intracranial findings.

Provisional findings phoned to referring clinician at time of reporting.

Reported by: Dr Siobhan Mathieson (ST2) and Dr Daniel Heffernan Ho
Verified by: Dr Siobhan Mathieson (ST2)

XR Lumbar spine

Performed	12-Oct-2015 09:47	Received	14-Oct-2015 11:09
Reported	14-Oct-2015 11:07	Order Number	G107H30731012
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

Discussed with referrer - ?COPD ?Pneumothorax

XR Chest :
Inspiratory and expiratory examinations have been performed. AP supine projections. No focal active pulmonary disease is seen. No evidence of pneumothorax. The bony thorax appears intact.

XR Lumbar spine :
The vertebral body heights, disc spaces and alignment are preserved. No convincing acute bony injury is seen.

XR Chest :
Please see above.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Chest

Performed	12-Oct-2015 09:47	Received	14-Oct-2015 11:09
Reported	14-Oct-2015 11:07	Order Number	G107H30731034
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

Discussed with referrer - ?COPD ?Pneumothorax

XR Chest :
Inspiratory and expiratory examinations have been performed. AP supine projections. No focal active pulmonary disease is seen. No evidence of pneumothorax. The bony thorax appears intact.

XR Lumbar spine :
The vertebral body heights, disc spaces and alignment are preserved. No convincing acute bony injury is seen.

XR Chest :
Please see above.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Chest

Performed	12-Oct-2015 09:47	Received	14-Oct-2015 11:09
Reported	14-Oct-2015 11:07	Order Number	G107H30731011
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

Discussed with referrer - ?COPD ?Pneumothorax

XR Chest :
Inspiratory and expiratory examinations have been performed. AP supine projections. No focal active pulmonary disease is seen. No evidence of pneumothorax. The bony thorax appears intact.

XR Lumbar spine :
The vertebral body heights, disc spaces and alignment are preserved. No convincing acute bony injury is seen.

XR Chest :
Please see above.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

CT Spine cervical

Performed	12-Oct-2015 09:24	Received	12-Oct-2015 09:57
Reported	12-Oct-2015 09:55	Order Number	G107H30730770
Status	Final	Source System	MiSys

CT Head Final
Theresa Sinclair
Clinical History :

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

(Information via Order Comms)

CT Head :
Noncontrast enhanced volume acquisition performed through the brain.
No significant intra or extra-axial abnormality has been identified. There is no evidence of acute intracranial haemorrhage.

CT Spine cervical :
Noncontrast enhanced volume acquisition performed through the cervical spine.
There is no evidence of distant spinal fracture or loss of alignment. This does not exclude ligamentous injury. No significant soft tissue abnormality seen in the lung apices appear clear.

In conclusion no significant injury demonstrated.

Reported by: Dr John Shand
Verified by: Dr John Shand

CT Head

Performed	12-Oct-2015 09:24	Received	12-Oct-2015 09:57
Reported	12-Oct-2015 09:55	Order Number	G107H30730769
Status	Final	Source System	MiSys

CT Head Final
Theresa Sinclair
Clinical History :

fall ? when whilst intoxicated. bruise on chin and pain in c spine at level c5-7. numbness right hand dermatomes C6/7. persistent headache and amt 2/4. also c/o tenderness on palpation of sternum and right lat ribs 6-7, equal AE and midline lumbar tenderness L4/5 level- no neurological deficit lower limbs ? fracture c spine/ lumbar spine ? rib fractures ? intracerebral bleed

(Information via Order Comms)

CT Head :
Noncontrast enhanced volume acquisition performed through the brain.
No significant intra or extra-axial abnormality has been identified. There is no evidence of acute intracranial haemorrhage.

CT Spine cervical :
Noncontrast enhanced volume acquisition performed through the cervical spine.
There is no evidence of distant spinal fracture or loss of alignment. This does not exclude ligamentous injury. No significant soft tissue abnormality seen in the lung apices appear clear.

In conclusion no significant injury demonstrated.

Reported by: Dr John Shand
Verified by: Dr John Shand

XR Shoulder Rt

Performed	28-Jun-2014 05:23	Received	28-Jun-2014 13:18
Reported	28-Jun-2014 13:16	Order Number	G107H29222595
Status	Final	Source System	MiSys

XR Shoulder Rt Final
Theresa Sinclair
Clinical History :

fall bony tenderness, clavicle, shoulder, humerus and elbow also left metecarpals

XR Shoulder Rt :
No acute bony injury demonstrated.

XR Elbow Rt :
No acute bony injury demonstrated.

XR Humerus Rt :
No acute bony injury demonstrated.

XR Hand Lt :
No acute bony injury demonstrated.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Humerus Rt

Performed	28-Jun-2014 05:23	Received	28-Jun-2014 13:18
Reported	28-Jun-2014 13:16	Order Number	G107H29222597
Status	Final	Source System	MiSys

XR Shoulder Rt Final
Theresa Sinclair
Clinical History :

fall bony tenderness, clavicle, shoulder, humerus and elbow also left metecarpals

XR Shoulder Rt :
No acute bony injury demonstrated.

XR Elbow Rt :
No acute bony injury demonstrated.

XR Humerus Rt :
No acute bony injury demonstrated.

XR Hand Lt :
No acute bony injury demonstrated.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Hand Lt

Performed	28-Jun-2014 05:23	Received	28-Jun-2014 13:18
Reported	28-Jun-2014 13:16	Order Number	G107H29222598
Status	Final	Source System	MiSys

XR Shoulder Rt Final
Theresa Sinclair
Clinical History :

fall bony tenderness, clavicle, shoulder, humerus and elbow also left metecarpals

XR Shoulder Rt :
No acute bony injury demonstrated.

XR Elbow Rt :
No acute bony injury demonstrated.

XR Humerus Rt :
No acute bony injury demonstrated.

XR Hand Lt :
No acute bony injury demonstrated.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

XR Elbow Rt

Performed	28-Jun-2014 05:23	Received	28-Jun-2014 13:18
Reported	28-Jun-2014 13:16	Order Number	G107H29222596
Status	Final	Source System	MiSys

XR Shoulder Rt Final
Theresa Sinclair
Clinical History :

fall bony tenderness, clavicle, shoulder, humerus and elbow also left metecarpals

XR Shoulder Rt :
No acute bony injury demonstrated.

XR Elbow Rt :
No acute bony injury demonstrated.

XR Humerus Rt :
No acute bony injury demonstrated.

XR Hand Lt :
No acute bony injury demonstrated.

Reported by: Dr Ross MacDuff
Verified by: Dr Ross MacDuff

RHYTHM REPORT

PATIENT and STUDY INFORMATION

Patient name: Theresa Sinclair

Patient ID: 1308636407

DOB/Age: 13-Aug-1963 (62 Years)

Gender: Female Unknown

Height: in Weight: lb

Location: 291 Room:

Referred by:

Confirmed by:

Test Reason:

Test Date/Time: 10-Feb-2026 14:27

INTERPRETATION

GREATER GLASGOW SITE

Ward
Telephone:

EXERCISE STRESS TEST REPORT

Patient Name: SINCLAIR, Theresa
Patient ID: 1308636407
Height: in
Weight: lb

DOB: 13-Aug-1963
Age: 51 yr
Gender: Female
Race: Unknown

Study Date: 15-Jul-2015
Test Type: Treadmill Stress Test
Protocol: BRUCE

Referring Physician: --
Attending Physician: --
Technician: CQ/KG

Medications:
--

Medical History:

Reason for Exercise Test:

Suspected Angina

Exercise Test Summary

Phase Name	Stage Name	Time in Stage	Speed (mph)	Grade (%)	HR (bpm)	BP (mmHg)	Comment
PRETEST	SUPINE	03:41	1.0	0.0	93	132/89	
Exercise	STAGE 1	00:01	1.0	0.0	93		
		00:58	1.7	10.0	117		
Recovery		01:01	0.0	0.0	104		
		02:10	0.0	0.0	90		

The patient exercised according to the BRUCE for 00:58, achieving a work level of Max. METS: 3.0. The resting heart rate of 91 bpm rose to a maximal heart rate of 131 bpm. This value represents 77 % of the maximal, age-predicted heart rate. The resting blood pressure of 132/89 mmHg , rose to a maximum blood pressure of 132/89 mmHg. The exercise test was stopped due to At patient's request.

Interpretation

Conclusions

Patient seemed unable to tolerate treadmill and requested to stop due to back pain, however, reported chest heaviness at test end.
No arrhythmia. No significant ST changes.

Physician_____ Technician_____

Department of Respiratory Medicine
Glasgow Royal Infirmary
Pulmonary Function Report

NHS Greater Glasgow and Clyde

CHI:	**1308636407**				
Last Name:	**Sinclair**	**Height:**	**154 cm**	**Physician:**	**Dr McClay**
First Name:	**Theresa**	**Weight:**	**73.1 kg**	**Ward:**	**--**
Date of Birth:	**13/08/1963**	**BMI:**	**31 kg/m²**	**Smoking status:**	
Age:	**61 Years**	**Race:**	**Caucasian**	**Smoking pk-yrs:**	
Gender:	**female**	**Pred. Module:**	**GLI_ECCS**	**Physiologist:**	**Vaughn R**
Visit date:	**06/05/2025**	**Indication:**			

Note GLI ethnic correction only adjusts for spirometry.

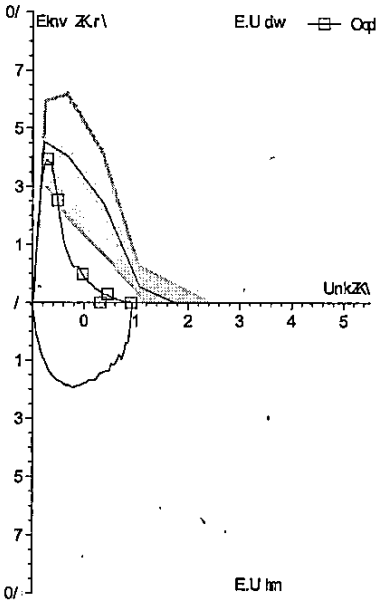
SR Range Normal +/- 1.64 to 1.64 Mild +/- 1.65 to 2.50 Moderate +/- 2.51 to 4.00 Severe +/- >4.00

Spirometry

		Pred	Best Pre	% Pred	SR	Best Post	% Pred	SR	% Chg	%Pred Chg
FVC	L	2.76	1.90	68.8	-2.10					
FEV 1	L	2.18	1.31	60.2	-2.60					
FEV 1 % FVC	%	80	69		-1.40					
FEV 1 % VC MAX	%	80	68		-1.53					
PEF	L/s	5.53	4.94	89.4	-0.65					
MMEF 75/25	L/s	2.04	0.74	36.1	-2.27					

Bodyplethysmography

		Pred	Best	% Pred	SR	SR Graph
FRCpleth	L	2.37	2.73	116	0.75	
TLC	L	4.51	4.33	96	-0.32	
VC	L	2.98	1.97	66	-2.58	
IC	L	2.18	1.60	73	-1.35	
ERV	L	0.70	0.37	53	-1.06	
RV	L	1.56	2.36	151	1.66	
RV % TLC	%	34	55	160	2.79	
FRCpl% TLC	%	55	63	115	1.39	



Transfer Factor

		Pred	Meas	% Pred	SR	SR Graph
Hb	g(Hb)/dL		12.50			
DLCO_SB	mmol/(min*kPa)	6.02	4.05	67	-2.39	
DLCOcSB	mmol/(min*kPa)	6.02	4.17	69	-2.22	
VA_SB	L	4.15	3.76	91	-0.78	
KCO_SB	mmol/(min*kPa*L)	1.46	1.08	74	-1.89	
KCOc_SB	mmol/(min*kPa*L)	1.46	1.11	76	-1.72	

Comments

Reported to ERS/ATS 2021 and ARTP 2020 guidelines unless otherwise stated.

Sgdqd hr rm ` hqkav nar sq bsmmnmcxm l hb sdr smf - Kt nf unkt l dr oqnct bd dultcdmbd ne ` hqsq ooimf at smn gxodqmk sinm Mnsd UB hr r hf mdb` mskx qdct bdc- O` sdmsg ` c aqnmbgnctk snqh l dch sdkx oqmqsn sdr smf - Ga bnqqlbsdc eqnl 17./ 3.1/ 14- Bnqqlbsdc CKBN hr l hckx qdct bdc- U` hr rmq ` kat sv hg ` qdct bdc J BN-

Qdonqsdc ax Q U` t f gm
Qdonqsudqedc ax E V hj hd

BRONCHOSCOPY REPORT
NHS GREATER GLASGOW AND CLYDE

Record created: 07/05/2026 Last modified: 11/05/2026 Procedure date: 11/05/2026

Name:	Theresa SINCLAIR	Address:	90a Main Street
CHI No:	1308636407		Lennoxtown
District:			Glasgow
Date of birth:	13/08/1963		G66 7DA
Case note no.:	1308636407		

GP:	WILSON, ROSALYN	Status:	Daypatient/NHS
Address:	Lennoxtown Medical Practice	Hospital:	Glasgow Royal
	Lennoxtown Hub	Ward:	Respiratory Dept.
	46 Main Street	Referring Cons:	Dr John Maclay
	Lennoxtown	Group:	Respiratory
	G66 7JJ		

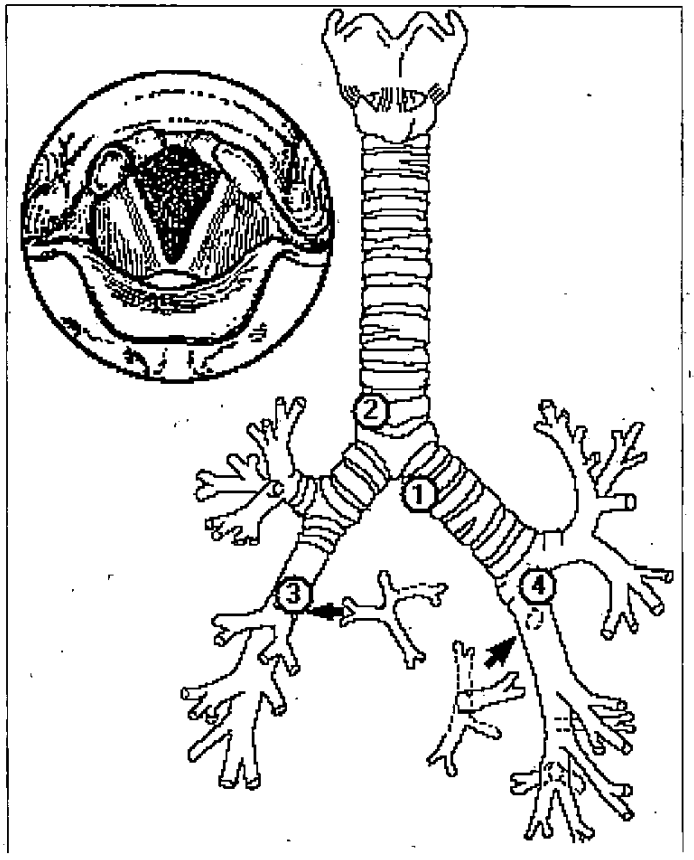
Clinical details: T1N0 on R and T2N0 on L EBUS TBNA 7L, 4R, 11R inf, 11L with new needle.

Drugs:

Midazolam (IV)	2 mgs	Lido\Lignocaine 1% to bronchial tree	16 mls
Fentanyl (IV)	50 ugs	Nasal cannulae	2 L min-1
Lido\Lignocaine 4% to larynx via scope	5 mls		

Instrument and method of access:
GRI EB-530USJU912AO28 EBUS via mouth

Findings:



Results:
Normal Bronchoscopy - Specimens taken
Notes:
Very well tolerated, normal cords, trachea and carina. No endbronchial lesion seen.

Staging EBUS - nodal survey. No size significant 4L.

7L - triangular, homoegnous, fatty hilum - looked benign, 3 passes.
4R - oval, fatty hilum, homogenous 3 passes.
11R inferior - plump rounded but homogenous, 3 passes.
11L - differwnr needle, oblong, homogenous likely benign, 3 passes.

Site 1 Left main bronchus

Site 2 Bottom third of trachea

Site 3 Intermediate bronchus

Site 4 Left lower lobe bronchus

Signature: _____
Operator: Harrison Stubbs
Consultant: John Maclay

CYTOLOGY

CASE NOTE NO.
1308636407
CHI NO **1308636407**

DEPT. No.

FOR LAB USE

SURNAME **SINCLAIR**

FORENAMES **THERESA**

DATE OF BIRTH	HOSPITAL	WARD
13/08/1963	**Glasgow Royal**	**Respiratory Dept.**

CONSULTANT	SEX	
Dr John Maclay	**Female**	**NHS**

DATE AND TIME TAKEN	LMP	PARITY
11/05/2026		

NATURE & SOURCE OF SPECIMEN

Source:
Left main bronchus

Specimen:
Fine needle aspirate: cytology

No Blocks	
No Pieces	
HE	CD3

Details of previous biopsies or cytology (please give ref. nos)

CLINICAL DETAILS
(Please include duration of symptoms, treatment, etc)

T1N0 on R and T2N0 on L EBUS TBNA 7L, 4R, 11R inf, 11L with new needle.

Specimen will not be processed unless this box is complete
Mandatory Information

HIGH RISK **YES**

If HIGH RISK give details	If URGENT please state why

NAME M.O.	SIGNATURE
Harrison Stubbs	

CYTOLOGY

CASE NOTE NO.
1308636407
CHI NO **1308636407**

DEPT. No.

FOR LAB USE

SURNAME **SINCLAIR**

FORENAMES **THERESA**

DATE OF BIRTH	HOSPITAL	WARD
13/08/1963	**Glasgow Royal**	**Respiratory Dept.**

CONSULTANT	SEX	
Dr John Maclay	**Female**	**NHS**

DATE AND TIME TAKEN	LMP	PARITY
11/05/2026		

NATURE & SOURCE OF SPECIMEN

Source:
Intermediate bronchus

Specimen:
Fine needle aspirate: cytology

No Blocks	
No Pieces	
HE	CD3

Details of previous biopsies or cytology (please give ref. nos)

CLINICAL DETAILS
(Please include duration of symptoms, treatment, etc)

T1N0 on R and T2N0 on L EBUS TBNA 7L, 4R, 11R inf, 11L with new needle.

Specimen will not be processed unless this box is complete
Mandatory Information

GH RISK YES

If HIGH RISK give details	If URGENT please state why

NAME M.O.	SIGNATURE
Harrison Stubbs	

CYTOLOGY

DEPT. No.

CASE NOTE NO.
1308636407
CHI NO **1308636407**

NATURE & SOURCE OF SPECIMEN

Source:
Left lower lobe bronchus

Specimen:
Fine needle aspirate: cytology

FOR LAB USE

SURNAME
SINCLAIR

FORENAMES
THERESA

DATE OF BIRTH	HOSPITAL	WARD
13/08/1963	**Glasgow Royal**	**Respiratory Dept.**
CONSULTANT	SEX	
Dr John Maclay	**Female**	**NHS**
DATE AND TIME TAKEN	LMP	PARITY
11/05/2026		

No Blocks	
No Pieces	
HE	CD3

Details of previous biopsies or cytology (please give ref. nos)

CLINICAL DETAILS
(Please include duration of symptoms, treatment, etc)

T1N0 on R and T2N0 on L EBUS TBNA 7L, 4R, 11R inf, 11L with new needle.

Specimen will not be processed unless this box is complete
Mandatory Information

IIGH RISK YES

If HIGH RISK give details

If URGENT please state why

NAME M.O.
Harrison Stubbs

SIGNATURE

Gastroscopy report

Performed	28-Aug-2018 08:25	Received	28-Aug-2018 08:40
Reported	28-Aug-2018 08:40	Order Number	UNI83053-1308636407
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name:	**Theresa SINCLAIR (F)**	Address:	**90a Main Street**
Date of birth:	**13/08/1963**		**Lennoxtown**
NHS No:	**1308636407**		**Glasgow**
Case Note No:	**1308636407**		**G66 7DA**
GP:	**WILSON, ROSALYN**	Procedure date:	**28th August 2018 (08:25)**
	Lennoxtown Medical Practice	Priority:	**Elective**
	Lennoxtown Hub	Hospital:	**GRI**
	46 Main Street	Ward:	**(none)**
	Lennoxtown	Referring Cons:	**GP (Direct Access)**
	G66 7JJ		

Indications
Reflux symptoms and bloating.

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.
Apparent mucosal junction at 39cm from the incisors.

Site a: Antrum
Gastritis: mild flat erosive with no bleeding.Specimens: Result of urease test proved negative for Helicobacter pylori.
Site b: First part
Duodenitis: mild associated with patchy erythema.

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Gastritis.
DUODENUM. Duodenitis.

Advice/Comments
Continue with PPI.
CLO TEST NEGATIVE

Follow up
No further follow up.

Consultant/Endosc
Fion
Nurses: S/N Catherine Anc
S/N Alexander Fer

Instrur
SCAN

Premedic
Midazolam (IV)

Fiona Beck
Nurse Endoscopist

Produced by Unisoft's GI Reporting Tool Compiled on 28/08/2018 at

EBUS TBNA FROM MULTIPLE SITES

Performed	11-May-2026 11:09	Received	11-May-2026 16:42
Reported	15-May-2026 20:27	Order Number	F,26.0001898.T
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 11.05.2026
Date received : 11.05.2026 Date reported: 15.05.2026

Reporting Pathologist : Nicola Gilmour PATH
Consultant Pathologist: Fraser Duthie

N.B. SUPPLEMENTARY REPORT ADDED on 15/05/26

EBUS TBNA FROM MULTIPLE SITES

CLINICAL HISTORY

T1 N0 on L, T1 N2 on R. Staging EBUS TBNA 7L, 4R, 11R inf, 11L with new needle

MACRO

A. EBUS TBNA 7L: Specimen in PreservCyt

B. EBUS TBNA 4R: Specimen in PreservCyt

C. EBUS TBNA 11R inf: Specimen in PreservCyt

D. EBUS TBNA 11L: Specimen in PreservCyt

MICROSCOPY

A - D. COMPOSITE REPORT

All of the 4 cytological specimens contain prominent small lymphocytes in keeping with lymph node sampling.

In addition, in the cell block for 4R (sample B) there are sheets of cytologically atypical epitheliod cells with vacuoles and occasional gland openings. The appearances are those of METASTATIC ADENOCARCINOMA.

Furthermore, in the thin prep for 11L (sample D) there is a single papillary group of atypical cells; raising suspicion of further adenocarcinoma. However, these cells are not identified on cell block and it is not possible to be definitive on such few atypical cells. Immunohistochemical testing is underway on this sample to identify any occult epitheliod cells. The supplementary report will follow.

ALK1, ROS1, PDL1, KRAS, BRAF and EGFR studies are currently

underway.

Dr C Maxwell , ST1
Dr Fraser Duthie, Consultant

Report written: 14/05/26
Authorised: 15/05/26 by Dr F Duthie

SUPPLEMENTARY REPORT - 15/05/26

Immunocytochemical staining highlights occasional crushed cells are felt most likely to represent benign epithelium from overlying bronchial mucosa, but does not highlight any convincing malignant cells within specimen D.

Dr C Maxwell , ST1
Dr Fraser Duthie, Consultant

Report written: 15/05/26
Authorised: 15/05/26 by Dr F Duthie

Intestinal Polyp

Performed	11-Feb-2025 14:14	Received	12-Feb-2025 12:18
Reported	31-May-2025 22:47	Order Number	D,25.0010812.Q
Status	Final	Source System	Telepath

Pathology Final

NHS GREATER GLASGOW AND CLYDE
PATHOLOGY DEPARTMENT ENQUIRIES TO: 0141-354-9487 (89487)

Date collected: 11.02.2025
Date received : 12.02.2025 Date reported: 31.05.2025

Reporting Pathologist : Will Smith PATH
Consultant Pathologist: Will Smith PATH

SIGMOID COLON POLYP - DISTAL

CLINICAL HISTORY

Alternating bowel habit & qFIT - 36.

Colonoscopy: 1 sessile polyp (3 mm) within the distal sigmoid colon. Background diverticular disease with associated diverticulitis within the left colon noted.

MACRO

5 mm piece of tissue.

MICROSCOPY

Microscopy shows sections of hyperplastic polyp. There is no dysplasia or malignancy.

Dr W Smith, ST4

Report written: 26/05/25
Authorised: 31/05/25 by Dr Will Smith

Reported via digital pathology (validated but currently out of scope for UKAS)

Previous Patient Notes for Acute Specialties GGC (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: 19-Feb-2026 11:06	**Created By:** smoking cessation advisor - Samina Ghani	**Role:** AHP - GGC
Specialty: Acute Specialties GGC	**Organisation:**	Sensitive

Note:

QYW Hospital Stop Smoking Service
Reviewed patient keen to stop with support. Commenced on Nicotinell 24hr/21mg Patches. Discharge with 2 weeks supply of product. Patient will be supported for up to 12 weeks and referral to Local Pharmacy Service for NRT for up to 12 weeks to complete course of treatment.

Patient Agreement to Investigation or Treatment
Consent Form

NHS Greater Glasgow and Clyde

Patient details (or pre-printed label)	
Hospital / clinic / GP practice	
Patient's surname / family name	1308636407 SINCLAIR F Theresa 13/08/1963 90a Main Street Lennoxtown Glasgow G66 7DA
Patient's first name	
Date of birth	Male ☐ Female ☐
CHI number	
Special requirements (e.g. other language / communication method)	

Statement for practitioner (to be filled in by practitioner with appropriate knowledge of proposed procedure)	
Describe proposed operation, investigation or other treatment. **Where appropriate specify site or side (write in full).**	endometrial ablation
Specific risks / complications Please detail any specific risk/complications related to the procedure that were discussed.	risks of bleeding, infection, failure, bowel injury, cystitis, non diagnostic
I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above). I have explained who will be doing the procedure if not myself.	
Signature of practitioner	[signature]
Name / Designation (print)	[illegible]
Date	24/4/21

Statement to be completed by patient / parent*
(*parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- The procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- Who will be performing my procedure on the day
- That any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

ave been told about additional procedures which may become necessary during treatment.
...ive listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree

- to the administration of an anaesthetic or to sedation if required,
- to the procedure named on this form,
- to the emergency administration of blood or blood products.

Additionally you have to agree or disagree to the following	**Agree**	**Disagree**
to photographic images and video recordings being held in records, and made available for teaching, audit and ethically-approved research purposes, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis future treatment may be used for medical education and ethically approved medical research.	☐	☐

Patient / parent agreement to treatment

Signature: S Sinclair	Date: 24-04-26
Name (print)	

Patient refusal for blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products, **even if this results in death.**

Signature	Date
Signature of practitioner	Date

DO NOT A[illegible] ONARY RESUSCITATION (DNACPR)

Name:	1308636407	.....
CHI/DoB:	SINCLAIR Theresa	F 13/08/1963 .....
Address: .	90a Main Street Lennoxtown	.....
.....	Glasgow	G66 7DA .....

Previous discussions may be recorded in the Key Information Summary (KIS); ***this should always be checked.***

NHS SCOTLAND

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)*

In the event of cardiac or respiratory arrest no attempts at cardiopulmonary resuscitation (CPR) are intended. This decision applies *only to CPR treatment*. All other appropriate treatment and care will be given (2222 or 999 calls may still be appropriate when immediate medical help is needed in an unexpected emergency).

Select reason for DNACPR decision: (please choose only A or B). Within Section A or B select the relevant communication or decision-making strategy by ticking the appropriate option

A ☑ **CPR will not be successful and is not a treatment option for this patient**

Explain why: .....

The patient is aware of this decision.

Yes ☑ Conversation date and where documented ....11/12/26 2p.....

No ☐ Reason (e.g. lack of capacity, judgement of harm to patient).....

.....

The welfare attorney/guardian and/or relevant other is aware of the decision.

Yes ☐ Name(s) .....Date.....

No ☐ Reason (e.g. reasonable efforts to contact unsuccessful so far).....

.....

The presumption is that the patient, and those close to the patient who lacks capacity, will be aware of the DNACPR decision – see Decision-making Framework for valid exceptions. Where the conversation has not yet happened, the full explanation and a clear plan to revisit this must be documented in the clinical notes.

B ☐ **CPR could be successful but the likely outcome would not be of overall benefit to the patient.** (The patient's informed views and wishes are of paramount importance.) **One of the following boxes must be ticked:**

The patient **has capacity** for the decision

☐ and does not wish CPR to be attempted.

☐ and does not wish to discuss CPR decisions at the moment. Decision has been made by clinical team in discussion with relevant others (name below) where confidentiality allows.

Name(s): .....

Explain: .....

(A clear plan to revisit this must be documented in clinical notes).

The patient **does not have capacity** for this decision

☐ but has a valid advance healthcare directive applicable to the current circumstances.

☐ but has a legally appointed welfare guardian/attorney (Name: .....) who agrees that CPR would not be of overall benefit for the patient.

☐ and no legal welfare guardian/attorney can be identified. Decision has been made by clinical team in discussion with relevant others: (Name(s): .....)

Explain: .....

Document capacity assessment and all discussions clearly in clinical notes.

NAMES OF MULTIDISCIPLINARY TEAM MEMBERS INVOLVED IN THE DECISION	
Healthcare Professional recording this DNACPR decision	**Responsible Senior Clinician** *(Dr or Nurse)*
Print: M_Mcl[illegible]	**Print:** M[illegible]
Sign: [illegible] **Date** 11/12/26	**Sign:** [illegible] **Date:** 11/12/26

This original DNACPR Form should follow the patient (e.g. on admission to, discharge from or transfer between hospitals) with the agreement of the patient and/or relevant others where appropriate.

Review of decision:

☐ Review not needed as decision will remain clinically appropriate until end of life.

☐ Review needed on clinically appropriate basis.

Review Date	Responsible Clinician (print & sign)	Outcome of DNACPR review (circle review decision)		Plan for next review
		still applicable	reversed	
		still applicable	reversed	
		still applicable	reversed	
		still applicable	reversed	

NB. Good practice guidance recommends review of the decision on transfer of clinical responsibility (e.g. hospital to community) ***for all patients.***

Reversal of a DNACPR order should be recorded on the form which should be scored through with a permanent marker **and** the word "reversed" written clearly across both sides of the form which should then be filed in the back of the clinical notes.

Communication with healthcare professionals and social carers – who has been informed of the DNACPR decision?

	Not Applicable	Names	Date informed	By whom
General Practitioner				
Community Nursing Team				
Ward Team.				
Care Provider				
Other				

Communication with Ambulance Crew

All other types of supportive care should be given as appropriate as with any other patient where there is a deterioration in clinical condition. If, whilst in transit, the patient's condition suddenly deteriorates such that death occurs or is imminent, please contact:

Name and tel no: ..... and take the patient to:

.....

Signed: ..... Name: ..... Date: .....

GP name/address: .....

..... Postcode: .....

Where it has not been possible to have a discussion to allow the DNACPR Form to be at home with the patient (because the conversation would cause harm) it should not be given to the ambulance crew but should be shown to them prior to the journey. The information that the Form is not going home with the patient, and the reason why, **must be communicated to the GP so that the KIS can be updated.**

DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR)*

[redacted]

NHS
Greater Glasgow and Clyde

[redacted]

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Treatment Escalation Plan (TEP)

ACUTE DETERIORATION MANAGEMENT

(This form only applies during the current admission)

Patients who may benefit from a TEP when admitted to hospital include those with:

- Any patient who has / will have a DNACPR form
- Risk of deterioration or instability
- Frailty, completely dependent for ADLs
- Progressive organ failure with or without multiple co-morbidities
- Advanced cancer
- At request of patient/ welfare attorney or guardian/ nearest relative or carers

Has a DNACPR order been completed: YES ☐ NO ☐

Please check whether existing information is available to assist with conversations/decision making e.g. eKIS, Anticipatory care Plan (ACP) - filed on Clinical Portal under "Care Plans" or "Acute Specialties GGC" - ReSPECT form or TEP from previous admission. These should be discussed with the patient and family for each new admission or change of care setting.

CLINICAL SITUATION AND GOALS OF TREATMENT
COPD - current smoker, 40 cigarettes a day Struggles to walk 10m - dyspnoea

Indicate appropriate escalation of treatment if required; select one of the four boxes below:

ITU referral and possibility of mechanical ventilation (If DNACPR in place d/w ITU before selecting)	
HDU referral – possible inotropes / advanced treatment	✓
Ward based care including consideration of appropriate investigations and interventions below	
Comfort: relief of symptoms (see 'GAEL' guide on Palliative care icon on Staffnet)	

Date and time of TEP	Initiating Clinician - Name & Signature	Position	Department
8/12/26 23:15	SHEA Pharm.	IMT3	MED

Patient aware of plan ☐ Main carer aware of plan ☐ Still to be discussed ☐ See overleaf for details

Responsible senior clinician

Signed: [redacted]

Print Name: [redacted]

Date: 11/12/26

TEP VALID UNTIL: _____

Date Reviewed	Signed / Print	Valid Until

* If significant changes are made to TEP please use a new document (and score through existing document) to ensure instructions are clear.
* 'Indefinite' can be added to the valid until box if no further review required.

On completion this form should be filed at the front of the Clinical Record. On discharge it should be filed with cover note in 'Patient preferences' in Clinical Portal

Name
1308636407
CHI N SINCLAIR
Theresa F
90a Main Street 13/08/1963
Lennoxtown
Glasgow
G66 7DA

NHS
Greater Glasgow and Clyde

INVESTIGATIONS AND INTERVENTIONS: Consider and indicate options below if appropriate. (TBA - to be assessed) When changes occur, please sign and date.			
Invasive Procedures e.g surgery, drain insertion, endoscopic and interventional radiology procedures, central lines (Please state)			
Intravenous Access	YES ☑ NO ☐ TBA ☐	NG, TPN, PEG feeding (circle)	YES ☐ NO ☐ TBA ☑
Intravenous Fluids	YES ☑ NO ☐ TBA ☐	Blood sampling	YES ☑ NO ☐ TBA ☐
Subcutaneous Fluids	YES ☑ NO ☐ TBA ☐	Clinical Observations	YES ☑ NO ☐ TBA ☐
Intravenous Medication	YES ☑ NO ☐ TBA ☐	NIV	YES ☑ NO ☐ TBA ☐
Antibiotics IV / oral (circle)	YES ☑ NO ☐ TBA ☐	Oral feeding appropriate with accepted aspiration risk	YES ☐ NO ☐ TBA ☑
Blood transfusion	YES ☑ NO ☐ TBA ☐		
Other Comments / Instructions (if recorded elsewhere please indicate location and date)			

Communication with the patient and their family regarding this plan is important. If it is not possible to have the discussion at the time of completion, then it must be planned for the first available time. You must ensure that the patient has mental capacity if you are asking the patient to make choices about which treatments they would elect to have. Where the patient does not have capacity, decisions will be made by any existing welfare attorney/guardian with relevant powers and an agreed care plan documented in the patients AWI treatment plan. In communication, please note who had the discussion and when (date/time), also documenting any support offered to patient / carer / family member (Chaplaincy / Support & Information Service / Carers Support Service).

MUST BE COMPLETED IN ALL CASES:

Has been discussed with the patient: YES ☐ NO ☐

If no state reason (e.g. Lack of capacity): .....

Section 47 AWI and Treatment plan completed? YES ☐ NO ☐

Is there a PoA / Welfare Guardian in place? YES ☐ NO ☐

Name of patient/welfare attorney or guardian/nearest relative or designated other & relationship to patient whom this has been communicated with:

.....

Patient's understanding of condition and issues and their preferences for care (including goals, spiritual needs and place of care): where this discussion has been documented in the clinical record, please note the date of this entry.
Family / carer understanding of patient's condition and issues:

On discharge or transfer, please add or update any relevant information onto the ACP summary on Clinical Portal (using Forms and Pathways) - this will be automatically shared with Primary Care. This may include DNACPR Status, goals of treatment, views on future hospital admissions etc. A request to update KIS can also be made via IDL.

NHS Greater Glasgow and Clyde

Endoscopy Care Plan

-13 00

1308636407
SINCLAIR F
Pa Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date: 11/2/25 **Consultant / Endoscopist:** Maguire

Patient liked to be known as: .....

Procedure

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

Discharge Arrangements

Name of Escort /contact Megan	**Escort Required** Yes ☑ No ☐	**Overnight supervision arranged** Yes ☑ No ☐
Relationship Daughter	**Escort to be contacted** Yes ☑ No ☐	**Overnight stay in ward** Yes ☐ No ☑
Contact tel no 07894467054	contacted	

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	✓		
Hypertension	✓		
Myocardial Infarction		✓	Date:
Artificial valves		✓	
Pacemaker		✓	
CABG		✓	
Coronary artery stent		✓	
Stroke/TIA		✓	
Asthma		✓	
COPD	✓		
Epilepsy		✓	
Liver disease		✓	
Arthritis	✓		Hips, Bottom of Spine
Orthopaedic implants		✓	Specify:
Glaucoma		✓	
Anaemia		✓	
Recent surgery		✓	
Previous endoscopy		✓	
CJD/VCJD risk			
Other			

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

F
13/08/1963 abel

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux			
Dysphagia			
Barretts			
Oesphageal/Gastric Varices			
Gastric ulcer			
Altered bowel habit			
PR bleeding			
Crohns disease			
Ulcerative colitis			
Surveillance colonoscopy			
Screening programme			
Other:	✓		Raised G fit

Mobility Assessment

Independent Yes ☒ No ☐ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☒

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify ...none.....

Sight impairment Yes ☒ No ☐ if yes specify .....

Communication Needs (answer only applicable question)

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 ☒ Language .....

Interpreter 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)

Aspirin		Dihydrocodeine		paracetamol	
Amitriptyline		Fluoxetine		peppermint oil	
Amaro Ellipta		glyceryl Trinitrate		pregabalin	
Bisoprolol		Isosorbide		Ramipril	
Diazepam		omeprazole	✓	Salbutamol	

ANTICOAGULANT THERAPY Yes ☐ No ☒ if yes current medication .....

When was this medication last taken Specify .....

INR Result .....

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7DA

Admission Observations

BP 130/77 Pulse 86 Oxygen Saturation 95

BM (if applicable) WNL (7.1) Respirations (if applicable) Regular

Fasted since 10/2/25 food (am)
19/2/25 fluids (am)

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets		x2				
Result- Good / Poor		watery yellow				

Patient Requests

Throat Spray ☐ IV Sedation ☑ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)
		✓ flushed			1·35	MC

Dentures removed (if applicable) Yes ☑ No ☐

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) .....

Signature of Admission Nurse .....

Patient's Declaration

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

Patient's signature .....

1308636407
SINCLAIR F
Theresa 13/08/1953
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Intra Procedure

Endoscopist (print) ..... SR MACMILLE .....

Endoscopy Room Nurses (print) ..... Fox ..... Laird .....

Surgical Pause carried out Yes ☑ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray						
Midazolam	✓		1345	2 mg	IV	
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl	✓		1345	50 mcg	IV	
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		
Prescribed by						

Endoscopist Signature .....

Start Time ..... 1345 ..... Finish Time ..... 1405 .....

Patient position Left Lateral ☑ Supine ☑ Prone ☐ All ☐ R1 scale ✓

Oxygen therapy Yes ☑ No ☐ nasal sponge ☑ cannula ☐ mask ☐ rate ..... 2L .....

ID: 5065476420001629 11/02/2025
STOB
EXPIRES: 11/02/2026 14:18

1308636407
SINCLAIR F
Theresa 13/08/1963 el
90a Main Street
Lennoxtown
Glasgow
G66 7D

Observations during procedure

Time	1344	1400				
Pulse	79	80				
SpO2	95%	94%				
BP	–	–				
Resps	Reg	Reg				

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 cluster	✓	sessile	
		PEG		Descending			
		Needle Aspiration		Splenic flexure			
		Brushings		Transverse			
		Washings		Hepatic flexure			
		Banding		Ascending			
		Insert of NJ tube		Caecum			
		Gastric Pacing Wire		Terminal Ileum			

Other :.....

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	✓
Drowsy		One or two episodes of mild discomfort, well tolerated	
Awake	✓	More than two episodes of discomfort, adequately tolerated.	
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments reassurance given

Specimens Yes ☑ No ☐

Pathology ☑ No of pots 1 H pylori test ☐ bacteriology ☐ cytology ☐ mytology ☐

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7D

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 via .....until ..... ☐

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

To be seen by endoscopist before discharge ☐

Further Instructions .....

.....

Endoscopy Room Nurse Signature .....

Recovery care

Post endoscopy observations

Time	14.10	14:15	14.30							
Blood pressure	109/66	101/62	114/69							
Pulse	79	75	74							
O2 Saturation	95%	92%	96%							
Respiratory Rate	Reg	Reg	Reg							
Sedation score	0	0	0							
Pain score	0	0	0							
Oxygen	AIR	AIR	AIR							
IV Cannula	(R)Arm	(R)Arm	(R)Arm							
BM	6.0	N/A	/							
Nurse initials	LW	H.A.	LW							

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

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7D

F
13/08/1963
el

Nurses notes

11/2/26 (14th) Patient arrived into recovery pt after procedure
14.50 - wakeful, recovering
position removed, pt left for
the home

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Discharge Criteria	Yes	No
Stable vital signs	☑	☐
Alert and Orientated	☑	☐
Pain score is 2 or below	☑	☐
Diet and fluids taken	☑	☐
IV Cannula removed	☑	☐
Received written instructions regarding sedation	☐	☐
Received verbal and written aftercare instructions	☑	☐
Patient Advice Leaflet given (if applicable)	☑	☐

Received Endoscopy Report/ Patient letter Yes ☑ No ☐

If no

Verbal report by endoscopist ☐

Follow up appointment indicated on report Yes ☐ No ☑

Follow up appointment (if given in department) .....time .....

Comments..... Awaiting Pathology Results .....

.....

.....

I confirm patient is satisfactory for discharge

Print Name ..... Signature .....

Discharged at ..... to care of .....

Irregular discharge Reason .....

.....

Patients' Signature ..... Nurses Signature .....

Consent Form

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Patient agreement to colonoscopy investigation

Test: Colonoscopy

Inspection of the lower gastrointestinal tract with
a flexible endoscope (with or without biopsy and photography) Specimens will be retained.

You have the right to change your mind at any time, including after you have signed this form.

Patient statement

I have read and understood the information in this booklet including the benefits and any risks.

I agree to the test described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the test.

I understand that any test in addition to that named on this form will only be carried out:

if it is necessary;

- is reasonable in the circumstances,
- in relation to the medical treatment proposed,
- and to safeguard or promote physical or mental health.

Have you ever been notified that you are at an increased risk of CJD/VCJD for public health purposes? ☐ Yes ☑ No

Consent signature

Signed: T Sinclair Date: 11-2-25

Name: (print in capitals): THERESA SINCLAIR

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature: ..... Date: .....

(For staff only)

Confirmation of consent (to be completed by a health care professional when the patient is admitted for the test)

I have confirmed that the patient understands what the test involves including any risks.

I have confirmed that the patient has no further questions and wishes the test to go ahead.

Signed: [signature] Date: 11/2/25

Name: (print in capitals): Anna Clark

Job title: Student Nurse / Staff Nurse

What happens after a Polyp is removed?

Often when large or multiple polyps are removed, the Endoscopist will advise a repeat procedure after a certain timescale to make sure the polyp has not re-grown and that new polyps have not developed. We will write to you about this after your colonoscopy.

After the Colonoscopy

You will be able to rest after the colonoscopy. We will offer you a drink and something to eat. You may feel a little bloated after the procedure as some of the air may remain in your bowel. This may cause some discomfort but will quickly pass.

Before you leave the department, a nurse or doctor will discuss results. You will receive a report of your test and we will tell you if you need any medication or further appointments.

Remember, if you had sedation:

- You may not remember the results. If you agree, we will tell your family or friend your results, so that they can remind you.
- You may feel fully alert after your test but as the drug stays in your body for up to 24 hours. You can feel drowsy with lapses of memory. It is important not to drive or drink alcohol during this time.
- You will need to arrange for someone aged 18 years or over to stay with you, or arrange to stay with your family or a friend overnight.

Next Steps after your Endoscopy Procedure

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7D

NHS
Greater Glasgow and Clyde

Thank you for attending for your endoscopy procedure on:
11/2/25

The clinician who performed your endoscopy was:
E. Maguire

You should have received a copy of your endoscopy report to take away with you which contains important information about your procedure. Please speak to a member of the nursing team if you do not have a copy of this.

Your clinician will have explained the next steps after your endoscopy procedure. It is important that you remember the following points if they are applicable to your care.

Next steps in your care	Applicable to you	
	Yes	No
You had biopsies taken or polyps removed during your procedure and you should receive the results in 12 weeks. **If you have not heard about your results after 12 weeks please call: 0141 201 3682**	✓	
You need to attend for a repeat procedure in _____ **If you have not had an appointment 2 weeks before this date please call: 0141 201 3682**		✓
No biopsies taken – follow up to be determined by the clinician who requested your endoscopy		
You do not need any follow up and will be discharged to the care of your GP.		

For staff:

Completed by: L Mcsorley

Designation: SLW

Date: 11/2/25

NHS Endoscopy Care Plan

Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/196
90a Main Street
Lennoxtown
Glasgow
G66 7D

Date: 11/05/26 **Consultant / Endoscopist:** Dr. Maclay

Patient liked to be known as: .....

Procedure

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

Discharge Arrangements

@ 11:50

Name of Escort /contact: Anne-marie	**Escort Required** Yes ☑ No ☐	**Overnight supervision arranged** Yes ☑ No ☐
Relationship: Daughter	**Escort to be contacted** Yes ☑ No ☐	**Overnight stay in ward** Yes ☐ No ☑
Contact tel no: 07453333109		

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	✓		GTN SPRAY
Hypertension	✓		
Myocardial Infarction		✓	Date:
Artificial valves		✓	
Pacemaker		✓	
CABG		✓	
Coronary artery stent		✓	
Stroke/TIA		✓	
Asthma		✓	
COPD	✓		
Epilepsy		✓	
Liver disease		✓	
Arthritis	✓		HIPS + SPINE
Orthopaedic implants		✓	Specify:
Glaucoma		✓	
Anaemia		✓	
Recent surgery		✓	
Previous endoscopy		✓	
CJD/VCJD risk		✓	
Other			

1308636407
F SINCLAIR
3 Theresa
90a Main Street
Lennoxtown
Glasgow
A

13/08/196

G66 7D.

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux		✓	
Dysphagia		✓	
Barretts		✓	
Oesphageal/Gastric Varices		✓	
Gastric ulcer		✓	
Altered bowel habit		✓	
PR bleeding		✓	
Crohns disease		✓	
Ulcerative colitis		✓	
Surveillance colonoscopy		✓	
Screening programme		✓	
Other:	✓		LUNG CA on SCAN

Mobility Assessment

Independent Yes ☑ No ☐ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☑

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify .....

Sight impairment Yes ☑ No ☐ if yes specify Reading + Distance .....

Communication Needs (answer only applicable question)

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 ☑ Language .....

Interpreter 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)

DIHYDROCODINE		CYANOCOBALAMIN		ISOSORBIDE	
PARACETAMOL		DIAZEPAM		METFORMIN	
ALLOPURINOL		DIGOXIN		TRELEGY (INHALER)	
APIXIBAN		FLUOXETINE		GTN SPRAY	
BISOPROLOL		FUROSEMIDE			

ANTICOAGULANT THERAPY Yes ☑ No ☐ If yes current medication APIXIBAN

When was this medication last taken Specify 8/5/26

INR Result .....

1308636407
F SINCLAIR
53 Theresa 13/08/19(
90a Main Street
Lennoxtown
Glasgow
IA G66 7D

Admission Observations

BP 158/79 Pulse 86 Oxygen Saturation 96% (air)

BM (if applicable) 7.1mmol/L Respirations (if applicable) 15

Fasted since FOOD: 21:00pm FLUID: 21:00pm

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor						

Patient Requests

Throat Spray ☑ IV Sedation ☑ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)

Dentures removed (if applicable) Yes ☐ No ☐ full set at patients home

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 ☐ 24/4/26

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) J MCAULAY

Signature of Admission Nurse .....

Patient's Declaration

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

Patient's signature T Sinclair

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
13/08/19
G66 7D

Intra Procedure

Endoscopist (print) Drs: H. Stubbs; J. MacLaf

Endoscopy Room Nurses (print) E. Milne; O. Mahony; T. Ballantyne

Surgical Pause carried out Yes ☐ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray						
Midazolam	✓		10 25	2 mg	IV	Stubbs
Midazolam				mg		
Midazolam				mg		
Pethidine				mg		
Pethidine				mg		
Pethidine				mg		
Fentanyl	✓		10 25	50 mcg	IV	Stubbs
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		
4% Lidocaine	✓		10 25		PO	Stubbs
1% Lidocaine			11 00	20 ml	IC	Stubbs

Prescribed by Stubbs

Endoscopist Signature Stubbs

Start Time 10 25 Finish Time 11 15

Patient position Left Lateral ☐ Supine ☑ Prone ☐ All ☐

Oxygen therapy Yes ☑ No ☐ nasal sponge ☐ cannula ☑ mask ☐ rate 2L

1308636407
SINCLAIR
Theresa 13/08/196
90a Main Street
Lennoxtown
Glasgow
G66 7D.

Observations during procedure

Time	10 30	10 45	11:40			
Pulse	100	108	104			
SpO2	94% 1L	97% 4L	96% 4L			
BP						
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			

Other .....

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	✓
Drowsy		One or two episodes of mild discomfort, well tolerated	
Awake	✓	More than two episodes of discomfort, adequately tolerated.	
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments

Specimens Yes ☑ No ☐

Pathology ☐ No of pots 4 H pylori test ☐ bacteriology ☐ cytology ☑ mytology ☐

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7D

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% ☐ Aim Sats over 92%

Oxygen 4 litres per minute until fully awake ☐

Oxygen .....per minute via.....until ..... ☐

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

To be seen by endoscopist before discharge ☐ 13:00 today

Further Instructions .....

Can restart APIXIBAN tomorrow per Dr Mackay

Endoscopy Room Nurse Signature .....

Recovery care

Post endoscopy observations

Time	1120	11.40									
Blood pressure	134/88	144/98									
Pulse	79	108									
O2 Saturation	95%	97%									
Respiratory Rate	Reg	15									
Sedation score	0	0									
Pain score	0	0									
Oxygen	2L	Air									
IV Cannula	Y	Insitu									
BM	NA	N/A									
Nurse initials	BS	AF									

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

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive

BRONCHOSCOPY REPORT
NHS GREATER GLASGOW AND CLYDE

Record created: 07/05/2026 Last modified: 11/05/2026 Procedure date: 11/05/2026

Name:	Theresa SINCLAIR	Address:	90a Main Street
CHI No:	1308636407		Lennoxtown
District:			Glasgow
Date of birth:	13/08/1963		G66 7DA
Case note no.:	1308636407		

GP:	WILSON, ROSALYN	Status:	Daypatient/NHS
Address:	Lennoxtown Medical Practice	Hospital:	Glasgow Royal
	Lennoxtown Hub	Ward:	Respiratory Dept.
	46 Main Street	Referring Cons:	Dr John Maclay
	Lennoxtown	Group:	Respiratory
	G66 7JJ		

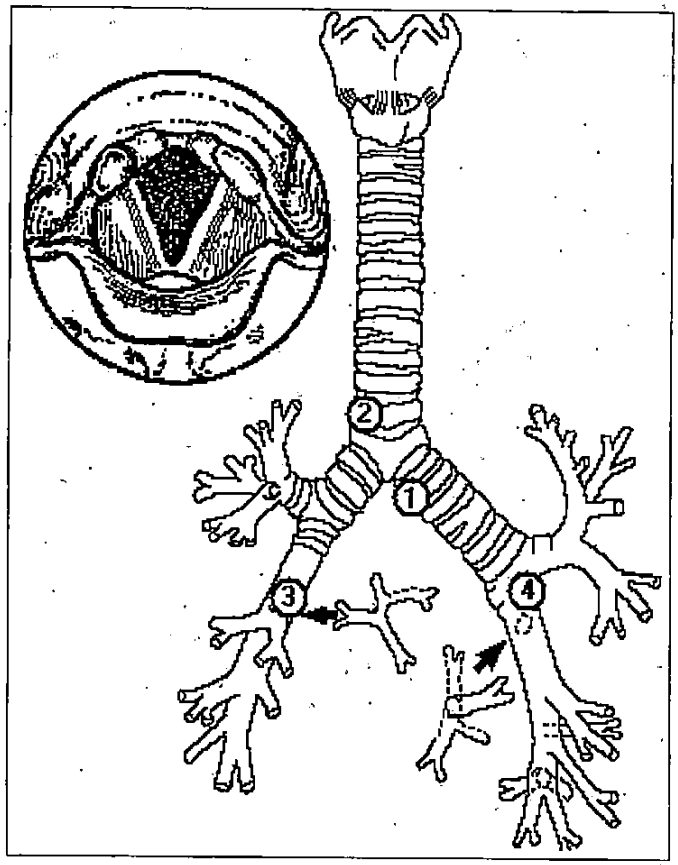
Clinical details: T1N0 on R and T2N0 on L EBUS TBNA 7L, 4R, 11R inf, 11L with new needle.

Drugs:

Midazolam (IV)	2 mgs	Lido\Lignocaine 1% to bronchial tree	16 ml
Fentanyl (IV)	50 ugs	Nasal cannulae	2 L m
Lido\Lignocaine 4% to larynx via scope	5 mls		

Instrument and method of access:
GRI EB-530USJU912AO28 EBUS via mouth

Findings:



Results:
Normal Bronchoscopy - Specimens taken
Notes:
Very well tolerated, normal cords, trachea and carina. No endbronchial lesion seen.

Staging EBUS - nodal survey. No size significant 4L.

7L - triangular, homoegnous, fatty hilum - looked benign, 3 passes.
4R - oval, fatty hilum, homogenous 3 passes.
11R inferior - plump rounded but homogenous, 3 passes.
11L - differwnr needle, oblong, homogenous likely benign, 3 passes.

Site 1 Left main bronchus
Site 2 Bottom third of trachea
Site 3 Intermediate bronchus
Site 4 Left lower lobe bronchus

Signature: _____
Operator: Harrison Stubbs
Consultant: John Maclay

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Nurses notes

1308636407
F SINCLAIR F
63 Theresa 13/08/1963
FECTED AER
E if wrap damaged.
s intended purpose.
y
Dept 3/5
FUJ-EB-530US-1
ID: 50554764200000020
FUJINON EB-530US
EXPIRES: 08/05/2020 11:47

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow

F
13/08/1963

G66 7DA

Discharge Criteria	Yes	No
Stable vital signs	☑	☐
Alert and Orientated	☑	☐
Pain score is 2 or below	☑	☐
Diet and fluids taken	☐	☑
IV Cannula removed	☑ AF	☐
Received written instructions regarding sedation	☑	☐
Received verbal and written aftercare instructions	☑	☐
Patient Advice Leaflet given (if applicable)	☑	☐

Received Endoscopy Report/ Patient letter Yes ☐ No ☑

If no

Verbal report by 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 ..A. FULTON.. Signature .....

Discharged at ..12.40.. to care of ..Daughter.....

Irregular discharge Reason .....

.....

Patients' Signature ..... Nurses Signature .....

STANDBY

			Patient Label
SAS CALLSIGN	Date: DD / MM / YYYY 28/2/26	TIME 1548	**Obtain CHI at time of standby pre-alert**
Age: 63	**Gender:** M / (F)	**Time Onset/Incident:**	

Mechanism / Injuries or Illness:

COPD ↑SOB

- ☐ Cardiac Arrest
- ☐ Trauma Team
- ☐ Code Red (EMRS)
- ☐ Stroke Team:

ONSET TIME or WAKE-UP?

Signs pre-hospital Sats (A)

RR: 34	**SpO2:** 92% ↑ 2L	**HR:** 109	**BP:** 119/82
GCS/AVPU: 15	**BM:** 12.2	**Temp:** 38.4	**NEWS:**

Treatments pre-hospital

ETA: 12 min

→ ***Upon Arrival PAUSE for ATMIST Handover*** *(Unless CPR or airway compromise)*	**Time:**
Key Symptoms:	
Age & Name	
Time of onset / Incident	
Medical Complaint / **M**echanism	
Injuries & Information related to complaint	
Signs & Clinical Findings	KEY SIGNS & CLINICAL FINDINGS IF DIFFERENT FROM STANDBY INFO
Treatment & Trends	Airway-OPA/NPA/I-gel/ETT, IV, Drugs Improved/Static/Deteriorated
→	***Transfer over - then QUESTION & CLARIFY where required***
Allergies	
Medication	
Background history	Family & if present or following on
Other information	Premorbid / Cognitive / Functional status

THERESA SINCLAIR

Scottish Ambulance Service

Age/Gender:	63Y, Female	**Incident Date:**	08/02/2026 14:15:00
DOB:	13/08/1963	**ePCR Number:**	14-2-080226-141545
Address:	90a main streetLennoxtown, G66 7DA	**Incident Number:**	CR012937645
CHI Number:		**Incident Type:**	EMG
Ethnicity:		**Incident Location:**	23 ELLISLAND DRIVE KIRKINTILLOCH GLASGOW, G66 2RR

PATIENT INFO

GP And Surgery

Address:	Lennoxtown Medical Practice, Lennoxtown Hub, 46 Main Street, Lennoxtown	**Name:**	Lennoxtown Medical Practice
Postcode:		G66 7JJ	

Next Of Kin

Forename:	Anne Marie	**Surname:**	Jenkins
Relationship To Patient:		Daughter	

ADDITIONAL COMMENTS

Presenting Complaint:	COPD Exacerbation

Timestamp	Additional Comment	Crew Name
08/02/2026 15:41:00	999 call to 63 y/o F with exacerbation of COPD.	-
08/02/2026 15:43:00	O/a crew met by p/t daughter and led crew to p/t and another crew who was already doing observations. P/t SPO2 sitting at 56% on air, other crew administered O2 when other crew arrived.	-
08/02/2026 15:52:00	O/e p/t SPO2 @56%, on auscultation UL plural rub and ML. On URL wheeze and MRL. P/t had an audible wheeze. P/t RR increased 34, Temp 38.4, BM12.2. P/t had an irregular pulse, ECG confirmed new onset AF. P/t reports change in urine (query UTI). p/t has productive cough (green phlegm).	-
08/02/2026 15:53:00	P/t pMHx COPD, new onset of unkown AF, HTN, T2DM, Angina.	-
08/02/2026 15:56:00	ePRF completed by Mitch student P124020S, Supervised by Tracy Altchsion.	-

ACVPU

Options:	Alert

CATASTROPHIC HAEMORRHAGE

Catastrophic Haemorrhage:	No

AIRWAY

Assessment:	Clear

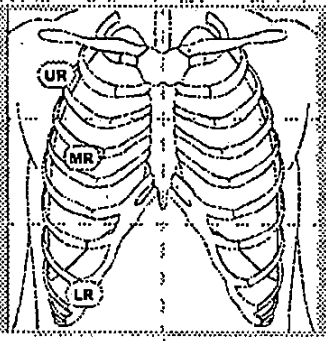
BREATHING

Breathing Adequately:	No	**Initial Respiratory Rate:**	34
Initial SpO2:	56	**Initial SpO2 On Air:**	Yes
Oxygen Given:		Yes	

Chest Examination

Chest Signs/Sounds:	Cough, Accessory Muscles, Audible Wheeze

Anterior

Wheeze	UR		UL
Wheeze	MR		ML
Reduced Air Entry	LR		LL

Other:	Plural rub TL, ML

Tension Pneumothorax

Tension Pneumothorax Suspected:	No

CIRCULATION

Pulse Rate:	69	Rhythm:	Irr
Most Distal Pulse Found:	Radial	Cap Refill:	<=2 Secs
Central Peripheral:	Peripheral	Arm:	Right
Systolic Pressure:	140	Diastolic Pressure:	93
ECG:		12 Lead	

Rhythm

Rhythm:	AF	Other:	New Onset of AF

Skin

Appearance:	Pale	Skin Texture:	Dry
Skin Temperature:		Warm	

IV/IO Access

IV/IO Access:	IV	Right Area:	Dorsum of Hand

PVC

Ensure That A PVC Is Clinically Indicated For This Patient:	Yes	Hand Hygiene Has Been Performed Immediately Before PVC Insertion Procedure:	Yes
Skin Cleansed With A Single-Use Antiseptic Wipe Containing 70% Isopropyl Alcohol & Left To Dry Before Insertion:	Yes	Aseptic Technique Is Maintained Throughout The Insertion Procedure:	Yes
Catheter Site Is Covered With A Sterile Transparent Semi Permeable Dressing, With Time And Date:	Yes		

DISABILITY

Initial GCS:

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
08/02/2026 15:18:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

Eyes

Left Pupil Size (Mm):	**3**	**Right Pupil Size (Mm):**	**3**
Pupils Equal And Reactive To Light (Pearl):		**Yes**	

Blood Glucose

Blood Sugar Value (MMOL/L):	**12.2**

OBSERVATIONS

Observations Assessment

Timestamp	Pulse	RR	BP	SpO2	CR	GCS	ACVPU	ETCO2	Temp	BM	ECG	P(L | R)	PEF	Crew
08/02/2026 14:39:00	69	34	140/93	90	<=2 Secs	15	Alert			12.2	AF	3|3		E9886688
08/02/2026 14:53:00	68	32	119/87	86	<=2 Secs	15	Alert							E9886688

GCS

Timestamp	Eyes Value	Eyes Score	Voice Value	Voice Score	Motor Value	Motor Score	Final Score
08/02/2026 14:39:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15
08/02/2026 14:53:00	Spontaneously	4	Orientated	5	Obeys Commands	6	15

COPD

Chronic Obstructive Pulmonary Disease

Assessment - Features:	**Increased Sputum, Increased Cough, Increased Wheeze, Upper Airway Symptoms**

Severe Features

Severe Features:	**Marked Dyspnoea, Use of Accessory Muscles, New Onset Cyanosis**

DRUGS

Drugs Table

Timestamp	Drug	Expiry	Dosage	Quantity	Route	Pain Before	Pain After	Source	Crew
08/02/2026 14:38:00	Salbutamol	2026-12	5 mg	NEB			MANUAL	E9886688	
08/02/2026 14:38:00	Ipratropium Bromide (Atrovent)	-	500 mcg	NEB			MANUAL	E9886688	
08/02/2026 14:47:00	Hydrocortisone	2030-02	100 mg	IV			MANUAL	E9886688	
08/02/2026 14:38:00	Oxygen	-	6 ltrs	INH			MANUAL	E9886688	
08/02/2026 14:49:00	Sodium Chloride 0.9% (Saline)	2027-05	5 ml	IV			MANUAL	E9886688	

CLOSE REPORT

Clinical Response Feedback

On-Scene Clinical Findings	**Emergency**

CONVEYANCE

Transport To Hospital	**Emergency Driving**	**Pre-Alert**	**Yes**
Destination Hospital	**GLASGOW ROYAL INFIRMARY**	**Patient Accompanied By**	**son**

INCIDENT INFORMATION

Dispatch

Dispatch Code	**06E01E**	**Dispatch Description**	**Known COAD with**

Incident Log

Status Time	Status	Callsign	Reason	Hospital
14:14:58	Call Received Time	LVD3943		
14:16:01	Call Received Time	KRK5740		
14:16:01	Call Received Time	KRK4890		
14:16:55	Mobile	KRK5740		
14:18:34	Mobile	LVD3943		
14:19:59	Mobile	KRK4890		
14:25:20	At Scene	KRK4890		
14:32:21	At Scene	KRK5740		
15:06:42	Clear	KRK4890		
15:08:15	Leave Scene	KRK5740		GLASGOW ROYAL INFIRMARY

CREW INFORMATION

Additional Crew

Crew ID	Crew Grade
E9886689	Ambulance Paramedic (AP)
E9886145	Ambulance Technician (AT)

CHI: 1308636407

Glasgow Royal Infirmary

2

Total Att: 25

12 Mth Att: 1

Title: MS

SINCLAIR Theresa

Annmarie Daughter. 07446 431010.

DOB: 13/08/1963 Age: 62y Sex: Female

90a Main Street
Lennoxtown
Glasgow
G66 7DA
07754676886

Next of kin: JENKINS, Annmarie
Relationship: Daughter
0745333109

Theresa (eldest daughter) 073 79 95 69 63.

GP: RM Wilson
01360 327300

Attendance Date: 08/02/2026 Arrival Time: 15:29

Christina Daughter: 07349 146 437.

Registration Time: 15:29 Date of Incident: 08/02/2026

Major Incident Desc:

Reason for Attendance: copd

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

Triage Category: 1 Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: 08/02/2026 15:36 Nurse name: Staff Nurse Ikey A Collins

RR		bpm
Oxygen		%
Air or O2		
SpO2		%
HR		bpm
BP	/	mmHg
CRT		
MAP		mmHg
AVPU		
Temp		C
EWS Total		

BM		mmol/L
PF		l/min
Expected PF		l/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: STANDBY TO MONITORS - SOB/DIB

To be Completed by Clinician		
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

Date	Clinical Notes	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

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

NOK: [redacted] Theresa (daughter) 07379956963.

Glasgow Royal Infirmary
Emergency Department

NHS
Greater Glasgow and Clyde

1308636407
SINCLAIR
Theresa
F
13/08/1963

Initial Investigations Ordered										
FBC ☐	COAG ☐	DD ☐	INR ☐		G+S ☐		X-match units			
U+Es ☐	LFT ☐	GLU ☐	CRP ☐	TROP ☐	Para ☐	Sal ☐	Ethanol ☐	Mg ☐	VBG ☐	ABG ☐
B culture ☐		C/MSSU ☐		Urinalysis ☐		BHCG ☐		Other		
CXR ☐	AXR ☐	Other imaging:								ECG ☐
Current location:								Sent by:		

Clinical Notes

8/7/26 1116-23 Laura Martin F/R3 Emergency

PC - SOB

DH: NKDA

HPC- 4/7 productive green cough
1/7 SOB ++
Pleuritic CP
Fever
Some nausea, hearing
Diarrhoea past few days

Pre alert

PMH: Angina T2DM
COPD OA
Gout overdose
Abstinent alcohol
Diverticulosis

SH: Lives alone.
40/day smoker
not working at present
no alcohol
SOB on mobilising

Glasgow Royal Infirmary
Emergency Department

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

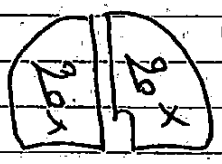
Clinical Notes

Date	Time	Name	Grade	Speciality

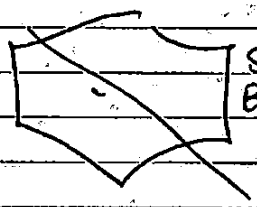
8/2/26 End of bed: audible wheeze, RR ~30, ↑SOB

Cont

A - Patent

B -  Widespread wheeze + coarse lung sounds
RR 27 95% 15L VM
Short sentences only
Cough productive green sputum.

C - Warm, sweaty
CRT 3 sec HR 110 irreg irreg (new AF)
BP 140/80 · calves SNT & oedema

D -  SNT
BSP on glads

E - T37°C

Imp: Treat as chest sepsis / severe ECOPD

Plan:
1) CXR
2) ECG, needs repeated
3) IV amoxicillin 1g
4) IVF
5) Prednisolone 40mg
6) Nacys 600mg
7) urine dip / monitor output
8) blood cultures + viral swabs
9) nicotine patch
10) ABG +/-
11) meds
12) bedlag
13) Sputum when able

Dr Laura Martin
GMC 8008398

Glasgow Royal Infirmary
Emergency Department

1308636407
SINCLAIR
Theresa
F
13/08/1963

Clinical Notes

Date	Time	Name	Grade	Speciality

Prev sputum + H. Influenzae (S) to amoxicillin

Reassessed 14:50 clinically improving, less WOB Now on 6L NC maintaining 96%. Wheeze reduced although remains.

Plan: 1) Second combivob
2) Repeat VBG in 1°

L. Martin. LM
Dr Laura Martin
GMC 8008298

Bloods: Urea 14.6 (4.5)
Creat. 239 (71) * Flu and Covid Negative *
eGFR 18 (>60)
CRP 455 (39)
WBC 12.4 (14.5)
Lact. 2.5

L. Martin

Reassessed 20:28, breathing much improved 97% on 6L NC wheeze/crepes remain

↳ Attempted VBG x2

Plan: 1) 3rd combivob
2) paracetamol
3) repeat ECG
4) VBG

LM
Dr Laura Martin
GMC 8008298

ABG: TARF improving CO_2
O_2 = 7.4
H^+ 52.6. D/W SAS Dr Joseph: given clinically improving + CO_2 coming down, cont. current tx. If deteriorates / clinical change → then would be for NIV.

Glasgow Royal Infirmary
Emergency Department

Patient Name
DoB
CHI Number

or affix label

HAEM	DATE or TIME		BIOCH	DATE or TIME			DATE or TIME		V/ABG	DATE or TIME	
WCC			Na			Bil			FiO_2		
Hb			K			ALT			H^+		
Plat			Cl			AST			$PaCO_2$		
Neut			Ur			GGT			PaO_2		
DD			Creat			A phos			Bic		
PT			eGFR			Alb			BE		
PTT			Glu			AdjCa			Lactate		
TT			CRP			Amyl			Ethanol		
INR			Mg			TropI HS			Para		
			Phos			BHCG			Sal		

Diagnosis and Plan

Review/Discussed with:

Handover

- ☐ Provisional Diagnosis
- ☐ Liquids/Fluids
- ☐ Analgesic/Medicines
- ☐ NEWS
- ☐ Investigations & Results
- ☐ Talk to receiving team/ward

mi • 287967 Version 1_0 • GGC0226

NHS GREATER GLASGOW & CLYDE

ED notes

CLINICAL NOTES - MEDICAL ☑

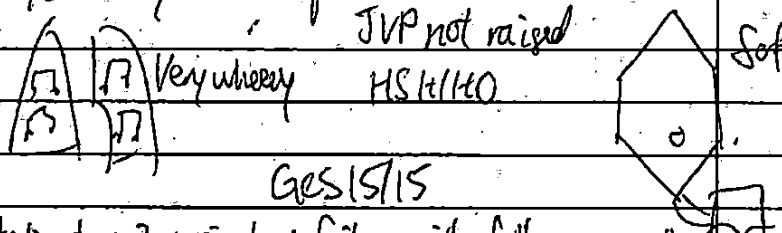
NURSING ☐

Please tick ✔ appropriate directorate



Date & Time					Signature, Print Name & Designation
8/2/26	Moved to resus as GCS 6 15 to 13				
22:10	E3 V4 M6.				
	Remains wheezy, now more somnolent				
	D/w EM SAS Dr Brittliff: repeat				
	Combined first instance, repeat ABG				L.Martin
	then NIV after nebuliser.				Dr Laura Martin
	for naloxone (AKI + opiod dihydrocodeine)				GMC [illegible]
	BM 15.3.				
	For urinary catheter to monitor output.				
	Gases:				
	① VBG	② ABG	③ ABG	④ ABG	
	@ 16:54	@ 21:02	@ 22:34	@ 00:37	
cH	~~54-5~~	52.6	52.9	46.4	
pCO_2	9.1	8.1	8.2	7.2	
pO2	4.5	7.4	8.7	8.3	
Lactate	2.3	1.6	2.7	1.7	
HCO_3	30.5	28.7	29.1	28.5	
	Plan: ① for NIV as although improved after naloxone + further neb, will likely bra.				
	Med reg paged on 13220 @ 22:40 for ? ward vs HDU.				L.Martin

83949 GCC0072

Date & Time	Review for HDU?	Signature, Print Name & Designation
8/2/26	Current smoker, 40 cigarettes a day. Admitted	A&E resus
23:15	with dyspnoea PMH COPD	
	Productive cough and copious sputum	
	O/E - Very wet cough.	
	JVP not raised	Soft non-bender
	 Very wheezy HS1+1+0	
	GCS 15/15	
	Static type 2 respiratory failure with full compensation, started on Bipap as unable to maintain sats on 6L NC	
8/2/26	Called NOK Anne Marie on	
23:24	074 53 33 109 x4 → number	
	appears to be missing from contact	
	number. No other valid Nº available	
	on Trakcare:	
	Theresa was unable enough to give	
	Contact from to phone:	
	Daughter also named Theresa is	
	on 073 79 95 69 63	
	Plan	
	1. Gas in 1 hour	
	2. Fit for ward level	SHO (MTS)
	3. Not for ICU, HDU ceiling	Dr 13210
	4. Send sputum culture	

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time 09/02/26 02[05] Consultant Ward SO-S1

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

- VTE ☐
- Med - Rec ☐
- Kardex ☐
- CxR ☐
- ECG ☐
- Oxygen ☐
- Patient on Bleeders list ☐

A. Breslin (locum SHO)

62F

PMHx: T2DM
IHD - Angina
COPD
OA
Diverticulosis

ECG: ΔT SOB
Sinus Tachy
Prem Ectopic atrial
Complexes
ϕ ischemia

Poor hx from pt - due to ↓ GCS. Will require collateral. From ED clerk-in:
- 4/7 productive cough (green sputum).
- Increased SoB 1/7

SHx:
- Noted pleuritic CP.

40/day Smoker
ϕ ETOH

Pt on NIV - 20/4 pressures
SpO_2 88-92%.

Family # overleaf.



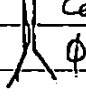
Biphasic Wheeze mainly ↑ & Upper A/W Secretory Noises.
Coarse lung sounds limited exam.

CXR:
RM/L2
Opacification
↳ similar to previous

GCS 14 (best response) - very lethargic - given 2nd dose Naloxone - Initially GCS 12 → increased



Soft - non-tender HS 1+11+0
HR Reg at present



Calves SNT
ϕ oedema

Pupils: E+R
ϕ pinpoint.

ABG: H+ 45.8
pCO_2 7.0
pO_2 9.0
HCO_3^- 28.6

PTO

Does obey commands
Eyes open to voice.

Ward Review

Cont.

NEWS: 6 (NIV (4L/ 20/L)

Bloods:

Urea : 14.6

Creat : 239

eGFR : 18

CRP : 455

WCC : 12.4

SpO2 89%.

BP 120/70

HR 97

Temp - no spikes

No POC noted.

Imp: 1ECOPD (severe)

P : IV Amox + Clari

= Collateral Hx in Arm

Cont NIV as tolerated

Nebs + Pred

Consider Chest Physio

IVF

Suspend NTs:

Repeat bloods.

w/hold sedatives

Monitor. GCS, if remaining flat, consider CT (H)

→ ? opoid toxic / accumulation ∫ sedative medicines Cm AKI

Viral Screen

Atypical Screen

Consider BCs

1308636407
SINCLAIR
Theresa F
90a Main Street 13/08/1963
Lennoxtown
Glasgow
G66 7DA

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics & ENT who have specialty-specific policies]

NHS Greater Glasgow and Clyde

- **Risk Assessment must be completed for all patients within 24 hours of admission to hospital**
- **Patients must be reassessed every 48-72 hours or sooner if condition changes**
- **Reassessment must be documented in Kardex**
- **Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.**

Pt Addressograph

Operative patients

Non-operative patients

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

Yes ☐

No ☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Complete Risk Assessment Result Box.

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy or tamoxifen	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Surgical procedure with total anaesthetic/surgical time >90 min, or >60 min if surgery on lower limb or pelvis	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or Inflammatory disease	☐	Acute surgical admission with inflammatory or intra-abdominal condition including Pelvic Inflammatory Disease	☐
Personal history or first degree relative with a history of VTE	☐	Hip fracture	☐
Varicose veins with phlebitis	☐	All gynaecological surgery except uncomplicated gynaecological diagnostic day case procedures	☐

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Indicators of high risk bleeding (tick √ all that apply)

Active bleeding	☐	Lumbar puncture, epidural/spinal anaesthesia • Expected within the next 12 hours • Within the previous 4 hours	☐
Acquired bleeding disorders (e.g. liver failure)	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Concurrent use of other anticoagulants (e.g. warfarin, rivaroxaban, apixaban, edoxaban) is a contra-indication to additional pharmacological thromboprophylaxis	☐		
Acute stroke (within 14 days)	☐	Acute bacterial endocarditis	☐
Persistent uncontrolled hypertension (BP > 230/120 mmHg)	☐	Surgery expected within the next 12 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Trauma with high bleeding risk e.g. Head Injury	☐
Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐	eGFR <30ml/minute/1.73m²: Dose reduction required	☐
High risk of peri- or post-procedural bleeding, e.g. neurosurgery, spinal, posterior eye surgery and thyroid surgery	☐	Heparin induced Thrombocytopenia	☐

- Discuss with senior clinical staff before deciding to prescribe pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes.

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Operative patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Non-operative patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐

If weight> 120kg, consider Enoxaparin 40mg bd (see StaffNet Guideline).

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral arterial disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Indicators of high risk bleeding: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

RAT Medicine & Surgery – TEST OF CHANGE 09

mi • 250744 Version 9_0 • GGC0015

Medicine Reconciliation Form

Source of information: ECS ☐

Patient ☐ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withhold	Stop	continue	Reason for alteration

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7DA

Consultant Review

See Separate Sheet

10/2/26

Lucsan

Khan

Check List

VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME	DESIGNATION
SIGNATURE	DATE & TIME

Clinical Notes

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 08/02/2026 22:35:02

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 08/02/2026 22:34:49
Sample Type: **Arterial**
Account Number:
Clinician:
Operator ID: CATRIONA YOUNG0

Patient

ID:	1308636407
Last Name:	SINCLAIR
First Name:	THERESA
Gender:	Female
Birth Date:	

Cartridge

Lot No.:	251211M
S/N:	000000000501368245
Exp. Date:	09/03/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	RESUS
S/N:	17030616

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	52.9	nmol/L	--	--	--	--
pCO_2	8.2	kPa	--	--	--	--
pO_2	8.7	kPa	--	--	--	--
Na^+	135	mmol/L	--	--	--	--
K^+	4.1	mmol/L	--	--	--	--
Cl^-	101	mmol/L	--	--	--	--
Ca^{++}	1.10	mmol/L	--	--	--	--
Glu	16.0	mmol/L	--	--	--	--
Lac	2.7	mmol/L	--	--	--	--
CO-Oximetry						
tHb	131	g/L	--	--	--	--
O_2Hb	89.7	%	--	--	--	--
COHb	2.3	%	--	--	--	--
MetHb	0.6	%	--	--	--	--
HHb	7.4	%	--	--	--	--
sO_2	92.4	%	--	--	--	--
Derived						
BE(B)	0.9	mmol/L	--	--	--	--
HCO_3^-(c)	29.1	mmol/L	--	--	--	--
Hct(c)	39	%	--	--	--	--

Other Information

Operator Entered
Temp 37.0 °C

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 09/02/2026 00:37:54

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 09/02/2026 00:37:41
Sample Type: Arterial (4)
Account Number:
Clinician:
Operator ID: CATRIONA YOUNG0

Patient

ID:	1308636407
Last Name:	SINCLAIR
First Name:	THERESA
Gender:	Female
Birth Date:	

Cartridge

Lot No.:	251211M
S/N:	000000000501368245
Exp. Date:	09/03/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	RESUS
S/N:	17030616

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	46.4	nmol/L	--	--	--	--
pCO_2	7.3	kPa	--	--	--	--
pO_2	8.3	kPa	--	--	--	--
Na^+	135	mmol/L	--	--	--	--
K^+	3.8	mmol/L	--	--	--	--
Cl^-	101	mmol/L	--	--	--	--
Ca^{++}	1.12	mmol/L	--	--	--	--
Glu	13.6	mmol/L	--	--	--	--
Lac	1.7	mmol/L	--	--	--	--
CO-Oximetry						
tHb	124	g/L	--	--	--	--
O_2Hb	88.5	%	--	--	--	--
COHb	2.2	%	--	--	--	--
MetHb	0.0	%	--	--	--	--
HHb	8.2	%	--	--	--	--
sO_2	90.6	%	--	--	--	--
Derived						
BE(B)	1.6	mmol/L	--	--	--	--
HCO_3^-(c)	28.5	mmol/L	--	--	--	--
Hct(c)	37	%	--	--	--	--

Other Information

Operator Entered
Temp 37.0 °C

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 09/02/2026 01:48:47

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 09/02/2026 01:48:34
Sample Type: **Arterial**
Account Number:
Clinician:
Operator ID:

Patient

ID:	1308636407
Last Name:	SINCLAIR
First Name:	Theresa
Gender/Age:	F 13/08/1963
Birth Date:	90a Main Street Lennoxtown Glasgow G66 7DA

Cartridge

Lot No.:	251208B
S/N:	000000000501363127
Exp. Date:	18/02/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	WD44
S/N:	17030614

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	↑ 45.8	nmol/L	[--	36.0	44.0	--]
pCO_2	↑ 7.0	kPa	[--	4.6	6.0	--]
pO_2	↓ 9.0	kPa	[--	10.5	14.0	--]
Na^+	136	mmol/L	[--	133	146	--]
K^+	3.7	mmol/L	[--	3.5	5.3	--]
Cl^-	100	mmol/L	[--	95	108	--]
Ca^{++}	↓ 1.12	mmol/L	[--	1.15	1.27	--]
Glu	↑ 12.3	mmol/L	[--	3.5	6.0	--]
Lac	1.4	mmol/L	[--	0.6	2.2	--]
CO-Oximetry						
tHb	125	g/L	[--	--	--	--]
O_2Hb	↓ 91.6	%	[--	95.0	98.0	--]
COHb	↑ 1.6	%	[--	0.5	1.5	--]
MetHb	0.5	%	[--	0.5	1.5	--]
HHb	↑ 6.2	%	[--	0.0	5.0	--]
sO_2	↓ 93.7	%	[--	95.0	98.0	--]
Derived						
BE(B)	1.9	mmol/L	[--	--	--	--]
HCO_3^-(c)	28.6	mmol/L	[--	--	--	--]
Hct(c)	38	%	[--	--	--	--]

↑↓ Outside Reference Range

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 12/02/2026 07:58:42

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 12/02/2026 07:58:29
Sample Type: **Arterial**
Account Number:
Clinician:
Operator ID: MARIYAM RIYAZ0

Patient

ID:	1308636407
Last Name:	SINCLAIR
First Name:	THERESA
Gender/Age:	Female, 62 years
Birth Date:	13/08/1963

Cartridge

Lot No.:	251208B
S/N:	000000000501363127
Exp. Date:	18/02/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	WD44
S/N:	17030614

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	↑ 50.6	nmol/L	[--	36.0	44.0	--]
pCO_2	↑ 9.6	kPa	[--	4.6	6.0	--]
pO_2	↓ 8.6	kPa	[--	10.5	14.0	--]
Na^+	143	mmol/L	[--	133	146	--]
K^+	3.7	mmol/L	[--	3.5	5.3	--]
Cl^-	104	mmol/L	[--	95	108	--]
Ca^{++}	1.20	mmol/L	[--	1.15	1.27	--]
Glu	↑ 9.6	mmol/L	[--	3.5	6.0	--]
Lac	1.6	mmol/L	[--	0.6	2.2	--]
CO-Oximetry						
tHb	118	g/L	[--	--	--	--]
O_2Hb	↓ 89.3	%	[--	95.0	98.0	--]
COHb	↑ 1.7	%	[--	0.5	1.5	--]
MetHb	↓ 0.2	%	[--	0.5	1.5	--]
HHb	↑ 8.8	%	[--	0.0	5.0	--]
sO_2	↓ 91.0	%	[--	95.0	98.0	--]
Derived						
BE(B)	6.8	mmol/L	[--	--	--	--]
HCO_3^-(c)	35.4	mmol/L	[--	--	--	--]
Hct(c)	35	%	[--	--	--	--]

↑↓ Outside Reference Range

(2)

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 08/02/2026 21:02:16

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 08/02/2026 21:02:04
Sample Type: **Arterial** on 28-1-UM
Account Number:
Clinician:
Operator ID: SOPHIE LOWE0

Patient

ID:	1308636407
Last Name:	**SINCLAIR**
First Name:	**THERESA**
Gender:	Female
Birth Date:	

Cartridge

Lot No.:	251211M
S/N:	00000000501368245
Exp. Date:	09/03/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	RESUS
S/N:	17030616

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	52.6	nmol/L	--	--	--	--
pCO_2	8.1	kPa	--	--	--	--
pO_2	7.4	kPa	--	--	--	--
Na^+	134	mmol/L	--	--	--	--
K^+	4.1	mmol/L	--	--	--	--
Cl^-	99	mmol/L	--	--	--	--
Ca^{++}	1.08	mmol/L	--	--	--	--
Glu	15.7	mmol/L	--	--	--	--
Lac	1.6	mmol/L	--	--	--	--
CO-Oximetry						
tHb	132	g/L	--	--	--	--
O_2Hb	84.3	%	--	--	--	--
COHb	1.9	%	--	--	--	--
MetHb	0.6	%	--	--	--	--
HHb	13.2	%	--	--	--	--
sO_2	86.5	%	--	--	--	--
Derived						
BE(B)	0.6	mmol/L	--	--	--	--
$HCO_3^-(c)$	28.7	mmol/L	--	--	--	--
Hct(c)	40	%	--	--	--	--

Other Information

Operator Entered

Temp	37.0

O2 and Vent Settings

FIO_2	[illegible]

1308636407
SINCLAIR F
Theresa 13/08/1963
Temperatur 90a Main Street
incorrect re: Lennoxtown
if result repo Glasgow
Please disre G66 7DA

Printed: 09/02/2026 07:16:55

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 09/02/2026 07:16:42
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: O'HARE AOIBH0

Patient

ID:	1308636407
Last Name:	**SINCLAIR**
First Name:	**THERESA**
Gender/Age:	Female, 62 years
Birth Date:	13/08/1963

Cartridge

Lot No.:	251208B
S/N:	00000000501363127
Exp. Date:	18/02/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	WD44
S/N:	17030614

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	42.9	nmol/L	--	--	--	--
pCO_2	7.2	kPa	--	--	--	--
pO_2	7.7	kPa	--	--	--	--
Na^+	138	mmol/L	--	133	146	--
K^+	3.6	mmol/L	--	3.5	5.3	--
Cl^-	102	mmol/L	--	95	108	--
Ca^{++}	↓ 1.14	mmol/L	--	1.15	1.27	--
Glu	↑ 7.7	mmol/L	--	3.5	6.0	--
Lac	1.0	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	121	g/L	--	--	--	--
O_2Hb	↓ 86.7	%	--	95.0	98.0	--
COHb	1.4	%	--	0.5	1.5	--
MetHb	0.6	%	--	0.5	1.5	--
HHb	↑ 11.3	%	--	0.0	5.0	--
sO_2	↓ 88.5	%	--	95.0	98.0	--
Derived						
BE(B)	4.7	mmol/L	--	--	--	--
$HCO_3^-(c)$	31.2	mmol/L	--	--	--	--
Hct(c)	36	%	--	--	--	--

↑↓ Outside Reference Range

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 12/02/2026 09:04:30

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 12/02/2026 09:04:17
Sample Type: **Arterial**
Account Number:
Clinician:
Operator ID: O'HARE AOIBH0

Patient

ID:	1308636407
Last Name:	SINCLAIR
First Name:	THERESA
Gender/Age:	Female, 62 years
Birth Date:	13/08/1963

Cartridge

Lot No.:	251208B
S/N:	00000000501363127
Exp. Date:	18/02/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	WD44
S/N:	17030614

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	40.8	nmol/L	--	36.0	44.0	--
pCO_2	↑ 7.9	kPa	--	4.6	6.0	--
pO_2	↓ 8.3	kPa	--	10.5	14.0	--
Na^+	141	mmol/L	--	133	146	--
K^+	3.8	mmol/L	--	3.5	5.3	--
Cl^-	102	mmol/L	--	95	108	--
Ca^{++}	1.16	mmol/L	--	1.15	1.27	--
Glu	↑ 8.9	mmol/L	--	3.5	6.0	--
Lac	1.3	mmol/L	--	0.6	2.2	--
CO-Oximetry						
tHb	123	g/L	--	--	--	--
O_2Hb	↓ 89.2	%	--	95.0	98.0	--
COHb	1.4	%	--	0.5	1.5	--
MetHb	0.6	%	--	0.5	1.5	--
HHb	↑ 8.7	%	--	0.0	5.0	--
sO_2	↓ 91.1	%	--	95.0	98.0	--
Derived						
BE(B)	8.8	mmol/L	--	--	--	--
$HCO_3^-(c)$	35.7	mmol/L	--	--	--	--
Hct(c)	37	%	--	--	--	--

↑↓ Outside Reference Range

Main Street
Boxtown
Glasgow
G66 7DA

Temperature Corrected cH(T) results may display incorrect results flags on printouts only, if result reports out with reference range. Please disregard result flag and refer to value.

Printed: 08/02/2026 16:54:55

Patient Sample Report

Status: **ACCEPTED**
Analyzed: 08/02/2026 16:54:42
Sample Type: **Venous**
Account Number:
Clinician:
Operator ID: JOCELYN BRITTLIFF0

Patient

ID:	1308636407
Last Name:	SINCLAIR
First Name:	THERESA
Gender:	Female
Birth Date:	

Cartridge

Lot No.:	251211M
S/N:	00000000501368245
Exp. Date:	09/03/2026

Analyzer

Model:	GEM® *Premier 5000*
Area:	GRI
Name:	RESUS
S/N:	17030616

Results

			Crit. Low	Reference Low	Reference High	Crit. High
Measured (37.0°C)						
cH	54.5	nmol/L	--	--	--	--
pCO_2	9.1	kPa	--	--	--	--
pO_2	4.5	kPa	--	--	--	--
Na^+	135	mmol/L	--	--	--	--
K^+	4.5	mmol/L	--	--	--	--
Cl^-	102	mmol/L	--	--	--	--
Ca^{++}	1.05	mmol/L	--	--	--	--
Glu	10.8	mmol/L	--	--	--	--
Lac	2.3	mmol/L	--	--	--	--
CO-Oximetry						
tHb	133	g/L	--	--	--	--
O_2Hb	52.9	%	--	--	--	--
COHb	1.8	%	--	--	--	--
MetHb	0.0	%	--	--	--	--
HHb	45.3	%	--	--	--	--
sO_2	53.9	%	--	--	--	--
Derived						
BE(B)	1.6	mmol/L	--	--	--	--
$HCO_3^-(c)$	30.5	mmol/L	--	--	--	--
Hct(c)	40	%	--	--	--	--

Other Information

Operator Entered

Temp	37.0	°C

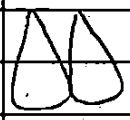
NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

F
13/08/1963

Date & Time	A·Breslin (Locum SHO)	Signature, Print Name & Designation
09/02	ATSP: Tachycardic ~140.	
0735	Rx as Chest Sepsis.	
	ECG: ~~AF~~ Atrial Flutter	
	- Variable AV block - QTc 404.	
	→ no known arrhythmia.	
	GCS 14.	
	Remains on NIV.	
	BP maintained + stable throughout	
	— SBP 130.	
	 ale throughout lung fields.	
	where remains	
	coarse lung sounds remain.	
	GCS 14 - Eyes open to voice	
	Obeys commands	
	Orientated.	
A	Patent D  mildly tender	
	No added sounds central abdomen	
	ϕ peritonitic.	
B	Weans NIV	
	Ir currently	
	Scale 2	
	Lungs as above	
		PTO
C	HS pure Looks clammy	
	Pulse irregularly irregular.	
	~~RR~~ CRT < 2	
	Well perfused.	

Date & Time	Cont.	Signature, Print Name & Designation
	Imp: Atrial flutter 2° to Sepsis	
	P: IVF ct. present	
	= If no improvement, β-block	
	given renal impairment not for Dig.	
	for Cons r/v early.	
	Chase formal electrolytes +/- replace.	
	VBG. H+ 42.9	
	pCO_2 7.2 HCO_3 - 31.2.	
	[redacted]	
	Lact 1.0	
	K+ 3.6	
09/02	WR C. SINCLAIR	
11.27		
	① R CAP \ ECOPD	
	- CRP 352 (455) WCC 9.6 (14.5)	
	- IV cmox + PO clari, BC in progress + Sputum.	
	- ABG T2RF	
	- NIV maybe at present, for HDU calling	
	② Fluids ?° Sepsis	
	- Bicarbonate 1.25% Commenced	
	- HR still uncontrolled, ~ 150	
	- IVF given.	
	Consult - feels OK at present. Comfortable breathing wise	
	Tolerating NIV. Seen with daughter.	
	NEWS 8 (3L O2, BP 105, HR ~ 150)	
	HR gradually ~ 120 - 150	
	NIV - to stay.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time	— Cont.	Signature, Print Name & Designation
	Plan - Cont IV abx	
	- Cont NIV	
	- Further Lefax Flowtec START 1.25mg i/v renin	
	- slow IVF 500ml	F.Sinclair
	- If BP < 90 systolic ? cardioversion.	(SHO)
17:41	D/w IMT 3:	
	Advised to commence digoxin as fluids can be	
	resisted to Lefax Flowtec. Renal function almost at baseline.	
	Plan - Load with 500mcg digoxin	
	- 250 mcg in 6hrs	
	- Maintenance 125mcg prescribed	
	- Cont NF + treating infection.	
	- Monitor HR response	F.Sinclair
	- Clarithromycin discontinued (interaction)	(SHO)

83949 CGCb072

Date & Time		Signature, Print Name
10/2/26	Respiratory CNS 62 years old, Current Smoker (40 a day) Admitted with SOB, cough productive of green sputum, fever and chest pain Rx for CAP/iecopd/T2RF PFT results show (June 2024) FVC 55%, FEV1 48% , FEV1/FVC 70%, DLCO 51%. PFT (May 2025) results show FVC 69%, FEV1 60% , FEV1/FVC 69%. CT Thorax; Emphysema, static cystic pulmonary abnormalities Eosinophils - 0 - Peak - 0.17 ~~Hx~~ Haemophilus in sputum On appropriate inhaled therapy; Trelegy Ellipata -92 ~~mcg~~ 55 ~~mcg~~ 22 mcg, Salbutamol 100mcg Has follow up appointment with Dr Marday in April 2026. Please contact our team if further input is needed. Jade Cayle Student Nurse	1308636407 SINCLAIR F Theresa 13/08/1963 90a Main Street Lennoxtown Glasgow G66 7DA – K. Waller (Cheas)

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR
Theresa
F
13/08/1963

Date & Time		Signature, Print Name & Designation
10/2/26	UR 50/51. CONS /IV.	
1045cm		
	CAP / IECOPD / TTZRF Requiring NIV.	
	Prev FVC 55% FEV1 48% (06/24)	CRP 300
	CT - emphysema	WCC 15.2
	40 + Gpd onjany.	Ast 47
	Clin. exam + radiology (R) CAP	a. 152C
	on abx / Neb / Steroids	MTZ + Tazpic
	AF E rapid VR	WCC 9.6.
	— bisoprolol 1.25 + dig added	CRP + FW
	Rate still 4 to 150bpm	— R.
	Sats maintained on 4L	
	2.5kg 5st 6lb neb	
	Feels a little better	
	Currently off NIV.	
	Keen for MRT pelvis.	
	On IV amox.	
	Gen improving + bloods	
	will need dig level. In due course	
	can have more bisoprolol if the rate is to be	
	>110bpm.	
	Stay here / resp overall.	
		KRees
		CRS.

83949 GCC0072

Date & Time	WR F. SINCLAIR (SHO)	Signature, Print Name & Designation
11/02		
09:25	① R CAP / IECOPD / T2RF ② Hunter/	F.Sinclair
	- clinically + radiologically -2° to infection.	
	- IV amox, note records ? never given - dig + bisoprolol	
	- CRP 149 (300) WCC 13 (15)	
	- T2RF on gas 09/02	
	- Sputum 10/02 haemophilus + moraxella	
	- previously on NIV. → now off	
	NEWS 7 Chest upper zone wheeze bilaterally	
	- 4L O² via NC Rhdo SNT. Irregular pulse	
	- HR ~120-150 No peripheral oedema	
	- RR 30 Dysphoric. Easily unsettle.	
	Reports feeling okay. Denies SOB, CP, cough.	
	Discussed current situation + plan.	
	Plan - Switch to Co-amox	
	- Pred (not had this admission)	
	- Slow IVF	
	- Start bisoprolol 1.25mg	
	- Cardio referral re uncontrolled HR → not requested currently (attending)	
	- Micro referral re sputum culture	
	- Cont regular nebs	
	- Updated ABG	F.Sinclair
	Pharmacy:	
	Please note, diltiazem dose typically doesn't reach steady state for 7-10 days once initiated. Please repeat level 14hrs post dose on 14/2/25. Thanks.	
		Pharmacy #17882

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7DA

Date & Time		Signature, Print Name & Designation
	TBI reviewed. Above would not benefit from ITU given significant underlying lung disease however may benefit from HDU. At present unsure exactly requiring support in ventilator + NIV can be provided on SDU if NIV for evaluation	
11/02 12:47	ABG - F.SINCLAIR (SHO)	
	cH+ 38.0	
	pCO_2 7.0	
	pO_2 6.0	
	sO_2 79%	
	Compensating for TCO^2 currently. D/w Dr Maynard (SIS) → not currently for NIV.	
	Has been off for ~36 hours now. Can try off NIV going forward but may need on overnight.	
	O^2 now up-titrated to 4L venturi (note ↓ SO^2)	

1308636407 F
SINCLAIR 13/08/1963
Theresa 07

Temperature Corrected cH(T) result
incorrect results flags on printouts
If result reports out with reference
Please disregard result flag and refer to value.
Printed: 11/02/2026 12:33:45

Patient Sample Report

Status: ACCEPTED
Analyzed: 11/02/2026 12:33:32
Sample Type: Arterial
Account Number: NC
Clinician: ZC
Operator ID: MATTHEW KERRIGAN0

Patient
ID: 1308636407
Last Name: SINCLAIR
First Name: THERESA
Gender/Age: Female, 62 years
Birth Date: 13/08/1963

Cartridge
Lot No.: 251208B
S/N: 00000000501363127
Exp. Date: 18/02/2026

Analyzer
Model: GEM® Premier 5000

83949 GGC0072

Date & Time		Signature, Print Name & Designation
18/02	dw Dr McKenna : for ↑ digoxin and to	
13:21	recalculate maintenance dose: new renal fx normal.	
	Weight > 60kg	
	Cr clearance > 50 ml/min	
	Daily dose: 250–375 mcg	
	dw Dr Wade, up-titrate to 187.5 mcg in first	
	instance. [redacted]	
	Plan - START 62.5 mcg	
	- Maintenance ↑ 187.5 mcg	F. Singh
18/2/26	A Wade - TMTD	
	· Discuss above / Myocardial Camera	
	- agrees	
	- scope to ↑ 250 micrograms maintenance	A Wade
		Prem
1/12/26	Wood Hamel Hill	
	1) ® CAT 1 (K COM)	
	CRT remains ↑ 160 (145)	
	Compensated Fx HF on 4L NC	
	On IV commands	
	Acted challenges	

NHS GREATER GLASGOW & CLYDE

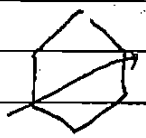
CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7DA

Date & Time		Signature, Print Name & Designation
	2) Fluid balances bolus excessive SVP not ↑ Overload	
	3) UTI / fluids Pt infect clinic ↑ dysp to 250mg Continue β bloods Clinic TFT,	
	4) Rhumat (-ve) Rheum Rhds SNT. BSW,	
	May need fmk NIV Would not be a candidate for ITU / CCU given pre-admit functional status (SOB on minimal exertion) DNR family	

83949 CGC0072

Date & Time	1 · HARRISON FYI	Signature, Print Name & Designation
12/2/26	ATSP re tachycardia . 133 , SpO2 80/. 10L vm .	
0600	62 F 9/w SOB , productive cough → IECOPD . T2RF on V commod .	
	PMH: T2DM , IHD, COPD , OA , diverticulosis	
	Patient reports no pain or breathlessness	
	O/E NEWS 11	
	Patient appears SOB++, ↑ work of breathing , Speaking short sentences .	
	Drowsy but rousable to speech .	
	 widespread wheeze	
	harsh lung sounds 92% on	
	SpO2 80 % on 10L vm → 15L vm . RR 25	
	HS I + II + 0 , irregular pulse , BP 160/80 HR 130 - 150 .	
	peripherally warm, well perfused . No peripheral oedema	
	ECG : A Flutter	Bloods
		CRP 160 , WCC 14.3
	 Abdomen discendu calves SNT	Hb 112
	soft , non tender	ASP 144 , ALT 69
	BS present . BO ✓ - liquid stools x 7 / 24	Alp 135 GGT 91
	Afebrile . GCS 15 .	
	(P) Update bloods	
	VBG → lactate 1.7	
	IVF	
	MSSA	
	Stool sample	Clyn FYI
	nebulisers	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7DA

Please tick ✔ appropriate directorate

Date & Time		Signature, Print Name & Designation
12/2/26	Gentry ST7 # 13220	
0810		
	Perri Arrest call	
	↓ SaO_2, Resp Distress, ↑ HR	
	Background noted ® CAP / IECOPD. NIV	
	this admission for decomp T2RF, AF & lost response	
	A - MoA	
	B - Resp distress, extremis, RR >30	
	On NHF 60/70 SaO_2 ~ 92%	
	Trachea central. AE bilaterally	
	B:- basal crepes	
	C - Tachycardia HR - 140	
	BP 180/70	
	Warm peripherally. No peripheral oedema	
	D - GCS 14/15	
	Glucose 9 Lactate 1.6	
	E - Abdomen soft	
	ABG on NHF H+ 50 pO_2 8. pCO_2 9 HCO_3 35	
	↳ Decomp T2RF	
	CXR - Bibasal patchy change to midzones	
		→

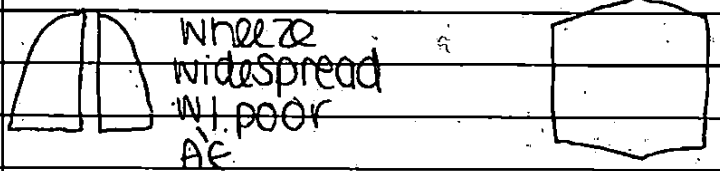
Date & Time		Signature, Print Name & Designation
12/2/26	Contd ST7 Cont	
0820		
	Imp Decomp TZRF on background of pneumonia	
	Decomp HF	
	Plan 1. IV Furosemide 50mg	
	2. IV Hydrocortisone 100mg	
	3. Restart NIV	
	4. Rpt ABG after 1hr	
	5 Continue IV co-amox & clari	
	6. Rlv response to above	
12/2/26	F. Beaton ST4 AMRU reg	
0910	Events noted O/N	
	Further deterioration this AM → ↓ NOT tolerating NIV / oxygen via face mask. SpO_2 ↓ 70%. Agitated ++	
	ISSUES:	
	1) CAP / IECOPD	
	- on IV co-amox / clarithromycin	
	- NB. sputum grew haemophilus + moraxella	
	- Haemophilus ® to co-amox	
	- CXR this AM: bibasal changes + ↑ opacification ⓛU2	
	2) Fluid balance	PTO.
	- Given IV furosemide this AM	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

Thomasina Sinclair F
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
13/08/1963 7
G66 7DA

Date & Time	F. Beaton ST4 CONT	Signature, Print Name & Designation
12/2	- 7700ml urine output	
CONT.	since	
	3) AF W/ RVR	
	- on Dig + DISOPROLOL	
	- HR ~ 130's	
	O/E: Distressed ++	
	Able to tolerate NHF briefly	
	but intermittently pulling it off.	
		SNT
	catheter posing	
	Requiring 60L/55% clear urine	
	to maintain SpO_2 88-92%.	
	Rpt ABG: H+ 40.8↓ pCO_2 7.9↓ pO_2 8.3	
	Lactate 1.3	
	Plan: 1) Further 50 mg IV Furosemide	
	2) NEBS - given but really struggled	
	to tolerate	
	3) DW micro re: abx - ideally IV	
	as didn't take PO meds this am	
	4) ACPS PRN to help facilitate	
	tolerating O_2	
	5) Given dig IV this AM	
	6) Overall prognosis guarded - I will	

83949 GCC0072

Date & Time	F. Beaton ST4 CONT.	Signature, Print Name & Designation
12/2	Update NOK.	
CONT.		
		Beat
12/2/26	F. Beaton ST4	
0935	Updated family on the ward.	
	→ Deterioration this AM with breathing	
	→ Treating for infection / overload.	
	→ Discussed challenges w/ tolerating tx d/t to agitation + giving tx to ↓ agitation.	
	→ Aware @ ceiling of tx and prognosis is guarded	
		Beat
12/2/26	A. O'Hare FYI	
0940	Phone call from micro - on call.	
	↳ Advised IV Tazocin appropriate to cover both haemophilus & moraxella given not tolerating PO tablets.	
	↳ STAT & regular tazocin prescribed on HEPMA ☑.	
		Aoibhe O'Hare FYI

NHS GREATER GLASGOW & CLYDE

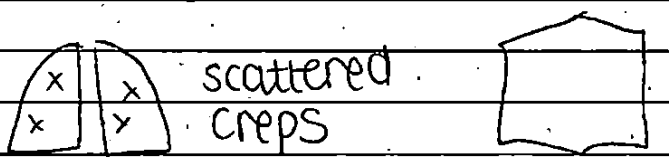
CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

THERESA SINCLAIR
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Date & Time		Print Name & Signation
12.2.26	WR nursery 55/07.	
11.55	H as dead	
	Still on ward treatment.	
	Not CXR reported v slowly	
	pneumonitis.	
	- Inhal cycle paed	
	- Cont IV Taz	
	- on cycle diuretic	
	- Wean O2 as able	
	- Awaiting results for agitation.	
	- DNACPR	
	- Family aware of poor prognosis	
13/2/26	F. Beaton ST4 AMRU reg	
10:25	1) CAP / ECOPD	
	→ Haemophilus / moraxella in sputum - IV taz (D_2) as per micro. BC -ve	
	→ CXR reported ? pneumonitis - on Pred 40mg	
	→ on NHFO2 ↓ FiO_2 O/N - 45L, 44%	
	2) Fluid overload	
	→ on regular IV Furosemide	
		PTO.
	3) AF W, RVR	
	→ Dig + bisoprolol - managed PO meds this AM	

83949 GCC0072

Date & Time	F. Beaton ST4 CONT.	Signature, Print Name & Designation
13/2	→ Rate improved now	
CONT	90-100	
	Blood 12/2 Bili 10	
	WCC (17.6) CRP (136) AST (301)	
	HD 115 ALT (187)	
	Plt (441) ALP (249)	
	A1D (30)	
	On review:	
	observations improving	
	→ HR ↓ 90-100, O_2 requirement ↓	
	SpO_2 88% on 4SL/44%.	
	comfortable.	
	Not agitated on RIV but	
	getting morphine / midaz	
	PRN S/C	
	 scattered creps SN7	
	Plan: 1) Blood today	
	2) continue current tx.	
	3) wean O_2 as able	
	4) prognosis remains guarded	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

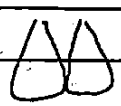
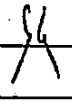
F
13/08/1963

Please tick ✔ a|

Ms T Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time	A Breslin (locum SHO)	Signature, Print Name & Designation
14/02/26	62F	
1120	PMHx: T2DM	
	IHD - Angina	
	COPD	
	OA	
	Diverticulosis	
	A/w (R) CAP | ECOPD |	
	→ was commenced on IV Taz Cov	
	+ve Sputum:	
	- Haemophilus Influenzae	
	- Moraxella Catarrhalis	
	——→ Day 3 IV Taz	
	Issues:	
(1)	Chest:	
	-(R) CAP → ECOPD	
	Rx as above	
	- Degree of pneumonitis on CXR	
	— on 40mg Pred	
	- On HFNO - 60L, 90%	
(2)	AF, rvr	
	- On IV Dig + PO Biso	
	- Rate controlled	
	- Needs on cardiac monitor - Taken off.	
	- Manual HR reading.	

83949 GCC0072

Date & Time	Cont.	Signature, Print Name & Designation
(3)	Overload	
	On reg IV frusemide.	
	Ø sig peripheral oedema	
	Volumes 14/2: In: 70 13/2: In: 500	
	Out: 562 Out: 1090	
	Monitor OP + Renal function +/- slow IVF if	
	reg.	
	Lesh centrally dry.	
	Bloods: 13/2: WCC 14·3 (17·6) Renal fcn improved	
	CRP 73 (135)	
	Nbt cholestatic LFTs - injury - ? 2° to co-trimox.	
	O/E:  Scattered creps	BNFs = ↓ freely
	wheeze noted B/L - upper alw	
	improved a/c ⊖ heart.	
	 SNT.  calves SNT	
	Ø oedema.	
	Pt brighter today - orientated TPP.	
	Very fatigued.	
	Midaz 2mg: 8 x 24/hr ⎫ no agitation ⊖	present
	Morph 2mg: 3 x 24/hr ⎭ very settled.	
	Imp: Clinically improving	
	- still very unwell.	
	P: Wean O2 as able	
=	Back on cardiac monitor given RVR.	
	Cont Taz	
	Chase Bloods	
	D/w family.	
	? CSCI - morph/midaz-	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☒ NURSING ☐

Please tick ✔ appropriate directorate

1308636407
F SINCLAIR F
33 Theresa 13/08/1963

Date & Time	A. Breslin (Locum SHO)	Signature, Print Name & Designation
14/02	Chase pt's bloods:	
e1950	- K^+ 3.1	
	- CRP 51	
	WCC 13.4	
	Volume: - ~500mls	
	Looks slightly dry.	
	For 500ml NaCl + KCl IV	
	- no further fluid.	
	- assess response	
	- caution given overload	
	On IV Furosemide OD 40mg → may req	
	close K^+ monitoring.	ABreslin
15/02	A. Breslin (Locum SHO)	
e0855	Hx + BG noted.	
	Bloods (14/02):	
	WCC: 13.4 (14.3)	
	CRP: 51 (73)	
	AST: 53 (67) ? Transaminitis ?2° to Co-Amox.	
	ALT: 88 (117)	
	ALP: 180 (206)	
	K^+: 3.1 (3.6) — Mg^{2+} added → given AF will rvr should aim	
	to maintain light touch	K^+ ~? > 4.
	↳ on IV Furosemide OD	
	Obs: → BP holding well	↳ BP 110 SBP.
	SpO_2 91%. HFNO 40L, 50%.	
	HR 80-90 → improved rvr.	PTO

Date & Time	cont.	Signature, Print Name & Designation
	Issues	
①	CAP → IECOPD.	
	– IV Taz – day 4	
	+ve sputum: Haemophilus Influenzae	
	Moraxella Catarrhalis.	
	– Pneumonitis on CXR	
	↳ on PO pred 40mg	
	– O_2 req. ↓ – cont to wean as able.	
	– Walkabile repeating CXR today	
②	AF rvr:	
	→ rate improved 80-90 bpm.	
	– remains on cardiac monitor	
	Cont. in persistent AF	
	→ On PO Biso & IV Dig	
	↳ prev NBM.	
③	Pulmonary Overload:	
	– On IV Furosemide 40mg OD.	
	– –ve fluid balance ~400mls.	
	– nil extensive peripheral oedema.	
	– Repeat CXR – move to PO furosemide	
	if ↓ Pul. oedema.	
	– remain centrally dry.	
	O/E:	
	Pt much brighter. Sitting up tolerating	
	HF – not requiring routine clinic.	
	Does not recall events of previous	PD
	week.	
	Orientated T+P.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☒ NURSING ☐

Please tick ✓ appropriate directorate

1308636407
F SINCLAIR
33 Theresa
90a Main Street
Lennoxtown
Glasgow
A
G66 7D
13/08/19

Date & Time	Cont.	Signature, Print Name & Designation
15/02	 remains wheezy - scattered creps. Good ale.	
	 SNT. ? stool chart	
	slightly distended compared to previous.	
	HS 1+11+0	SNT calves
	HR irreg. irreg.	Ø oedema.
	↳ rate 80-90.	
	Imp: Overall improving clinical condition.	
	↳ Hypokalaemia 2' to IV furosemide + lack of intake.	
	P: ~~Bloods~~ Repeat CXR ✓	
	= Move IV furosemide → PO	✓
	Keep IV dig → ? NOST 16/02	
	Chase Bloods	
	Cont ABx	
	Wean O2 as able.	
	Repeat ABGs if desat/↑ tiredness/↑ SoB.	
	~~Utilise midaz/morphine~~	
	D/c midaz/morphine	

83949 GGC0072

Date & Time	Pharmacy	Signature, Print Name & Designation
16/02	• Note edible PO intake / med admin	
0930	↳ ; ↓ digoxin back to PO @ 187.5 micrograms OD	Manuel RN #1330
	• Usual overperiods Zang OD rx on UHMA.	
16/2/26	improving day 5 tazocin	
1625	NEWS: 3. (Still on HFNO but ↓ O_2 40 litres, 50%.)	
	CRP: 27. LFTs improving	
	Plan: , wean O_2	
	• Complete 7/7 tazocin	
	• No more fluids / encourage PO intake	
	• Long term will need DOAC. Repeat CXR today	
	Gulay	
	Prof Gerry McKay Consultant Physician + Clinical Pharmacologist GMC 4057822	
17/02/26	J- While (COPD) 50-51 R/v	
09.00		
	62 (F) a/w ↑ SOB	
	BG: T2DM, IHD, COPD, OA, Diverticulosis	
	Issues	
	(1) ↑ECOPD	
	↳ Sputum cultures grew ~~mor~~ moraxella catarrhalis + haemophilus influenzae	
	→ on D5/7 of tazocin	
	→ on HFNO	
	(2) AF w/ RVR	
	-HR ~90 bpm	→

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
F SINCLAIR
53 Theresa 13/08/191
60a Main Street
Lennoxtown
Glasgow
A G66 7C

Date & Time	S-White (CDF) ctd	Signature, Print Name & Designation
17/02/26	- on bisoprolol + digoxin	
09:00	- on enoxaparin currently, however, will need DOAC counselling in due course.	
	(3) Fluid overload	
	- CxR showed evidence of pulmonary oedema	
	- on 40 mg furosemide daily	
	NEWS 3 - RR 17, SpO2 88% on 10L/21% NHFO2, BP 130/70, HR 90, Afebrile	
	Theresa feeling well. No longer has a cough. Denies SOB	
	O/E HS ITC/TD PEARL Caves SNT	
	Imp: PE (DVT) - improving	
	P (1) Complete abx course	
	(2) bloods today	
	(3) wean off O2	
	(4) ↓ furosemide back to 20mg	
	(5) ECG today	
	(6) once off NHFO2, could go d/c resp	
	(7) OP ECHO (8) DOAC counselling in due course	

83949 GCC0072

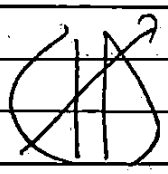
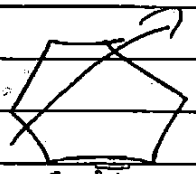
Date & Time		Signature, Print Name & Designation
13/2/22	Y ALI FY1 DAILY RY.	
	NEW TO WARD 7/16.	
	62 ♀ a/w SOB Hx and recent events noted	
	BG: T2DM, IHD, COPD, OA, DIVERTICULOSIS	
	① R CAP + IECOPD. Bloods 17/2.	
	• on D7/7 Taroccin K R-8 URE otherwise.	
	• +sputum cultures CRP 9 WCC 11.6.	
	- Haemophilus Influenzae LFTs deranged.	
	- Moraxella Catarhalis Hb 133.	
	• CXR (8/2/22) - pneumonitis	
	• CXR (12/2/22) - b/L midllower zone consolidation	
	• CXR (18/2) - R zone consolidation, L consolidation improved	
	• completed 5/7 prednisolone	
	• ~~on oxygen~~	
	② AF rvr.	
	• rate unprotected	
	• on PO bisoprolol + digoxin	
	• on enoxaparin, will need DOAC in longer term	
	③ Pulm oedema	
	• on furosemide ~~40mg~~ 20mg OD ~~BD~~	
	NEWS 4	
	90% O_2 on OSLNC BP 98/63	
	RR 16 HR 87	
	apyrexial	
		cont.

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Date & Time		Print Name & Designation
	chest clear nil added sounds   SNT.	HS 1+1+0 wwp. nil peripheral oedema
	Pt feels well, nil SOB/CP/cough.	
	~~Resp~~ c/o back pain and R knee pain (longstanding)	
	improving	
	Plan:	
	· complete Tazocin today	
	· repeat bloods.	
	· wean off O2	
	· OP echo	
	· DOAC counselling	
18/2/22	Plan	
1215	K+ 2.8 even with 5mls K.	
	Also rep. replen. Mg^{2+}.	
	Noted previous digoxin level 1.9. Digoxin changes recently. Also rpt digoxin level today maybe after 2.30pm (6-24 hours post dose)	
15/02	L. MCCLAIN INT2.	
	Aimed: if can cease off cardiac monitor -	
	→ DR stable for several days	
	→ on bisop + dig	
	can stop monitoring	

Date & Time		Signature, Print Name & Designation
18/2/16	S. Boyce Locum SHO (FY1 on-call)	
20:00	→ H10 digoxin level needing done, I note was per any time after 2:30pm + could be 6-24h post dose	
	↳ Due to clinical demand not able to do as yet ∴ have put on HAN for 6am for ward Drs to chase please in AM.	would need to be chased by night team
19/2/16	W1 W17 OB 13.	
	G2 no o/e ↳ Acute Lt no AFO; complex emphysema on CT ↳ Being followed up by respiratic/cardiac on CT T2DM. HTN.	
	Admitted in T2AF.	
	Treated as exac COPD / CAP / HAP.	
	Required fluid of NIV.	
	CRS 300 → 9.	
	Mild CKI also.	
	WCC 11.6.	
	Mrsa/Klebs + Hx. of, in sputum ↳ completed 7/7 treatment	
	AF → on bisoprolol + digoxin → on furosemide 20 (with. 40 + 20) → Mg 0.9 (0.5-1.0)	
	NEWS 3 SI 90% on 0+2 Hx 96+100	

FT/ →

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR
Theresa
F
13/08/1963

Date & Time		Signature, Print Name & Designation
19/2/16	(cont)	
	Rhythm	
	Chest - mins [illegible] crackles,	
	No oedema,	
	INR keeping low - CXR / ECHO + RT.	
	(1) Complete ABx.	
	Replace IV ✓	
	Monitor LFTs,	
	Warm O2.	
	Refer cardiology ward.	
	Mobilise.	
	Check TFTs ✓	
	Echo.	
	DOAC + DOAC counselling.	
	? to document CHADSVASC.	
	Look to start radiotherapy	completed
	med room.	
19/2/16	Plan	CTPO - [illegible]
1158	Digoxin level 0.9 - within range.	Cons
	Advise to check when digoxin at steady state	
	6-24 hours after dose between 23rd - 26th Feb.	
	Mg++ course changed to 3 days - review when	
	course complete	

83949 CCC0072

Date & Time	Phalmacy	Signature, Print Name & Designation
1·40pm 19/2/26	Theresa educated on apixaban BD dosing which will be added to dosette box. Has dental appt pending for false teeth, advised to let dental surgery know in advance. Information card and booklet supplied Laurie White pharm tech #16849	
20/02 10:05	L-MCLEAN IMT2	
	62yo admitted 8/2	
	Issues 1) CAP / exac COPD	
	- tazocin completed	
	- still on reg ipatropium + sal bitannol nebs	
	2) AF	
	- now on apixaban + bisoprolol + rate controlled	
	3) Pulm oedema	
	- furosemide 20mg OD.	
	- alw echo.	
	NEWS 3 9190 0·5L	
	Bloods 19/02 U+ES N K 4·1	
	LFTs improving AST 46 (72) ALT 77 (103)	
	WCC 12·0 (10·9)	
	Feeling well	
	Chest clear - no wheeze	
	Meds - resume mesalazine, mirtazapine, pregabalin	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR F
Theresa 13/08/1983
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time		Signature, Print Name & Designation
	- leave ramipril (BP controlled overnight), simvastatin (LFTs)	
	- stop amitriptyline as hasn't needed it	
	- Spoke to Theresa about stopping diazepam as hasn't had since admission - will have a think	
	Plan 1) wean O2	
	2) ?TTE echo	
	3) med changes as above.	
	4) ?H over weekend w/ CE echo if off O2	
	- will discuss at board round.	
20/2/26	BP 127/70.	
	Improving.	
	If clinically O, ? (H) over weekend w/ CE echo.	
	Does not need IV Lasix	
	Is known inferior CT, planned under A+E pathway.	
	T2RF	
	Is CE update MRI	
	Is IV Lasix choice with CE? Advice of CE home adv.	
	(P) If well, (H) over weekend	
	Pract. MC.	

83949 GGC0072

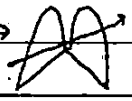
Date & Time		Signature, Print Name & Designation
	L-MCCCOM	
	pCO2 now (N).	
	→ cont. as per prev.	
22/02/26	L. AL SALLOUM (FY2) Discharge Review	
10:30	(62) ♀ Admitted 08/02/26 w/ worsening SOB and productive cough.	
	PMH: T2DM (Metformin). IHD - Angina; COPD; OA; Diverticulitis	
	Bloods (20/02): UrEs - NAD Bili 8 Plts 412	
	CRP 12 AST 51 Albumin 28	
	WCC 12.0 ALT 77.	
	Admission issues:	
	1) CAP / COPD Exacerbation	
	↳ Completed course of IV Tazocin	
	↳ Has been on regular ipratropium and salbutamol nebs	
	2) AF	
	↳ Anticoagulated w/ Apixaban on this admission	
	↳ Rate controlled w/ Bisoprolol	
	3) Pulmonary oedema	
	↳ On PO Furosemide 20mg OD	
	↳ Awaiting OP echo	
	NEWS: 0 SpO2 98% on (A); BP 113/64mmHg; P 70bpm; Apyrexic	
	On RV: Now off oxygen and very keen for home	
	No acute concerns at present	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☑ NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR F
Theresa 13/08/1963

Date & Time	L. AL BALLOUM (FY2) - cont...	Signature, Print Name & Designation
22/02/26	O/E: Alert and orientated	
	A → Patent and own	
	B →  Chest clear B/L	
	No ↑ WoB.	
	C → HS I+II +0. Pulse regular and good volume. CRT <2s	
	D → GCS 15/15. PEARL	
	E → Abdo SNT. BS +ve. Calves SNT.	
	Plan: 1) (H) w/ OP echo.	[signature] BOOBIU

83949 GGC0072

Date & Time		gnature, Print Name & Designation

CHI: 1308636407

Glasgow Royal Infirmary

12

Total Att: 19

12 Mth Att: 0

Title: MS

SINCLAIR Theresa

DOB: 13/08/1963 Age: 52y Sex: Female

90a Main Street
Lennoxtown
Glasgow
G66 7DA

Next of kin: JENKINS, TERESA
Relationship: Daughter
078876623809

GP: RM Wilson
01360 310357

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Attendance Date: 12/10/2015 Arrival Time: 06:40

Registration Time: 06:40 Date of Incident: 12/10/2015

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:

Observation Date: 12/10/2015 07:02

Nurse name: Nurse Linda Spencer

Temp	35.6	C
HR	77	bpm
BP	123/56	mmHg
MAP	78.33	mmHg
RR	16	bpm
SpO2	99	%
Oxygen		%

BM		mmol/L
PF		l/min
Expected PF		l/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: fell 2/7 ago bruising to chin, intoxicated at the time, ? loc, sternal pain since ? struck chest, c spine tenderness collar applied

1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa
1308636407 13/08/1963 SINCLAIR Theresa

To be Completed by Clinician		
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

Date	**Clinical Notes**	
	Seen By	Time Seen

Once Only Prescriptions (Including Tetanus Prophylaxis)

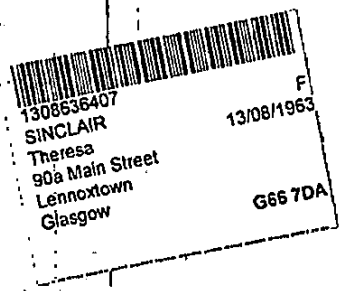
Date Given	Drug (Block capitals)	Dose	Method of Administration	Time of Administration	Signature	Given By

E-Pacer PATIENT REPORT

Time	06:19	Date	12/10/2015

PATIENT AND INCIDENT DETAILS

Incident number	CR002448952.001
Name	THERESA SINCLAIR
Age	Unknown ye
Date of birth	13/08/1963
Gen( )	Female
Incident location	90A MAIN STREET LENNOXTOWN GLASGOW
Incident post code	G66 7DA
Incident type	EMG
Call received	12/10/2015, 05:34
Call passed	12/10/2015, 05:41
Crew mobile	12/10/2015, 05:43
Crew at scene	12/10/2015, 05:53



PRIMARY SURVEY

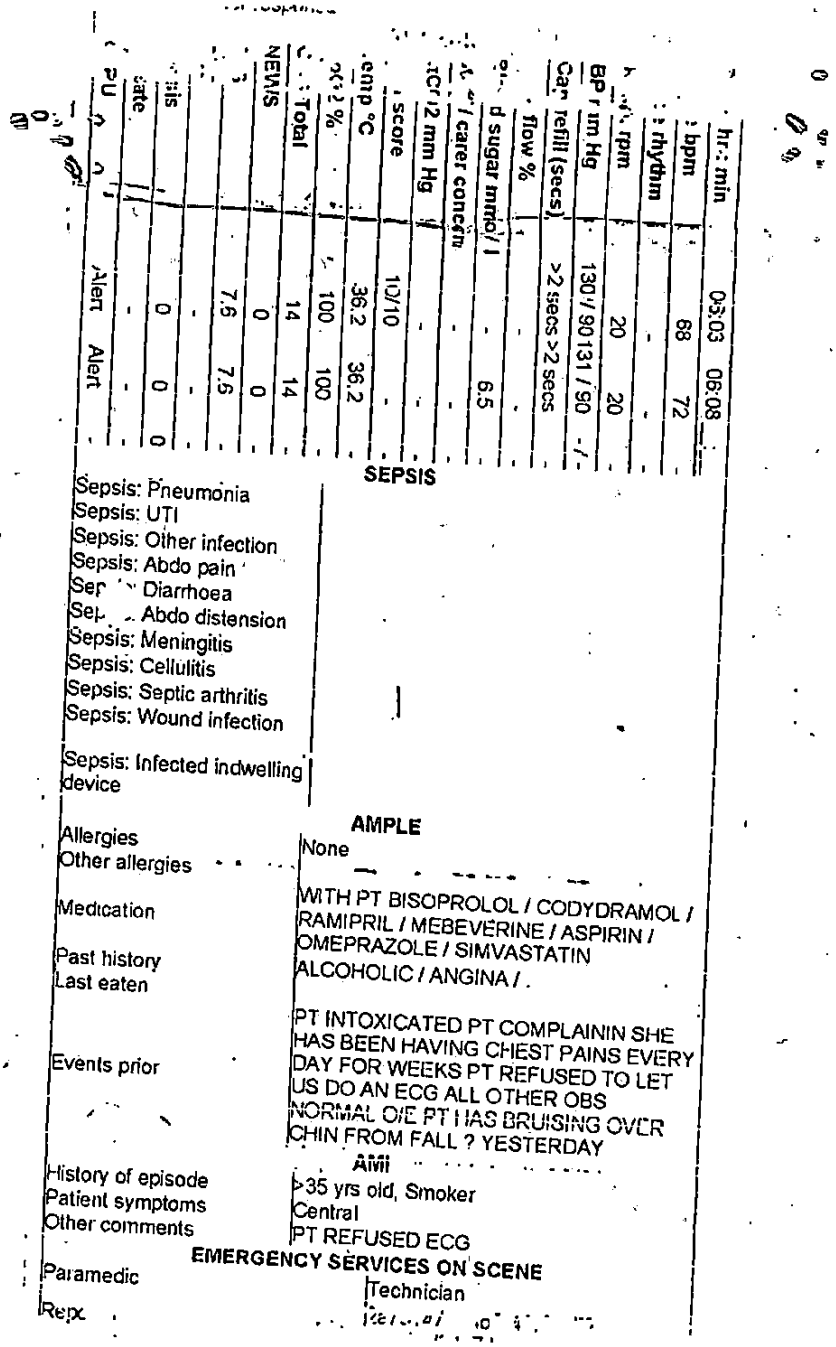
RESPONSE	
AVPU	Alert
AIRWAY	
Airway assessment	Clear
BREATHING	
Breathing rate	Normal
Respiratory rate	20
CIRCULATION	
Pulse rate	Normal
Most peripheral pulse found	Radial
Ca( )ll rate	>2 secs
Skin colour	Normal

AMPDS

Final code	10C02	Chest Pains, Heart Attack or angina history

GCS

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



	hr:: min	05:03	06:08
	bpm	68	72
	rhythm	-	-
	rpm	20	20
BP	mm Hg	130 / 90	131 / 90
Cap	refill (secs)	>2 secs	>2 secs
	flow %	-	-
d	sugar mmol / l	6.5	-
	carer concern	-	-
	12 mm Hg	-	-
	score	10/10	-
	temp °C	36.2	36.2
	%	100	100
	Total	14	14
NEWS		0	0
		7.6	7.6
	itis	0	0
	ate	-	-
PU		-	-
	Alert	Alert	-

SEPSIS

Sepsis: Pneumonia
Sepsis: UTI
Sepsis: Other infection
Sepsis: Abdo pain
Sep Diarrhoea
Sep Abdo distension
Sepsis: Meningitis
Sepsis: Cellulitis
Sepsis: Septic arthritis
Sepsis: Wound infection

Sepsis: Infected indwelling device

AMPLE

Allergies	None
Other allergies	
Medication	WITH PT BISOPROLOL / CODYDRAMOL / RAMIPRIL / MEBEVERINE / ASPIRIN / OMEPRAZOLE / SIMVASTATIN
Past history	ALCOHOLIC / ANGINA / .
Last eaten	
Events prior	PT INTOXICATED PT COMPLAININ SHE HAS BEEN HAVING CHEST PAINS EVERY DAY FOR WEEKS PT REFUSED TO LET US DO AN ECG ALL OTHER OBS NORMAL O/E PT I HAS BRUISING OVER CHIN FROM FALL ? YESTERDAY

AMI

History of episode	>35 yrs old, Smoker
Patient symptoms	Central
Other comments	PT REFUSED ECG

EMERGENCY SERVICES ON SCENE

Paramedic	Technician
Rep.	

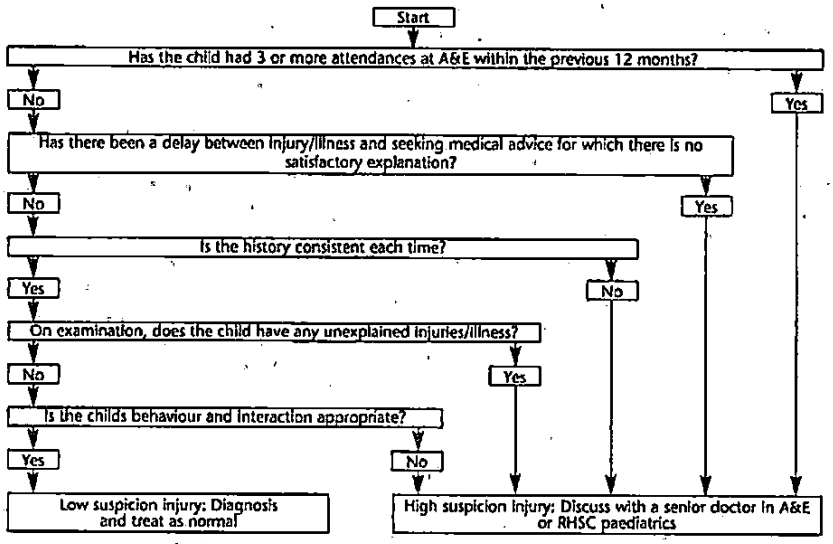
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Injury/Illness Flow Chart for all Patients 16 and under

Please tick the appropriate box as you go through the Flow Chart



All Clinical Staff Consider

H.I.Form ☐

Audit Form ☐

Police Consent ☐

Clinical Notes

[illegible] 10/15 0830 [illegible] [illegible] [illegible]

52 ♀ BIBA pain in neck/back, headache & bruising on cheek.

BG:- prev oD's
- adhesive capsulitis
- depression/suicidal attempts.
- angina
- alcohol xs.

HPC - Pt doesn't remember why she called ambulance or even if it was her.
- Complaining of pain in neck & lower back & headache. Nauseating
- Unsure if she had a fall or how got bruise on cheek/pains.
- Slightly confused re circumstances. Normal disturbance

Please complete where appropriate:

AMT (if >65 years)	CURB Score (if <65 years)
	SIRS

80907

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7DA

Clinical Notes

Date	Time	Name	Grade	Specialty

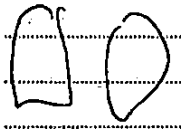
Dhx fluoxetine bisoprolol
codydramol ranitidine
diazepam CTN
nekeveine NKDA

Shx - lives alone.
- ?S alcohol · smoke.
denies any illicit drug use.

SR nil other symptoms note.

O/E Obs: temp 35·6 HR 97 reg BP 123/56 RR 16 sats 99% RA
BM 4·6.
GCS 14 → AVPU 2/4 PEARL.

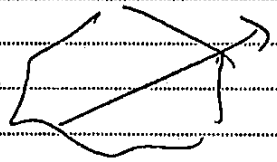
Bruise to chin. No other obvious head injury. - ENT - NAD
CNS - grossly intact. No signs
PNS → Grossly intact → Power ↓, sensn ⓦ ⓝ movement Lat skull #
↳ ↓ sensn C6/7 dermatome Ⓡ hand.



scattered wheeze
trachea central
equal AE

tenderness sternum
& Ⓡ rib 6/7 laterally
No crepitus / bruising

Hx due to
canes INT



INT
↓
nephric instability

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record
(Part A - Acute Assessment)

NHS
Greater Glasgow and Clyde

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Clinical Notes

Date	Time	Name	Grade	Speciality

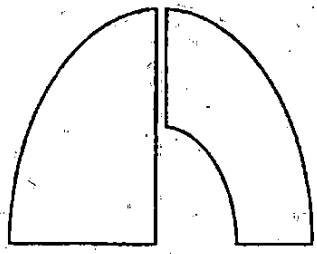
Imp ? Intracerebral bleed
? c-spine / lumbar spine xray #
acute alcohol intoxication

P/ - Bloods, IV access
- CT head/neck, xray lumbar spine & CXR
- ECG - NSR, nil acute
- Pabrinex, cIWS, analgesia
- Immobilised until imgng r/v'd (H-Surg)

- Bloods (W). ethanol level 237
- CT head/neck → nil # / bleed
- CXR no PTx / #'s
- Lumbar xray - N.A.D.

→ Admit medics → acute alcohol intoxication.
(H-Gen)

X-Ray results



Patient Name
DoB
Unit Number

or affix label

ECG findings

Other investigations

Biochem/Haematology results

Indicate which lab tests have been requested

Haem	12/10/15 d time
WCC	8.2
Hb	123
Plat	366
MCV	95.3
Neut	1.9
DDim	Date and time
PT	12
PTT	35
TT	14.

Bioch	12/10/15 d time
Na+	145
K+	4.3
Cl-	(110)
Ur	2.7
Creat	72.
Glu	4.6
CRP	2
Bil	Date and time
AST	25
ALT	16
GGT	(48)
ALP	85
Prot	
Alb	35
Glob	
Ca++	
Amyl	Date and time
TSH	
FT4	
eGFR	760
TropI	Date and time
Chol	
Trig	
Para	Date and time
Sat	
S osm	
ABG	Date and time
H+	
P_aCO_2	
P_aO_2	
Bic	
BE	
FiO_2	
Lactate	

ethanol 237

Fluids Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Drugs Prescribed in A&E

Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time
Drug	dose	route	freq	prescriber	signature	administered by	time

Refusal of Treatment

Hereby I declare that I am leaving

*(or taking _____ away from)

the _____ Hospital at my own desire and contrary to the advice of medical staff.

I have had the risks of so doing explained to me; and accept full responsibility for my action.

Signature _____

Witness Date _____

* Delete whichever is inapplicable.

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/1963

Hospital: GRI	Ward: 50
Date of admission: 12/10/15	Time: 1150
Admitting Consultant:	Admitting Nurse: S Jacobs
Expected date of discharge: / /	

1. Patient Details

Preferred name: TERESA

Age: 87

Religion: RC

Telephone:

Dr. RM Wilson
Lennoxtown Medical Practice
Health Clinic
Main Street
Lennoxtown
G66 7DD

GP telephone:

Next of Kin (NoK): TERESA [illegible]

Relationship: Daughter. CATRINA

NoK Address:

NoK Telephone: 07 884 636043

NoK Aware of admission: ☐ Yes ☑ No

Consent for information to be given to relatives:
☐ Yes ☐ No
Nominated family contact:
Telephone - Day:
Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☑ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Why does the patient think they are in hospital? *Use patients own words:* DOESNT REMEMBER

3. Allergies (including food allergies)

No known allergies: ☐

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
			76	124 | 82	16	97	~~96~~ 35.4
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

7. Risk Assessment

MUST

1. Is the patient's BMI: H 5ft 2 W 8 1/2 st
   - > 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score ☐
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score ☐
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0

   Score ☐

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Name: [redacted]
Adc 1308636407 F
SINCLAIR 13/08/1963
DoB Theresa
CHI 90a Main Street
Lennoxtown
Glasgow G66 7DA

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade.....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☑ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☑ Yes ☐ No

If 'Yes' how many per day: 20-40pd

Does the patient use nicotine replacement therapy? ☐ Yes ☑ No

Does the patient wish referral to Smoking Cessation Service? ☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT):	Signature:
Designation:	Date:

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: GRI	Ward: 50
Date of Assessment: 12/10/15	Time: 1150

Name: .....
Address: .....
1308636407
SINCLAIR
Theresa F
DoB: ..... 90a Main Street 13/08/1963
CHI numbe Lennoxtown
Glasgow
G66 7DA

1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [ ] No symptoms
- [x] Known cardiac or circulatory problems

Problem identified: [ ] Yes [ ] No If 'Yes' please describe

ANGINA.

Initial JW

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

ENGLISH

Interpreter: Required [ ] Not required [x]

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome?
[ ] Yes [x] No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.
Liaison Learning Disability Team contacted:
[ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia?
[ ] Yes [x] No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- [x] Normal vision
- [ ] Glasses – [ ] Distance [ ] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Mental Status

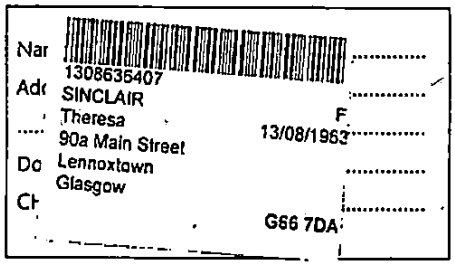
Mental Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Unconcious

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial JW

5. Hydration and Nutrition



MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☐ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☐ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☐ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial JW

6. Elimination

Continent:
☐ Bladder
☐ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☐ No If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☐ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☐ No
If 'Yes' please specify and list appliances used:

Problem identified: ☐ Yes ☐ No If 'Yes' please describe

Initial JW

1308635407
SINCLAIR
Name: Theresa F
Address: 90a Main Street 13/08/1963
Lennoxtown
Glasgow
DoB:
CHI number: G66 7DA
Affix patient data label

7. Personal Hygiene, Oral Health and Skin Assessment

Personal hygiene:
- [x] Self-caring and independent
- [ ] Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☐ Yes	☐ No
Does the the patient have a sore mouth	☐ Yes	☐ No
Does the patient have a non healing mouth ulcer	☐ Yes	☐ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:
- ☐ Required
- ☐ Not required

Dentures:
- [x] Not worn
- ☐ Upper set
- ☐ Lower set
- ☐ Full set
- ☐ Dentures with patient on admission

Skin assessment:
- [x] Skin healthy with no evidence of damage
- ☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes [x] No ☐ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

Problem identified: ☐ Yes [x] No If 'Yes' please describe

Initial JW

8. Mobility

Patient fully mobile / independent? [x] Yes ☐ No If 'No' complete Moving and Handling Assessment.

- ☐ Limited mobility
- ☐ Mobile with aid – Specify:
- ☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
- ☐ Yes ☐ No

Problem identified: ☐ Yes [x] No If 'Yes' please describe

Initial JW

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes [x] No

If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes [x] No

Bed rails required:
- ☐ Required
- [x] Not required

Problem identified: ☐ Yes [x] No If 'Yes' please describe

Initial JW

1308636407
Name: SINCLAIR F
Theresa 13/08/1963
Address: 90a Main Street
Lennoxtown
Glasgow
G66 7DA
DoB:
CHI number:
Affix patient data label

10. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☑ None ☐ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☐ No

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

	Initial
	JW

11. Social Circumstances

☐ Employed ☑ Unemployed ☐ Retired
☑ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☑ None

If support services in place, please provide details:

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

	Initial
	JW

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?
☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
13/08/1963
G66 7DA

14. Anticipatory Care
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☒

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:	Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐	Home: ☐ Hospital ☐ Hospice ☐
Current treatment – please identify (e.g. chemotherapy/ radiotherapy):	Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT):

Signature:

Designation: | Date:

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
12/10/15	NURSING NOTES	
	53 YEAR OLD FEMALE ADMITTED TO WARD	
	VIA A&E, OBS STABLE ON ARRIVAL	
	APPEARS INTOXICATED. AWAITS	
	CONSULTANT R/V ON WARD	TLOR (S/N)

Clinical Notes continue on next page

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation

Glasgow Royal Infirmary
Acute Medicine Unit

(Part B - Medical Admission)

NHS
Greater Glasgow and Clyde

Patient Name
1308636407
SINCLAIR
Theresa
F
13/08/1963

Date & Time	Consultant	Ward

Ward Review (Should be completed within 2hrs of transfer from ED)

Check List

VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
Patient on Bleeders list	☐

Ward Review

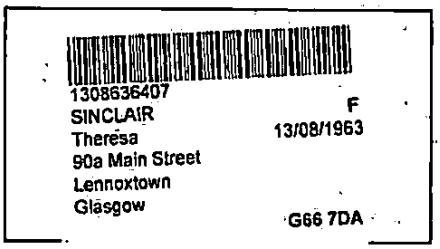
12/10/15 Nursing
12[N]: 52 yr old female pt got admitted through A&E c/o BIBA c/o neck/back/headach. O/E pt is alert - but could not remember anything. Still intoxicated. oriented to ward. awaiting Seniour review.

Sheen CSW

NHS GG&C Adult Risk Assessment for Venous Thromboembolism (VTE)

[excluding orthopaedics, obstetrics and gynaecology & ENT who have specialty-specific policies]

- Risk Assessment must be completed for all patients within 24 hours of admission to hospital
- Patients must be reassessed every 48-72 hours or sooner if condition changes
- Reassessment must be documented in Kardex
- Please complete risk assessment and then sign and date Risk Assessment Result box at bottom of page.



Surgical patients start here

Non-operative [mainly medical] patients start here

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

Yes ☐ No ☐

Does the patient have any risk factors for thrombosis? (tick √ all that apply)

Age >60	☐	Use of oestrogen-containing contraceptive therapy	☐
Active cancer or cancer treatment	☐	Use of hormone replacement therapy	☐
Dehydration	☐	Pregnancy or < 6 weeks post partum [seek specialist advice]	☐
Known thrombophilias	☐	Critical care admission eg HDU/ITU	☐
Obesity (BMI>30)	☐	Total anaesthetic + surgical time >90 minutes	☐
Current significant medical condition e.g. Serious infection, Heart failure, Respiratory disease or inflammatory disease	☐	Surgery involving pelvis or lower limb with a total anaesthetic + surgical time >60 minutes	☐
Personal history or first degree relative with a history of VTE	☐	Acute surgical admission with inflammatory or intra-abdominal condition	☐
Varicose veins with phlebitis	☐	Hip fracture	☐

- No thromboprophylaxis required.
- Continue to reassess every 48-72 hours or sooner if condition changes.
- Document all reassessments in drug kardex.
- Risk assessment now complete
- Complete Risk Assessment Result Box

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (tick √ all that apply)

Active bleeding	☐	Untreated inherited bleeding disorders (e.g. haemophilia or von Willebrands)	☐
Acquired bleeding disorders (e.g. acute liver failure)	☐	Neurosurgery, spinal or posterior eye surgery	☐
Concurrent use of anticoagulants (such as warfarin with INR>2)	☐	Lumbar puncture, epidural/spinal anaesthesia expected within the next 12 hours	☐
Acute stroke	☐	Other procedure with high bleeding risk – discuss with senior if unsure	☐
Uncontrolled hypertension (230/120 mmHg or higher)	☐	Lumbar puncture, epidural/spinal analgesia within the previous 4 hours	☐
Thrombocytopenia (<75 x 10⁹/l)	☐	Thyroid surgery	☐

- Discuss with senior clinical staff before prescribing pharmacological prophylaxis
- Consider mechanical prophylaxis e.g. AES unless contra-indicated.
- Reassess patient every 48-72 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical patients – Enoxaparin 40mg + AES ☐*

*prior to application of AES, please check contraindications to AES

Medical patients – Enoxaparin 40mg ☐

Prescribe Enoxaparin at 6pm

[on day of surgery, at the later of either 4h post-op or 6pm]

Reduce Enoxaparin to 20mg if <50Kg or eGFR <30ml/minute/1.73m² ☐

Discontinue at discharge or when returned to pre-morbid mobility

Contraindications to anti-embolism stockings (AES) Y ☐ N ☐

Peripheral neuropathy	☐
Peripheral vascular disease	☐
Cellulitis or Gross oedema	☐
Leg deformity or Fragile skin	☐
Leg / foot ulcers	☐
Allergy	☐
Unusual leg size/shape	☐

Risk assessment result – please tick √ all that apply

VTE risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis: YES ☐ NO ☐ Prescribed: LMWH ☐ AES ☐ NONE ☐

Patient informed of VTE risks and benefits of thromboprophylaxis YES ☐ NO ☐ N/A ☐ Information leaflet provided YES ☐ NO ☐

Print Assessor's Name: _____ Signature: _____ Date: _____

Medicine Reconciliation Form

Source of information: ECS ☑

Patient ☑ Relative/carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☑ Other (specify) _____

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	withold	Stop	continue	Reason for alteration
fluoxetine	40mg	od	o					
co-dydramol 10/500	1	qds	o				✓	
Diazepam	2mg	od	o	✓				*Daily dispense.
mebeverine	135mg	tds	o				✓	
bisoprolol	2.5mg	od	o				✓	
Simvastatin	40mg	nocte	o				✓	
Lansoprazole	2.5mg	od	o				✓	
GTN spray	1	prn	SL				✓	
Aspirin	75mg	od	o				✓	
Omeprazole	20mg	od	o				✓	
Allergies/adverse events	NKDA							

List obtained by Eimear Gordon Designation Pharmacist

Recently altered/discontinued medicines prior to admission and reasons why _____

Compliance aid? Y ☐ N ☐ Type _____ If, Y Community Pharmacy _____ Phone _____

Senior Medical staff review: Sign _____ Title _____ Date and Time _____

Reviewed by pharmacist _____ Date and Time 13/10/15

Comments

Consultant Review

Admits to drinking alcohol to excess

Binge drinking, wine + spirits since

past 4/52, Prev 4/0 05's, but clean

Pharmacy Head injuries

q/c few telangiectasia (spider naevi)

N° signs of hepatic or splenic ↑

Bloods (N) except ↑ GGT

↓ Alcohol excess

Pan counsel FAST sheet

Comms - few issued above if appropriate

Pharmacy

Pan (N) Thiamine if withdrawing

1308636407
SINCLAIR
Theresa
F
13/08/1953

Check List	
VTE	☐
Med - Rec	☐
Kardex	☐
CxR	☐
ECG	☐
Oxygen	☐
EDD	

PRINT NAME CLEARLY	DESIGNATION
SIGNATURE	DATE COMPLETED

Nad ops

Clinical Notes

13·10·15 @ 0600 NURSING CMCFTU. Comfortable overnight, no complaints offered. Symptoms triggered GMAWS discontinued as consistently scoring 0. Vitals stable. Oral medications as per Kardex. Please note pt usually takes fluoxetine 20mg in the morning & then 20mg at night. Aplleo

13/10/15 WM COWAN
1100

WELL.
NOT SCORING ON GMAWS
BGS STABLE.
CHAS CAT FOLLOW 15/10

→ (H) ON THIAMINE

WCowan
COWAN | CMHS | 35466

13/10/15 1130AM (NURSING) Self caring with ADLs.
Morning medicines given.
Mobile around room
Taking diet and fluids
IV pabrinex stopped
Observations as charted
for house on thiamine.

TM

Care Rounds Checklist

Date: 09/02/26

Attach A

1308635407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

NHS Greater Glasgow and Clyde

Ward: 5015

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

1. Signed GR Name GRobertson Designation CN
2. Signed [signature] Name [signature] Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

keep me up to date.

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	01 46	05 30	09 00	12 30	15 10	18 30
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		Y	Y	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:		Y	N	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	/	INT	INT	M	M
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	L	B	R	B	B
		Chair Assist to walk or stand (W/ST)		/	/	-	T	T	T
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		C	C	C	C	C	C
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N	N
		Drink taken?		N	S	Y	Y	Y	Y
		Food, snack, or supplement taken?		N	S	N	Y	N	Y
		Has oral hygiene been carried out as per care plan?		N	S	N	N	N	/
	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 lowest position?		Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	N	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	N	N	NA	NA
		Care provider / role		GR	/	CR	CR	N	N

Care Rounds Variance Sheet

Attach Addressograph Label	NHS Greater Glasgow and Clyde
Ward:	

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
9/2/26	1500	3	Patient has moisture damage under apron folds.	
			Remain 3° CRC as 2° turns will not help apron	
			folds.	Carol Crawford
	1850	4	Refused to turn on side as comfortable on back.	
			Remaining on back preferable due to ↓ sats +	
			NIV requirement. Carol Crawford.	

mi • 278936 v2.1 • GGC0098

Fluid Balance Chart

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Hospital: GRI
Ward: ED
Date: 8/9/26

Reason for Fluid Balance Chart: AKI
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids? Yes ☐ No ☐ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type circle how many daily 1 2 3
2. Type circle how many daily 1 2 3
Signature: Designation: RN

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00										60						60	CH
02:00																	
03:00																	
04:00					IVF	100ml											
05:00										260						320	LM
06:00																	
07:00					IVF	500ml											
08:00					IVF	500			1500	180						500	KE
09:00										70						570	KE
10:00																	
11:00										130						700	KE
12:00					IVF	500			2000	60						760	KE
13:00										80						840	KE
14:00										40						880	KE
15:00					IVF	500			2500	80						960	KE
16:00																	
17:00										180						1140	KE
18:00										280						1420	KE
19:00										100						1520	KE
20:00																	
21:00																	
22:00					IV	500					bag emptied						
23:00																	
							*Total Intake						*Total Output			*24 hr Fluid Balance +/-	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

IDE 1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

NIV Proforma - to be completed for all patients commencing NIV acutely

NHS Greater Glasgow and Clyde

- **All patients must have COPD and acidotic type II respiratory failure**
- **All patients should have 1 hour of standard medical therapy prior to starting NIV**

Escalation	HDU	ITU	DNACPR
	(YES) / NO	YES / NO	YES / NO

Plans for escalation should be determined prior to commencing NIV and documented in case notes

ABG:	Initial	1hr (0057)	4hr	12hr
PaO_2	~~8.2~~ 8.2	8.3		
$PaCO_2$	8.7	7.2		
H^+	52.9	46.4		
HCO	29.1	28.5		

	1. Setting	2. Setting	3. Setting	4. Setting	5. Setting	6. Setting	Extra changes	Date/Time Extra changes
IPAP	10	12	14	16	18	20	20	
EPAP	4	4	4	4	4	4	4	
FiO2	6L	6L	5L	5L	5L	5L	4L	
SpO2	91%	93%	91%	91%	91%	90%	89%	

1. Start IPAP at 10. Increase by increments of 2 every 2-5 minutes. Aim for IPAP 20
2. EPAP at 4
   Rise Time 1
   Exp Trigger 2
   Insp Trigger 2
   Do not change, but refer to respiratory team at earliest opportunity.
3. Minimum FiO_2 to keep SaO_2 88-92%
4. ABG @ 1hr, 4hrs, 12hrs and only outwith if clear clinical deterioration.
5. Can come off mask for medications, nebs, hydration and breaks.
6. Continuous pulse oximetry, Hourly RR, BP, and GCS in first 12 hours.
7. If benefit is acheived from NIV it should not be stopped abruptly (see example weaning schedule)

Weaning can commence once acidosis has resolved and clinical condition improved.

Example:

Day 1 – Extend breaks during the day, continuous overnight

Day 2 – Off during the day, continuous overnight

Day 3 – Stop

- **Failure to wean sufficiently can result in further episodes of respiratory acidosis**
- **The above schedule is an example, longer treatent may be necessary**
- **Most patients will require nocturnal NIV for 2 further nights after respiratory acidosis has resolved.**

Patient
Address

AFFIX PATIENT ID

Hospital No.
DOB

NIV Observation Chart

Respiratory Department

NHS Greater Glasgow and Clyde

Date _____ Ward _____

If H+ and CO2 remain elevated, then increase IPAP in increments of 1-2cms H20 as tolerated by patient

CONTINUING NIV						
Time	IPAP	EPAP	FiO2	RR	O² sats	HR
2300	20	4	1L	32	88	133

MIS 299635

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS
Greater Glasgow and Clyde

1

1308636407
SINCLAIR
Theresa F
90a Main Street 13/08/1963
Lennoxtown
Glasgow
G66 7DA

	Date	Ward	Time
Admitted			
Transferred	9/2/26	5015	0120
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☒
Signature:	Signature: Laura Martin	If yes, add details of oxygen therapy
Print Name:	Print Name: LAURA MARTIN	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY: LM	
Date:	Date: 8/2/26	

Document all actions and interventions

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: .....

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
13/08/1963
Fit ID

| | | |

(2)

NEWS 2 Key | 1 | 2 | 3

| | | |

Glasgow Coma Scale

| | | |

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date & Time		Signature, Print Name & Designation
	3 month CT scan + telephone	
	full PFTs	
	Social: 20/day - 50 pack yrs, no ETOH 7 yrs, no drugs, coping w/ ADLs	
	Can walk 50 metres + one flight of stairs.	
	NO haemoptysis / weight loss / night sweats, no ankle swelling / chest pain	
	Sputum → H. influenzae - treated + so improved	

Inpatient prescription & administration record for Theresa Sinclair (1308636407)
Admission: 09/02/2026 => 22/02/2026

04:04
25/02/26

Patient Demographics

SINCLAIR Theresa (1308636407)
DOB: 13/08/1963
90A Main Street, Lennoxtown,
Glasgow,
G66 7DA

Admitted: 09/02/2026 01:20
Discharged: 22/02/2026 14:23

Transfer history

Admission	2026-02-08 15:30:00	RAE GRI ED
Transfer	2026-02-09 01:20:00	R50 GRI WD 50/1
Transfer	2026-02-17 21:49:00	R7 GRI WD 7/16

Responsible Consultant history

Assigned No Consultant	08/02/26	15:30
Frances Mcmanus	09/02/26	01:20
David Carty	12/02/26	09:42
Brian Choo-Kang	21/02/26	14:20

Allergy

Admission Allergy Check performed by:
Current recorded allergy (reaction): No Known Drug Allergies

Allopurinol 100 mg Tablets

☒ 09/02/26 07:00 100 mg ONCE daily at 7am (Oral) — Antoin Breslin

09/02/26	07:00	09/02/2026	09:15	Rebecca Crawford
10/02/26	07:00	10/02/2026	08:42	Lynn Costello
11/02/26	07:00	11/02/2026	08:06	Lynn Costello
12/02/26	07:00			Holly Bell Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha
15/02/26	07:00	15/02/2026	08:31	Nicole Cunningham
16/02/26	07:00	16/02/2026	08:11	Nicole Cunningham
17/02/26	07:00	17/02/2026	09:11	Cavel Flemming-Gumbs
18/02/26	07:00	18/02/2026	08:18	Ann-Marie Gilfoyle
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
20/02/26	07:00	20/02/2026	07:59	Ann-Marie Gilfoyle
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham

Amitriptyline 10 mg Tablets

☒ 09/02/26 22:00 10 mg ONCE daily at 10pm (Oral) — Antoin Breslin

09/02/26	22:00	Suspended

☒ 10/02/26 22:00 20 mg ONCE daily at 10pm (Oral) — Lucy Wells PIP

10/02/26	22:00	Suspended
11/02/26	22:00	Suspended
12/02/26	22:00	Suspended
13/02/26	22:00	Suspended
14/02/26	22:00	Suspended
15/02/26	22:00	Suspended

Discontinued on: 16/02/2026 09:24:24 by: Cameron Hannah PIP . Reason: Discontinued due to conflict .

☒ 16/02/26 22:00 20 mg ONCE daily at 10pm (Oral) — Cameron Hannah PIP

16/02/26	22:00	Suspended
17/02/26	22:00	Suspended
18/02/26	22:00	Suspended
19/02/26	22:00	Suspended

Discontinued on: 20/02/2026 11:06:00 by: Lauren McLean . Reason: Course Complete

Amoxicillin 1000 mg (1g) Injection

☒ 09/02/26 07:00 1,000 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Intravenous Slow Bolus Injection) — Antoin Breslin

09/02/26	07:00	09/02/2026	07:03	Alana Geddes/ Claire-Ann Rennie
09/02/26	12:00	09/02/2026	12:51	Rebecca Crawford/ Lynsey Barrie
09/02/26	17:00	09/02/2026	17:46	Rebecca Crawford/ Flora Chinenye Ike-Anekwe
09/02/26	22:00	09/02/2026	21:38	Emma Connor/ Kathryn Mackie

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Amoxicillin 1000 mg (1g) Injection *(Continued)*

10/02/26	07:00	10/02/2026	07:00	Kathryn Mackie/ Chloe Linning	
10/02/26	12:00	10/02/2026	12:57	Lynn Costello/ Kirsty McDougall	
10/02/26	17:00			Lynn Costello	Prescription Clarification Required
10/02/26	22:00	10/02/2026	21:19	Emma Connor/ Jodie Middlemass	

☒ 11/02/26 07:00 1,000 mg THREE TIMES DAILY 7am:12pm:10pm (Intravenous Slow Bolus Injection) — Jordan Gan

11/02/26	07:00	11/02/2026	05:21	Aimee Wojcik/ Emma Connor	

Discontinued on: 11/02/2026 09:14:19 by: Duncan Finlay Sinclair . Reason: Discontinued due to conflict

☒ 09/02/26 02:40 1,000 mg (Intravenous Slow Bolus Injection) — Antoin Breslin

09/02/26	02:40	09/02/2026	02:40	Claire-Ann Rennie/ Rodrigo Dela pena	

Apixaban 5 mg Tablets

☒ 19/02/26 22:00 5 mg TWICE daily at 7am and 10pm (Oral) — Lauren McLean

19/02/26	22:00	19/02/2026	21:43	Nicole Valentine	
20/02/26	07:00	20/02/2026	08:06	Ann-Marie Gilfoyle	
20/02/26	22:00	20/02/2026	22:34	Elizabeth Walsh	
21/02/26	07:00	21/02/2026	08:40	Sarah Cunningham	
21/02/26	22:00	21/02/2026	23:02	Elizabeth Walsh	
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham	

Aspirin 75 mg Dispersible Tablets

☒ 09/02/26 07:00 75 mg ONCE daily at 7am (Oral) — Antoin Breslin

09/02/26	07:00	09/02/2026	09:08	Rebecca Crawford	
10/02/26	07:00	10/02/2026	08:44	Lynn Costello	
11/02/26	07:00	11/02/2026	08:07	Lynn Costello	
12/02/26	07:00			Holly Bell	Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
15/02/26	07:00	15/02/2026	08:33	Nicole Cunningham	
16/02/26	07:00	16/02/2026	08:12	Nicole Cunningham	
17/02/26	07:00	17/02/2026	09:12	Cavel Flemming-Gumbs	
18/02/26	07:00	18/02/2026	08:21	Ann-Marie Gilfoyle	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	

Discontinued on: 19/02/2026 12:04:00 by: Lauren McLean . Reason: Course Complete

Bisoprolol 1.25 mg Tablets

☒ 09/02/26 07:00 1.25 mg ONCE daily at 7am (Oral) — Antoin Breslin

09/02/26	07:00	09/02/2026	09:16	Rebecca Crawford	
10/02/26	07:00	Suspended			

Discontinued on: 10/02/2026 10:58:48 by: Kate Stevens . Reason: Discontinued due to conflict

☒ 09/02/26 11:42 1.25 mg (Oral) — Duncan Finlay Sinclair

09/02/26	11:42	09/02/2026	12:24	Rebecca Crawford	

☒ 11/02/26 09:24 1.25 mg (Oral) — Duncan Finlay Sinclair

11/02/26	09:24	11/02/2026	09:43	Lynn Costello	

Bisoprolol 2.5 mg Tablets

☒ 11/02/26 07:00 2.5 mg ONCE daily at 7am (Oral) — Kate Stevens

11/02/26	07:00	11/02/2026	08:08	Lynn Costello	

Discontinued on: 11/02/2026 09:24:40 by: Duncan Finlay Sinclair . Reason: Discontinued due to conflict

☒ 10/02/26 10:58 2.5 mg (Oral) — Kate Stevens

10/02/26	10:58	10/02/2026	11:01	Lynn Costello	

☒ 10/02/26 16:09 2.5 mg (Oral) — Caitlin Christie

10/02/26	16:09	10/02/2026	16:12	Lynn Costello	

Bisoprolol 3.75 mg Tablets

☒ 12/02/26 07:00 3.75 mg ONCE DAILY MORNING 7am (Oral) — Duncan Finlay Sinclair

12/02/26	07:00			Lyndsay Wilson	Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
15/02/26	07:00	15/02/2026	08:36	Nicole Cunningham	
16/02/26	07:00	16/02/2026	08:13	Nicole Cunningham	
17/02/26	07:00	17/02/2026	09:14	Cavel Flemming-Gumbs	

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Bisoprolol 3.75 mg Tablets *(Continued)*

18/02/26	07:00	18/02/2026	08:23	Ann-Marie Gilfoyle	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	
20/02/26	07:00	20/02/2026	08:04	Ann-Marie Gilfoyle	
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham	
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham	

Clarithromycin 500 mg Tablets

☒ 09/02/26 07:00 500 mg TWICE daily at 7am and 10pm (Oral) — Antoin Breslin

09/02/26	07:00	09/02/2026	09:12	Rebecca Crawford	

Discontinued on: 09/02/2026 12:37:49 by: Duncan Finlay Sinclair . Reason: Discontinued due to conflict

☒ 09/02/26 02:40 500 mg (Oral) — Antoin Breslin

09/02/26	02:40	09/02/2026	02:40	Claire-Ann Rennie/ Rodrigo Dela pena	

☒ 11/02/26 22:00 500 mg TWICE daily at 7am and 10pm (Oral) for 5 day(s) — Naznin Ferdhusi

11/02/26	22:00	11/02/2026	22:26	Emma Connor	
12/02/26	07:00			Aoibh Ohare	Drug discontinued

Discontinued on: 12/02/2026 09:43:00 by: Aoibh Ohare . Reason: Course Complete

Co-amoxiclav 1000/200 Intravenous Injection

☒ 11/02/26 12:00 1,200 mg THREE times daily - 7am;12pm;10pm (Intravenous Slow Bolus Injection) — Duncan Finlay Sinclair

11/02/26	12:00	11/02/2026	12:49	Lynn Costello/ Holly Bell	
11/02/26	22:00	11/02/2026	21:52	Emma Connor/ Jodie Middlemass	
12/02/26	07:00	12/02/2026	06:39	Emma Connor/ Sarah Kelly	

Discontinued on: 12/02/2026 09:43:00 by: Aoibh Ohare . Reason: Course Complete

Colecalciferol 1,000 units Tablets

☒ 09/02/26 07:00 1,000 unit ONCE daily at 7am (Oral) — Antoin Breslin

09/02/26	07:00	09/02/2026	09:15	Rebecca Crawford	
10/02/26	07:00	10/02/2026	08:43	Lynn Costello	
11/02/26	07:00	11/02/2026	08:06	Lynn Costello	
12/02/26	07:00			Holly Bell	Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
15/02/26	07:00	15/02/2026	08:32	Nicole Cunningham	
16/02/26	07:00	16/02/2026	08:11	Nicole Cunningham	
17/02/26	07:00	17/02/2026	09:11	Cavel Flemming-Gumbs	
18/02/26	07:00	18/02/2026	08:18	Ann-Marie Gilfoyle	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	
20/02/26	07:00	20/02/2026	08:00	Ann-Marie Gilfoyle	
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham	
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham	

Cyanocobalamin 50 micrograms Tablets

☒ 09/02/26 07:00 100 microgram ONCE DAILY MORNING 7am (Oral) — Antoin Breslin

09/02/26	07:00	09/02/2026	09:15	Rebecca Crawford	
10/02/26	07:00	10/02/2026	08:43	Lynn Costello	
11/02/26	07:00	11/02/2026	08:06	Lynn Costello	
12/02/26	07:00			Holly Bell	Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
15/02/26	07:00	15/02/2026	08:32	Nicole Cunningham	
16/02/26	07:00	16/02/2026	08:12	Nicole Cunningham	
17/02/26	07:00	17/02/2026	09:11	Cavel Flemming-Gumbs	
18/02/26	07:00	18/02/2026	08:20	Ann-Marie Gilfoyle	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	
20/02/26	07:00	20/02/2026	08:00	Ann-Marie Gilfoyle	
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham	
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham	

Diazepam 2 mg Tablets

☒ 09/02/26 07:00 2 mg TWICE DAILY 7am:10pm (Oral) — Antoin Breslin

09/02/26	07:00	Suspended			
09/02/26	22:00	Suspended			
10/02/26	07:00	Suspended			
10/02/26	22:00	Suspended			

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Diazepam 2 mg Tablets *(Continued)*

11/02/26 07:00	Suspended	
11/02/26 22:00	Suspended	
12/02/26 07:00	Suspended	
12/02/26 22:00	Suspended	
13/02/26 07:00	Suspended	
13/02/26 22:00	Suspended	
14/02/26 07:00	Suspended	
14/02/26 22:00	Suspended	
15/02/26 07:00	Suspended	
15/02/26 22:00	Suspended	
16/02/26 07:00	Suspended	
16/02/26 22:00	Suspended	
17/02/26 07:00	Suspended	
17/02/26 22:00	Suspended	
18/02/26 07:00	Suspended	
18/02/26 22:00	Suspended	
19/02/26 07:00	Suspended	
19/02/26 22:00	Suspended	
20/02/26 07:00	Suspended	
20/02/26 22:00	Suspended	
21/02/26 07:00	Suspended	
21/02/26 22:00	Suspended	
22/02/26 07:00	Suspended	

Digoxin 62.5 micrograms Tablets

☒ 11/02/26 13:18 62.5 microgram (Oral) — Duncan Finlay Sinclair

11/02/26 13:18	11/02/2026 13:45	Lynn Costello		

☒ 12/02/26 07:00 187.5 microgram ONCE DAILY MORNING 7am (Oral) — Duncan Finlay Sinclair

12/02/26 07:00		Aoibh Ohare	Drug discontinued

Discontinued on: 12/02/2026 09:27:00 by: Aoibh Ohare . Reason: Formulation/Route Change

☒ 11/02/26 18:57 62.5 microgram (Oral) — Naznin Ferdhusi

11/02/26 18:57	11/02/2026 19:13	Lynn Costello	

☒ 17/02/26 07:00 62.5 microgram ONCE DAILY MORNING 7am (Oral) — Cameron Hannah PIP

17/02/26 07:00	17/02/2026 09:19	Cavel Flemming-Gumbs
18/02/26 07:00	18/02/2026 08:24	Ann-Marie Gilfoyle
19/02/26 07:00	19/02/2026 07:52	Sarah Cunningham
20/02/26 07:00	20/02/2026 08:05	Ann-Marie Gilfoyle
21/02/26 07:00	21/02/2026 08:39	Sarah Cunningham
22/02/26 07:00	22/02/2026 08:48	Sarah Cunningham

Digoxin 125 micrograms Tablets

☒ 10/02/26 07:00 125 microgram ONCE DAILY MORNING 7am (Oral) — Duncan Finlay Sinclair

10/02/26 07:00	10/02/2026 08:48	Lynn Costello
11/02/26 07:00	11/02/2026 08:08	Lynn Costello

Discontinued on: 11/02/2026 13:19:05 by: Duncan Finlay Sinclair . Reason: Discontinued due to conflict

☒ 17/02/26 07:00 125 microgram ONCE DAILY MORNING 7am (Oral) — Cameron Hannah PIP

17/02/26 07:00	17/02/2026 09:18	Cavel Flemming-Gumbs
18/02/26 07:00	18/02/2026 08:24	Ann-Marie Gilfoyle
19/02/26 07:00	19/02/2026 07:52	Sarah Cunningham
20/02/26 07:00	20/02/2026 08:05	Ann-Marie Gilfoyle
21/02/26 07:00	21/02/2026 08:39	Sarah Cunningham
22/02/26 07:00	22/02/2026 08:48	Sarah Cunningham

Digoxin 250 micrograms Tablets

☒ 09/02/26 12:37 500 microgram (Oral) — Duncan Finlay Sinclair

09/02/26 12:37	09/02/2026 12:54	Rebecca Crawford

Digoxin 500 micrograms in 2mL Injection

☒ 13/02/26 07:00 150 microgram ONCE DAILY MORNING 7am (Intravenous Intermittent Infusion) — Aoibh Ohare

13/02/26 07:00	13/02/2026 06:04	Aimee Wojcik/ Jaqulin Prince
14/02/26 07:00	14/02/2026 06:33	Christina Martin/ Eilidh Robertson
15/02/26 07:00	15/02/2026 07:01	Charles Emem/ Sarah Kelly
16/02/26 07:00	16/02/2026 07:02	Charles Emem/ Ibrahim Mohammed

Discontinued on: 16/02/2026 09:20:54 by: Cameron Hannah PIP . Reason: Discontinued due to conflict

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Digoxin 500 micrograms in 2mL Injection *(Continued)*

☒ 12/02/26 09:27 150 microgram (Intravenous Intermittent Infusion) Aoibh Ohare

12/02/26	09:27	12/02/2026	10:43	Lyndsay Wilson/ Aileen Elizabeth McKenna

Enoxaparin (Inhixa) 40 mg in 0.4mL Pre-Filled Syringe

☒ 09/02/26 17:00 40 mg ONCE daily at 5pm (Subcutaneous Bolus Injection) Lucy Wells PIP

09/02/26	17:00	09/02/2026	17:27	Rebecca Crawford
10/02/26	17:00	10/02/2026	17:42	Lynn Costello
11/02/26	17:00	11/02/2026	17:57	Lynn Costello
12/02/26	17:00	12/02/2026	16:42	Lyndsay Wilson
13/02/26	17:00	13/02/2026	16:59	Lawrencia Ekwugha/ Carly Gilchrist
14/02/26	17:00	14/02/2026	17:20	Lawrencia Ekwugha
15/02/26	17:00	15/02/2026	17:28	Nicole Cunningham
16/02/26	17:00	16/02/2026	17:10	Nicole Cunningham
17/02/26	17:00	17/02/2026	17:32	Cavel Flemming-Gumbs
18/02/26	17:00	18/02/2026	18:38	Ann-Marie Gilfoyle

Discontinued on: 19/02/2026 12:06:26 by: Lauren McLean . Reason: Discontinued due to conflict

Fluoxetine 20 mg Capsules

☒ 09/02/26 07:00 40 mg ONCE DAILY MORNING 7am (Oral) Antoin Breslin

09/02/26	07:00	09/02/2026	09:15	Rebecca Crawford
10/02/26	07:00	10/02/2026	08:42	Lynn Costello
11/02/26	07:00	11/02/2026	08:05	Lynn Costello
12/02/26	07:00			Holly Bell Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha
15/02/26	07:00	15/02/2026	08:30	Nicole Cunningham
16/02/26	07:00	16/02/2026	08:11	Nicole Cunningham
17/02/26	07:00	17/02/2026	09:08	Cavel Flemming-Gumbs
18/02/26	07:00	18/02/2026	08:18	Ann-Marie Gilfoyle
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
20/02/26	07:00	20/02/2026	07:59	Ann-Marie Gilfoyle
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham

Furosemide 20 mg Tablets

☒ 09/02/26 12:00 20 mg ONCE daily at midday (Oral) Antoin Breslin

09/02/26	12:00	Suspended
10/02/26	12:00	Suspended
11/02/26	12:00	Suspended

Discontinued on: 12/02/2026 08:06:22 by: Zati Md Hussin . Reason: Discontinued due to conflict

☒ 18/02/26 07:00 20 mg ONCE DAILY MORNING 7am (Oral) Sophie White

18/02/26	07:00	18/02/2026	08:26	Ann-Marie Gilfoyle
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
20/02/26	07:00	20/02/2026	08:06	Ann-Marie Gilfoyle
21/02/26	07:00	21/02/2026	08:40	Sarah Cunningham
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham

Furosemide 40 mg Tablets

☒ 09/02/26 07:00 40 mg ONCE DAILY MORNING 7am (Oral) Antoin Breslin

09/02/26	07:00	Suspended
10/02/26	07:00	Suspended
11/02/26	07:00	Suspended
12/02/26	07:00	Suspended

Discontinued on: 12/02/2026 08:06:22 by: Zati Md Hussin . Reason: Discontinued due to conflict

☒ 16/02/26 07:00 40 mg ONCE DAILY MORNING 7am (Oral) Antoin Breslin

16/02/26	07:00	16/02/2026	08:14	Nicole Cunningham
17/02/26	07:00	17/02/2026	09:18	Cavel Flemming-Gumbs

Discontinued on: 17/02/2026 09:20:29 by: Sophie White . Reason: Discontinued due to conflict

Furosemide 50 mg in 5mL Injection

☒ 12/02/26 08:06 50 mg (Intravenous Intermittent Infusion) Zati Md Hussin

12/02/26	08:06	12/02/2026	08:37	Holly Bell/ Lyndsay Wilson

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Furosemide 50 mg in 5mL Injection *(Continued)*

☒ 13/02/26 07:00 50 mg ONCE DAILY MORNING 7am (Intravenous Intermittent Infusion) Zati Md Hussin

13/02/26	07:00	13/02/2026	06:04	Aimee Wojcik/ Jaquiln Prince
14/02/26	07:00	14/02/2026	06:33	Christina Martin/ Eilidh Robertson
15/02/26	07:00	15/02/2026	07:01	Charles Emem/ Sarah Kelly

Discontinued on: 15/02/2026 10:44:00 by: Antoin Breslin . Reason: Course Complete

☒ 12/02/26 08:58 50 mg (Intravenous Intermittent Infusion) Fiona Beaton

12/02/26	08:58	12/02/2026	09:04	Lyndsay Wilson/ Holly Bell

Hydrocortisone sodium succinate 100 mg Injection

☒ 12/02/26 07:59 100 mg (Intravenous Slow Bolus Injection) Zati Md Hussin

12/02/26	07:59	12/02/2026	08:37	Holly Bell/ Lyndsay Wilson

Ipratropium bromide 250 micrograms in 1mL Nebuliser Soln.

☒ 09/02/26 07:00 250 microgram FOUR TIMES DAILY 7am:12pm:5pm:10pm (Nebulised) Antoin Breslin

09/02/26	07:00	09/02/2026	09:11	Rebecca Crawford
09/02/26	12:00	09/02/2026	12:14	Rebecca Crawford
09/02/26	17:00	09/02/2026	17:27	Rebecca Crawford
09/02/26	22:00	09/02/2026	21:56	Emma Connor
10/02/26	07:00	10/02/2026	08:46	Lynn Costello
10/02/26	12:00	10/02/2026	12:32	Lynn Costello
10/02/26	17:00	10/02/2026	17:41	Lynn Costello
10/02/26	22:00	10/02/2026	21:56	Emma Connor
11/02/26	07:00	11/02/2026	08:08	Lynn Costello
11/02/26	12:00	11/02/2026	12:48	Lynn Costello
11/02/26	17:00	11/02/2026	17:57	Lynn Costello
11/02/26	22:00	11/02/2026	22:26	Emma Connor
12/02/26	07:00	12/02/2026	08:37	Holly Bell/ Lyndsay Wilson
12/02/26	12:00	12/02/2026	12:47	Lyndsay Wilson
12/02/26	17:00	12/02/2026	16:42	Lyndsay Wilson
12/02/26	22:00	12/02/2026	22:13	Christina Martin
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
13/02/26	12:00	13/02/2026	12:50	Lawrencia Ekwugha/ Esther Smith
13/02/26	17:00	13/02/2026	16:57	Lawrencia Ekwugha/ Carly Gilchrist
13/02/26	22:00	13/02/2026	21:43	Christina Martin
14/02/26	07:00	14/02/2026	11:14	Lawrencia Ekwugha
14/02/26	12:00			Lawrencia Ekwugha Other - see patient nursing notes
14/02/26	17:00	14/02/2026	17:20	Lawrencia Ekwugha
14/02/26	22:00	14/02/2026	22:03	Charles Emem
15/02/26	07:00	15/02/2026	08:35	Nicole Cunningham
15/02/26	12:00	15/02/2026	12:38	Nicole Cunningham
15/02/26	17:00	15/02/2026	17:09	Nicole Cunningham
15/02/26	22:00	15/02/2026	22:30	Charles Emem
16/02/26	07:00	16/02/2026	08:17	Nicole Cunningham
16/02/26	12:00	16/02/2026	12:33	Nicole Cunningham
16/02/26	17:00	16/02/2026	17:10	Nicole Cunningham
16/02/26	22:00	16/02/2026	22:14	Eilidh Robertson
17/02/26	07:00	17/02/2026	09:13	Cavel Flemming-Gumbs
17/02/26	12:00	17/02/2026	13:04	Cavel Flemming-Gumbs
17/02/26	17:00	17/02/2026	17:31	Cavel Flemming-Gumbs
17/02/26	22:00	17/02/2026	21:22	Georgie Mclatchie
18/02/26	07:00	18/02/2026	08:22	Ann-Marie Gilfoyle
18/02/26	12:00	18/02/2026	12:39	Ann-Marie Gilfoyle
18/02/26	17:00	18/02/2026	18:38	Ann-Marie Gilfoyle
18/02/26	22:00	18/02/2026	22:03	Nicole Valentine
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
19/02/26	12:00	19/02/2026	12:47	Sarah Cunningham
19/02/26	17:00	19/02/2026	17:26	Sarah Cunningham
19/02/26	22:00	19/02/2026	21:43	Nicole Valentine
20/02/26	07:00	20/02/2026	08:03	Ann-Marie Gilfoyle

Discontinued on: 20/02/2026 10:51:00 by: Lauren McLean . Reason: Course Complete

Isosorbide mononitrate 25 mg Modified Release Capsules

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Isosorbide mononitrate 25 mg Modified Release Capsules *(Continued)*

☒ 09/02/26 07:00 25 mg ONCE DAILY MORNING 7am (Oral) Antoin Breslin

09/02/26	07:00	09/02/2026	09:11	Rebecca Crawford	
10/02/26	07:00	10/02/2026	08:46	Lynn Costello	
11/02/26	07:00	11/02/2026	08:07	Lynn Costello	
12/02/26	07:00			Holly Bell	Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
15/02/26	07:00	15/02/2026	08:34	Nicole Cunningham	
16/02/26	07:00	16/02/2026	08:16	Nicole Cunningham	
17/02/26	07:00	17/02/2026	09:12	Cavel Flemming-Gumbs	
18/02/26	07:00	18/02/2026	08:28	Ann-Marie Gilfoyle	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	
20/02/26	07:00	20/02/2026	08:01	Ann-Marie Gilfoyle	
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham	
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham	

Magnesium aspartate (6.5g) 10 mmol Sachets

☒ 19/02/26 07:00 10 mmol ONCE DAILY MORNING 7am (Oral) Yunus Ali

19/02/26	07:00			Sarah Cunningham	Prescription Clarification Required

☒ 20/02/26 07:00 10 mmol ONCE DAILY MORNING 7am (Oral) for 3 day(s) Artem Osipenko PIP

20/02/26	07:00	20/02/2026	08:06	Ann-Marie Gilfoyle	
21/02/26	07:00	21/02/2026	09:21	Sarah Cunningham	

☒ 18/02/26 12:41 10 mmol (Oral) Yunus Ali

18/02/26	12:41	18/02/2026	12:47	Ann-Marie Gilfoyle	

☒ 19/02/26 11:55 10 mmol (Oral) Artem Osipenko PIP

19/02/26	11:55	19/02/2026	11:58	Sarah Cunningham	

Metformin 500 mg Modified Release Tablets

☒ 09/02/26 07:00 500 mg TWICE daily at 7am and 12 midday (Oral) Antoin Breslin

09/02/26	07:00	Suspended			
09/02/26	12:00	Suspended			
10/02/26	07:00	Suspended			
10/02/26	12:00	Suspended			
11/02/26	07:00	Suspended			
11/02/26	12:00	Suspended			
12/02/26	07:00	Suspended			
12/02/26	12:00	Suspended			
13/02/26	07:00	Suspended			
13/02/26	12:00	Suspended			
14/02/26	07:00	Suspended			
14/02/26	12:00	Suspended			
15/02/26	07:00	Suspended			
15/02/26	12:00	Suspended			
16/02/26	07:00	Suspended			
16/02/26	12:00	Suspended			
17/02/26	07:00	Suspended			
17/02/26	12:00	Suspended			
18/02/26	07:00	Suspended			
18/02/26	12:00	Suspended			
19/02/26	07:00	Suspended			
19/02/26	12:00	Suspended			
20/02/26	07:00	Suspended			
20/02/26	12:00	20/02/2026	13:11	Ann-Marie Gilfoyle	
21/02/26	07:00	21/02/2026	09:30	Sarah Cunningham	
21/02/26	12:00	21/02/2026	13:35	Sarah Cunningham	
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham	
22/02/26	12:00	22/02/2026	13:24	Sarah Cunningham	

Mirtazapine 15 mg Tablets

☒ 09/02/26 22:00 15 mg ONCE DAILY NIGHT 10pm (Oral) Antoin Breslin

09/02/26	22:00	Suspended			
10/02/26	22:00	Suspended			
11/02/26	22:00	Suspended			
12/02/26	22:00	Suspended			
13/02/26	22:00	Suspended			
14/02/26	22:00	Suspended			
15/02/26	22:00	Suspended			

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Mirtazapine 15 mg Tablets *(Continued)*

16/02/26	22:00	Suspended		
17/02/26	22:00	Suspended		
18/02/26	22:00	Suspended		
19/02/26	22:00	Suspended		
20/02/26	22:00	20/02/2026	22:31	Elizabeth Walsh
21/02/26	22:00	21/02/2026	23:01	Elizabeth Walsh

Nicotinell TTS 30 (Step1) 21mg in 24hours Transdermal Patch

☒ 11/02/26 07:00 21 mg ONCE DAILY MORNING 7am (Transdermal) Kate Stevens

11/02/26	07:00	11/02/2026	08:08	Lynn Costello
12/02/26	07:00	12/02/2026	12:47	Lyndsay Wilson
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
14/02/26	07:00	14/02/2026	11:14	Lawrencia Ekwugha
15/02/26	07:00	15/02/2026	08:35	Nicole Cunningham
16/02/26	07:00	16/02/2026	08:27	Nicole Cunningham
17/02/26	07:00	17/02/2026	09:16	Cavel Flemming-Gumbs
18/02/26	07:00	18/02/2026	08:23	Ann-Marie Gilfoyle
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
20/02/26	07:00	20/02/2026	08:04	Ann-Marie Gilfoyle
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham

Omeprazole 20 mg Capsules

☒ 17/02/26 07:00 20 mg ONCE DAILY MORNING 7am (Oral) Cameron-Hannah PIP

17/02/26	07:00	17/02/2026	09:19	Cavel Flemming-Gumbs
18/02/26	07:00	18/02/2026	08:25	Ann-Marie Gilfoyle
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
20/02/26	07:00	20/02/2026	08:05	Ann-Marie Gilfoyle
21/02/26	07:00	21/02/2026	08:40	Sarah Cunningham
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham

Oral Care

☒ 12/02/26 12:00 1 Dose FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) Aoibh Ohare

12/02/26	12:00	12/02/2026	12:47	Lyndsay Wilson
12/02/26	17:00	12/02/2026	16:42	Lyndsay Wilson
12/02/26	22:00	12/02/2026	22:13	Christina Martin
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
13/02/26	12:00	13/02/2026	12:50	Lawrencia Ekwugha/ Esther Smith
13/02/26	17:00	13/02/2026	16:59	Lawrencia Ekwugha/ Carly Gilchrist
13/02/26	22:00	13/02/2026	21:43	Christina Martin
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha
14/02/26	12:00	14/02/2026	13:08	Lawrencia Ekwugha/ Claire Sobze
14/02/26	17:00	14/02/2026	17:20	Lawrencia Ekwugha
14/02/26	22:00	14/02/2026	22:03	Charles Emem
15/02/26	07:00	15/02/2026	08:37	Nicole Cunningham
15/02/26	12:00	15/02/2026	12:38	Nicole Cunningham
15/02/26	17:00	15/02/2026	17:08	Nicole Cunningham
15/02/26	22:00	15/02/2026	22:29	Charles Emem
16/02/26	07:00	16/02/2026	08:16	Nicole Cunningham
16/02/26	12:00	16/02/2026	12:33	Nicole Cunningham
16/02/26	17:00	16/02/2026	17:10	Nicole Cunningham
16/02/26	22:00	16/02/2026	22:15	Eilidh Robertson
17/02/26	07:00	17/02/2026	09:17	Cavel Flemming-Gumbs
17/02/26	12:00	17/02/2026	13:04	Cavel Flemming-Gumbs
17/02/26	17:00	17/02/2026	17:32	Cavel Flemming-Gumbs
17/02/26	22:00	17/02/2026	21:22	Georgie Mclatchie
18/02/26	07:00	18/02/2026	08:23	Ann-Marie Gilfoyle
18/02/26	12:00	18/02/2026	12:39	Ann-Marie Gilfoyle
18/02/26	17:00	18/02/2026	18:38	Ann-Marie Gilfoyle
18/02/26	22:00	18/02/2026	22:03	Nicole Valentine
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
19/02/26	12:00	19/02/2026	12:47	Sarah Cunningham
19/02/26	17:00	19/02/2026	17:26	Sarah Cunningham
19/02/26	22:00	19/02/2026	21:43	Nicole Valentine
20/02/26	07:00			Ann-Marie Gilfoyle Self Administers
20/02/26	12:00			Ann-Marie Gilfoyle Self Administers
20/02/26	17:00			Ann-Marie Gilfoyle Self Administers
20/02/26	22:00	20/02/2026	22:32	Elizabeth Walsh
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

HEPMA MAP v1.0

Oral Care *(Continued)*

21/02/26	12:00	21/02/2026	13:09	Sarah Cunningham
21/02/26	17:00	21/02/2026	18:32	Sarah Cunningham
21/02/26	22:00	21/02/2026	23:02	Elizabeth Walsh
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham
22/02/26	12:00	22/02/2026	13:24	Sarah Cunningham

Peppermint oil 0.2 mL Gastro-resistant Capsules

☒ 09/02/26 07:00 1 Capsule THREE times daily at 7am, 12 noon, and 5pm (Oral) Antoin Breslin

09/02/26	07:00	09/02/2026	09:16	Rebecca Crawford
09/02/26	12:00	09/02/2026	12:12	Rebecca Crawford
09/02/26	17:00	09/02/2026	17:25	Rebecca Crawford
10/02/26	07:00	10/02/2026	08:44	Lynn Costello
10/02/26	12:00	10/02/2026	12:32	Lynn Costello
10/02/26	17:00	10/02/2026	17:41	Lynn Costello
11/02/26	07:00	11/02/2026	08:06	Lynn Costello
11/02/26	12:00	11/02/2026	12:48	Lynn Costello
11/02/26	17:00	11/02/2026	17:57	Lynn Costello
12/02/26	07:00			Holly Bell Nil by mouth / Fasting
12/02/26	12:00			Lyndsay Wilson Nil by mouth / Fasting
12/02/26	17:00			Lyndsay Wilson Nil by mouth / Fasting
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
13/02/26	12:00	13/02/2026	12:50	Lawrencia Ekwugha/ Esther Smith
13/02/26	17:00			Lawrencia Ekwugha Refused by Patient
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha
14/02/26	12:00			Lawrencia Ekwugha Other - see patient nursing notes
14/02/26	17:00	14/02/2026	17:20	Lawrencia Ekwugha
15/02/26	07:00	15/02/2026	08:33	Nicole Cunningham
15/02/26	12:00	15/02/2026	12:37	Nicole Cunningham
15/02/26	17:00	15/02/2026	17:08	Nicole Cunningham
16/02/26	07:00	16/02/2026	08:12	Nicole Cunningham
16/02/26	12:00	16/02/2026	12:31	Nicole Cunningham
16/02/26	17:00	16/02/2026	17:09	Nicole Cunningham
17/02/26	07:00	17/02/2026	09:12	Cavel Flemming-Gumbs
17/02/26	12:00	17/02/2026	13:03	Cavel Flemming-Gumbs
17/02/26	17:00	17/02/2026	17:31	Cavel Flemming-Gumbs
18/02/26	07:00	18/02/2026	08:20	Ann-Marie Gilfoyle
18/02/26	12:00	18/02/2026	12:29	Ann-Marie Gilfoyle
18/02/26	17:00	18/02/2026	18:37	Ann-Marie Gilfoyle
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham
19/02/26	12:00	19/02/2026	12:45	Sarah Cunningham
19/02/26	17:00	19/02/2026	17:25	Sarah Cunningham
20/02/26	07:00	20/02/2026	08:01	Ann-Marie Gilfoyle
20/02/26	12:00	20/02/2026	13:11	Ann-Marie Gilfoyle
20/02/26	17:00	20/02/2026	17:57	Ann-Marie Gilfoyle
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham
21/02/26	12:00	21/02/2026	13:09	Sarah Cunningham
21/02/26	17:00	21/02/2026	18:32	Sarah Cunningham
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham
22/02/26	12:00	22/02/2026	13:24	Sarah Cunningham

Piperacillin Tazobactam 4g/0.5g (4.5 g) Injection

☒ 12/02/26 12:00 4,500 mg THREE TIMES DAILY 7am:12pm:10pm (Intravenous Intermittent Infusion) Aoibh Ohare

12/02/26	12:00	12/02/2026	13:05	Lyndsay Wilson/ Flora Chinenye Ike-Anekwe
12/02/26	22:00	12/02/2026	22:19	Christina Martin/ Jaqulin Prince
13/02/26	07:00	13/02/2026	06:04	Aimee Wojcik/ Jaqulin Prince
13/02/26	12:00	13/02/2026	12:50	Lawrencia Ekwugha/ Esther Smith
13/02/26	22:00	13/02/2026	21:56	Eilidh Robertson/ Christina Martin
14/02/26	07:00	14/02/2026	06:33	Christina Martin/ Eilidh Robertson
14/02/26	12:00	14/02/2026	13:08	Lawrencia Ekwugha/ Claire Sobze
14/02/26	22:00	14/02/2026	22:39	Sarah Kelly/ Charles Emem
15/02/26	07:00	15/02/2026	07:01	Charles Emem/ Sarah Kelly
15/02/26	12:00	15/02/2026	12:53	Olivia El-Attar/ Nicole Cunningham
15/02/26	22:00	15/02/2026	23:02	Amy Tollan/ Charles Emem
16/02/26	07:00	16/02/2026	07:03	Charles Emem/ Ibrahim Mohammed

☒ 16/02/26 12:00 4,500 mg THREE TIMES DAILY 7am:12pm:10pm (Intravenous Intermittent Infusion) for 7 day(s) Sophie White

16/02/26	12:00	16/02/2026	12:54	Christie Blair/ Nicole Cunningham
16/02/26	22:00	16/02/2026	22:44	Eilidh Robertson/ Esther Smith
17/02/26	07:00	17/02/2026	06:53	Holly Weir/ Eilidh Robertson

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Piperacillin Tazobactam 4g/0.5g (4.5 g) Injection *(Continued)*

17/02/26	12:00	17/02/2026	13:49	Cavel Flemming-Gumbs/ Christie Blair
17/02/26	22:00	17/02/2026	22:28	Nicole Valentine/ W
18/02/26	07:00	18/02/2026	06:21	Nicole Valentine/ W
18/02/26	12:00	18/02/2026	13:06	Ann-Marie Gilfoyle/ Stacey Bradley
18/02/26	22:00	18/02/2026	22:23	Nicole Valentine/ W
19/02/26	07:00	19/02/2026	07:19	Nicole Valentine/ W

☒ 12/02/26 09:45 4,500 mg (Intravenous Intermittent Infusion) Aoibh Ohare

12/02/26	09:45	12/02/2026	10:43	Lyndsay Wilson/ Aileen Elizabeth McKenna

Prednisolone 5 mg Tablets

☒ 12/02/26 07:00 40 mg ONCE DAILY MORNING 7am (Oral) for 4 day(s) Duncan Finlay Sinclair

12/02/26	07:00		Zati Md Hussin	Order suspended
13/02/26	07:00	Suspended		
14/02/26	07:00	Suspended		
15/02/26	07:00	Suspended		

☒ 11/02/26 09:33 40 mg (Oral) Duncan Finlay Sinclair

11/02/26	09:33	11/02/2026	09:43	Lynn Costello

☒ 13/02/26 07:00 40 mg ONCE DAILY MORNING 7am (Oral) for 5 day(s) Antoin Breslin

13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha
15/02/26	07:00	15/02/2026	08:37	Nicole Cunningham
16/02/26	07:00	16/02/2026	08:13	Nicole Cunningham
17/02/26	07:00	17/02/2026	09:17	Cavel Flemming-Gumbs

Pregabalin 75 mg Capsules

☒ 09/02/26 07:00 150 mg ONCE DAILY MORNING 7am (Oral) Antoin Breslin

09/02/26	07:00	Suspended
10/02/26	07:00	Suspended
11/02/26	07:00	Suspended
12/02/26	07:00	Suspended
13/02/26	07:00	Suspended
14/02/26	07:00	Suspended
15/02/26	07:00	Suspended
16/02/26	07:00	Suspended

Discontinued on: 16/02/2026 09:24:24 by: Cameron Hannah PIP . Reason: Discontinued due to conflict

☒ 09/02/26 17:00 75 mg ONCE daily at 5pm (Oral) Antoin Breslin

09/02/26	17:00	Suspended
10/02/26	17:00	Suspended
11/02/26	17:00	Suspended
12/02/26	17:00	Suspended
13/02/26	17:00	Suspended
14/02/26	17:00	Suspended
15/02/26	17:00	Suspended

Discontinued on: 16/02/2026 09:24:24 by: Cameron Hannah PIP . Reason: Discontinued due to conflict

☒ 16/02/26 22:00 75 mg TWICE DAILY 7am:10pm (Oral) Cameron Hannah PIP

16/02/26	22:00	Suspended		
17/02/26	07:00	Suspended		
17/02/26	22:00	Suspended		
18/02/26	07:00	Suspended		
18/02/26	22:00	Suspended		
19/02/26	07:00	Suspended		
19/02/26	22:00	Suspended		
20/02/26	07:00	Suspended		
20/02/26	22:00	20/02/2026	22:32	Elizabeth Walsh
21/02/26	07:00	21/02/2026	08:40	Sarah Cunningham
21/02/26	22:00	21/02/2026	23:02	Elizabeth Walsh
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham

Ramipril 2.5 mg Capsules

☒ 09/02/26 07:00 2.5 mg ONCE DAILY MORNING 7am (Oral) Antoin Breslin

09/02/26	07:00	Suspended
10/02/26	07:00	Suspended
11/02/26	07:00	Suspended
12/02/26	07:00	Suspended
13/02/26	07:00	Suspended

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Ramipril 2.5 mg Capsules *(Continued)*

14/02/26	07:00	Suspended
15/02/26	07:00	Suspended
16/02/26	07:00	Suspended
17/02/26	07:00	Suspended
18/02/26	07:00	Suspended
19/02/26	07:00	Suspended
20/02/26	07:00	Suspended
21/02/26	07:00	Suspended
22/02/26	07:00	Suspended

Salbutamol 2.5 mg in 2.5mL Nebuliser Solution

☒ 09/02/26 07:00 2.5 mg FOUR times daily - 7am;12pm;5pm;10pm (Nebulised) Antoin Breslin

09/02/26	07:00	09/02/2026	09:11	Rebecca Crawford	
09/02/26	12:00	09/02/2026	12:13	Rebecca Crawford	
09/02/26	17:00	09/02/2026	17:27	Rebecca Crawford	
09/02/26	22:00	09/02/2026	21:56	Emma Connor	
10/02/26	07:00	10/02/2026	08:47	Lynn Costello	
10/02/26	12:00	10/02/2026	12:32	Lynn Costello	
10/02/26	17:00	10/02/2026	17:41	Lynn Costello	
10/02/26	22:00	10/02/2026	21:56	Emma Connor	
11/02/26	07:00	11/02/2026	08:08	Lynn Costello	
11/02/26	12:00	11/02/2026	12:48	Lynn Costello	
11/02/26	17:00	11/02/2026	17:57	Lynn Costello	
11/02/26	22:00	11/02/2026	22:26	Emma Connor	
12/02/26	07:00	12/02/2026	08:37	Holly Bell/ Lyndsay Wilson	
12/02/26	12:00	12/02/2026	12:47	Lyndsay Wilson	
12/02/26	17:00	12/02/2026	16:42	Lyndsay Wilson	
12/02/26	22:00	12/02/2026	22:13	Christina Martin	
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
13/02/26	12:00	13/02/2026	12:50	Lawrencia Ekwugha/ Esther Smith	
13/02/26	17:00	13/02/2026	16:57	Lawrencia Ekwugha/ Carly Gilchrist	
13/02/26	22:00	13/02/2026	21:43	Christina Martin	
14/02/26	07:00	14/02/2026	11:14	Lawrencia Ekwugha	
14/02/26	12:00			Lawrencia Ekwugha	Other - see patient nursing notes
14/02/26	17:00	14/02/2026	17:20	Lawrencia Ekwugha	
14/02/26	22:00	14/02/2026	22:03	Charles Emem	
15/02/26	07:00	15/02/2026	08:34	Nicole Cunningham	
15/02/26	12:00	15/02/2026	12:38	Nicole Cunningham	
15/02/26	17:00	15/02/2026	17:09	Nicole Cunningham	
15/02/26	22:00	15/02/2026	22:30	Charles Emem	
16/02/26	07:00	16/02/2026	08:17	Nicole Cunningham	
16/02/26	12:00	16/02/2026	12:32	Nicole Cunningham	
16/02/26	17:00	16/02/2026	17:10	Nicole Cunningham	
16/02/26	22:00	16/02/2026	22:14	Eilidh Robertson	
17/02/26	07:00	17/02/2026	09:13	Cavel Flemming-Gumbs	
17/02/26	12:00	17/02/2026	13:04	Cavel Flemming-Gumbs	
17/02/26	17:00	17/02/2026	17:31	Cavel Flemming-Gumbs	
17/02/26	22:00	17/02/2026	21:22	Georgie Mclatchie	
18/02/26	07:00	18/02/2026	08:22	Ann-Marie Gilfoyle	
18/02/26	12:00	18/02/2026	12:39	Ann-Marie Gilfoyle	
18/02/26	17:00	18/02/2026	18:38	Ann-Marie Gilfoyle	
18/02/26	22:00	18/02/2026	22:03	Nicole Valentine	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	
19/02/26	12:00	19/02/2026	12:46	Sarah Cunningham	
19/02/26	17:00	19/02/2026	17:25	Sarah Cunningham	
19/02/26	22:00	19/02/2026	21:43	Nicole Valentine	
20/02/26	07:00	20/02/2026	08:03	Ann-Marie Gilfoyle	

Discontinued on: 20/02/2026 10:51:00 by: Lauren McLean . Reason: Course Complete

Sando-K 12 mmol Effervescent Tablets

☒ 16/02/26 22:00 2 Tablet THREE TIMES DAILY 7am:12pm:10pm (Oral) for 3 day(s) Sophie White

16/02/26	22:00	16/02/2026	22:15	Eilidh Robertson	
17/02/26	07:00	17/02/2026	09:20	Cavel Flemming-Gumbs	
17/02/26	12:00	17/02/2026	13:04	Cavel Flemming-Gumbs	
17/02/26	22:00	17/02/2026	21:22	Georgie Mclatchie	
18/02/26	07:00	18/02/2026	08:25	Ann-Marie Gilfoyle	
18/02/26	12:00	18/02/2026	12:39	Ann-Marie Gilfoyle	
18/02/26	22:00			Nicole Valentine	Prescription Clarification Required
19/02/26	07:00			Sarah Cunningham	Prescription Clarification Required

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Sando-K 12 mmol Effervescent Tablets *(Continued)*

Discontinued on: 19/02/2026 11:34:00 by: Lauren McLean . Reason: Course Complete

Simvastatin 40 mg Tablets

☒ 09/02/26 22:00 40 mg ONCE daily at 10pm (Oral) Antoin Breslin

09/02/26	22:00	09/02/2026	21:56	Emma Connor
10/02/26	22:00	10/02/2026	21:56	Emma Connor
11/02/26	22:00	11/02/2026	22:26	Emma Connor
12/02/26	22:00	12/02/2026	22:13	Christina Martin
13/02/26	22:00	Suspended		
14/02/26	22:00	Suspended		
15/02/26	22:00	Suspended		
16/02/26	22:00	Suspended		
17/02/26	22:00	Suspended		
18/02/26	22:00	Suspended		
19/02/26	22:00	Suspended		
20/02/26	22:00	Suspended		
21/02/26	22:00	Suspended		

Thiamine 50 mg Tablets

☒ 09/02/26 07:00 50 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) Antoin Breslin

09/02/26	07:00	09/02/2026	09:11	Rebecca Crawford	
09/02/26	12:00	09/02/2026	12:13	Rebecca Crawford	
09/02/26	17:00	09/02/2026	17:25	Rebecca Crawford	
09/02/26	22:00	09/02/2026	21:56	Emma Connor	
10/02/26	07:00	10/02/2026	08:45	Lynn Costello	
10/02/26	12:00	10/02/2026	12:32	Lynn Costello	
10/02/26	17:00	10/02/2026	17:41	Lynn Costello	
10/02/26	22:00	10/02/2026	21:56	Emma Connor	
11/02/26	07:00	11/02/2026	08:07	Lynn Costello	
11/02/26	12:00	11/02/2026	12:48	Lynn Costello	
11/02/26	17:00	11/02/2026	17:57	Lynn Costello	
11/02/26	22:00	11/02/2026	22:26	Emma Connor	
12/02/26	07:00			Holly Bell	Nil by mouth / Fasting
12/02/26	12:00			Lyndsay Wilson	Nil by mouth / Fasting
12/02/26	17:00			Lyndsay Wilson	Nil by mouth / Fasting
12/02/26	22:00	12/02/2026	22:13	Christina Martin	
13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
13/02/26	12:00	13/02/2026	12:50	Lawrencia Ekwugha/ Esther Smith	
13/02/26	17:00			Lawrencia Ekwugha	Refused by Patient
13/02/26	22:00	13/02/2026	21:43	Christina Martin	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
14/02/26	12:00			Lawrencia Ekwugha	Other - see patient nursing notes
14/02/26	17:00	14/02/2026	17:20	Lawrencia Ekwugha	
14/02/26	22:00	14/02/2026	22:03	Charles Emem	
15/02/26	07:00	15/02/2026	08:33	Nicole Cunningham	
15/02/26	12:00	15/02/2026	12:37	Nicole Cunningham	
15/02/26	17:00	15/02/2026	17:08	Nicole Cunningham	
15/02/26	22:00	15/02/2026	22:29	Charles Emem	
16/02/26	07:00	16/02/2026	08:12	Nicole Cunningham	
16/02/26	12:00	16/02/2026	12:32	Nicole Cunningham	
16/02/26	17:00	16/02/2026	17:09	Nicole Cunningham	
16/02/26	22:00	16/02/2026	22:13	Eilidh Robertson	
17/02/26	07:00	17/02/2026	09:12	Cavel Flemming-Gumbs	
17/02/26	12:00	17/02/2026	13:04	Cavel Flemming-Gumbs	
17/02/26	17:00	17/02/2026	17:31	Cavel Flemming-Gumbs	
17/02/26	22:00	17/02/2026	21:22	Georgie Mclatchie	
18/02/26	07:00	18/02/2026	08:21	Ann-Marie Gilfoyle	
18/02/26	12:00	18/02/2026	12:29	Ann-Marie Gilfoyle	
18/02/26	17:00	18/02/2026	18:37	Ann-Marie Gilfoyle	
18/02/26	22:00	18/02/2026	22:03	Nicole Valentine	
19/02/26	07:00	19/02/2026	07:52	Sarah Cunningham	
19/02/26	12:00	19/02/2026	12:46	Sarah Cunningham	
19/02/26	17:00	19/02/2026	17:25	Sarah Cunningham	
19/02/26	22:00	19/02/2026	21:43	Nicole Valentine	
20/02/26	07:00	20/02/2026	08:01	Ann-Marie Gilfoyle	
20/02/26	12:00	20/02/2026	13:09	Ann-Marie Gilfoyle	
20/02/26	17:00	20/02/2026	17:57	Ann-Marie Gilfoyle	
20/02/26	22:00	20/02/2026	22:32	Elizabeth Walsh	
21/02/26	07:00	21/02/2026	08:39	Sarah Cunningham	

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

Thiamine 50 mg Tablets *(Continued)*

21/02/26	12:00	21/02/2026	13:09	Sarah Cunningham
21/02/26	17:00	21/02/2026	18:32	Sarah Cunningham
21/02/26	22:00	21/02/2026	23:02	Elizabeth Walsh
22/02/26	07:00	22/02/2026	08:48	Sarah Cunningham
22/02/26	12:00	22/02/2026	13:24	Sarah Cunningham

Trelegy Ellipta 92/55/22 Dry Powder for Inhalation

☒ 13/02/26 07:00 1 Dose ONCE daily at 7am (Inhalation) Cameron Hannah PIP

13/02/26	07:00	13/02/2026	08:55	Lawrencia Ekwugha	
14/02/26	07:00	14/02/2026	11:13	Lawrencia Ekwugha	
15/02/26	07:00			Nicole Cunningham	Self Administers
16/02/26	07:00			Nicole Cunningham	Self Administers
17/02/26	07:00	17/02/2026	09:17	Cavel Flemming-Gumbs	
18/02/26	07:00	18/02/2026	08:28	Ann-Marie Gilfoyle	
19/02/26	07:00			Sarah Cunningham	Self Administers
20/02/26	07:00			Ann-Marie Gilfoyle	Self Administers
21/02/26	07:00			Sarah Cunningham	Self Administers
22/02/26	07:00			Sarah Cunningham	Self Administers

Dihydrocodeine 30 mg Tablets as required

☒ 18/02/26 13:03 30 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) FOR PAIN Yunus Ali

30.00	18/02/2026	13:03	Ann-Marie Gilfoyle	
30.00	18/02/2026	18:24	Stacey Bradley	
30.00	19/02/2026	07:55	Sarah Cunningham	
30.00	19/02/2026	12:52	Sarah Cunningham	
30.00	19/02/2026	18:14	Sarah Cunningham	

☒ 19/02/26 18:15 60 mg FOUR TIMES DAILY 7am:12pm:5pm:10pm (Oral) FOR PAIN Dearbhail Killoran

60.00	20/02/2026	17:57	Ann-Marie Gilfoyle
60.00	20/02/2026	22:36	Elizabeth Walsh
60.00	21/02/2026	08:48	Sarah Cunningham
60.00	21/02/2026	13:10	Sarah Cunningham
60.00	21/02/2026	18:33	Sarah Cunningham
60.00	21/02/2026	23:03	Elizabeth Walsh
60.00	22/02/2026	08:50	Sarah Cunningham
60.00	22/02/2026	13:26	Sarah Cunningham

Glyceryl trinitrate 400 micrograms per Sublingual Spray as required

☒ 12/02/26 12:43 800 microgram (Sublingual) FOR CHEST PAIN Cameron Hannah PIP

Hyoscine butylbromide 20 mg in 1 mL Injection as required

☒ 12/02/26 09:10 20 mg every HOUR (Subcutaneous Bolus Injection) FOR SECRETIONS MAX 120MG/24HRS THEN RV Aoibh Ohare

Discontinued on: 15/02/2026 10:42:00 by: Antoin Breslin . Reason: Diagnosis Changed

Ipratropium bromide 250 micrograms in 1mL Nebuliser Soln. as required

☒ 09/02/26 02:39 250 microgram FOUR TIMES DAILY 7am:12pm:5pm:10pm (Nebulised) BREATHLESSNESS Antoin Breslin

250.00	11/02/2026	01:21	Emma Connor
250.00	11/02/2026	04:32	Emma Connor

Levomepromazine 25 mg in 1mL Injection as required

☒ 12/02/26 09:10 2.5 mg every 12 hours (Subcutaneous Bolus Injection) FOR NAUSEA/VOMITING *prescribed as part of either/or protocol:Anticipatory Care Medicines Morphine* Aoibh Ohare

Discontinued on: 15/02/2026 10:42:00 by: Antoin Breslin . Reason: Course Complete

☒ 12/02/26 09:10 5 mg every 12 hours (Subcutaneous Bolus Injection) FOR NAUSEA AND VOMITING *prescribed as part of either/or protocol:Anticipatory Care Medicines Morphine* Aoibh Ohare

Discontinued on: 15/02/2026 10:42:00 by: Antoin Breslin . Reason: Course Complete

Midazolam 10 mg in 2mL Injection as required

☒ 12/02/26 09:10 2 mg every HOUR (Subcutaneous Bolus Injection) AGITATION/DISTRESS MAX 6 DOSES IN 24 HOURS Aoibh Ohare

2.00	12/02/2026	09:17	Lyndsay Wilson/, Esther Smith
2.00	12/02/2026	13:18	Lyndsay Wilson/, Holly Bell

Key: Prescription details | Recorded as "Admitted On" | Prescribed as "Self Administer" | Discontinuation details | HEPMA Prescription additional notes | HEPMA Patient admission notes (admission specific) | HEPMA Patient retained notes (not specific to admission)

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Midazolam 10 mg in 2mL Injection as required *(Continued)*

2.00	12/02/2026	16:46	Lyndsay Wilson/ Holly Bell
2.00	12/02/2026	17:50	Lyndsay Wilson/ Holly Bell
2.00	12/02/2026	19:21	Lyndsay Wilson/ Holly Bell
2.00	12/02/2026	20:25	Christina Martin/ Jaqulin Prince
2.00	12/02/2026	22:19	Christina Martin/ Jaqulin Prince
2.00	12/02/2026	23:55	Christina Martin/ Jaqulin Prince
2.00	13/02/2026	01:12	Jaqulin Prince/ Amy Tollan
2.00	13/02/2026	03:01	Christina Martin/ Jaqulin Prince
2.00	13/02/2026	04:16	Christina Martin/ Sarah Kelly
2.00	13/02/2026	07:04	Christina Martin/ Jaqulin Prince
2.00	13/02/2026	11:57	Lawrencia Ekwugha/ Carly Gilchrist
2.00	13/02/2026	17:11	Lawrencia Ekwugha/ Carly Gilchrist
2.00	13/02/2026	22:35	Aimee Wojcik/ Christina Martin
2.00	14/02/2026	00:47	Christina Martin/ Eilidh Robertson
2.00	14/02/2026	02:56	Kirsty Bell/ Christina Martin
2.00	14/02/2026	04:41	Christina Martin/ Sarah Kelly
2.00	14/02/2026	07:02	Christina Martin/ Aimee Wojcik
2.00	14/02/2026	11:11	Lawrencia Ekwugha/ Laura Wheatley

Discontinued on: 15/02/2026 10:41:00 by: Antoin Breslin . Reason: Course Complete

Morphine sulfate 10 mg in 5mL Oral Solution as required

☒ 12/02/26 08:57 2.5 mg every 4 HOURS (Oral) FOR PAIN Max 6 dose/24h thn Dr r/v — Fiona Beaton

2.50	12/02/2026	09:14	Lyndsay Wilson
2.50	12/02/2026	13:40	Lyndsay Wilson
2.50	17/02/2026	14:52	Cavel Flemming-Gumbs

Discontinued on: 20/02/2026 15:13:00 by: Lauren McLean . Reason: Course Complete

Morphine sulfate 10 mg in 1mL Injection as required

☒ 12/02/26 09:10 2 mg every HOUR (Subcutaneous Bolus Injection) FOR PAIN/SOB MAX 6 DOSES IN 24 HOURS — Aoibh Ohare

Discontinued on: 12/02/2026 09:11:00 by: Aoibh Ohare . Reason: Rationalising Medication

☒ 12/02/26 14:32 2 mg (Subcutaneous Bolus Injection) FOR PAIN/SOB MAX 6 DOSES IN 24 HOURS — Aoibh Ohare

2.00	12/02/2026	16:46	Lyndsay Wilson/ Holly Bell
2.00	12/02/2026	17:50	Lyndsay Wilson/ Holly Bell
2.00	12/02/2026	19:21	Lyndsay Wilson/ Holly Bell
2.00	12/02/2026	20:25	Christina Martin/ Jaqulin Prince
2.00	12/02/2026	22:19	Christina Martin/ Jaqulin Prince
2.00	12/02/2026	23:55	Christina Martin/ Jaqulin Prince
2.00	13/02/2026	01:12	Jaqulin Prince/ Amy Tollan
2.00	13/02/2026	03:01	Christina Martin/ Jaqulin Prince
2.00	13/02/2026	04:16	Christina Martin/ Sarah Kelly
2.00	13/02/2026	07:04	Christina Martin/ Jaqulin Prince
2.00	13/02/2026	11:57	Lawrencia Ekwugha/ Carly Gilchrist
2.00	13/02/2026	17:11	Lawrencia Ekwugha/ Carly Gilchrist
2.00	14/02/2026	11:11	Lawrencia Ekwugha/ Laura Wheatley

Discontinued on: 15/02/2026 10:41:00 by: Antoin Breslin . Reason: Course Complete

Paracetamol 500 mg Tablets as required

☒ 09/02/26 02:32 1,000 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN — Antoin Breslin

1,000.00	09/02/2026	18:27	Rebecca Crawford
1,000.00	10/02/2026	15:17	Lynn Costello

☒ 10/02/26 15:18 500 mg FOUR times daily - 7am;12pm;5pm;10pm (Oral) FOR PAIN — Antoin Breslin

500.00	16/02/2026	01:41	Charles Emem
500.00	16/02/2026	23:53	Holly Weir
500.00	18/02/2026	08:50	Ann-Marie Gilfoyle

Salbutamol 2.5 mg in 2.5mL Nebuliser Solution as required

☒ 09/02/26 02:38 2.5 mg FOUR times daily - 7am;12pm;5pm;10pm (Nebulised) Breathlessness — Antoin Breslin

2.50	11/02/2026	01:21	Emma Connor
2.50	11/02/2026	04:32	Emma Connor
2.50	12/02/2026	08:52	Holly Bell

Water for injection 10 mL (DILUENT for IDL only) as required

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Water for injection 10 mL (DILUENT for IDL only) as required *(Continued)*

☒ 12/02/26 09:10 1 Ampoule (Subcutaneous Injection) AS PER PALLIATIVE CARE FOR IDL ONLY Aoibh Ohare

1.00	13/02/2026	11:57	Lawrencia Ekwugha/ Carly Gilchrist
1.00	13/02/2026	17:11	Lawrencia Ekwugha/ Carly Gilchrist

Patient level notes

added by **Samina Ghani** on 19/02/2026 at 11:08

Title: QYW Hospital Stop Smoking Service

QYW Hospital Stop Smoking Service

Discharge with 2 weeks supply of product. Patient will be supported for up to 12 weeks and referral to Local Pharmacy Service for NRT for up to 12 weeks to complete course of treatment.

added by **Samina Ghani** on 19/02/2026 at 11:07

Title: Nicotinell 24hr/21mg Patches

QYW Hospital Stop Smoking Service

Reviewed patient keen to stop with support. Commenced on Nicotinell 24hr/21mg Patches. Discharge with 2 weeks supply of product. Patient will be supported for up to 12 weeks and referral to Local Pharmacy Service for NRT for up to 12 weeks to complete course of treatment.

The information contained in this document is privileged and confidential. This document must not be copied or distributed without prior authorisation. Any unauthorised disclosure of the information contained in this document is prohibited and may be unlawful. The information contained within this document is only valid at the time of its creation - the HEPMA team cannot be held responsible for changes subsequent to this document's creation.

Please ensure this document is destroyed after use.

Report developed by HEPMA teams NHS Lanarkshire, NHS Dumfries & Galloway, NHS Ayrshire & Arran and NHS Greater Glasgow & Clyde

MEDICINE

PRESCRIPTION FORM

Hospital Name: ..Gl.....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

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

Hospital 1308636407

DOB: SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Date of Glasgow
Consultant G66 7DA

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
8/2	PREDNISOLONE	40mg	PO	1626	Laura Martin	[illegible]	16:35
8/2	SALBUTAMOL [EPRATROPIUM]	5mg	neb	1626	Laura Martin	[illegible]	16:35
8/2	AMOXICILLIN	1g	IV	1645	Laura Martin	[illegible]	17:05
8/2	ACETYLCYSTEINE	600mg	PO	1705	Laura Martin	[illegible]	17:19
8/2	SALBUTAMOL [EPRATROPIUM]	5mg	neb	1735	Laura Martin	[illegible]	17:35
8/2	CLARITHROMYCIN	500mg	PO	2045	Laura Martin	[illegible]	20:48
8/2	NALOXONE	200mcg	IV		[illegible]	[illegible]	2215

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%

88 – 92% (e.g. in hypercapnic respiratory failure)

Other (please specify)

On Home Oxygen? Yes / (No) ____ L/min

DATE: 8 / 2 / 26 PRESCRIBER (PRINT & SIGN): Laura Martin

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

Patient's Own Medicine

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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.

Oral and Other Drugs: Regular Prescription

DATE: 29
MONTH: 3

H — DRUG: AMOXICILLIN
BEFORE ADMISSION ☐ | NEW DOSE ☑ | NEW MEDICATION ☐
DOSE: 1g | ROUTE: IV | DATE: 3/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Laura Martin
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time: 01:00
0700-0900: 09:00
1200-1400:
1600-1800: 1700
2200-2400:
Other time:
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG: PREDNISOLONE
BEFORE ADMISSION ☐ | NEW DOSE ☑ | NEW MEDICATION ☐
DOSE: 40mg | ROUTE: PO | DATE: 3/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Laura Martin
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time:
0700-0900: X
1200-1400:
1600-1800:
2200-2400:
Other time:
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG: ACETYLCYSTEINE
BEFORE ADMISSION ☐ | NEW DOSE ☑ | NEW MEDICATION ☐
DOSE: 600mg | ROUTE: PO | DATE: 3/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Laura Martin
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time:
0700-0900: X
1200-1400:
1600-1800:
2200-2400:
Other time:
Patient's Own Medicine: For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG: TRELEGY ELLIPTA
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 92/55/22 | ROUTE: Inhale | DATE: 3/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Laura Martin
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time:
0700-0900: X
1200-1400:
1600-1800: X
2200-2400:
Other time:
Patient's Own Medicine: For Use Y/N | Qty: | Date: | 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 | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☑ | **NEW DOSE** ☐ | **NEW MEDICATION** ☐

M | DRUG: FLUOXETINE
DOSE: 40mg | ROUTE: PO | DATE: 8/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Lara Mar
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time | 0700-0900 ☒ | 1200-1400 | 1600-1800 | 2200-2400 | Other time

BEFORE ADMISSION ☑ | **NEW DOSE** ☐ | **NEW MEDICATION** ☐

N | DRUG: FUROSEMIDE
DOSE: 40mg | ROUTE: PO | DATE: 8/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Lara Mar
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

BEFORE ADMISSION ☑ | **NEW DOSE** ☐ | **NEW MEDICATION** ☐

P | DRUG: BISOPROLOL
DOSE: 1.25mg | ROUTE: PO | DATE: 8/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Lara Martin
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time | 0700-0900 | 1200-1400 | 1600-1800 ☒ | 2200-2400 | Other time

BEFORE ADMISSION ☐ | **NEW DOSE** ☐ | **NEW MEDICATION** ☐

R | DRUG: Isosorbide mononitrate
DOSE: 25mg MR | ROUTE: PO | DATE: OD | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Lara Martin
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time | 0700-0900 ☒ | 1200-1400 | 1600-1800 | 2200-2400 | 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 →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

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

Row S

BEFORE ADMISSION ☐ | NEW DOSE ☑ | NEW MEDICATION ☐

S | DRUG: CLARITHROMYCIN

DOSE: 500mg | ROUTE: PO | DATE: 8/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): Laura Mahn

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 ✕ | 1200-1400 | 1600-1800 ✕ | 2200-2400 | Other time

Row T

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

T | DRUG: THIAMINE

DOSE: 50mg | ROUTE: PO | DATE: 8/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): Laura Mahn

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 ✕ | 1200-1400 ✕ | 1600-1800 ✕ | 2200-2400 ✕ | Other time

Row V

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V | DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Row W

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W | DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 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 →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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 →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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 ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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.

All Routes: As Required Prescriptions

BEFORE ADMISSION		DRUG	STOPPED DATE:	DATE																							Patient's Own Medicine For Use Y/N
☑	LL	PARACETAMOL	INITIALS:	TIME	8/9																						Qty:
NEW DOSE ☐	DOSE 1g	ROUTE PO	INDICATION Pain	DOSE	1g																						Date:
	PRESCRIBER (PRINT & SIGN) Laura Martin	MAX.FREQ. QDS	DATE: 8/2	GIVEN BY	LC																						Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																										Ordered from Pharm.
BEFORE ADMISSION ☑	MM	DRUG DIHYDROCODEINE	STOPPED DATE:	DATE																							For Use Y/N
NEW DOSE ☐	DOSE 60mg	ROUTE PO	INDICATION PAIN	TIME																							Qty:
	PRESCRIBER (PRINT & SIGN) Laura Martin	MAX.FREQ. QDS	INITIALS: DATE: 8/2	DOSE																							Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY																							Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION ☑	NN	DRUG GTN	STOPPED DATE:	DATE																							For Use Y/N
NEW DOSE ☐	DOSE 400-800 micrograms	ROUTE SL	INDICATION CP	TIME																							Qty:
	PRESCRIBER (PRINT & SIGN) Laura Martin	MAX.FREQ. ✓	INITIALS: DATE: 8/2	DOSE																							Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY																							Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION ☐	PP	DRUG SALBUTAMOL	STOPPED DATE:	DATE	8/9																						For Use Y/N
NEW DOSE ☑	DOSE 2.5mg-5mg ~~5mg~~	ROUTE ~~PRN~~	INDICATION SOB	TIME	20	22	14																				Qty:
	PRESCRIBER (PRINT & SIGN) Laura Martin	MAX.FREQ. 2°	INITIALS: DATE: 8/2	DOSE	5	5																					Date:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY	✓	GN																					Assessed by:
																											Ordered from Pharm.

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

[redacted]

BEFORE ADMISSION		NEW DOSE	NEW MEDICATION					STOPPED		DATE																						Patient's Own Medicine
☐	RR	☑	☐	DRUG: IPRATROPIUM				DATE:		DATE	6/2	8																				For Use Y/N
				DOSE: 0.5mg	ROUTE: Neb	INDICATION: SOB		INITIALS:		TIME	20:35	22 14																				Qty:
				PRESCRIBER (PRINT & SIGN): Raina Main			MAX.FREQ. QDS	DATE: 8/2		DOSE	0.5mg	05																				Date:
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY	N	CM																				Assessed by:
																																Ordered from Pharm.
BEFORE ADMISSION	SS	NEW DOSE	NEW MEDICATION	DRUG				STOPPED	DATE:	DATE																						For Use Y/N
☐		☐	☐	DOSE	ROUTE	INDICATION			INITIALS:	TIME																						Qty:
				PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:		DOSE																						Date:
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY																						Assessed by:
																																Ordered from Pharm.
BEFORE ADMISSION	TT	NEW DOSE	NEW MEDICATION	DRUG				STOPPED	DATE:	DATE																						For Use Y/N
☐		☐	☐	DOSE	ROUTE	INDICATION			INITIALS:	TIME																						Qty:
				PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:		DOSE																						Date:
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY																						Assessed by:
																																Ordered from Pharm.
BEFORE ADMISSION	VV	NEW DOSE	NEW MEDICATION	DRUG				STOPPED	DATE:	DATE																						For Use Y/N
☐		☐	☐	DOSE	ROUTE	INDICATION			INITIALS:	TIME																						Qty:
				PRESCRIBER (PRINT & SIGN)			MAX.FREQ.	DATE:		DOSE																						Date:
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY						GIVEN BY																						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.

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963

Name —

CHI No — G66 7DA

Drug Allergies / Sensitivities None Known ☑ Yes ☐ (provide details below)

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - 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.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

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 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. 0800, 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	= nasojejunostomy	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
(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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

N	.....
A	.....
...	1308636407 SINCLAIR F
	Theresa 13/08/1963 .....
D	90a Main Street .....
C	Lennoxtown .....
	Glasgow .....
	G66 7DA

Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☐

Self-administering insulin: Yes ☐ No ☐

Usual diabetes medication and device:

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	4.0-14.9	≥15	Insulin Preparation	Dose - (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
11/2						units / units					Y / N
						units / units					Y / N
	Before Breakfast					units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed		13.7			units / units					Y / N
12/2						units / units					Y / N
						units / units					Y / N
	Before Breakfast		12			units / units					Y / N
			9.8			units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed		7.3			units / units					Y / N
13/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast					units / units					Y / N
						units / units					Y / N
	Before Lunch		9.1			units / units					Y / N
						units / units					Y / N
	Before Dinner		12.0			units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N

Date	Time	CBG Readings (mmol/L) <4	4.0-14.9	≥15	Insulin Preparation	Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
14/2						units / units					Y / N
						units / units					Y / N
	Before Breakfast		5.9			units / units					Y / N
						units / units					Y / N
	Before Lunch		9.1			units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
15/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		7.1			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
	1330			15.6		units / units					Y / N
	Before Dinner					units / units					Y / N
				15.2		units / units					Y / N
	Before Bed					units / units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L

Requires urgent treatment as per protocol: **www.diabetes.org.uk** or **StaffNet**

Urgent medical review if unwell/deteriorating at any stage.

- **Mild and able to swallow:** 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice
- **Severe:** 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic)

Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**

Hyperglycaemia: Glucose ≥ 15mmol/L

Check urine or blood for ketones – need urgent medical review if ketones present or if unwell.

Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion.

Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes.

If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1.0 • GGC0123

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Nam[illegible] 1308636407 Addr[illegible] F SINCLAIR .....33 Theresa 13/08/19[illegible] 90a Main Street DoB:. Lennoxtown Glasgow Chi n[illegible]A G66 7[illegible]	Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☐ Self administering insulin: Yes ☐ No ☐ Usual diabetes medication and device: If unwell, vomiting or septic, check for ketones and request urgent medical review.	• When prescribing insulin always write the word units in full (do not abbreviate to U or IU) • Always measure the dose and administer insulin using an insulin syringe • Rapid acting and premix insulin should be given with meals • Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
16/12/25						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch		8.9			units units					Y / N
						units units					Y / N
	Before Dinner			20.7	NOVORAPID	4 units units	[illegible] Mohammad				Y / N
						units units					Y / N
	Before Bed		12.4			units units					Y / N
17/12/25						units units					Y / N
						units units					Y / N
	Before Breakfast		6.0			units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
	1.84		13.1			units units					Y / N
	Before Bed		7.9			units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
18/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		7.4			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
19/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		6.6			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
20/2	Before Dinner					units / units					Y / N
	AM - 7.4					units / units					Y / N
	Before Bed					units / units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/L
Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet Urgent medical review if unwell/deteriorating at any stage. • **Mild and able to swallow:** 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice • **Severe:** 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic) Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but do not omit insulin in type 1 diabetes.	Check urine or blood for ketones – need urgent medical review if ketones present or if unwell. Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion. Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes. If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check Injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☐

Self administering insulin: Yes ☐ No ☐

Usual diabetes medication and device:

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to **guidelines on reverse of form** when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
20/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		7.4			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
21/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		7.4			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
22/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		6.4			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/L
Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet Urgent medical review if unwell/deteriorating at any stage. • Mild and able to swallow: 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice • Severe: 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic) Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**	Check urine or blood for ketones – need urgent medical review if ketones present or if unwell. Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion. Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes. If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Patient label

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

F
13/08/1963

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
8/2/25	17 00	Hartmanns	1000	IV	2°		Laura Mann		8/2	17:23	JC		to 6°
09/02		Hartmanns	500	IV	4°		Aoibh O' Hare FY1		9/2	04:15	CR		
09/02		Hartmanns	500	IV	4°		Aoibh O' Hare FY1						
09/02		Hartmanns	500	IV	4°		Aoibh O' Hare FY1						
9/02		0.9% Nacl	500	IV	STAT		COF		9/2/25	0900	RL		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
09/02	0720	HARTMANNS	500	IV	STAT				09/2				
09/02	0750	Hartmanns	500	IV	2°		Abibh O Hare FY1		9/2	0800			
09/02	1150	HARTMANN'S	500	IV	2°		J-Carr FY1		9/2	1155			
09/02	15:11	HARTMANN'S	500	IV	4°				9/2	1510			
09/02	2300	HARTMANNS	500	IV	2°				9/2	2300			
10/02	0115	HARTMANNS	500	IV	2°				10/2	0115			
11/02	07:30	HARTMANNS	500	IV	4°				11/2	0100			
12/2		HARTMANNS	500	IV	4°		ellyn FY1		12/2	0600			

*Prescriber should sign this box if the fluid/additive is no longer required.

1308636407

Patient nai SINCLAIR F
Theresa 13/08/1963
Date of bir 90a Main Street
Lennoxtown
Glasgow
CHI No:..... G66 7DA

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
11/2		NaCl 0.9%. / KCl	500 / 40mm	IV	6				18/2/26	1610	AG.		
19/02		NaCl 0.9% / KCl	500ml / 40mmol	IV	6				19/2/26	1200			25528007 05/2027

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow = Volume of fluid (ml) x 20 / Duration of admin (min) (drops/min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient na[illegible] [illegible] I.IC
1308636407
Date of bi[illegible] F
/83 Theresa
CHI No:.....
90a Main Street
Lennoxtown
Glasgow
)A G66 7DA label

SINCLAIR F
13/08/1963

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration (hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
14/02	1950	NaCl 0.9 +40mmol KCl	500	IV	6		[illegible]		15/02/08	01:30	CE	SH	255-14808 07/2005
						Nil Else							
15/02	2015	NaCl 0.9 +40 mmol KCl	500	IV	6		[illegible]						

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
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

Hospital N
DOB:
Date of Ad
Consultant

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
12/10	Fabulex 1+11	11	IV		[illegible]	[illegible]	0915

	DATE →	12	13																						
	MONTH →	10	10																						

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

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG: Pabrinex I+2

DOSE: 2 pots | ROUTE: IV | DATE: 12/10 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): SL

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time																									
0700-0900	10																								
1200-1400																									
1600-1800																									
2200-2400																									
Other time																									

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time																									
0700-0900																									
1200-1400																									
1600-1800																									
2200-2400																									
Other time																									

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time																									
0700-0900																									
1200-1400																									
1600-1800																									
2200-2400																									
Other time																									

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Parenteral Drugs: Regular Prescription

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE

PRESCRIBER (PRINT & SIGN)

STOPPED DATE: INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Oral and Other Drugs: Regular Prescription

DATE → 12 13
MONTH → 10 10

Patient's Own Medicine

H — DRUG: BISOPROLOL
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 2.5mg | ROUTE: ORAL | DATE: 12/10/15 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): EM
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900: MA | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG: SIMVASTATIN
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 40mg | ROUTE: ORAL | DATE: 12/10/15 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): EM
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400: MA | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG: RAMIPRIL
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 2.5mg | ROUTE: ORAL | DATE: 12/10/15 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): EM
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900: MA | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG: DIAZE
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: | ROUTE: | DATE: | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow

F
13/08/1963

G66 7DA

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow

F
13/08/1963

G66 7DA

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Patient's Own Medicine

| | | |

						Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	RR DRUG	STOPPED DATE: INITIALS:	DATE			For Use Y/N
	DOSE / ROUTE / INDICATION		TIME			Qty:
	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE			Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY			Assessed by:
						Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	SS DRUG	STOPPED DATE: INITIALS:	DATE			For Use Y/N
	DOSE / ROUTE / INDICATION		TIME			Qty:
	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE			Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY			Assessed by:
						Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	TT DRUG	STOPPED DATE: INITIALS:	DATE			For Use Y/N
	DOSE / ROUTE / INDICATION		TIME			Qty:
	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE			Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY			Assessed by:
						Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	VV DRUG	STOPPED DATE: INITIALS:	DATE			For Use Y/N
	DOSE / ROUTE / INDICATION		TIME			Qty:
	PRESCRIBER (PRINT & SIGN) / MAX.FREQ.	DATE:	DOSE			Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY		GIVEN BY			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.

1308636407

Name SINCLAIR Theresa 90a Main Street Lennoxtown Glasgow — F — 13/08/1963

CHI No G66 7DA

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - 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.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

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 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	= naso[e]junostomy	PEJ	= percutaneous endoscopic [e]junostomy
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		

Cat. No. 40995 Ver 4, 09/2010

Patient name

Patient CHI

1308636407 F
SINCLAIR
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow G66 7DA

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

Initial when complete	Required?		Init		Required?		Init
Patient prepared for exam	Y	N		Pain score	Y	N	
NEWS/MEWS/ PEWS chart	Y	N		Peak flow	Y	N	
ID Band	Y	N		MSSU Results:			
12-Lead ECG	Y	N					
Blood samples	Y	N					
Blood Gas	Y	N					
Viral Swab	Y	N		B-HCG	+ve	-ve	

Communication

	Required?	
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

Signature:

PVC

Circle reason: D R I F T

Diagnostic
Resuscitation
Intravenous
Fluids
Transfusion

Insertion Date: 8/12/96 Time:

Insertion Side: L R

Insertion Site: ACF

Size of PVC: Pink

Inserted by

Signature

Hand Hygiene Yes ☐

Skin Decontamination 2% chlorhexidine in 70% isopropyl alcohol Yes ☐

Sterile transparent semi-permeable dressing affixed Yes ☐

PVC Reason Explained Yes ☐

Risk Assessments and Screening Tools

	Required?		Init		Required?		Init
				SEPSIS	Y	N	
FAST +VE	Y	N		STOPPS	Y	N	
				ED Falls Risk Assessment	Y	N	
				Mental Health Triage Assessment	Y	N	
				Ligature low room	Y	N	
				GMAWS	Y	N	
				Public Protection Concern (Adult/Child)	Y	N	
				Notification of Concern Completed (NOC)	Y	N	
				Frailty Assessment Completed	Y	N	
				4AT Assessment	Y	N	

Pause for Discharge

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band Removed	Y	N
Risk Assessment/Screening Tools Completed	Y	N
Discharge Information	Y	N
NEWS Chart completed within 1 hour of discharge	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
Notes Complete	Y	N
Belongings	Y	N
Transport arranged	Y	N
Own/Taxi/Relative/SAS (Please circle)	Y	N
PVC Removed Prior to Discharge	Y	N

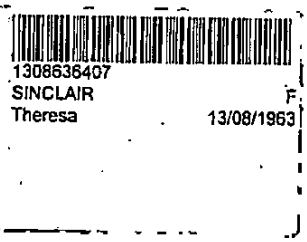
Signature:

Pause for Transfer

GGC Red Bag with Patient (nursing home resident)	Y	N
Relatives / Carer with Patient	Y	N
Name Band in situ	Y	N
Risk Assessment/Screening Tools Complete	Y	N
Bed Available	Y	N
SBAR complete	Y	N
NEWS Chart completed within 1 hour of transfer	Y	N
Medications/Fluids prescribed as per medication prescription form	Y	N
PVC/CVC Bundle	Y	N
Notes Complete	Y	N
Belongings	Y	N
Escort Required	Y	N

Signature:

Patient name ...



Patient CHI ...

NHS
Greater Glasgow and Clyde

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	1325									
	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/ Review analgesia		N									
S	3	SKIN INSPECTION Pressure areas checked?		Y									
		R = RED D = Discloured PU - Pressure Ulcer INT = Intact M = Moisture		INT									
K	4	KEEP MOVING Has the patient moved or walked?		Y									
		Bed R =Right side (30°) tilt L =Left side (30°) tilt B =Back Chair W/ST = Assist to walk / stand		B									
		ELIMINATION Does the patient need the toilet?		N									
I	5	I = Independent A - Assistance given IC = Incontinent (urine/ faeces)		CATH									
N	6	FOOD FLUIDS AND NUTRITION Is the patient nil by mouth?		N									
		Drink taken?		N									
		Food, snack, or supplements taken?		N									
		Has oral hygiene been carried out as per care plan?		N									
	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?		YES/N									
	8	INFORMATION Is there anything else I can help you with? Inform the patient of the time of return		N									
	9	ESCALATION Is there anything else I can help you with? Inform the patient of the time of return		NA									
		Care provider		SR									
		Role		RN									

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

Patient name .....

Patient CHI .....

or use sticker

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

NHS Greater Glasgow and Clyde

Attach addressograph	**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

Pressure damage	**No RISK** ↓	**At RISK** ↓	**Grade 1 – non blanching skin** **Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD)** ↓	**Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing** ↓
YOU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (below)	2 hourly positioning with skin checks, Complete SSKINS care plan (below)	All devices need a SSKINS care plan (below)

1	PressureDamage	**Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?**
2	Mobility	**Does the person require assistance to mobilise or change position?**
3	Continence	**Does the person have moisture issues, or, 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. medical devices; neurological deficit; surgery; medication; co-morbidities?**
6	Judgement	**In your clinical judgement, is this person at risk of developing pressure damage?**

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan below.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
8/2/26	1535	N	N	N	N	Y	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

	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: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

Patient name .....

Patient CHI .....

or use sticker

NHS
Greater Glasgow and Clyde

Use the following Codes:	**Y** = Yes **S** = Sleeping	**N** = No	**NA** = Not Applicable **O** = Off the ward	**NT** = No Thanks **I** - Independent

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
Food, Fluid, Nutrition (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment reviewed/checklist									
Skin assessed and supported (PURDRA)									
Pain assessment									
SBAR up to date and completed									
Patient/ relatives updated									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									
PVC/CVC Bundle. Consider is; Dressing intact? PVC patent?									Commence CVC/PVC chart

Patient name .....

Patient CHI

1308636407
SINCLAIR
Theresa
F
13/08/1963

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time		Name/Signature
1540 8/2/26	Standby to monitor) SOB/DIB ✓ on arrival to ed A - patent, requiring 6l o2 to maintain sats 94%. B → RR 34 CS 128/112, HR 113- CL- GCS 15, Bm 12.2 with crew E - Known COPD	
	for bloods ecg lat and medical ✓IV	Sln/caning
8/2/26 2015	Repeat ECG done	
2045	Combined given	JM Vogan
2045	Clarithromycin 500mg tab given	
2215	Pt GCS ↓ to 13 ↑ WOB pale colour - retaining medic walking past - moved to resus for reassessment	EMDoyle.
	Indication AKI Residual Volume (ml) >20 Colour of Urine Yellow Easy Insertion ✓ Y N If No, why? Name Shona Signed Date 8/2/26	
	PTFE AquaFlato P310112 (PHS3000) PTFE Coated Latex Short/Medium-Term (up to 4 weeks use) LOT 40E25C2493 Standard, 2-way Foley 2030-02-28 SIZE: Ch. 12 O.D.: 4.0mm / 10ml Teleflex Medical, IDA Business and Technology Park, Dublin Road, Athlone, Co. Westmeath, Ireland	
2230.	Catheterised due to severe AKI.	Shona Sinclair

Patient

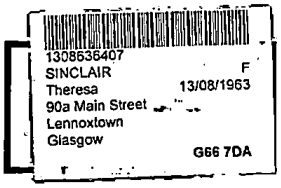
Patient

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time		Name/Signature
8/2/26	Commenced NIV at post ABG,	
22[55] ~~1055~~	tolerating well at present.	
	med reg made aware.	Alcaught
23[00]	med reg will review in department.	Alcaught.
23.25.	sputum culture obtained abl	
	sent.	Alcaught.
23.45	Reg reg happy for ANO TEP	
	to take.	
	ED doctor updated family	Alcaught



GRI – PATIENT RISK ASSESSMENTS TRACKING SHEET

WARD: 7 **BED NUMBER:** Bed 6

RISK ASSMEMENTS	DATE OF NEXT ASSESSMENT	DATE OF NEXT ASSESSMENT	DATE OF NEXT ASSESSMENT	DATE OF NEXT ASSESSMENT	DATE OF NEXT ASSESSMENT	DATE OF NEXT ASSESSMENT
MUST Score (within 24 hrs of transfer and weekly)	25/2/26					
Falls Risk Assessment (within 24 hrs of transfer and weekly/post fall)	25/2/26					
Bed Rail Assessment (within 24 hrs of transfer and weekly)	25/2/26					
Moving and Handling Risk Assessment (with 24 hrs of transfer and weekly)	25/2/26					
4 AT	29/2/26					
Discharge Checklist (Initiate at the time of transfer and complete at the time of discharge)	initiated 9/2/26					
Name & Signature of the Staff Nurse	PP Nicole Valentine					
Date	18/2/26					

Write or affix label

1308636407
F SINCLAIR F
53 Theresa 13/08/1963
I 90a Main Street
I Lennoxtown
I Glasgow
IA G66 7DA

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC
As above and including: palpable venous cord	4	Seek further advice
As above and including: pyrexia	5	

NHS Greater Glasgow and Clyde

Insertion details:	Where inserted:	Insertion site:	Side:	Size of cannula:	Inserted by:
Date: 16/2/26 (Day 1)	☐ ED ☐ Theatre ☐ ITU/HDU	☐ Hand	☐ Left	☐ 26G Purple	Print:
Time: 22:50	☑ Ward 50151	☑ Arm	☑ Right	☐ 24G Yellow ☐ 18G Green	Signature: Medics
	☐ Unknown	Other		☐ 23G Blue ☐ 16G Grey	Designation:
				☑ 20G Pink ☐ 14G Orange	

Clinical indication:	☐ Diagnostics	☐ Resuscitation	☑ IV medications	☐ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☑ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☑ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☑ Yes ☐ No	PVC explained to patient/carer ☑ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ Transfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:

a CLINICAL IMPROVEMENT in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS
a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption)
a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness
Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
IF not responsive MICROBIOLOGY switch to oral as outlined below

Paediatric IVOST Guideline:

1308638407

F SINCLAIR F
13 Theresa 13/08/1963
Name: 90a Main Street
Address: Lennoxtown
CHI: A Glasgow
DOB: G66 7DA
Hospital & Ward: GRI W45

PVCs should be removed as soon as no longer clinically indicated.

NHS Greater Glasgow and Clyde

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation: -
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 16/2/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ___	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night GQ Robertson GN
Day 2 17/2/26	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day S/N K Night
Day 3 18/2/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ___	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4 19/2/26	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ___	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5 20/2/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ___	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night Emily Burgess SN
Day 6 21/2/26	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night Emily Burgess SN
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ___	VIP ___	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

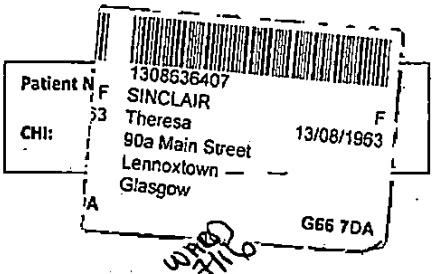
PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed __/__/__

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

Infection Control Care Plan for a patient with Loose Stools of unknown origin / Gastroenteritis

This care checklist should be used with patients who have loose stools of unknown origin OR Gastroenteritis. This care checklist should be followed to reduce the risk of transmitting faecal organisms to other patients, staff, carers and visitors, while the patient is considered infectious and then signed off at end of the isolation period / discharge. Each criteria should be ticked √ if in place or X if not, the checklist should be then initialled after completion, daily.

Date Isolation commenced: .....



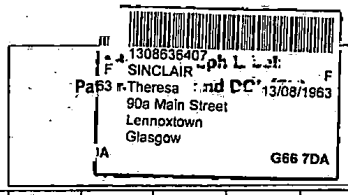
		Date:						
		15/2	16/2	17/2	18/2	19/2		
	Patient Placement/ Assessment of Risk	Daily check (√/x)						
Patient Placement /Assessment of risk	Patient isolated in a single room with *en suite* facilities / own commode until 48 hours asymptomatic. If a single room is not available, an IPCT risk assessment is completed (see Appendix 1)			✓	✓	✓		
	The yellow IPC isolation sign must be placed on the door to the patient's room. In Mental Health Services (MHS), on advice of IPCT			✓	✓	✓		
	Door to isolation room is closed when not in use. If for any reason this is not appropriate then an IPCT risk assessment is completed			✓	✓	✓		
	A Bristol stool chart is in use and is up to date			✓	✓	✓		
Standard Infection Control & Transmission Based Precautions	**Hand Hygiene (HH)**							
	All staff must use correct 6 step technique for hand hygiene at 5 key moments with liquid soap and water			✓	✓	✓		
	HH facilities are offered to patient after using the toilet and prior to mealtimes etc. (clinical wash hand basin/ wipes where applicable)			✓	✓	✓		
	Personal Protective Clothing (PPE)							
	Disposable gloves and yellow apron should be worn. FRSM advised for routine care if patient is vomiting. HH must be carried out following removal of PPE.			✓	✓	✓		
	Safe Management of Care Equipment							
	Single-use items are used where possible OR equipment is dedicated to patient while in isolation.			✓	✓	✓		
	There are no non-essential items in room. (e.g. Excessive patient belongings)			✓	✓	✓		
	Twice daily decontamination of the patient equipment by HCW is in place using 1,000 ppm solution of chlorine based detergent with 5 minute contact time before rinsing off and drying.			✓	✓	✓		
	Safe Management of Care Environment							
	Twice daily clean of isolation room is completed by Domestic services, using a solution of 1,000 ppm chlorine based detergent with 5 minute contact time. A terminal clean will be arranged on day of discharge/ end of isolation.			✓	✓	✓		
	Remove any uncovered food from patient lockers.				✓	✓		
	Laundry and Clinical/Healthcare waste							
	All laundry is placed in a water soluble bag, then a clear plastic bag (brown bag used in mental health areas), tied then into a white laundry hamper bag. Some wards and departments may use red laundry hamper bags as the outer bag.			✓	✓	✓		
	Clean linen must not be stored in the isolation room.			✓	✓	✓		
	All waste should be disposed of within the isolation room as clinical/ Healthcare waste			✓	✓	✓		
Information for patients/carers	**Information for patients and their carers**							
	The patient has been given information on their infection / isolation and provided with a patient information leaflet (PIL) if available.				✓	✓		
	If taking soiled clothing home, carers have been issued with a Washing Clothes at Home PIL. (NB. Personal laundry is placed into a patient water soluble bag and then into a patient clothing bag before being given to carer to take home)			✓	✓	✓		
	HCW Daily Initial :			CG	MW	N		

Date Isolation ceased/ Terminal Clean completed: 19/2/26 **Signature:** ..... **Date:** 19/2/26

Date Specimens Obtained: Please note there should be 24hours between each sample for culture & c diff testing

Culture & C Diff	Virology
1.	1.
2.	
3.	

Appendix 1: Infection Prevention and Control Risk Assessment
(for patients with known or suspected infection that cannot be isolated)



NHS Greater Glasgow and Clyde

Daily Assessment / Review Required

	COMMENTS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Daily Assessment Performed by *Initials*		15/2	16/2	17/2				
Known or suspected Infection e.g. unexplained loose stools, MRSA, Group A Strep, *C. difficile*, Influenza, pulmonary tuberculosis. *Please state*	17/2/25 Loose Stools Cause			CPE				
Infection Control Risk, e.g. unable to isolate, unable to close door of isolation room. *Please state*	Nurse in SL Door Closed			CPE				
Reason unable to isolate / close door to isolation room, e.g. falls risk, observation required, clinical condition. *Please state*	Nurse in Side Room			CPE				
Additional Precautions put in place to reduce risk of transmission, e.g. nursed next to a clinical wash hand basin, at end of ward, trolley containing appropriate PPE at end of bed, next to low risk patient, clinical waste bin placed next to bed space.. *Please state*								
Infection Prevention and Control have been informed of patient's admission and are aware of inability to adhere to IPC Policy? *Yes / No*								
Summary Detail of Resolution								

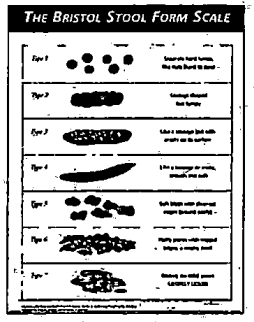
Daily risk assessments are no longer required

Signed _____

Date _____

Stool Chart

Key		
Consistency	Colour	Amount
0 = Watery	0 = Chalky	0 = Very Small
1 = Soft	1 = Pale	1 = Small
2 = Normal	2 = Normal	2 = Normal
3 = Firm	3 = Dark	3 = Large
4 = Constipated	4 = Black	4 = Very Large
	5 = Red	



1. Separate hard lumps, like nuts (hard to pass)
2. Sausage-shaped but lumpy
3. Like a sausage but with cracks on its surface
4. like a sausage or snake, smooth and soft
5. Soft blobs with clear-cut edges (passed easily)
6. Fluffy pieces with ragges edges, a mushy stool
7. Watery, no solid pieces ENTIRELY LIQUID

NHS
Greater Glasgow and Clyde

1308636407
SINCLAIR F
Theresa 13/08/1963

Date	Time	Colour	Type	Consistency	Amount	Specimen Obtained	Blood	Mucus	Signature
11·2·26	04·30	2	7	0	1	NO	NO	NO	SML
11·2·26	06·30	2	7	0	2	NO	NO	NO	SML
11.2.26	0830	2	7	0	0	N	N	N	
12/2/26	0000	3	7	0	0	N	N	N	
12/2/26	0040	3	7	0	0	N	N	N	
12/2/26.	0930 am	2.	7.	0.	0.	N.	N.	N.	AMQ McKenna
14/2/26	23:20	2	7	0	1				Qua
15/2/26	10:30	2	7	0	2	N	N	N	E·D
15/2/26	13:10	3	6	0	2	N	N	N	E·D
15/2/26	14:30	3	6	0	2	N	N	N	E·D
17/2/26	0200	2	6	0	1	N	N	N	BLQ.
17/2/26	0900	—	BND	—	—	—	—	—	CG 9/2

Date	Time	Colour	Type	Consistency	Amount	Specimen Obtained	Blood	Mucus	Signature
17/2/26	1310	2	5	1	2	N	N	N	S/N OTG
18.2.26	06:15	3	5	1	2	NO	—	—	[illegible]
18·2·26	13 15	2	5	2	1	NO	—	—	[illegible]
18·2·26	21·.00	3	5	1	1	NO	—	—	[illegible]

1308636407
F SINCLAIR
53 Theresa
90a Main Street
Lennoxtown
Glasgow
A
G66 7D
13/08/19

Write or affix label

1308838407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC
As above and including: palpable venous cord	4	Seek further advice
As above and including: pyrexia	5	

NHS Greater Glasgow and Clyde

Insertion details: Date: 08/2/16 (Day 1) Time: ____	**Where inserted:** ☑ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ____ ☐ Unknown	**Insertion site:** ☐ Hand ☑ Arm Other ____	**Side:** ☑ Left ☐ Right	**Size of cannula:** ☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☐ 23G Blue ☐ 16G Grey ☑ 20G Pink ☐ 14G Orange	**Inserted by:** Print: ____ Signature: ____ Designation: ____
Clinical indication:	☐ Diagnostics	☐ Resuscitation	☑ IV medications	☑ Fluids	☐ Transfusion
Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No	

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ Transfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Paediatric IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily
Can antibiotic therapy be stopped? (eg: alternative diagnosis)?
If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

Switch to oral when:
- a CLINICAL IMPROVEMENT in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS
- a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption)
- a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness
Record the stop date on HEPMA

If IVOST criteria met → Switch to oral
Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures
IF not responsive MICROBIOLOGY switch to oral as outlined below

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

PVCs should be removed as soon as no longer clinically indicated.

NHS Greater Glasgow and Clyde

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Print: Designation:
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 08/02/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night [illegible]
Day 2 9/2/26	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day R L Crawford Night
Day 3 10/2/26	☑ Yes ☐ No	☑ Yes ☐ No	VIP 0	VIP 0	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☑ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4 11/2/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5 12/2/26	☐ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6 13/2/26	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day CPSN Night
Day 7 15/2/26	☐ Yes ☐ No	☑ Yes ☐ No	VIP ____	VIP 0	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed 16/2/26

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

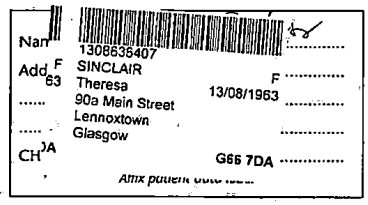
Patient Monitoring:

(please tick relevant box to right)

- ☐ Stress & Distressed behaviour
- ☐ Challenging behaviour
- ☐ Monitoring the use of bed / chair alarms
- ☐ Step down one-to-one care

NHS Greater Glasgow and Clyde

Week commencing: _____



How to complete the chart: Identify patient's behaviour. Enter each code at the time the behaviour is observed – see example and codes listed below.

Update 2 hourly day and night or when behaviour changes. Give each behaviour a separate number code.

Date	8.00am	10.00am	12 noon	2.00pm	4.00pm	6.00pm	8.00pm	10.00pm	12 m'night	2.00am	4.00am	6.00am
08.09.14	2	4	1 + 2	3	2	3 + 4	7	1 + 3	6	1 + 2	1 + 2	1 + 2
12/2/26							4,9,6	4,9,6	4,9,6	2,9,6	2,9	2,6
13/2/26	1,2	1,2	1,1	2,1	2 1	1, 1	1,2,9	2,9,4,6	2 9	6 9	9 9	2,9
14/2/26	9, 9	2, 9	9, 2	9 9	2, 1	9, 2	9, 1	1,9	9, 2	1,2,9	1,9,2	9,1

Codes:

1. Settled
2. Sleeping
3. Getting up from chair unassisted
4. Agitated
5. Verbally aggressive
6. Getting up from bed unassisted
7. Physically aggressive
8. Fall
9. Pulling off O2
10. _____
11. _____
12. _____

Identify level of nursing observation required to ensure patient's safety, use 2014 Guidance. If situation unmanageable or unsafe, escalate to Line Manager/coordinator.

Guidelines to step down one-to-one observation

Look for patterns of settled behaviour. After discussion with the MDT re. patterns of settled behaviour, gradually withdraw one-to-one care at these times. Designate a member of staff to commence 15 minute observations. Ensure patient is in an observable area of the ward and has their call bell to hand. Ensure patient has all their personal effects to hand and all needs are met. Discuss safety precautions with the patient and their family.

Management of patients with behavioural disturbance

Name: .....
Address: .....
.....
.....
CHI Number: .....
Affix patient data label

Tick that all areas have been considered on each shift

Nursing Interventions Date Day (D) / Night (N)			13/2/26		14/2/26									
	D	N	D	N	D	N	D	N	D	N	D	N	D	N
Is the patient in pain, constipated or dehydrated? Use pain, bowel, fluid charts.			✓		✓									
Does the patient have delirium? Follow NHSGGC Delirium Guidelines. Any signs of infection?			✓		✓									
GMAWS if indicated by FAST assessment, referral to addictions service if necessary.			NA		NA									
Continually assess body language, speech, behaviour, level of distress or agitation. Don't restrict patient's mobility unless a risk to self or others. Guard your own exit, don't block patient's exit.			✓		✓									
Approach and speak to patient calmly, allowing time for reply. Don't make sudden movements. Tell patient who you are and what you are going to do, every time.			✓		✓									
What is the best ward environment or placement for patient? Reduce noise/activity to minimum.			✓		✓									
Minimise potential weapons and falls risks: ensure only essential items in room or on your person			✓		✓									
Identify level of nursing observation required to ensure patient's safety, use 2014 Guidance. If situation unmanageable or unsafe, escalate to Line Manager/coordinator.			✓		✓									
Record all actions in clinical notes, particularly level of observation required and strategies used.			✓		✓									
Medical Management plan: ensure medication is given as prescribed, use sedation as last resort.			✓		✓									
Seek Psychiatric Liaison advice where necessary and ensure advice is acted upon.			✓		✓									
Does the patient have reduced cognitive function? Use AMT4/4AT/TIME. Consider AWI. Complete 'Getting to Know Me'/'What matters to Me'. Involve family members, ask for their help in interpreting behaviours and suggesting calming or diversionary strategies. Familiar faces may comfort and help situation if patient distressed.			✓		✓									
Previous violent history? If ongoing situation, complete H&S risk assessment with clinical management plan.			✓		✓									
Report any significant incidents on Datix; inform manager, H&S/V&A team, Alert on Trakcare.			✓		✓									
If assistance required - shout for help or use emergency call bells/panic buttons. If severe situation, phone police on **999** (not local police number).			✓		✓									
Sign/Initial			[illegible]		[illegible]									

1308536407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow G66 7DA

Adult Urethral Urinary Catheter(UUC)

Insertion & Maintenance Care Plan

Catheter Batch Label

NHS Greater Glasgow and Clyde

Insertion – Complete all sections				
Date and time inserted: 8/2/26 2215	Urethral Urinary Catheter inserted: Hospital ARI; ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐	Gauge: 12	10 mls in balloon	Inserted by (Print name & designation [if known]): [illegible]
Clinical indication for urethral urinary catheterisation: ARI	Long term urethral urinary catheter ☐ (> 28 days)	Short term urethral urinary catheter ☑ (≤ 28 days)		
Patient had urethral urinary catheter inserted in the community/out with NHS GGC: Yes ☐ No ☑	Date UUC inserted (if known):			

Insertion Criteria		Comments
Alternatives to urethral urinary catheterisation considered	Yes ☐ No ☑	
Hand hygiene is performed immediately before urethral urinary catheter insertion	Yes ☑ No ☐	
Aseptic technique performed at insertion	Yes ☑ No ☐	
Urethral Urinary catheter of smallest gauge used and balloon filled to recommended level	Yes ☑ No ☐	
Urethral meatus cleaned with sterile saline and sterile lubricant used	Yes ☑ No ☐	
Aseptic technique maintained when connecting urethral urinary catheter to closed drainage system	Yes ☑ No ☐	

DAILY MAINTENANCE: FOR ALL PATIENTS WITH A URETHRAL URINARY CATHETER:

- Staff must wear gloves and apron and perform hand hygiene before and after urinary catheter procedures
- The drainage bag must be emptied when clinically indicated using a clean disposable container for each patient. Please refer to Insertion and maintenance of adult indwelling urethral urinary catheter SOP.

Maintenance – To be completed daily (observe for signs and symptoms of infection)						
Please regard Day 1 as day of insertion or the day patient is admitted to hospital with Urethral Urinary Catheter.	Ward	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out? (soap and water)	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 1 8/2/26		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	[illegible]
Day 2 9/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	[illegible]
Day 3 10/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	

Date removed: 18/2/26 Time removed: 20:55 Reason for Urethral Urinary Catheter removal: NOT REQUIRED Removed by: [illegible]

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

eted daily (observe for signs and symptoms of infection)						
	Yard	Does the patient still require a urethral urinary catheter?	Is the urethral urinary catheter connected to a closed drainage system and changed in line with manufacturer's instructions?	Daily meatal hygiene has been carried out?	Urine drainage bag is situated below the level of the bladder and not in contact with any surface e.g. floor?	Signature and Print Name
Day 4 11/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	
Day 5 12/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	
Day 6 13/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	clpSN
Day 7 14/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 8 15/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 9 16/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐	ALE Robertson CN
Day 10 17/2/26	50/51	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☑ No ☐	ALE Robertson CN
Day 11 18/2/26	7/16	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	CN
Day 12 19/2/26	7/16	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	E Mangan EMN
Day 13 20/2/26	7/16	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 14 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 15 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 16 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 17 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 18 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 19 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 20 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 21 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 22 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 23 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 24 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 25 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 26 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 27 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	
Day 28 __/__/__		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

NHS Greater Glasgow and Clyde

AMU

Drug Summary of Intake / Urine

Fluid balance discontinued: date: by:

Routine Urinalysis

Bilirubin							
Urobilinogen							
Ketones							
Glucose							
Protein							
Blood							
Nitrite							
pH							
Spec. Grav.							
Leucocytes							
Colour							
Sample(Y/N)							
Comments							
Initial							

Other Swabs Taken e.g. C.diff / MRSA / Wound Swabs

Date						
Result						

1308636407
SINCLAIR F
Theresa 13/08/1963

Date 9/2/26.

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti-arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	AF	148		✓		✓		
11.00 AM	AF	144		✓		✓		
12.00 PM	AF	139		✓		✓		
1.00 PM	AF	123		✓		✓		
2.00 PM	AF	141		✓		✓		
3.00 PM	AF	143		✓		✓		
4.00 PM	AF	149		✓		✓		
5.00 PM	AF	135		✓		✓		
6.00 PM	AF	135		✓		✓		
7.00 PM	AF	139		✓		✓		
8.00 PM	Af	135		✓		✓		
9.00 PM	Af	132		✓		✓		
10.00 PM	Af	134		✓		✓		
11.00 PM	Af	129		✓		✓		
12.00 AM	Af	133		✓		✓		
1.00 AM	Af	129		✓		✓		
2.00 AM	Af	132		✓		✓		
3.00 AM	Af	121		✓		✓		
4.00 AM	Af	125		✓		✓		
5.00 AM	Af	129		✓		✓		
6.00 AM	Af	134		✓		✓		
7.00 AM								
8.00 AM								
9.00 AM								
10.00 AM	Af	152		✓		✓		

MIS 169085

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date 10.2.26

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti--arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM								
11.00 AM	ST							
12.00 PM	ST	135		✓		✓		
1.00 PM	ST	125		✓		✓		
2.00 PM	ST	130		✓		✓		
3.00 PM								
4.00 PM	Flutter	137-156	✓			✓		
5.00 PM	A flutter	103-137						
6.00 PM								
7.00 PM	A flutter	102-124	✓			✓		
8.00 PM	AFlut	108		✓		✓		
9.00 PM	AFlut	112		✓		✓		
10.00 PM	AFl	131		✓		✓		
11.00 PM	AFlut.	127		✓		✓		
12.00 AM	Aflut	129		✓		✓		
1.00 AM	AFlutt	134		✓		✓		
2.00 AM	Aflutter	132		✓		✓		
3.00 AM	Aflutter	129		✓		✓		
4.00 AM	Aflutter	135		✓		✓		
5.00 AM	Aflutter	132		✓		✓		
6.00 AM								
7.00 AM								
8.00 AM	Aflutt	126		✓		✓		
9.00 AM								
10.00 AM	Aflutter	133		✓		✓		

MIS 169085

1308636407
SINCLAIR F
Theresa 13/08/1963

Date 11.2.26

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti-arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	A flutter	153		✓		✓		
11.00 AM	A flutter	117-134		✓		✓		
12.00 PM								
1.00 PM	A flutter	124-152						
2.00 PM								
3.00 PM	A flutter	138-145						
4.00 PM								
5.00 PM	A. flutter	140 S		✓		✓		
6.00 PM								
7.00 PM								
8.00 PM	Aflut	118		✓		✓		
9.00 PM	Aflutt	110		✓		✓		
10.00 PM	Aflutter	118		✓		✓		
11.00 PM	Aflutter	129		✓		✓		
12.00 AM	Aflutter	119		✓		✓		
1.00 AM	Aflutter	120		✓		✓		
2.00 AM	Aflutter	129		✓		✓		
3.00 AM	Aflutter	122		✓		✓		
4.00 AM	Aflutter	145		✓		✓		
5.00 AM	Aflutter	128		✓		✓		
6.00 AM	Aflutte	127		✓		✓		
7.00 AM								
8.00 AM	AF	139		✓		✓		
9.00 AM	AF	148		✓		✓		
10.00 AM								

MIS 169085

Ms T Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date 1 2 / 2 . / 2 6

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti--arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM								
11.00 AM	AF	134		✓		✓		
12.00 PM	AF	146		✓		✓		
1.00 PM	AF	130		✓		✓		
2.00 PM	AF	113		✓		✓		
3.00 PM	AF	108		✓		✓		
4.00 PM	AF	100		✓		✓		
5.00 PM								
6.00 PM	AF	101		✓		✓		
7.00 PM								
8.00 PM	AF	101		✓		✓		
9.00 PM	AF	96		✓		✓		
10.00 PM	AF	116		✓				
11.00 PM	AF	102		✓		✓		
12.00 AM	AF	120		✓		✓		
1.00 AM	AF	130		✓		✓		
2.00 AM	AF	116		✓		✓		
3.00 AM	AF	111		✓		✓		
4.00 AM	AF	118		✓		✓		
5.00 AM	AF	124		✓		✓		
6.00 AM	AF	115		✓		✓		
7.00 AM								
8.00 AM	AF	108		✓		✓		
9.00 AM	AF	116		✓		✓		
10.00 AM	AF	103		✓		✓		

MIS 169085

Patient I.D. Label

Theresa Sinclair

Date 13/2/26

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti-arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	AF	103		✓		✓		
11.00 AM	AF	86		✓		✓		
12.00 PM	AF	100		✓		✓		
1.00 PM	AF	91		✓		✓		
2.00 PM	AF	99		✓		✓		
3.00 PM	AF	94		✓		✓		
4.00 PM	AF	98		✓		✓		
5.00 PM	AF	101		✓		✓		
6.00 PM	AF	99		✓		✓		
7.00 PM	AF	105		✓		✓		
8.00 PM	AF	98		✓		✓		
9.00 PM	AF	92		✓		✓		
10.00 PM	AF	88		✓		✓		
11.00 PM	AF	84		✓		✓		
12.00 AM	AF	86		✓		✓		
1.00 AM	AF	72		✓		✓		
2.00 AM	AF	89		✓		✓		
3.00 AM	AF	102		✓		✓		
4.00 AM	AF	108		✓		✓		
5.00 AM	AF	113		✓		✓		
6.00 AM	AF	89		✓		✓		
7.00 AM	AF	110		✓		✓		
8.00 AM	Declined							
9.00 AM	Declined							
10.00 AM	AF	88		✓		✓		

MIS 169085

Patient I.D. Label

Theresa Sinclair

Date 14/2/26

NHS Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti-arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	AF	88		✓		✓		
11.00 AM	Taken off by patient							
12.00 PM	AF	85		✓		✓		
1.00 PM	AF	98		✓		✓		
2.00 PM	AF	99		✓		✓		
3.00 PM	Taken off by patient							
4.00 PM	Taken off by patient							
5.00 PM	AF	106		✓		✓		
6.00 PM	AF	99		✓		✓		
7.00 PM	AF	88		✓		✓		
8.00 PM	AF	102		✓		✓		
9.00 PM	AF	99		✓		✓		
10.00 PM	AF	91		✓		✓		
11.00 PM	AF	91		✓		✓		
12.00 AM	AF	89		✓		✓		
1.00 AM	AF	91		✓		✓		
2.00 AM	AF	103		✓		✓		
3.00 AM	AF	93		✓		✓		
4.00 AM	AF	86		✓		✓		
5.00 AM	AF	98		✓		✓		
6.00 AM	AF	90		✓		✓		
7.00 AM	AF	92		—		—		
8.00 AM	AF	89	—			—		
9.00 AM	AF	86		—		—		
10.00 AM	AF	90		—		—		

MIS 169085

1308636407
F SINCLAIR
63 Theresa
90a Main Street
Lennoxtown
Glasgow
)A
G66 7[
13/08/19

Date 16/2/26

NHS
Greater Glasgow and Clyde

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti--arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	AF	90		✓		✓		
11.00 AM	AF	103		✓		✓		
12.00 PM	AF	130		✓		✓		
1.00 PM	AF	112		✓		✓		
2.00 PM	AF	118		✓		✓		
3.00 PM	AF	98		✓		✓		
4.00 PM	AF	114		✓		✓		
5.00 PM	AF	100		✓		✓		
6.00 PM	AF	91		✓		✓		
7.00 PM	AF	89		✓		✓		
8.00 PM	AF	92		✓		✓		
9.00 PM	AF	102		✓		✓		
10.00 PM	AF	90		✓		✓		
11.00 PM	AF	105		✓		✓		
12.00 AM	AF	109		✓		✓		
1.00 AM	AF	102		✓		✓		
2.00 AM	AF	92		✓		✓		
3.00 AM	AF	100		✓		✓		
4.00 AM	AF	85		✓		✓		
5.00 AM	AF	79		✓		✓		
6.00 AM	AF	89		✓		✓		
7.00 AM	AF	88		✓		✓		
8.00 AM	AF	95		✓		✓		
9.00 AM	AF	97		✓		✓		
10.00 AM	AF	113		✓		✓		

MIS 169085

1308636407
SINCLAIR
Theresa 13/08/19
90a Main Street
Lennoxtown
Glasgow
G66 7E

Date 16/2/26.

NHS
Greater Glasgow and Clyde

(42)

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti--arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	AF	113		✓		✓		
11.00 AM	AF	105		✓		✓		
12.00 PM	AF	110		✓		✓		
1.00 PM	AF	130		✓		✓		
2.00 PM	AF	117		✓		✓		
3.00 PM	AF	107		✓		✓		
4.00 PM	AF	114		✓		✓		
5.00 PM	AF	111		✓		✓		
6.00 PM	AF	105		✓		✓		
7.00 PM	AF	100		✓		✓		
8.00 PM	AF	106		✓		✓		
9.00 PM	AF	108		✓		✓		
10.00 PM	AF	106		✓		✓		
11.00 PM	AF	108		✓		✓		
12.00 AM	AF	103		✓		✓		
1.00 AM	AF	103		✓		✓		
2.00 AM	AF	108		✓		✓		
3.00 AM	AF	96		✓		✓		
4.00 AM	AF	98		✓		✓		
5.00 AM	AF	99		✓		✓		
6.00 AM	AF	86		✓		✓		
7.00 AM	AF	96		✓		✓		
8.00 AM	AF	103		✓		✓		
9.00 AM	AF	94		✓		✓		
10.00 AM	AF	114		✓		✓		

MIS 169085

1308636407
F SINCLAIR
i3 Theresa F
13/08/1963
90a Main Street
Lennoxtown
Glasgow
A G66 7DA

Date 17/2/26

NHS
Greater Glasgow and Clyde

3/3

Medical Receiving Unit

Cardiac Monitor Chart

Time	Rhythm	Rate	Chest pain		GTN infusion		Other Anti-arrhythmic meds	B/P
			Yes	No	Yes	No		
10.00 AM	~~AF~~ AF	114		—		—		
11.00 AM	AF	99		—		—		
12.00 PM	AF	103		—		—		
1.00 PM	AF	111		—		—		
2.00 PM	AF	104		—		—		
3.00 PM	~~AF 135~~	135		—		—		
4.00 PM	AF	85		—		—		
5.00 PM	AF	125		—		—		
6.00 PM	AF	119		—		—		
7.00 PM	AF	110		—		—		
8.00 PM	AF	116		✓		✓		
9.00 PM								
10.00 PM								
11.00 PM	AF	98						
12.00 AM	AF	111						
1.00 AM	AF	106						
2.00 AM	AF	98						
3.00 AM	SR	74						
4.00 AM	SR	78						
5.00 AM	SR	74						
6.00 AM	SR	72						
7.00 AM	SR	78						
8.00 AM								
9.00 AM								
10.00 AM								

MIS 169085

Fluid Balance Chart

1308836407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Hospital: CRH
Ward: 80/81
Date: 10/2/26

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00										140							
01:00					IV	250				60						200	
02:00					IV	250											
03:00										140						340	
04:00																	
05:00	Juice	100								110						450	
06:00																	
07:00	BREAST O									110						560	
08:00																	
09:00	SUPS																
10:00										100		B/O T3				660	LC
11:00	FLUID									30						690	LC
12:00	REF	LUNCH															
13:00										60						780	
14:00												B/O T3					
15:00										60							
16:00																	
17:00	DINNER	300								90		B/O T4				870	
18:00																	
19:00										40							
20:00																	
21:00																	
22:00	Tea	100								80							
23:00												130					
							*Total Intake		[redacted]						*Total Output	[redacted]	

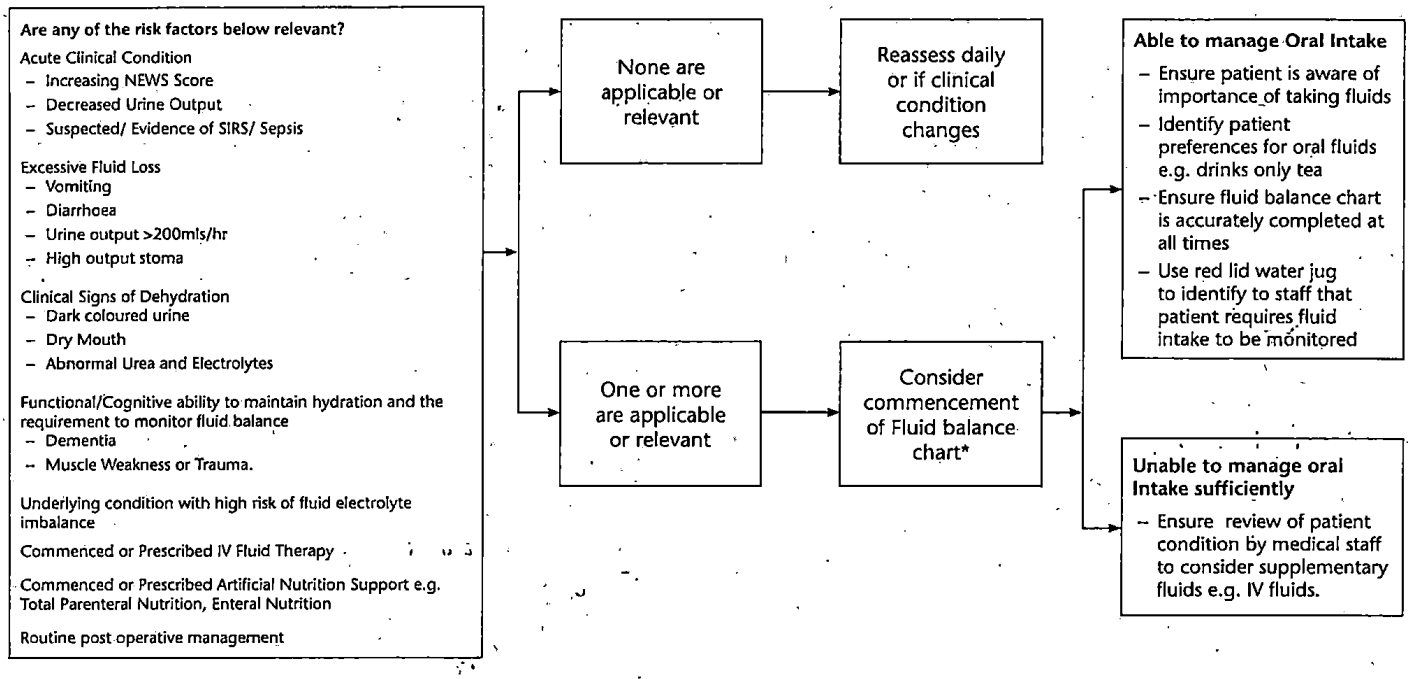
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

1308636407
SINCLAIR F
Theresa 13/08/1963

Hospital: GRI
Ward: 50/51
Date: 11/2/26

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00										100		BO				100	
02:00																	
03:00																	
04:00												BO					
05:00										80						180	
06:00	Juice																
07:00																	
08:00										120		BIO				280	LC
09:00	Wtr	180			IVF	500											
10:00										40						320	
11:00										20						340	
12:00	Lunch	2							850								
13:00																	
14:00												BIO Smart					
15:00										60						400	
16:00																	
17:00	Wtr	500								60		BIO				460	
18:00												BIO					
19:00																	
20:00	Juice	100															
21:00					IV	500				80							
22:00																	
23:00																	
									*Total Intake						*Total Output		

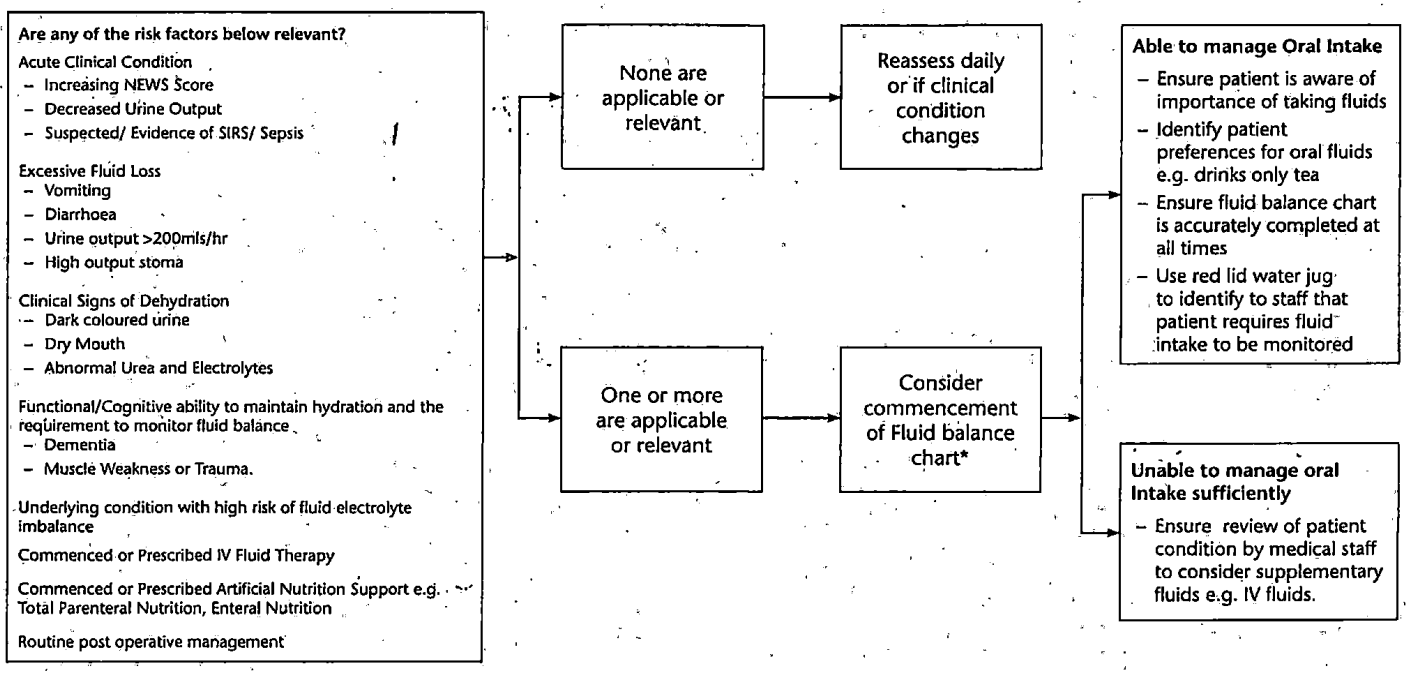
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS. • EDU • 237971-2

Fluid Balance Chart

1308636407
SINCLAIR
Theresa F
90a Main Street 13/08/1963
Lennoxtown
Glasgow
G66 7DA

Hospital: GRI
Ward: 50/51
Date: 12/6/26

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00										80.		100					
01:00												80					
02:00																	
03:00												80					
04:00																	
05:00										100		810				180	SMc
06:00					IV AB 100												
07:00					IVF 250				350	140						320	
08:00					IV Diuretic												
09:00					IV STEROIDS	100			450	340						660	
10:00										400 + 440						1880	
11:00					IV ABX	100			550	1440 7220.						1840	Ama
12:00										~~1480~~						3020	
13:00	SIPS									400						3420	
14:00					IVABX	100			650	120						3540	
15:00																	
16:00										100						3640	
17:00																	
18:00										60						3700	
19:00																	
20:00										80.						3780	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

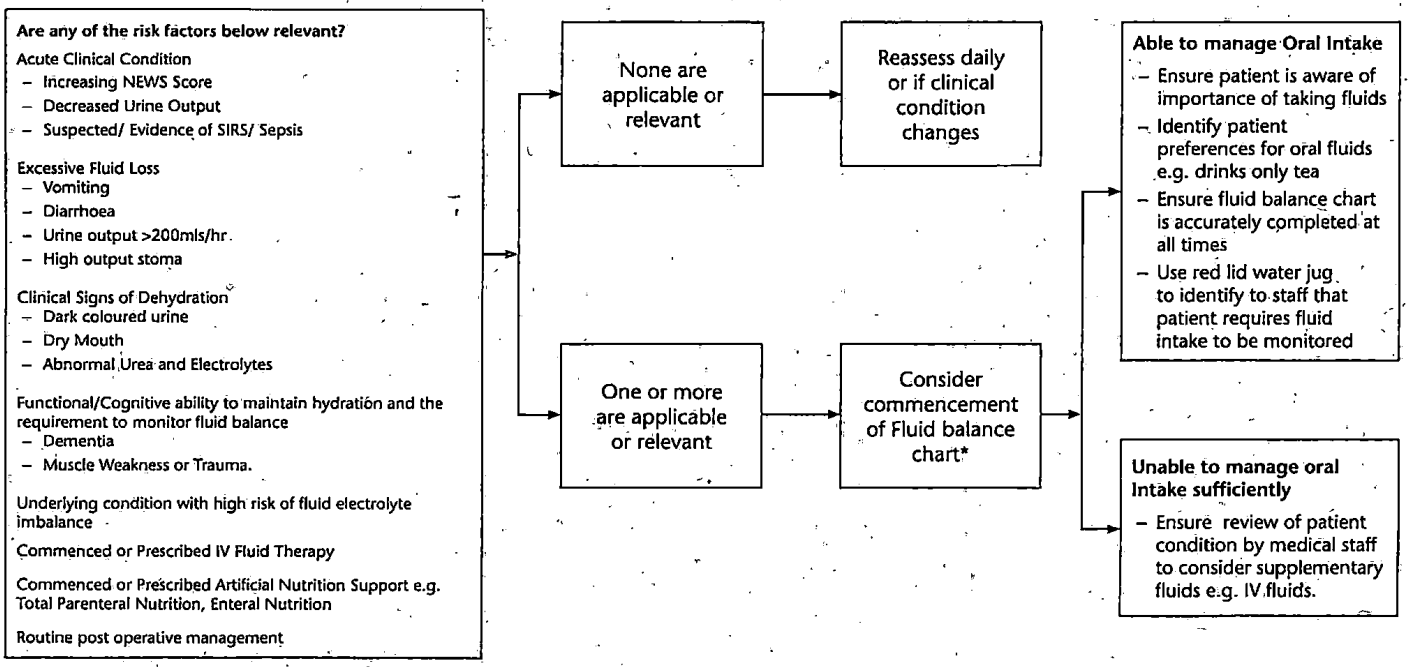
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

Name: Theresa
DoB: Sinclair
Chi number:
Affix patient data label

Hospital: GRI
Ward: 50/57
Date: 13/2/26

Reason for Fluid Balance Chart
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids?
Yes ☐ No ☐ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type circle how many daily 1 2 3
2. Type circle how many daily 1 2 3
Signature: Designation:

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00										60						60	
01:00																	
02:00										30						90	
03:00	water	50								40						130	
04:00																	
05:00																	
06:00										35						165	KO
07:00										500						665	KO
08:00	water	50															
09:00																	
10:00	water	100															
11:00																	
12:00										130						795	
13:00																	
14:00	water	100								90						885	
15:00	water	150															
16:00																	
17:00																	
18:00																	
19:00																	
20:00										140						1025	
21:00										25						1050	
22:00										30						1080	
23:00										10						1090	
							*Total Intake		[redacted]						*Total Output	[redacted]	

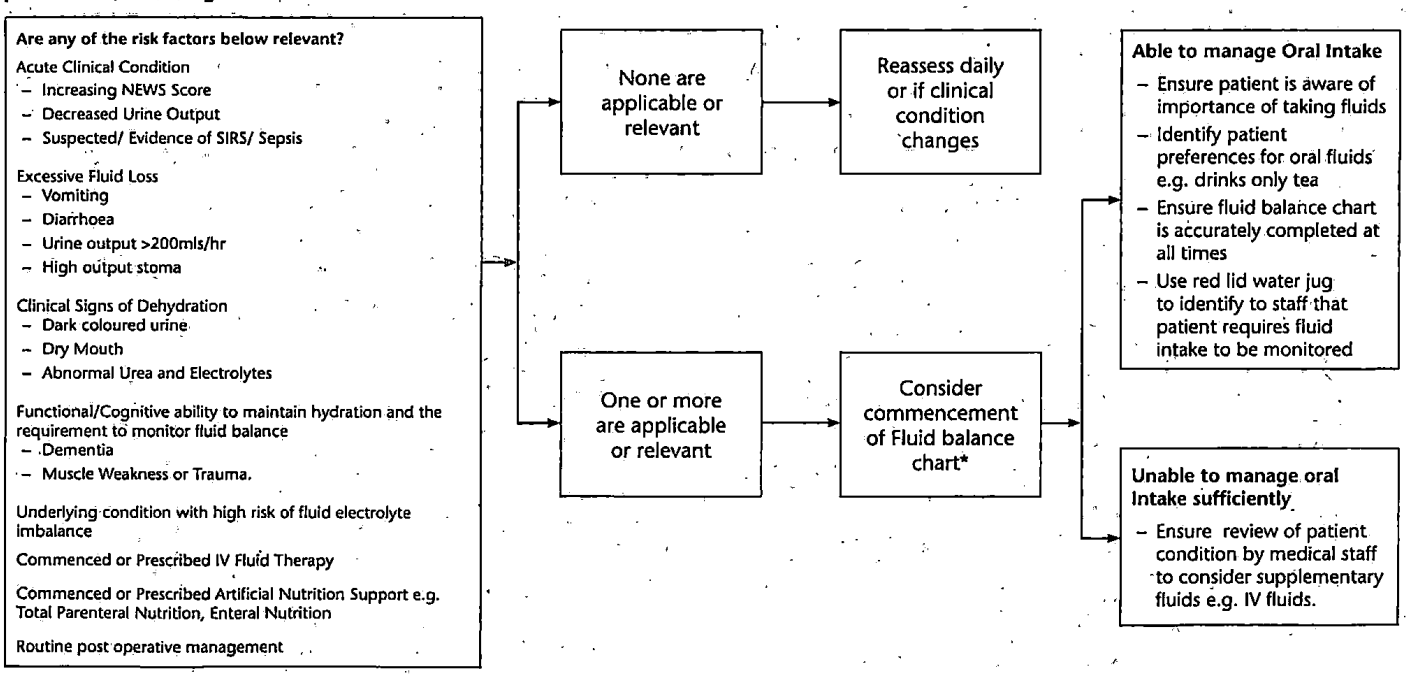
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

Name: Theresa Sinclair

DoB: .....

Chi number: .....

Affix patient data label

Hospital: GRI

Ward: 56/17

Date: 14/2/26

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:

1. Type _____ circle how many daily 1 2 3

2. Type _____ circle how many daily 1 2 3

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00										40							
02:00																	
03:00	~~Flavoured~~ Water	50							50	20						60	PD
04:00	Water	50								50						110	SMc
05:00	Water	20							70	40						150	PD
06:00										22						172	PD
07:00									0	90						262	PD
08:00																	
09:00																	
10:00										300						562	CDM
11:00																	
12:00	Mixed lunch (Juice 100)									300						862	EMW
13:00										200							
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00										240						1102	DMS
21:00																	
22:00																	
23:00										120						1222	DMS
								*Total Intake							*Total Output		

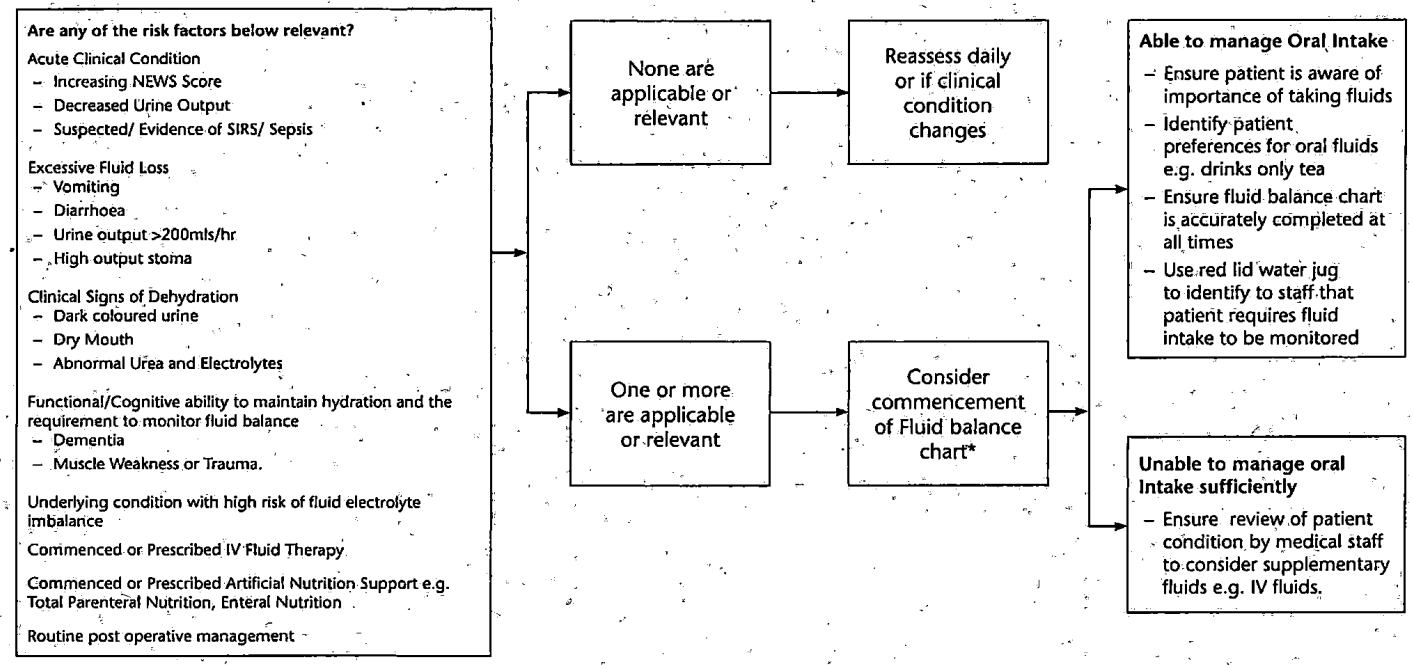
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart



1308636407
F SINCLAIR
63 Theresa
90a Main Street
Lennoxtown
Glasgow
)A
G66 7t
13/08/19

Hospital: GRI
Ward: 5f
Date: 15/02/08

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00										80						80	JM
02:00																	
03:00																	
04:00																	
05:00																	
06:00										150						180	JM
07:00	water	100							100	40	Catheter	Drained				220	JM
08:00	Juice	150							250	400						620	EO
09:00	Juice	100							350	240						860	EO
10:00	Tea	200							550			BO					
11:00	Juice	200							750	100						960	EO
12:00	Yoghurt	200							950	180						1140	EO
13:00										200		BO				1340	EO
14:00	water	150							1100			BO					
15:00	water	150							1250								
16:00										240						1580	EO
17:00	milk	100							1350								
18:00	mix	100							1450	80	BAG	EMPTIED				1660	EO
19:00	water	100							1550								
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

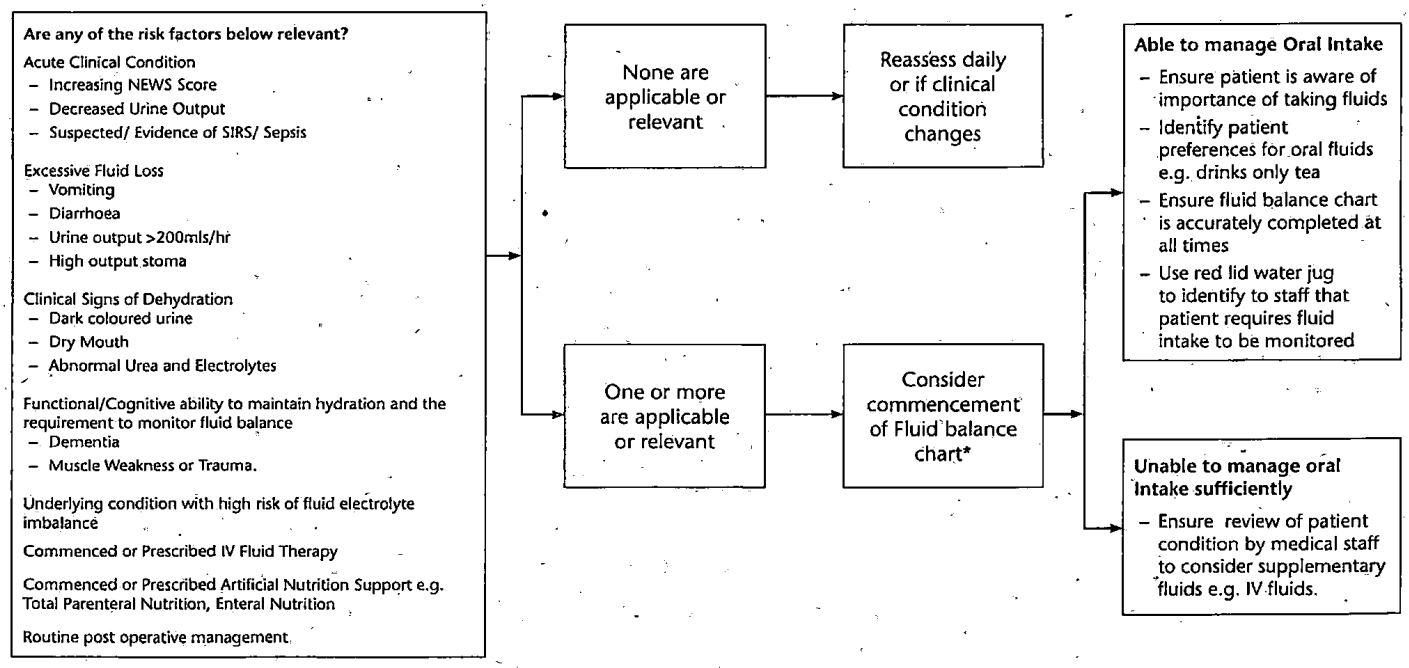
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

1308636407
F SINCLAIR
53 Theresa
90a Main Street
Lennoxtown
Glasgow
)A G66 7C
13/08/191-

Hospital: GRH
Ward: SD/S1
Date: 16/02/2026

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00										240						240	SS
11:00																	
12:00	Ref Lunch									50						290	SS
13:00	Soup Tea	300ml								50							
14:00																	
15:00																	
16:00	Juice	100								100						390	SS
17:00	Dinner	300															
18:00																	
19:00												BO					
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

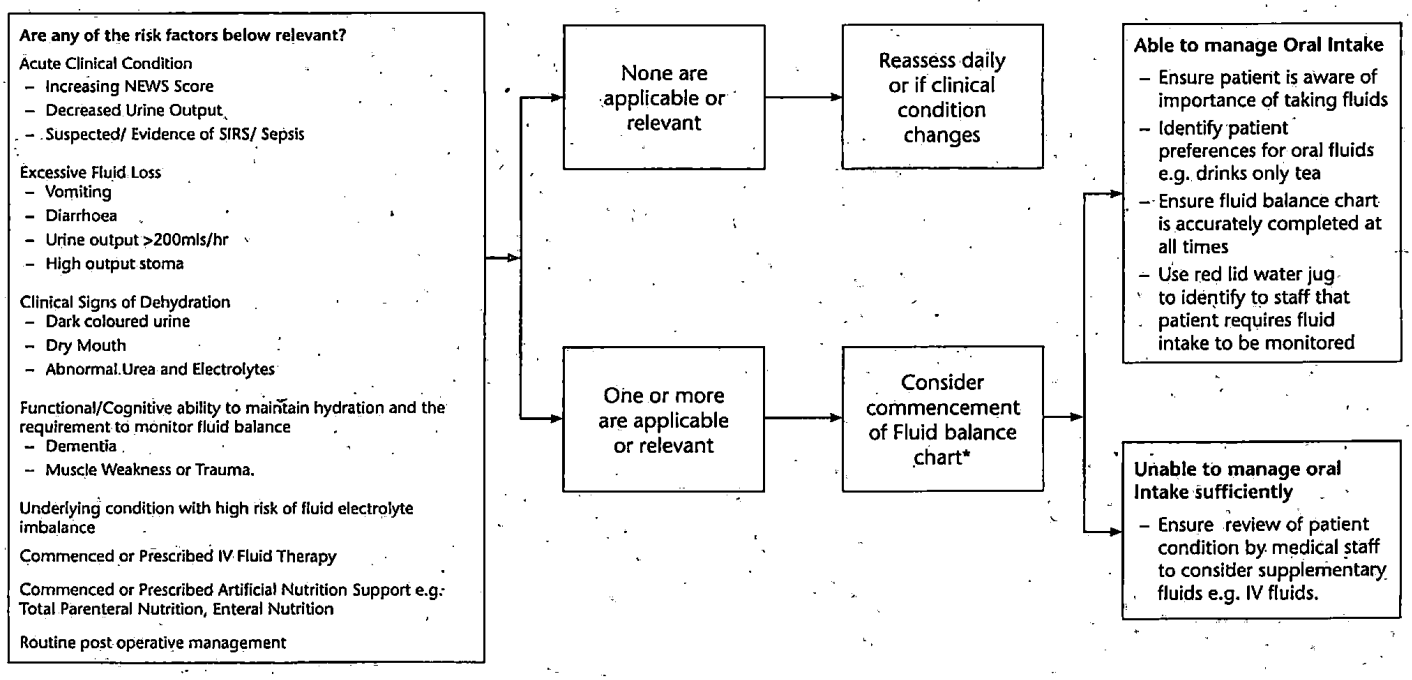
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

Name:
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7D
13/08/19

Hospital: GRI
Ward: 50/51
Date: 17/2/26

Reason for Fluid Balance Chart: Routine
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids? Yes ☐ No ☑ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type ____ circle how many daily 1 2 3
2. Type ____ circle how many daily 1 2 3
Signature: GR Designation: CN

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input: Oral Fluids Type	Oral Fluids Volume	Enteral Type	Enteral Volume	IV / Other Type	IV / Other Volume	IV / Other Type	IV / Other Volume	Running Total INPUT	Output: Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
00:00																	
01:00																	
02:00										120		BO				120	GR
03:00																	
04:00																	
05:00																	
06:00										60						180	GR
07:00																	
08:00																	
09:00	water	100ml								0							CB
10:00																	
11:00	Tea	Spilled								600ml	(500ml in bg					780ml	CB
12:00	Lunch				0.9% NS - IV TKO	120ml	+ Flush	SR2	400								
13:00																	CB
14:00																	
15:00																	
16:00																	
17:00	water	100ml															CB
18:00																	
19:00																	
20:00	tea	200								340						1120	
21:00																	
22:00	Alpro	100															
23:00																	
								*Total Intake	400						*Total Output	1120	

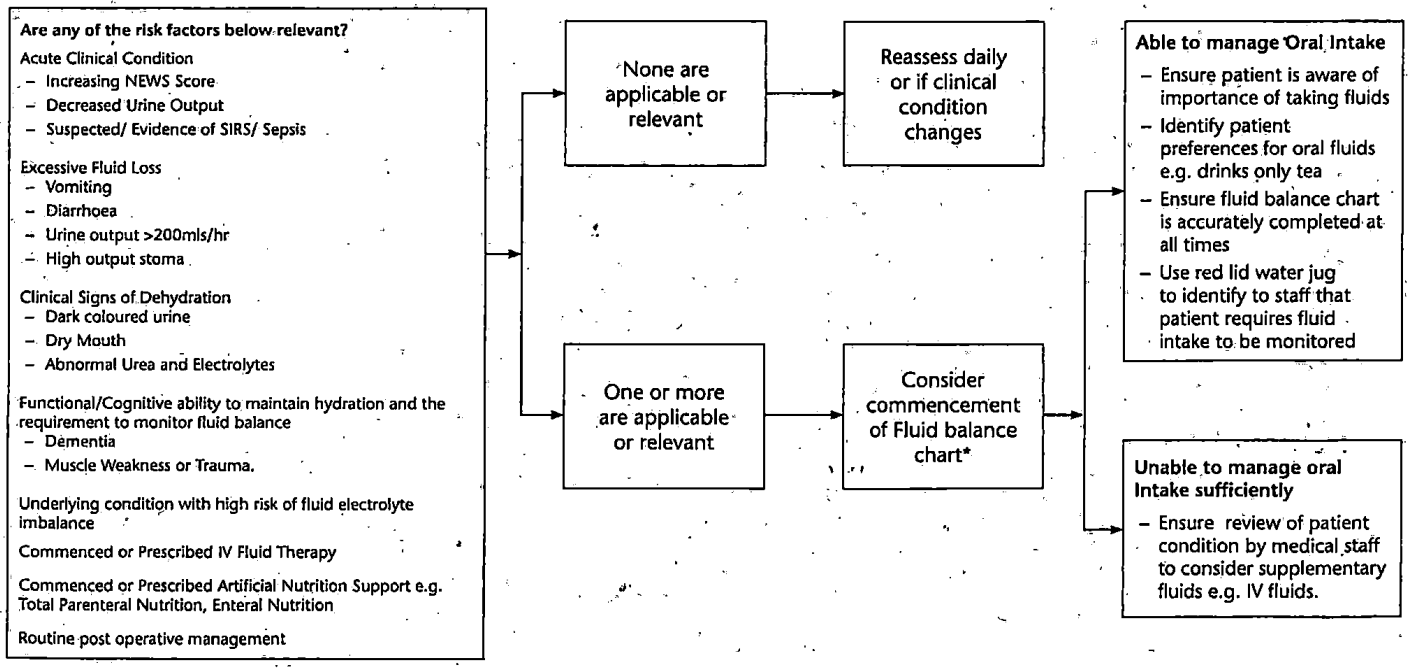
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Hospital: QEH
Ward: 7-16.
Date: 18.2.26

Reason for Fluid Balance Chart IP OP
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? /
Fluid balance from previous 24hrs +VE 180

Does patient require thickened fluids? Yes ☐ No ☑ Stage ____
Is the patient on an oral supplement? Yes ☐ No ☑ If YES please indicate:
1. Type / circle how many daily 1 2 3
2. Type / circle how many daily 1 2 3
Signature: [signature] Designation: HCA

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input 960								Running Total INPUT	Output 1120						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00										100						100	JM
03:00																	
04:00																	
05:00																	
06:00	WATER	50							50	160	Bag emptied					260	M
07:00	B/fast	300							350								
08:00																	
09:00																	
10:00	Tea	200							600								
11:00																	
12:00	Lunch	200							800								
13:00					IVAB	100			900	140						400	HR
14:00	Tea	950			IVF	500			1850								
15:00																	
16:00																	
17:00	Dinner	300							1850		520						
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

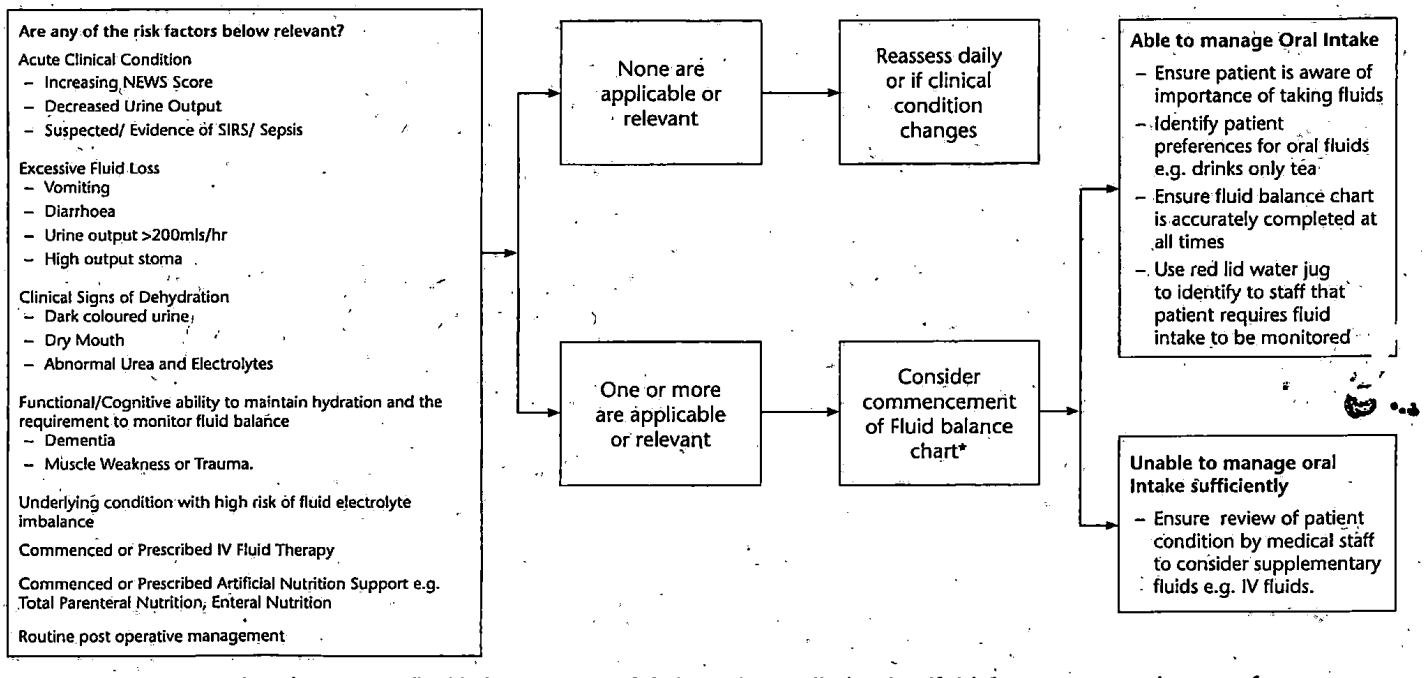
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 10/2/26

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

1. Signed [signature] Name [signature] Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attac 1308536407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Ward: Lennoxtown
Glasgow G66 7DA

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
keep updated

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	07:30	08:30	09:30	10:15	11:00	14:30	17:30	19:30	21:45
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	N	N	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		S	N	N	N	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:		Y	Y	R	~~X~~	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	INT	—	R insignt	int	int	int	int	INT
K	4	KEEP MOVING Has the patient moved or walked?		Y	1	Y	Y	BG	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	B	B	R	L	L	B	B
		Chair Assist to walk or stand (W/ST)		/	/	—	/		/	/	/	/
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		C	C	C	A	Cath	A	A	Cath	BO C
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N	N	N	N	N	N
		Drink taken?		N	1	N	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?		N	N	N	N	Y	N	N	N	Y
		Has oral hygiene been carried out as per care plan?		N	N	N	N	N	N	N	N	N
	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 lowest position?		Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		N	N	NT	NT	NO	NT	NT	NT	N
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		N	N	~~X~~	NAD	9	NA	NA	NA	N
		Care provider / role		AY	LA	LA	LA	LA	LL	LL	LL	LL

Care Rounds Variance Sheet

Attach Addressograph Label Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
10/2	830	3	Patient refused all Personal care needs this morning. —	MTHyde

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 11/2/26

Attach

1308636407
SINCLAIR Theresa F 13/08/1963
90a Main Street
Ward: Lennoxtown Glasgow G66 7DA

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)

1. Signed [signature] Name [signature] Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

keep updated

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	01	04	06	08	10	12	14	16	18	20								
				00	30	30	00	00	00	00	00	00	30								
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N								
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N	N	N	N								
S	3	SKIN INSPECTION Pressure areas checked:		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT	INT	INT	INT	INT	M	INT	INT	INT	INT								
K	4	KEEP MOVING Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B/L	B	B	B	B	B	R	B	L	B								
	1	Chair Assist to walk or stand (W/ST)		T				=													
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		BO C	BO C	BIO C	BO C	C	Cath-care	BO	BO	BO	BO								
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N	N	N	N	N	N	N								
		Drink taken?		Y	N	Y	N	N	Y	N	Y	Y	Y								
		Food, snack, or supplement taken?		N	N	N	N	N	Y	N	N	N	N								
		Has oral hygiene been carried out as per care plan?		N			N	N	N	N	N	N	N								
	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 lowest position?		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y								
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		N	N	N	N	N	N	NO	NO	NO	NO								
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		N			Y			NO	NO	NO	N								
		Care provider / role		[illegible]	[illegible]	[illegible]	EC	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 12/2/26

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)

1. Signed _____ Name _____ Designation 8R
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attac 1308635407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Ward Lennoxtown
Glasgow
G66 7DA

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
Keep updated.

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	0000	0030	0230	0300	0500	0730	1030	1400	1600	1730	2000							
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	2	2	2	2	~	Y.	~	~	2	N							
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	2	2	2	2	2	~	N.	~	~	2	Y							
S	3	SKIN INSPECTION Pressure areas checked:	Y	Y	Y	Y	Y	Y	X	Y	~	Y	Y							
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	Int	Int	Int	Int	Int	Int	—	R	R							
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y.	Y	Y	Y	Y							
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	L	L	L	B	R.	L	R	B	B							
		Chair Assist to walk or stand (W/ST)	/	/				T		T	T	T								
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	BO C	BO C	BO C	BO C	BO C	CATH	IC. Cath	CATH	CATH	CATH	C							
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	2	2	2	2	2	~	N.	~	~	2	2							
		Drink taken?	2	2	2	2	2	Y	N	Y	Y	Y	2							
		Food, snack, or supplement taken?	2	2	2	2	2	~	Y	~	~	2	2							
		Has oral hygiene been carried out as per care plan?	2	2				~	Y	~	~	2	2							
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	2	2	2	2	2	Y	Y	Y	Y	Y	Y							
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	2	2				~	Y	~	~	~	~							
		Care provider / role			SW	SW	SW					IW								

Care Rounds Variance Sheet

Attach Addressograph Label	NHS Greater Glasgow and Clyde
Ward:	

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
12/2/26	10^{30} am	①	Suspected delirium to monitor – patient already appears more alert following deterioration at 08^{00} am. For monitoring – good family support.	A McKenna CPE

mi • 278936 v2.1 • GGC0098

(2)

Rounds Checklist

Date: 13/2/22

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

1. Signed [signature] Name [illegible] Designation CN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

Theresa Sinclair

Ward:

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	00	08	00	00
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:		N	N	N	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		-	-	-	
K	4	KEEP MOVING Has the patient moved or walked?		Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		R	B	B	R
		Chair Assist to walk or stand (W/ST)					
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		C	C	C	C
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N
		Drink taken?		N	N	N	N
		Food, snack, or supplement taken?		N	N	N	N
		Has oral hygiene been carried out as per care plan?		N	N	N	N
	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 lowest position?		Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA
		Care provider / role		[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

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

N.B, Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • CGC0098

(1)

Care Rounds Checklist

Date: 13/2/25

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

1. Signed _____ Name CMOAffG Designation On
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label
Theresa Sinclair

Ward:

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
1:1 nurse - Needs necessary Dep family upd

USE FOLLOWING CODES:
Y = Yes, N = No, NA = Not applicable, NT = No Thanks, S = Sleeping, O = Off the ward, I = Independent

		Times	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	N	N	N	N	N	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	R	R	R	R	R	R	R	R	R	—	R	R	-	—	—	—	—	—	-
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	L	R	L	R	L	Q	B	B	L	L	R	R	B	B	L	B	B	B	B
		Chair - Assist to walk or stand (W/ST)	I	I	I	I	I	I	I	I	—	—	—	—	—	—	—	—	—	—	—	-
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	NT	NT	NT	NT	NT	NT	N	N	N	N	N	N	N	N	N	N
		Drink taken?	NT	N	N	Y	N	N	N	N	N	Y	N	Y	N	N	N	N	Y	Y	Y	N
		Food, snack, or supplement taken?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
		Has oral hygiene been carried out as per care plan?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	Y	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
		Care provider / role	C	KO	KO	KO	KO	KO	KO	KO	PG	PG	PG	PG	LM	LM	PG	PG	PG	PG	LM	LM

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GCC0098

Care Rounds Checklist

Date: 14/2/26

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

1. Signed _____ Name Cmanera Designation CA
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label
Theresa Sinclair

Ward:

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
1:1 MUVS

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00 00	01 10	02 10	03 [illegible]	04 50	05 [illegible]	06 [illegible]	07 20	08 20	09 [illegible]	10 [illegible]	12 00	13 00	14 00	16 00	17 30	18 20	19 10
T	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	Y	Y	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	N	N	N	N	N	N	Y	N	Y	N	N	Y	N	N	N	Y	N	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	-	-	-	-	-	R	-	R	-	-	R	N	-	-	R	-	-
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	L	R	B	B	L	B	R	B	B	L	B	R	B	L	R	L	L
		Chair -Assist to walk or stand (W/ST)										/	/		/	/	/	/	/	/
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	C	C	C	C	IC C	C	IC C	IC C	IC C	[illegible]	[illegible]	C	C	C	C	C
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
		Drink taken?	S	N	N	Y	Y	Y	N	N	N	N	N	Y	Y	N	Y	N	N	Y
		Food, snack, or supplement taken?	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
		Has oral hygiene been carried out as per care plan?	S	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT	NT	NT	NT	[illegible]		N	N	N	N	N	N
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	[illegible]		N	N	N	N	N	N
		Care provider / role	[illegible]																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GCC0098

Care Rounds Checklist

Date: 14/15/02/06

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

1. Signed _____ Name Charles Emeran Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addre
There

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7E
13/08/19

NHS Greater Glasgow and Clyde

Ward: 9

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes, N = No, NA = Not applicable, NT = No thanks, S = Sleeping, O = Off the ward, I = Independent

		Times	20 00	21 10	22 05	23 20	00 20	01 20	02 30	03 15	04 30	05 20	06 20	07 15	08 30	09 10	10 32	11 05	12 15	13 10
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	Y	N	N	Y	Y	N	N	N	N	N	Y	Y	Y	N	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	R	–	–	R	R	–	R	R	–	–	R	R	R	–	R	–	R	R
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	B	L	R	L	L	R	L	R	L	B	Sit	L	R	R	R	L	R
		Chair Assist to walk or stand (W/ST)	–	–	–	T	T	–	T	T	–	–	–	–	T	T	T	T	T	T
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	C	IC	C	C	C	C	C	C	C	C	C	C	IC	C	C	BO C
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y
		Food, snack, or supplement taken?	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	Y	Y
		Has oral hygiene been carried out as per care plan?	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	N	N	N	N	N	N
		Care provider / role																		

Care Rounds Checklist

Date: 15/02/26

Attach Addressograph

1308636407
F SINCLAIR
63 Theresa
90a Main Street
Lennoxtown
Glasgow
13/08/19
G66 7L

Ward: 50/51

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)

1. Signed [signature] Name [illegible] Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
get dates

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No thanks S = Sleeping O = Off the ward I = Independent

		Times	14 30	15 10	16 05	17 10	18 20	19 PB	20 00	21 02	22 00	23 00	00 00	01 00	02 00					
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	2	2	2	2	2	2	2	2	2	2	2	2					
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	2	2	2	2	2	2	2	2	2	2	2	2	2					
S	3	SKIN INSPECTION Pressure areas checked:	2	4	2	2	Y	2	NT	NT	NT	NT	NT	NT	NT					
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	R	/	–	~~B~~	–	/	/	/	/	/	/	/					
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R	R	L	R	R	B	B	B	~~R~~ R	R	R	R					
		Chair Assist to walk or stand (W/ST)	–	T	–	T	T	–	–	–	–	–	–	–	/					
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	BO	C	C	C	C	C	C	C	C	C	C	C	C					
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	2	2	2	2	2	2	2	2	2	2	2	2	2					
		Drink taken?	Y	Y	2	Y	Y	2	2	Y	2	2	2	2	2					
		Food, snack, or supplement taken?	Y	2	2	2	2	2	2	Y	2	2	2	2	2					
		Has oral hygiene been carried out as per care plan?	2	2	2	2	2	2	2	2	2	2	2	2	2					
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	I	I	I	I	I	I	I	NT	NT	NT	NT	NT	NT					
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	2	2	2	2	2	2	2	NA	NA	NA	NA	NA	NA					
		Care provider / role	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE	CE					

Care Rounds Checklist

Date: 16/02/2026

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

1. Signed _____ Name NUNNINGHAM Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Address

Theresa

Ward: 80/51

1308636407
F SINCLAIR 13/08/19
33 Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7L

NHS Greater Glasgow and Clyde.

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

get better

USE FOLLOWING CODES

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

		Times	00	01	02	03	04	08	09	14	15	16	18	20	22	00	02	04	06	08
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	2	2	2	2	2	N	N	N	N	N	N	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	2	2	2	2	2	2	N	N	N	N	N	N	N	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	NC	NT	NT	NT	NT	R	R	R	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	/	/	/	/	/	/	/	R	R	R	R	R	R	R	R	R	R
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right-side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R	R	B	B	R	R	L	B	R	B	B	B	B	B	B	B	B
		Chair Assist to walk or stand (W/ST)	/	/	/	/	/	/	/	/	/	A	B	/	/	/	/	/	/	/
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C	C
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	2	2	2	2	2	2	N	N	N	N	N	N	N	N	N	N	N	N
		Drink taken?	2	2	2	2	2	2	N	N	N	R	Y	Y	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	2	2	2	2	2	2	N	N	N	R	Y	Y	Y	Y	Y	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	2	2	2	2	2	2	N	N	N	I	I	N	N	N	N	N	N	N
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	N	N	N	N	N	N	N	N	N	N	N	N	N
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	N	N	N	N	NA	N	N	N	N	N	N	N	N
		Care provider / role	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP	CP

Care Rounds Checklist

Date: 13/12/26

1308636407
Attach F SINCLAIR F
33 Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
IA G66 7DA
Ward: 5051

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)

1. Signed GR Name Roberts Designation CN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

Keep me up to date

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00 30	02 00	06 00	10 20	13 30	17 15	22 15											
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N											
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N											
S	3	SKIN INSPECTION Pressure areas checked:	Y	Y	Y	Y	Y	Y	Y											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	INT	INT	INT	Int	Int	Int											
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	L	B	CH	B	B											
		Chair Assist to walk or stand (W/ST)	–	ST	–	W	WST	–	ST											
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	A C	C	C	Y	Y	C											
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N	N	N											
		Drink taken?	Y	Y	Y	Y	Y	Y	Y											
		Food, snack, or supplement taken?	N	N	N	Y	Y	Y	NT											
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I	I	I											
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y											
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT											
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA											
		Care provider / role	CA CN	CA CN	CA CN	CA	CA	CA	CA A											

* Fluid & Stool Charts *

SR1

Care Rounds Checklist

Date: 18.2.26

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)

1. Signed [signature] Name _____ Designation Dr
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Address

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

F
13/08/1963

Ward: 7-16

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

TO GO HOME

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	02 15	06 15	08 00	12 00	13 00	17 15	21 15	23 55
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	N	N	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	N	Y	N	N	N	N	Y	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	Int	/	-	/	/	Int	/
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	B	B	/	B	B	WS	L
		Chair Assist to walk or stand (W/ST)	/	ST	/	WS	/	/	/	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	C	C BO	C	C	C	C BO	A (V)	NT
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N
		Drink taken?	S	Y	Y	Y	Y	Y	Y	N
		Food, snack, or supplement taken?	S	N	Y	Y	Y	Y	N	N
		Has oral hygiene been carried out as per care plan?	S	N	I	—	/	N	N	N
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT	NT	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA	NA
		Care provider / role	NA HCA	NA RGN	HP RGN	OT	HA RGN	HA RGN	NA RGN	NA RGN

Care Rounds Variance Sheet

Attach Address

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Ward: 7-10

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
18.2.21	21:15	5+8	Catheter removed. (Not passed urine yet)	M McGill

mi • 276936 v2.1 • GGC0098

NB STOOL CHART ok

SR1.

Care Rounds Checklist

Date: 19.2.26.

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)

1. Signed CN.CL Name _____ Designation J.
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addre

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Ward: 7-16

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

TO GO HOME.

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	03 00	06 30	07 55	11 40	15 10	18 20	22 45										
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N										
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N										
S	3	**SKIN INSPECTION** Pressure areas checked:	N	N	N	N	N	N	NT										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	I	/	-	/	/	/										
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	B	B	-	B	B	I										
		Chair Assist to walk or stand (W/ST)	/	/	/	CH	/	/	/										
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	NT	I	I	I	I	I	I										
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N										
		Drink taken?	N	Y	Y	-	Y	Y	Y										
		Food, snack, or supplement taken?	N	N	Y	-	Y	N	Y										
		Has oral hygiene been carried out as per care plan?	N	N	I	-	I	N	I										
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT										
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA										
		Care provider / role	NA RN	NA RN	HA RN	HA	HA RN	HA RN	SD										

Care Rounds Variance Sheet

Attach Addı

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Ward: 7-16

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name
19.2.26	06.30	578	Patient passed 200ml of urine post catheter removal.	dl McCall bx

mi • 278936 v2.1 • GGC0098

Stool chart.

SR1

Care Rounds Checklist

Date: 20-2-26

Attach Addr
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7DA

NHS Greater Glasgow and Clyde

Ward: 7-16

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)

1. Signed [signature] Name Siobhan Donnelly Designation SW
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
To feel better soon.

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	02	06	10	14	18	22															
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N	N	N	N														
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N	N	N	N	N	N	N														
S	3	SKIN INSPECTION Pressure areas checked:		NT	NT	NT	NT	NT	NT	NT														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		—	—	✓	✓	✓	✓	—														
K	4	KEEP MOVING Has the patient moved or walked?		Y	Y	Y	Y	Y	Y	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		L	L	B	B	B	B	L														
		Chair Assist to walk or stand (W/ST)		—	—	✓	✓	✓	✓	✓														
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I	I	I	I	I	I	I														
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N	N	N	N	N	N														
		Drink taken?		S	Y	Y	Y	Y	Y	Y														
		Food, snack, or supplement taken?		S	N	Y	Y	N	Y	Y														
		Has oral hygiene been carried out as per care plan?		S	N	I	I	N	I	I														
	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 lowest position?		Y	Y	Y	Y	Y	Y	Y														
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT	NT	NT	NT	NT	NT	NT														
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA	NA	NA	NA	NA														
			Care provider / role	SD	SD	HA	HA	HA	HA	SD														

Care Rounds Variance Sheet

Attach Ad

1308636407
SINCLAIR F
Theresa 13/08/1953
90a Main Street
Lennoxtown
Ward: Glasgow
G66 7DA

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

ccstool chart x

6/7

Care Rounds Checklist

Date: 21.2.26

Attach Adc

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Ward: 7.16

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)

1. Signed [signature] Name Siobhan Donnelly Designation SW
2. Signed [signature] Name Emma Designation S/N
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

To feel better soon.

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	01 80	08 40	08 00	10 00	12 00	14 00	18 00											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N											
S	3	**SKIN INSPECTION** Pressure areas checked:	NT	NT	N	NT	NT	NT	NT											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	–	–	–	–	–	–											
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y	Y											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	L	L	–	–	B	L											
		Chair Assist to walk or stand (W/ST)	–	–	–	CH	CH	–	–											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N											
		Drink taken?	S	S	Y	Y	Y	Y	Y											
		Food, snack, or supplement taken?	S	S	Y	Y	Y	N	N											
		Has oral hygiene been carried out as per care plan?	I	I	N	N	N	N	N											
	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 lowest position?	Y	Y	Y	Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT	NT											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	NA											
		Care provider / role	SO	SO	SW	SW	SW	SW	SW											

Care Rounds Variance Sheet

Attach Ad

1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

●● *STOOL CHART* ●●

6FT

Care Rounds Checklist

Date: 22/02/26

Attach Addre 1308636407
SINCLAIR
Theresa F
90a Main Street 13/08/1963
Lennoxtown
Glasgow
G66 7DA

GRI

Ward: 7/16

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)

1. Signed Name Designation S/N
2. Signed Name Designation
3. Signed Name Designation

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
To Feel Better

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	04:30	08:00	09:25	10:00														
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	2	2	2														
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	2	2	2														
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	I	I	I														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	-	-	-														
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	(B)	B	-	B														
		Chair Assist to walk or stand (W/ST)	I	I	N	-														
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	I	I														
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N														
		Drink taken?	S	Y	N	Y														
		Food, snack, or supplement taken?	S	Y	N	Y														
		Has oral hygiene been carried out as per care plan?	S	N	N	N														
	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 lowest position?	Y	Y	Y	Y														
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT	NT	NT														
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NAD	NAD	NAD														
		Care provider / role	BA	[illegible]	[illegible]	[illegible]														

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

m • 278936 v2.1 • GCC0098

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

2

1306636407
SINCLAIR
Theresa
50a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1983

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 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:	

Document all actions and Interventions

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: .....

Glasgow Coma Scale

Eyes	Spontaneously	4	
	To sound	3	
	To pressure	2	
	None	1	
Verbal	Orientated	5	
	Confused	4	
	Words	3	
	Sounds	2	
	None	1	
Motor	Obeys commands	6	
	Localises pain	5	
	Normal flexion	4	
	Abnormal flexion	3	
	Extension	2	
	None	1	

Pupil Reaction and size: s = sluggish, + = reaction, n = no reaction, c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Affix Patient ID

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

mi = 316654 v5.1 • GGC0364

[redacted]

NEWS 2 Key | 1 | 2 | 3

Affix Patient ID

Date

Time

A + B
Respirations
Breaths/min

≥25	3	
21-24	2	
12-20	0	
9-11	1	
≤8	3	

A + B
SpO2 Scale 1
Oxygen saturation (%)

≥96	0	
94-95	1	
92-93	2	
≤91	3	

SpO2 Scale 2
Oxygen saturation (%)
Target saturation range 88-92% for those at risk of hypercapnoeic 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	
86-87	1	
84-85	2	
≤83	3	

Air or oxygen?

Air (A) or O2 device	0	
O2 L/min 2	2	

C
Blood Pressure mmHg
(Score uses systolic BP only)

≥220	3	
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

≥131	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	
≤30	3	

D
Any changes in sleuro response, do GCS, immediate medical review. Check Blood Glucose. Think Delirium.

A Alert	0	
C New Confusion	3	
V Verbal	3	
P Pressure	3	
U Unresponsive	3	

E
Temperature

≥39	2	
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

Affix Patient ID

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

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
RM	Reservoir Mask (Emergency use only)

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.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Affix Patient ID

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name: F. BEATON	
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
	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:.....

Pupil Reaction and Size

s = sluggish
f = fixed
- = no reaction
c = eyes closed

Pupil Size (mm): 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date:
Time:

| | | |

NEWS 2 Key | 1 | 2 | 3

Affix Patient ID

Date	1/11
Time	11.00

A + B Respirations Breaths/min

≥25	3
21-24	2
12-20	0
9-11	1
≤8	3

A + B SpO2 Scale 1 Oxygen saturation (%)

≥96	0
94-95	1
92-93	2
≤91	3

SpO2 Scale 2 (Oxygen saturation (%) for Scale 2 target range 88-92% e.g. COPD, 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
86-87	1
84-85	2
≤83	3

Air or oxygen? A

Air (A) or O2 device*	0
*O2 L/min 2	2

C Blood Pressure mmHg

(Score uses systolic BP only)

≥220	3
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	1
61-70	3
51-60	3
≤50	3

C Pulse Beats / min

≥131	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
≤30	3

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
RM	Reservoir Mask (Emergency use only)

D Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

A Alert	0
C New Confusion	3
V Verbal	3
P Pressure	3
U Unresponsive	3

Affix Patient ID

E Temperature

≥39	2
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	0
Blood glucose	7.0
Pain / function score	QA
Time Pt last passed urine	10.20
Fluid balance chart indicated Y/N	N
GCS indicated Y/N	N
Time NEWS due	23.00
Escalation of care Y/N	N
Initials	AB

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.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7L

12/08/19

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 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:	

Document all actions and Interventions

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: .....

Glasgow Coma Scale

| | | |

Lennoxtown
G66 7JJ

NEWS 2 Key | 1 | 2 | 3

Affix Patient ID

| | | |

NHSGGC Adult In-Patient National Early Warning Score (NEWS)

NHS Greater Glasgow and Clyde

1308836407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

As per previous chart in ICU

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 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:	

Document all actions and interventions

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:.....

Pupil Reaction and size
s = sluggish
a = reaction
- = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date:			
Time:			
Eyes closed by swelling, NT	E Y E S	Spontaneously	4
		To sound	3
		To pressure	2
		None	1
		Eyes closed	NT
Endotracheal tube or tracheostomy = NT	V E R B A L	Orientated	5
		Confused	4
		Words	3
		Sounds	2
		None	1
		Not testable	NT
Always record the best response	M O T O R	Obeys commands	6
		Localising pressure	5
		Normal flexion	4
		Abnormal flexion	3
		Extension	2
		None	1
		Not testable	NT
TOTAL	/15		
Right size:			
Right reaction:			
Left size:			
Left reaction:			
Record right (R) and left (L) responses separately if there is a difference between the two sides	A R M S	Normal power	5
		Mild weakness	4
		Severe weakness	3
		Some flexion	2
		Extension	1
		No response	0
Record right (R) and left (L) responses separately if there is a difference between the two sides	L E G S	Normal power	5
		Mild weakness	4
		Severe weakness	3
		Some flexion	2
		Extension	1
		No response	0

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

NEWS 2 Key 1 2 3

| | | |

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
1308636407
SINCLAIR F
Theresa 13/08/1953
90a Main Street
Lennoxtown
Glasgow.
DoB G66 7DA

X
NT

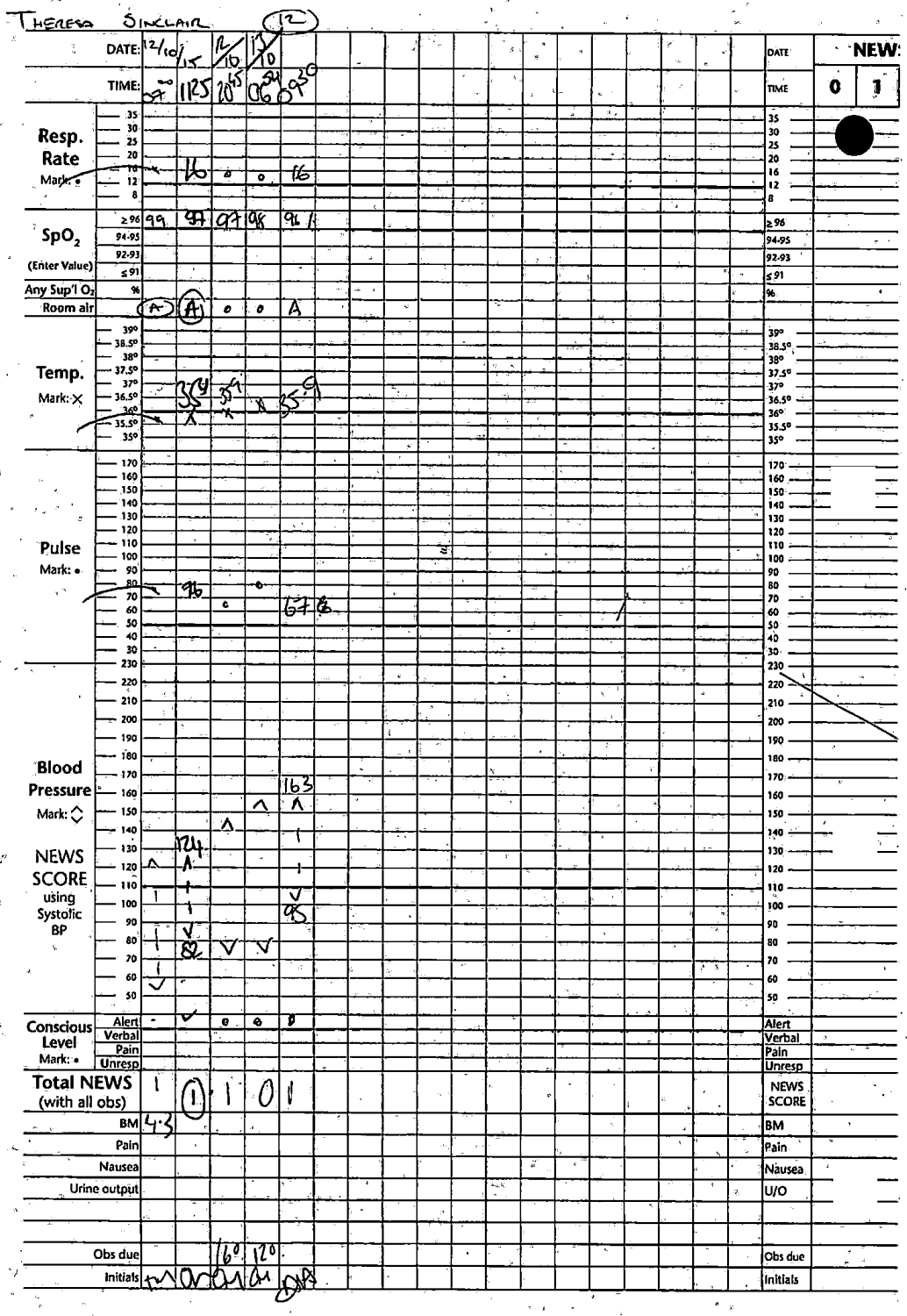
	Date	Ward
Admitted		
Transferred		
Transferred		

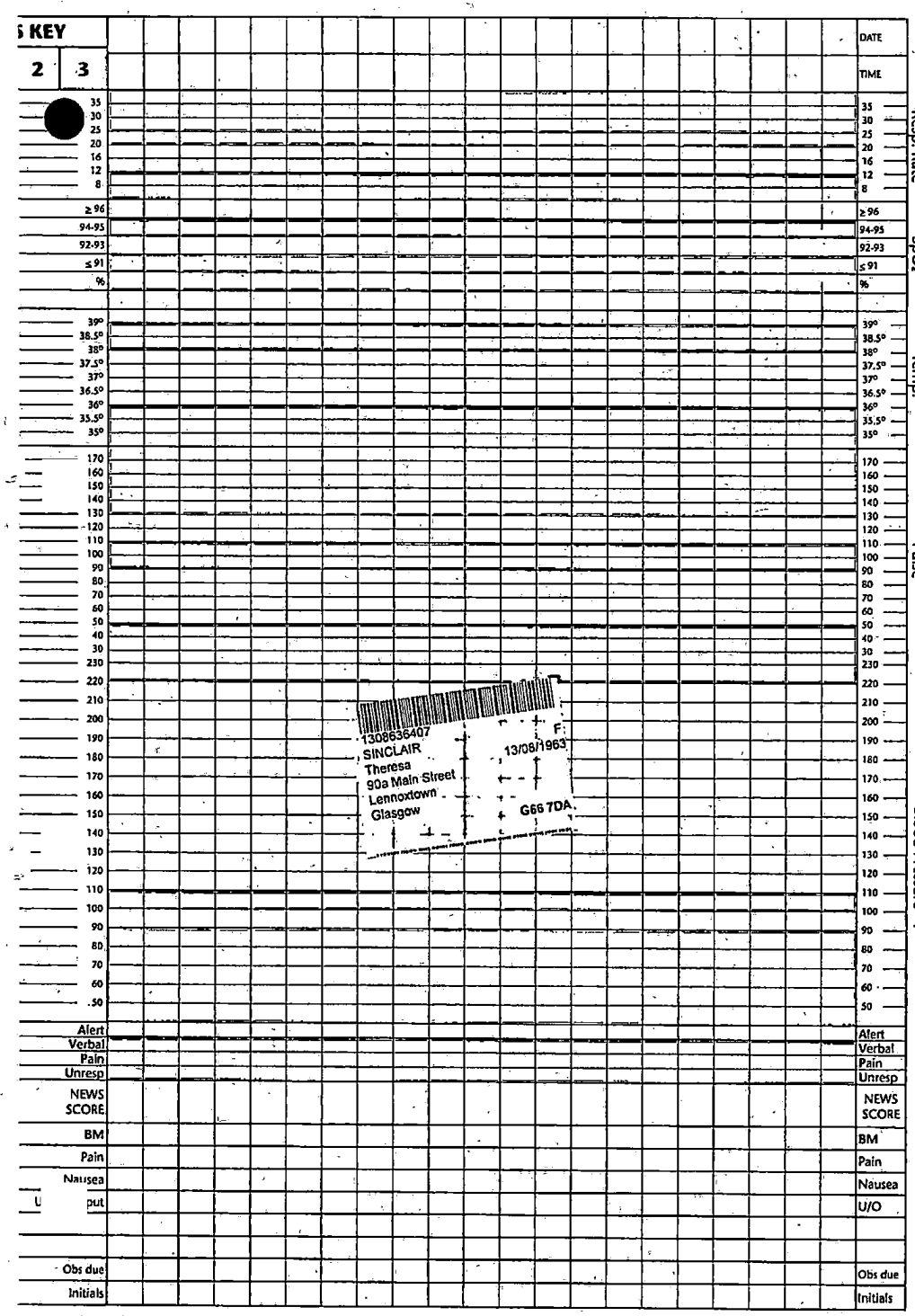
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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


THERESA SINCLAIR
DATE:
TIME:
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS
SCORE
0
1


KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7DA
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Neurological Observations

| | | |

Emergency Department Nursing Documentation

NHS Greater Glas and Clyd

h Label

1308636407
SINCLAIR F
Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Presenting Complaint: Fall

Date and Time: 12/10/15 0640

Named Nurse(s): C. CARMICHAEL / C. ATTKINSON

Patient preparation (Please tick when completed)	Initials:		Communication (Please tick when completed)	Initials:	
Prepare patient for examination		☐	Communication Aids (spectacles / hearing aid)		☐
Provide blankets if required		☐	Relatives present?		☐
Clothing bagged, labelled and stored under trolley		☐	Relatives / NOK Informed		☐
Name-band (if required)		☐	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) dated and timed	☐
Peak Flow 1. 2. 3.	☐	Blood samples taken	☐
12 Lead ECG	☐	Urinalysis and Specimen if indicated *Results:*	☐
Cardiac Monitoring	☐		
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	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*	☐
GMAWS	Y / N	Pressure damage identified on arrival in ED is documented in clinical notes	☐
Swallow test (if CVA/stroke)	Y / N	Grade 3 or 4 Pressure Ulcers are reported on DATIX	☐

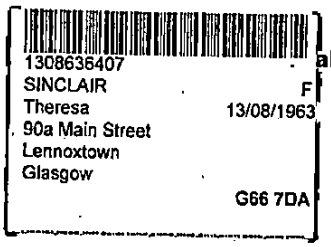
Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives informed	☐	☐	Information on discussion with relatives
	Cannula dated and timed	☐	☐	
	Name band	☐	☐	
	AMT4	☐	☐	
	NEWS chart	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
	Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
	Bed requested, accepted and ward informed	☐	Always	
	Notes: medical notes, GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐	☐	
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on O_2: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

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

Date and Time		Print Name and Signature



Nursing Notes

Date and Time		Print Name and Signature

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 1hour 2 hours

Signed ..... Name .....

Patient Addressograph Label

			Time							
	1.	PAIN: Assess and address If in pain inform registered nurse Y or N/A								
S	2.	SKIN INSPECTION A. Pressure areas checked:								
		B. Redness (R) / Discolouration (D) / Pressure Ulcer (PU)								
K	3.	KEEP MOVING: A. Have you moved or walked Y / N / I (independent)								
		B. Trolley Right side (30° tilt) – R Left Side (30° tilt) – L Back– B								
		C. 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 trolley in lowest position?								
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return.								
	8.	ESCALATION: Escalate any issues to the Registered Nurse / Dr Y / N/A								
		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
Continence		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			
		Fully mobile	0				
Special Risks – Surgery/Trauma		Restless/Fidgety	1			Special Risks - Medication	
On table > 6 hours	8	Apathetic (sedated/depressed/ reluctant to move)	2			Cytotoxic, anti-inflammatory, long term/high dose steroids (Max 4)	4
Orthopaedic / below waist/Spinal (up to 48 hrs post-op)	5			BMI > 20 Score 0 BMI 18.5-20 Score 1 BMI < 18.5 Score 2			
On table > 2 hours (up to 48 hrs post op)	5	Bed bound (unconscious/unable to change position/traction)	4			Risk Score: 10+ = 'At risk' 15+ = 'High Risk' 20+ = 'Very High Risk'	
		Chair Bound	5	Patient acutely ill or no nutritional intake > 5 days	2		

Patient's Initial Waterlow Score = If Score ≥10 Complete the Adapted Waterlow Pressure Area Risk Assessment Chart

Fluid Balance Chart

Name: .....
1308636407 F
SINCLAIR 13/08/1963
Theresa
90a Main Street
Lennoxtown
Glasgow G66 7DA

Hospital: CRI
Ward: 50
Date: 12/10/15

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00	LUNCH	200								UTT							
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

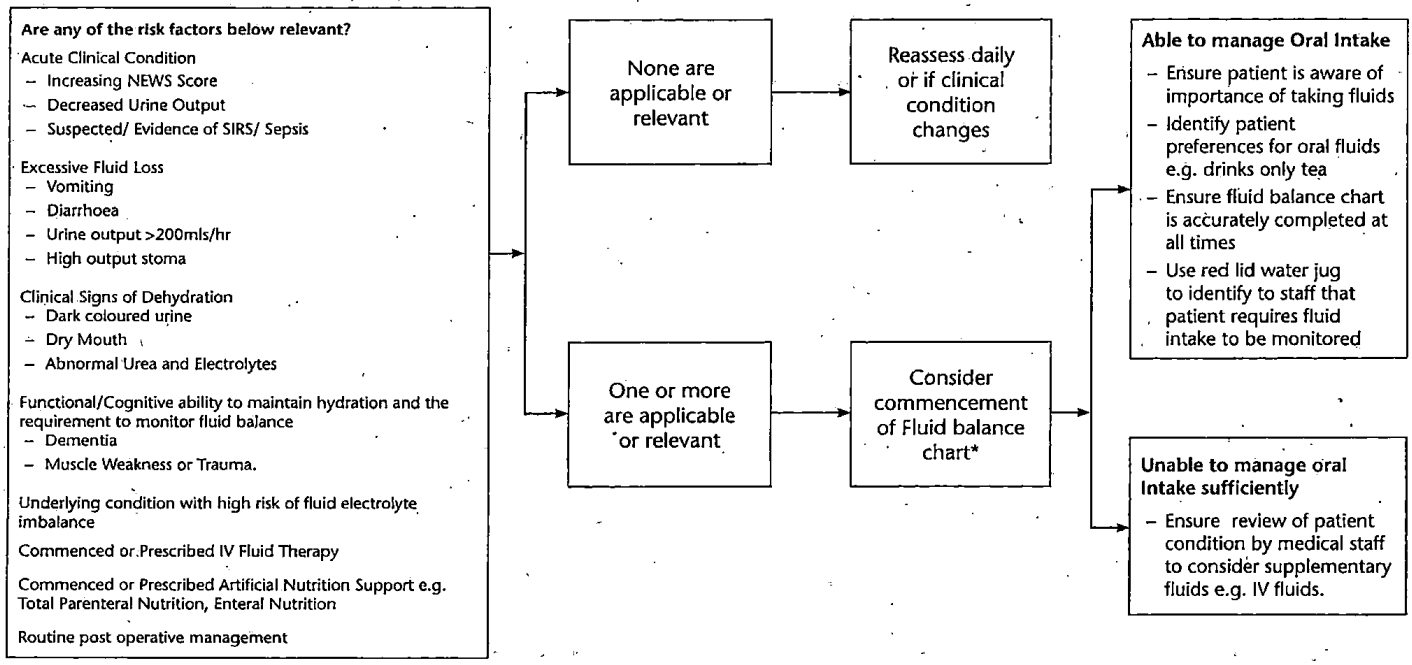
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA

F
13/08/1963

Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	~~Breathing~~, and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
				Independent	
	No problems				
	2, 3. Communication and senses			8. Mobility	
	Not remember anything of it Still detoxicated			Independent	
	4. Cognitive status			9. Maintaining a safe environment	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
				Not a good sleeper	
	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
	Normal diet fluids.				
	6. Elimination			Negotiated care -	
	~~Non~~ Continent			Care discussed with patient / family Yes / No Patient able to participate Yes / No	

223591

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

Write 1308636407
Nam SINCLAIR F
Addr Theresa 13/08/1963
90a Main Street
CHI: Lennoxtown
DOE Glasgow
Hosi G66 7DA

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phleb [illegible] 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 Seek further advice
As above including: palpable venous cord	4	
As above including :pyrexia	5	

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
ED Theatre Ward_____	12/10/15	Elbow	Pink.	

Clinical Indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:

Insertion Criteria (If no: please explain in comments below)	Clean field used	Hand hygiene	Skin asepsis	Dressing affixed	Non touch technique (do not re- contaminate cleaned skin)
	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

MIS 269426
81117

CHI:	Modified V.I.P (Visual Infusion Phlebitis) Score	
	IV site appears healthy	
	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 Seek further advice
	As above including: palpable venous cord	4
	As above including :pyrexia	5

Insertion – Complete all sections

PVC inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical Indication: IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

Acute Services Division

Hospital / Department

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: ..... 1308636407 SINCLAIR .....

Ward: ..... Theresa F

90a Main Street 13/08/1963

CHI number: ..... Lennoxtown .....Unit/Hospital number .....

Glasgow

G66 7DA

Contents

1. **Canard 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: 12/10 Ward: 50	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			1						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		6						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1, 3, 23						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 12/12 Ward: 50	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
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. Buzzer explained	✓ SJ						

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-amilofruse.

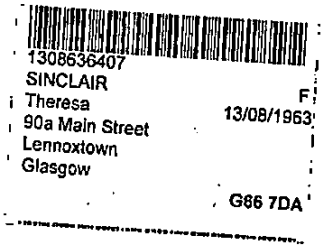
SEDATIVES / ANALGESIA AT NIGHT include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane) Morphine PCA, Fentanyl, Tramadol and Oxycontin.

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.



Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 12/10/15
Address: 1308636407 SINCLAIR Theresa 90a Main Street Lennoxtown Glasgow G66 7DA	Time: 1150
DoB: 13/08/1963 F	HOSPITAL: GRI
CHI number:	Ward: 50
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 5F 2 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 9 St 0 kg Actual ☐ Patient/ carer reported ☑ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☐ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☑ If 'Yes' why?:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☑ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): S. Farrow Signature: Date: 12/10/15

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	02/10											
Initials	SJ											
Height (see page 1) 5F2 Weight	9st											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	23											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK – *Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK – *Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK – *Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

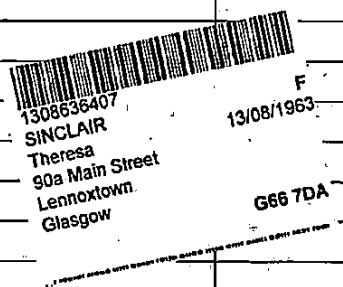
FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

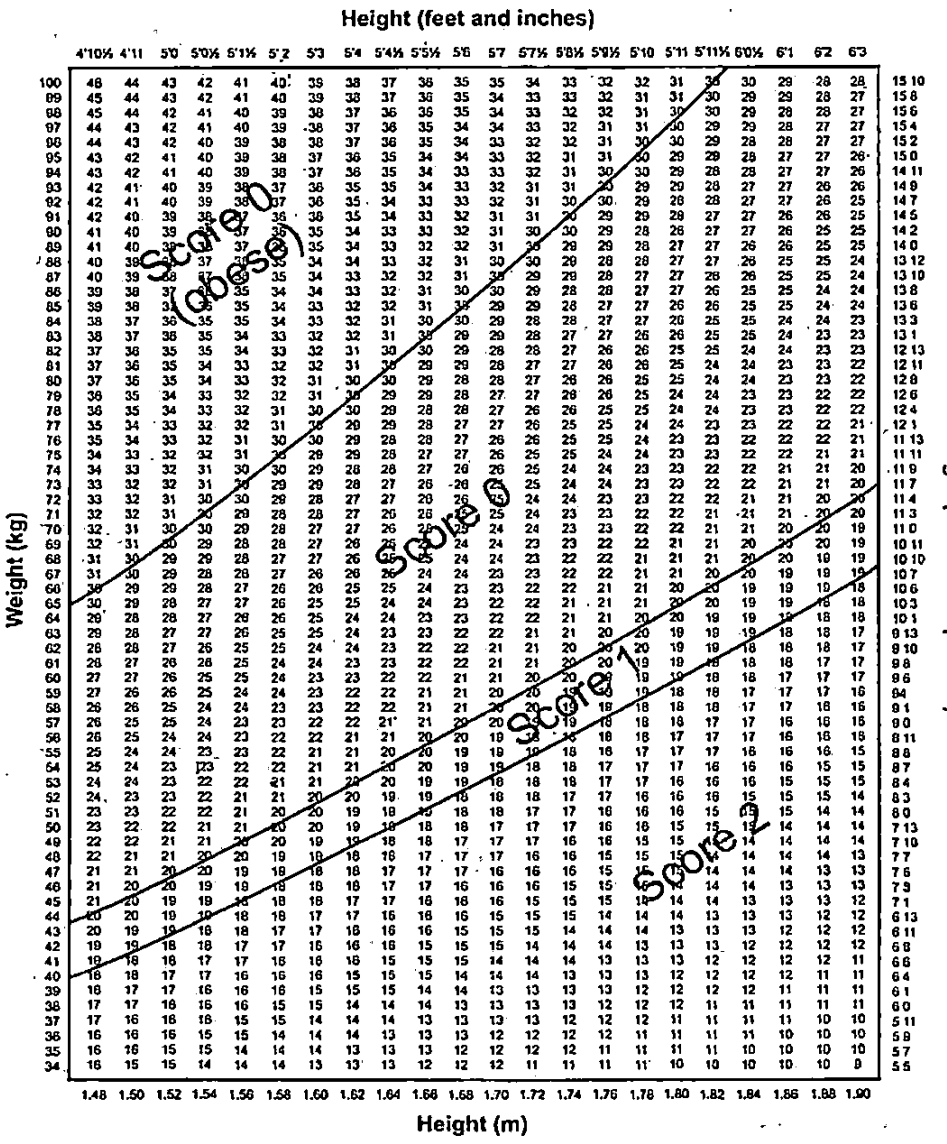
Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation



Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Medical Illustration Services • 235261
STORES ORDER CODE 41850

C 1308536407 nt) Moving and Handling Risk Assessment Form

Patient name:	SINCLAIR Theresa 90a Main Street. Lennoxtown Glasgow G66 7DA	F 13/08/1963	Named Nurse:	S. Jacob	If Patient is totally independent, tick here and go to date box	✓	Risk: Low Medium High

Obese		Tall	
Above average		Medium	
Average		Short	
Below average			
RISK OF FALLS			
High		Low	

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:	12/10/15		
Assessor's signature:			
Proposed Review date:			

05236

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

WRITE, 1308636407
Surnam SINCLAIR F
Forenar Theresa 13/08/1963
DoB .... 90a Main Street
Lennoxtown
Locatio Glasgow G66 7DA

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

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

Sex		12/10							
Male	1								
Female	2	✓							
Age									
14 -49	1								
50 -64	2	✓							
65 - 74	3								
75 - 80	4								
81+	5								
Build/Weight for Height (BMI=weight in Kg/height in m²)									
Average - BMI 20-24.9	0	✓							
Above average - BMI 25-29.9	1								
Obese - BMI > 30	2								
Below average - BMI < 20	3								
Continence									
Complete/catheterised	0								
Incontinent urine	1								
Incontinent faeces	2								
Doubly incontinent (urine & faeces)	3								
Skin Type - Visual Risks Area									
Healthy	0	✓							
Tissue paper (thin/fragile)	1								
Dry (appears flaky)	1								
Oedematous (puffy)	1								
Clammy (moist to touch)/pyrexia	1								
Discoloured (bruising/mottled)	2								
Broken (established ulcer)	3								
Mobility									
Fully mobile	0								
Restless/fidgety	1								
Apathetic (sedated/depressed/reluctant to move)	2								
Restricted (restricted by sever pain or disease)	3								
Bedbound (unconscious/unable to change position/traction)	4								
Chairbound (unable to leave chair without assistance)	5								
Nutritional Element									
Unplanned weight loss in past 3-6 months									
<5% Score **0**, 5-10% Score **1**, >10% Score **2**	0-2								
BMI > 20 Score **0**, BMI 18.5-20 Score **1**, BMI < 18.5 Score **2**	0-2								
Patient acutely ill or no nutritional intake > 5 days	2								
Special Risks - Tissue Malnutrition									
Multiple organ failure/terminal cachexia	8								
Single organ failure e.g. cardiac, renal, respiratory	5								
Peripheral vascular disease	5								
Anaemia = Hb < 8	2								
Smoking	1								
Special Risks - Neurological Deficit									
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6								
Special Risks - Surgery/Trauma									
On table > 6 hours	8								
Orthopaedic/below waist/spinal (up to 48 hours post op)	5								
On table > 2 hours (up to 48 hours post op)	5								
Special Risks - Medication									
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4								
Total Score		4							
Date		12/10							
Initials		SJ							
Time		15							

83826

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

ELECTRONIC PATIENT RECORDS

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 CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

BADGERNET	☐
CAREVUE	☐
MEDICAL ILLUSTRATION	☐
METAVISION	☐
PHYSIOTHERAPY	☐
RADIOLOGY	☑
WEST MARC	☐
LABS	☐

Final Discharge Letter

NHS
Greater Glasgow and Clyde
Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
0141 201 3000

Dr. RM Wilson
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Main Switchboard:	
Department:	Urology
Contact Tel:	0141 355 1799
Enquiries to:	Karen Johnstone
Letter Date:	19/01/2026
Reference:	CO'C/KL
Dictated Date:	09/10/2025
Transcribed Date:	13/11/2025

Dear Dr. RM Wilson,

Theresa Sinclair; D.O.B: 13/08/1963; CHI: 1308636407
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Admission: Specialty - Urology; Ward - STO UROHA - ACH Urology Area I
Consultant - Nurse Carol OConnell; Date of Admission - 09/10/2025
Date of Discharge - 09/10/2025; Discharged to - Private Residence - living alone

Procedures:
09/10/2025 UNSPECIFIED DIAGNOSTIC ENDOSCOPIC EXAMINATION OF BLADDER

Clinical Comments:
Diagnosis:

Non visible haematuria on two occasions and back pain

Procedure:

Flexible cystoscopy

Follow up:

Discharged

Mrs Sinclair attended today for a flexible cystoscopy to investigate non visible haematuria. Today on dip testing her urine there were some leukocytes evident but no blood or nitrites. She consented to have the procedure undertaken.

I am pleased to say that her bladder is entirely healthy with both UOs viewed and normal. She has had an ultrasound already undertaken which has shown no concerning features of her kidneys. I have reassured her and discharged her back to your care.

Yours sincerely

Carol O'Connell

CNS Urology

Electronically Signed: Nurse Carol OConnell, Consultant

cc.

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Urology GGC Urology USOC	—	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital 133 Balornock Road Glasgow G21 3UW	—	**Hospital** and **hospital address** Hospital location code. G207H Email address

Urgency of referral Urgent - Suspected Cancer
Date of referral 17-Sep-2025 **Date sent** 17-Sep-2025

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

Voice: 07754676886
E-mail: theresasinclair95@gmail.com

1010376772185 | Unique Care Pathway Number: 1010376772185

REGISTERED GP DETAILS

Name	Dr Rosalyn Wilson		
GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (18862)		
Practice code	43261		

Practice address

Lennoxtown Medical Practice
Lennoxtown HUB
46 Main St
Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300
E-mail: GG-UHB.gp43261clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Fiona Hunter

Practice address

Lennoxtown Hub
46 Main Street

GMC code	6050643	GP code	07854
Practice name	Lennoxtown Medical Practice (43261)		
Practice code	43261		

Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: NVH, low back pain

Comment: This lady presents with low back pain but no specific urine symptoms. Her mother had bladder cancer age 73. She has had positive dip for blood + x 2, 2 weeks apart and x 2 negative MSU. BP normal, Hb 140, UE normal.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Gout	-	01-May-2025	01-May-2025
Diverticulosis	-	11-Feb-2025	11-Feb-2025
Colonic polyp	-	11-Feb-2025	11-Feb-2025
Type 2 diabetes mellitus	-	03-Feb-2025	03-Feb-2025
Abstinent from substance misuse	Abstinent from alcohol for 7 years	04-Jul-2024	04-Jul-2024
Osteoarthritis	Minor changes to L hip and lower L spine	20-Jun-2024	20-Jun-2024
Chronic obstructive pulmonary disease	Moderate on spirometry	17-Jan-2019	17-Jan-2019
New onset angina	-	15-Jul-2015	15-Jul-2015
Adhesive capsulitis of the shoulder	-	13-Aug-2014	13-Aug-2014
Overdose of drug	-	16-Apr-2011	16-Apr-2011
Overdose of drug	citalopram	16-Apr-2011	16-Apr-2011
Overdose of drug	-	16-Sep-2010	16-Sep-2010
[X]Intentional self-harm	overdose of drug	06-Jul-2009	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	21-Jun-2008	21-Jun-2008
Overdose of drug	-	02-Jul-2007	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	27-Oct-2003	27-Oct-2003
Suicide and selfinflicted injury	OVERDOSE	20-Feb-2000	20-Feb-2000
Single major depressive episode	-	20-Dec-1999	20-Dec-1999
Alcohol dependence syndrome	-	18-Jun-1999	18-Jun-1999
Suicide and selfinflicted injury	-	15-Jun-1999	15-Jun-1999
Haematemesis	Mild	14-Jan-1999	14-Jan-1999
Suicide and selfinflicted injury	-	10-Aug-1998	10-Aug-1998
Suicide and selfinflicted injury	-	29-May-1998	29-May-1998
Suicide and selfinflicted injury	-	01-Jan-1993	01-Jan-1993
Single major depressive episode	-	20-Oct-1990	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Mammography normal	03-Apr-2025	03-Apr-2025
Mammography normal	15-Dec-2021	15-Dec-2021

Family conditions (All priorities)

Description	Comment	Date of Onset
FH: MI- Myocardial infarct <60 (Father, Sister)	07-Jul-2015	
FH: Ischaemic heart dis. <60	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008
No family history diabetes	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started

						Date last issued
Stexerol-D3 Tablets 1,000 units	60	60 TABLET	ONE DAILY	-	16-Sep-2025	16-Sep-2025
Allopurinol Tablets 100 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	04-Sep-2025	04-Sep-2025
Salbutamol Dry Powder Inhaler 100 micrograms/actuation	200	200 DOSE	ONE OR TWO DOSES TO BE INHALED WHEN REQUIRED	-	21-Aug-2025	21-Aug-2025
Metformin Hydrochloride M/R tablets 500 mg	84	84 tablet	ONE TO BE TAKEN THREE TIMES DAILY	-	18-Jun-2025	04-Sep-2025
Furosemide Tablets 20 mg	56	56 TABLET	ONE AT LUNCH TIME	-	05-Mar-2025	04-Sep-2025
Furosemide Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN EACH MORNING	-	07-Feb-2025	04-Sep-2025
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	07-Feb-2025	21-Aug-2025
Pregabalin Capsules 75 mg	56	56 capsule	ONE TWICE DAILY IN THE MORNING AND ONE AT TEA TIME	-	26-Aug-2024	21-Aug-2025
Amitriptyline Hydrochloride Tablets 10 mg	112	112 TABLET	TWO AT NIGHT AND INCREASE TO UP TO 5 TABLETS AT NIGHT	-	12-Mar-2024	04-Sep-2025
Dihydrocodeine Tablets 30 mg	224	224 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY	-	21-Feb-2024	11-Sep-2025
Paracetamol Tablets 500 mg	224	224 TABLET	TAKE TWO FOUR TIMES DAILY	-	21-Feb-2024	26-Aug-2025
Peppermint Oil E/c capsules 0.2 ml	84	84 capsule	ONE TO BE TAKEN THREE TIMES A DAY BEFORE FOOD	-	25-Feb-2020	11-Sep-2025
Fluoxetine Hydrochloride Capsules 20 mg	112	112 CAPSULE	2 DAILY DISPENSE MONTHLY	-	17-Sep-2018	30-Jul-2025
Omeprazole Capsules (Gastro-Resistant) 20 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	11-Sep-2025
Bisoprolol Fumarate Tablets 1.25 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	21-Aug-2025
Isosorbide Mononitrate M/R capsules 25 mg	56	56 capsule	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	28-Aug-2025
Thiamine Tablets 50 mg	224	224 tablet	ONE TO BE TAKEN FOUR TIMES A DAY	-	23-Feb-2018	19-Aug-2025
Aspirin Dispersible tablets 75 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	24-Jul-2025
Simvastatin Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	09-Sep-2015	24-Jul-2025
Ramipril Capsules 2.5 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	21-Aug-2025
Diazepam Tablets 2 mg	56	56 TABLET	ONE TAB TWICE DAILY, DISP WEEKLY ON WEDNESDAY	-	03-Jun-2015	20-Aug-2025

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Piroxicam Gel 0.5 %	112	112 gram	Rub into the affected site three to four times daily	-	04-Sep-2025	04-Sep-2025
	100	100 ML		-	04-Sep-2025	

Morphine Sulfate Oral solution 10 mg/5 ml			2.5ML TO 5ML TO BE TAKEN WHEN REQUIRED FOR BREAKTHROUGH PAIN.			04-Sep-2025
Salbutamol Cfc-free Inhaler 100 micrograms/puff	200	200 dose	2 PUFFS AS REQUIRED	-	25-Aug-2025	25-Aug-2025
Trelegy Ellipta Dry Powder Inhaler 92 micrograms + 55 micrograms + 22 micrograms/dose	60	60 DOSE	ONE PUFF TO BE USED ONCE DAILY	-	06-Aug-2025	15-Sep-2025
Prednisolone Tablets 5 mg	30	30 tablet	SIX TO BE TAKEN IN THE MORNING	-	17-Jul-2025	17-Jul-2025
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	17-Jul-2025	17-Jul-2025
Relvar Ellipta Dry Powder Inhaler 184 micrograms + 22 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	16-Jul-2025	16-Jul-2025
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING	-	12-Jun-2025	12-Jun-2025
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	12-Jun-2025	12-Jun-2025
Salbutamol Cfc-free Inhaler 100 micrograms/puff	200	200 dose	2 PUFFS AS REQUIRED	-	10-Jun-2025	10-Jun-2025
Easychamber Spacer device with adult mask (6 years - adult)	1	1 DEVICE	AS DIR	-	06-Jun-2025	06-Jun-2025
Amoxicillin Capsules 500 mg	21	21 capsule	ONE TO BE TAKEN THREE TIMES A DAY FOR 7 DAYS	-	30-May-2025	30-May-2025
Salbutamol Cfc-free Inhaler 100 micrograms/puff	200	200 dose	2 PUFFS AS REQUIRED	-	13-May-2025	13-May-2025
Colchicine Tablets 500 micrograms	12	12 tablet	1 TAB 4 TIMES DAILY FOR 3 DAYS	-	02-May-2025	09-May-2025
Ibuprofen Gel 5 %	100	100 gram	APPLY TO THE AFFECTED AREA UP TO THREE TIMES A DAY	-	28-Apr-2025	28-Apr-2025
Timodine Cream	60	60 gram	APPLY TO AFFECTED SKIN THREE TIMES DAILY	-	28-Apr-2025	28-Apr-2025
Piroxicam Gel 0.5 %	112	112 gram	APPLY THREE TIMES DAILY	-	28-Apr-2025	28-Apr-2025
Metformin Hydrochloride Tablets 500 mg	56	56 TABLET	ONE TWICE DAILY	-	19-Feb-2025	06-Jun-2025
Cyanocobalamin Tablets 100 micrograms	28	28 TABLET	1 Tab Daily	-	20-Dec-2024	20-Aug-2025
Anoro Ellipta Dry Powder Inhaler 55 micrograms + 22 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	04-Dec-2024	09-Jun-2025
Salbutamol Breath-Actuated Inhaler (Cfc-Free) 100 micrograms/dose	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED	-	06-Feb-2019	20-Aug-2025

Blood Pressure

Date Recorded	Systolic	Diastolic
25-Aug-2025	122	74

03-Feb-2025	120	70
20-Dec-2024	108	68
11-Apr-2024	167	110
24-Aug-2023	125	78

Body Measurements

Date Recorded	Height	Weight	BMI
25-Aug-2025	155	86	35.8
19-Feb-2025	155	86	35.8
24-Aug-2023	155	72.05	29.99
02-Feb-2023	-	77.3	32.59
25-Oct-2019	154	74	31.2

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Trying to give up smoking:		19-Feb-2025
Cigarette smoker, 20 Cigarettes/day:		04-Jul-2024
Ready to stop smoking:		14-Jun-2024
Current smoker:		14-Jun-2024
Current smoker:		24-Aug-2023
Alcohol consumption, 0 units/week:		19-Feb-2025
Alcohol consumption, 0 units/week:		24-Aug-2023
Alcohol consumption, 0 units/week:		25-Oct-2019
Alcohol consumption, 0 units/week:		02-Oct-2019
Alcohol consumption, 0 units/week:		29-Nov-2018
Avoids even trivial exercise:		25-Oct-2019
Avoids even trivial exercise:		29-Nov-2018
GPPAQ physcl act ind: inactive:		29-Nov-2018
Avoids even trivial exercise:		03-Aug-2017
GPPAQ physcl act ind: inactive:		03-Aug-2017

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Aged 45 and over and have unexplained visible haematuria without UTI:Yes

For Bladder and Kidney - Recent UEs::Yes

eGFR:greater than 60

Complete:true

Is patient aware they are being referred under a suspicion of cancer pathway?:No - I understand I will need to inform patient of any change to referral status after vetting.

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

Letter to Patient:

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW

Theresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Main Switchboard: 0141 201 3000
Department: General Surgery
Contact Tel:
Enquiries to: emma.maguire@ggc.scot.nhs.uk
Letter Date: 19/06/2025
Reference: EM/CH
Dictated Date: 02/06/2025
Transcribed Date: 18/06/2025

Dear Mrs Sinclair,

I now have the results of the polyps removed at your colonoscopy carried out on 11th February 2025. The pathology report ahs confirmed that the polyp removed is a tiny hyperplastic polyp with no worrying features detected. As per current guidelines no further follow up is required for this.

Yours sincerely,

Emma Maguire

Nurse Endoscopist

Electronically Signed: Nurse Emma Maguire, Consultant

cc. Dr RM Wilson:
Lennoxtown Medical Practic:
Lennoxtown Hub:
46 Main Street:
Lennoxtown:
Glasgow:
G66 7JJ

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Vascular Surgery - 26032025_Clinical Letter_415419

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Vascular Surgery GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Glasgow Royal Infirmary 84 Castle Street Glasgow G4 0SF	——	**Hospital** and **hospital address** Hospital location code. G107H Email address -

Urgency of referral Routine
Date of referral 17-Apr-2025 **Date sent** 17-Apr-2025

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

Voice: 07754676886
E-mail: theresasinclair95@gmail.com

101036231874F Unique Care Pathway Number: 101036231874F

REGISTERED GP DETAILS

Name	Dr Rosalyn Wilson		
GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (18862)		
Practice code	43261		

Practice address

Lennoxtown Medical Practice
Lennoxtown HUB
46 Main St
Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300
E-mail: GG-UHB.gp43261clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Fiona Hunter

Practice address

Lennoxtown Hub

GMC code	6050643	GP code	07854
Practice name	Lennoxtown Medical Practice (43261)		
Practice code	43261		

46 Main Street
Lennoxtown
G66 7JJ

Contact number(s)

Voice:,01360 327300

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: intermittent claudication, borderline ABPI

Comment: I would be grateful for your review of this lady with intermittent calf pain in both legs on walking. ABPI right 0.9, borderline, left 1.09.
? does she need repeat or further investigation?

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Diverticulosis	-	11-Feb-2025	11-Feb-2025
Colonic polyp	-	11-Feb-2025	11-Feb-2025
Type 2 diabetes mellitus	-	03-Feb-2025	03-Feb-2025
Abstinent from substance misuse	Abstinent from alcohol for 7 years	04-Jul-2024	04-Jul-2024
Osteoarthritis	Minor changes to L hip and lower L spine	20-Jun-2024	20-Jun-2024
Chronic obstructive pulmonary disease	Moderate on spirometry	17-Jan-2019	17-Jan-2019
New onset angina	-	15-Jul-2015	15-Jul-2015
Adhesive capsulitis of the shoulder	-	13-Aug-2014	13-Aug-2014
Overdose of drug	-	16-Apr-2011	16-Apr-2011
Overdose of drug	citalopram	16-Apr-2011	16-Apr-2011
Overdose of drug	-	16-Sep-2010	16-Sep-2010
[X]Intentional self-harm	overdose of drug	06-Jul-2009	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	21-Jun-2008	21-Jun-2008
Overdose of drug	-	02-Jul-2007	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	27-Oct-2003	27-Oct-2003
Suicide and selfinflicted injury	OVERDOSE	20-Feb-2000	20-Feb-2000
Single major depressive episode	-	20-Dec-1999	20-Dec-1999
Alcohol dependence syndrome	-	18-Jun-1999	18-Jun-1999
Suicide and selfinflicted injury	-	15-Jun-1999	15-Jun-1999
Haematemesis	Mild	14-Jan-1999	14-Jan-1999
Suicide and selfinflicted injury	-	10-Aug-1998	10-Aug-1998
Suicide and selfinflicted injury	-	29-May-1998	29-May-1998
Suicide and selfinflicted injury	-	01-Jan-1993	01-Jan-1993
Single major depressive episode	-	20-Oct-1990	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Mammography normal	15-Dec-2021	15-Dec-2021

Family conditions (All priorities)

Description	Comment	Date of Onset
FH: MI- Myocardial infarct <60 (Father, Sister)	07-Jul-2015	
No family history diabetes	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008
FH: Ischaemic heart dis. <60	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started

						Date last issued
Furosemide Tablets 20 mg	56	56 TABLET	ONE AT LUNCH TIME	-	05-Mar-2025	04-Apr-2025
Metformin Hydrochloride Tablets 500 mg	56	56 TABLET	ONE TWICE DAILY	-	19-Feb-2025	01-Apr-2025
Furosemide Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN EACH MORNING	-	07-Feb-2025	04-Apr-2025
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	07-Feb-2025	01-Apr-2025
Anoro Ellipta Dry Powder Inhaler 55 micrograms + 22 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	04-Dec-2024	03-Apr-2025
Pregabalin Capsules 75 mg	56	56 capsule	ONE TWICE DAILY IN THE MORNING AND ONE AT TEA TIME	-	26-Aug-2024	14-Apr-2025
Amitriptyline Hydrochloride Tablets 10 mg	112	112 TABLET	TWO AT NIGHT AND INCREASE TO UP TO 5 TABLETS AT NIGHT	-	12-Mar-2024	14-Mar-2025
Dihydrocodeine Tablets 30 mg	224	224 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY	-	21-Feb-2024	14-Apr-2025
Paracetamol Tablets 500 mg	224	224 TABLET	TAKE TWO FOUR TIMES DAILY	-	21-Feb-2024	14-Apr-2025
Peppermint Oil E/c capsules 0.2 ml	84	84 capsule	ONE TO BE TAKEN THREE TIMES A DAY BEFORE FOOD	-	25-Feb-2020	16-Apr-2025
Salbutamol Breath-Actuated Inhaler (Cfc-Free) 100 micrograms/dose	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED	-	06-Feb-2019	01-Apr-2025
Fluoxetine Hydrochloride Capsules 20 mg	112	112 CAPSULE	2 DAILY DISPENSE MONTHLY	-	17-Sep-2018	14-Mar-2025
Omeprazole Capsules (Gastro-Resistant) 20 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	06-Mar-2025
Bisoprolol Fumarate Tablets 1.25 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	16-Apr-2025
Isosorbide Mononitrate M/R capsules 25 mg	56	56 capsule	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	01-Apr-2025
Thiamine Tablets 50 mg	224	224 tablet	ONE TO BE TAKEN FOUR TIMES A DAY	-	23-Feb-2018	14-Apr-2025
Aspirin Dispersible tablets 75 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	04-Apr-2025
Simvastatin Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	09-Sep-2015	04-Apr-2025
Ramipril Capsules 2.5 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	16-Apr-2025
Diazepam Tablets 2 mg	56	56 TABLET	ONE TAB TWICE DAILY. DISP WEEKLY ON WEDNESDAY	-	03-Jun-2015	09-Apr-2025

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING	-	19-Feb-2025	19-Feb-2025
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	19-Feb-2025	

						19-Feb-2025
Furosemide Tablets 20 mg	7	7 tablet	ONE AT LUNCH TIME FOR 1 WEEK	-	19-Feb-2025	19-Feb-2025
Furosemide Tablets 40 mg	28	28 tablet	ONE TO BE TAKEN EACH MORNING	-	28-Jan-2025	28-Jan-2025
Clotrimazole Cream 1 %	20	20 GRAM	APPLY TWO TO THREE TIMES DAILY	-	27-Jan-2025	27-Jan-2025
Easychamber Spacer device with adult mask (6 years - adult)	1	1 DEVICE	AS DIR	-	14-Jan-2025	14-Jan-2025
Salbutamol Cfc-free inhaler 100 micrograms/puff	200	200 dose	2 PUFFS AS REQUIRED	-	14-Jan-2025	18-Feb-2025
Cyanocobalamin Tablets 100 micrograms	28	28 TABLET	1 Tab Daily	-	20-Dec-2024	03-Apr-2025
Ferrous Fumarate Tablets 210 mg	84	84 tablet	1 Tab Daily	-	20-Dec-2024	20-Dec-2024
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	20-Dec-2024	20-Dec-2024
Doxycycline Hyclate Capsules 100 mg	6	6 CAPSULE	TWO TO BE TAKEN ON THE FIRST DAY THEN ONE TO BE TAKEN EACH DAY FOR 4 DAYS	-	13-Dec-2024	13-Dec-2024
Metformin Hydrochloride Tablets 500 mg	112	112 TABLET	ONE TO BE TAKEN TWICE A DAY	-	13-Dec-2024	20-Feb-2025
Timodine Cream	30	30 gram	APPLY THREE TIMES DAILY	-	04-Dec-2024	04-Dec-2024
Fluconazole Capsules 50 mg	7	7 capsule	ONE DIALY FOR 7 DAYS	-	04-Dec-2024	04-Dec-2024
Fostair Nexthaler Dry Powder Inhaler 100 micrograms + 6 micrograms/dose	240	240 DOSE	TWO PUFFS TO BE USED TWICE DAILY	-	03-Dec-2024	03-Dec-2024
Nystatin Oral suspension 100,000 units/ml	30	30 ML	USE 1ML IN THE MOUTH FOUR TIMES DAILY AFTER FOOD FOR 7 DAYS CONTINUED FOR 48 HOURS AFTER LESIONS HEALED	-	25-Nov-2024	25-Nov-2024
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	25-Nov-2024	25-Nov-2024
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING FOR 3 TO 5 DAYS	-	25-Nov-2024	13-Dec-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
03-Feb-2025	120	70
20-Dec-2024	108	68
11-Apr-2024	167	110
24-Aug-2023	125	78

25-Oct-2019	140	70

Body Measurements

Date Recorded	Height	Weight	BMI
19-Feb-2025	155	86	35.8
24-Aug-2023	155	72.05	29.99
02-Feb-2023	-	77.3	32.59
25-Oct-2019	154	74	31.2
02-Oct-2019	154	-	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Trying to give up smoking:		19-Feb-2025
Cigarette smoker, 20 Cigarettes/day:		04-Jul-2024
Ready to stop smoking:		14-Jun-2024
Current smoker:		14-Jun-2024
Current smoker:		24-Aug-2023
Alcohol consumption, 0 units/week:		19-Feb-2025
Alcohol consumption, 0 units/week:		24-Aug-2023
Alcohol consumption, 0 units/week:		25-Oct-2019
Alcohol consumption, 0 units/week:		02-Oct-2019
Alcohol consumption, 0 units/week:		29-Nov-2018
Avoids even trivial exercise:		25-Oct-2019
Avoids even trivial exercise:		29-Nov-2018
GPPAQ physcl act ind: inactive:		29-Nov-2018
Avoids even trivial exercise:		03-Aug-2017
GPPAQ physcl act ind: inactive:		03-Aug-2017

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

Vascular Surgery - 26032025 Clinical Letter 415419

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery - Colorectal GGC Colorectal	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital 133 Balornock Road Glasgow G21 3UW	——	**Hospital** and **hospital address** Hospital location code. G207H Email address -

Urgency of referral Urgent - Suspected Cancer
Date of referral 17-Jan-2025 **Date sent** 17-Jan-2025

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

Voice: 07754676886
E-mail: theresasinclair95@gmail.com

1010353198289

Unique Care Pathway Number: 1010353198289

REGISTERED GP DETAILS

Name	Dr Rosalyn Wilson		
GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (18862)		
Practice code	43261		

Practice address

Lennoxtown Medical Practice
Lennoxtown HUB
46 Main St
Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300
E-mail: GG-UHB.gp43261clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Rosalyn Wilson

Practice address

Lennoxtown Hub
46 Main Street

GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (43261)		
Practice code	43261		

Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: raised qfit

Comment: Thanks for seeing this patient who has a raised qfit and new onset diarrhoea. She has normal haemoglobin but low ferritin when she was having routine bloods done to investigate her symptoms. She has also noticed a bit of unintentional weight loss but cannot quantify this for me. Theresa is also being investigated by respiratory for nodules in a previous CT scan and is awaiting an interval scan. She has been a life long heavy smoker.

thanks for seeing her urgently to arrange scopes.

Dr Rosalyn Wilson

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Ankle swelling	-	15-Jan-2025	15-Jan-2025
O/E - blood pressure reading	-	20-Dec-2024	20-Dec-2024
Abstinent from substance misuse	Abstinent from alcohol for 7 years	04-Jul-2024	04-Jul-2024
Osteoarthritis	Minor changes to L hip and lower L spine	20-Jun-2024	20-Jun-2024
Chronic obstructive pulmonary disease	Moderate on spirometry	17-Jan-2019	17-Jan-2019
New onset angina	-	15-Jul-2015	15-Jul-2015
Adhesive capsulitis of the shoulder	-	13-Aug-2014	13-Aug-2014
Overdose of drug	-	16-Apr-2011	16-Apr-2011
Overdose of drug	citalopram	16-Apr-2011	16-Apr-2011
Overdose of drug	-	16-Sep-2010	16-Sep-2010
[X]Intentional self-harm	overdose of drug	06-Jul-2009	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	21-Jun-2008	21-Jun-2008
Overdose of drug	-	02-Jul-2007	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	27-Oct-2003	27-Oct-2003
Suicide and selfinflicted injury	OVERDOSE	20-Feb-2000	20-Feb-2000
Single major depressive episode	-	20-Dec-1999	20-Dec-1999
Alcohol dependence syndrome	-	18-Jun-1999	18-Jun-1999
Suicide and selfinflicted injury	-	15-Jun-1999	15-Jun-1999
Haematemesis	Mild	14-Jan-1999	14-Jan-1999
Suicide and selfinflicted injury	-	10-Aug-1998	10-Aug-1998
Suicide and selfinflicted injury	-	29-May-1998	29-May-1998
Suicide and selfinflicted injury	-	01-Jan-1993	01-Jan-1993
Single major depressive episode	-	20-Oct-1990	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Mammography normal	15-Dec-2021	15-Dec-2021

Family conditions (All priorities)

Description	Comment	Date of Onset
FH: MI- Myocardial infarct <60 (Father, Sister)	07-Jul-2015	
FH: Ischaemic heart dis. <60	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008
No family history diabetes	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Anoro Ellipta Dry Powder Inhaler 55 micrograms + 22 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	04-Dec-2024	04-Dec-2024
Pregabalin Capsules 75 mg	56	56 capsule	ONE TWICE DAILY IN THE MORNING AND ONE AT TEA TIME	-	26-Aug-2024	03-Jan-2025
Amitriptyline Hydrochloride Tablets 10 mg	112	112 TABLET	TWO AT NIGHT AND INCREASE TO UP TO 5 TABLETS AT NIGHT	-	12-Mar-2024	28-Nov-2024
Dihydrocodeine Tablets 30 mg	224	224 TABLET	TWO TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY	-	21-Feb-2024	03-Jan-2025
Paracetamol Tablets 500 mg	224	224 TABLET	TAKE TWO FOUR TIMES DAILY	-	21-Feb-2024	20-Dec-2024
Peppermint Oil E/c capsules 0.2 ml	84	84 capsule	ONE TO BE TAKEN THREE TIMES A DAY BEFORE FOOD	-	25-Feb-2020	03-Jan-2025
Salbutamol Breath-Actuated Inhaler (Cfc-Free) 100 micrograms/dose	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED	-	06-Feb-2019	13-Jan-2025
Fluoxetine Hydrochloride Capsules 20 mg	112	112 CAPSULE	2 DAILY DISPENSE MONTHLY	-	17-Sep-2018	06-Jan-2025
Omeprazole Capsules (Gastro-Resistant) 20 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	12-Dec-2024
Bisoprolol Fumarate Tablets 1.25 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	06-Jan-2025
Isosorbide Mononitrate M/R capsules 25 mg	56	56 capsule	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	28-Nov-2024
Thiamine Tablets 50 mg	224	224 tablet	ONE TO BE TAKEN FOUR TIMES A DAY	-	23-Feb-2018	07-Nov-2024
Glyceryl Trinitrate Pump spray 400 micrograms/dose	200	200 dose	SPRAY ONE OR TWO DOSES UNDER THE TONGUE WHEN REQUIRED FOR CHEST PAIN AND THEN CLOSE MOUTH	-	31-Mar-2017	15-Mar-2024
Aspirin Dispersible tablets 75 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	06-Jan-2025
Simvastatin Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	09-Sep-2015	28-Nov-2024
Ramipril Capsules 2.5 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	10-Jan-2025
Diazepam Tablets 2 mg	56	56 TABLET	ONE TAB TWICE DAILY. DISP WEEKLY ON WEDNESDAY	-	03-Jun-2015	06-Jan-2025

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Easychamber Spacer device with adult mask (6 years - adult)	1	1 DEVICE	AS DIR	-	14-Jan-2025	14-Jan-2025

Salbutamol Cfc-free inhaler 100 micrograms/puff	200	200 dose	2 PUFFS AS REQUIRED	-	14-Jan-2025	14-Jan-2025
Cyanocobalamin Tablets 100 micrograms	56	56 tablet	1 Tab Daily	-	20-Dec-2024	20-Dec-2024
Ferrous Fumarate Tablets 210 mg	84	84 tablet	1 Tab Daily	-	20-Dec-2024	20-Dec-2024
Mirtazapine Tablets 15 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	20-Dec-2024	20-Dec-2024
Doxycycline Hyclate Capsules 100 mg	6	6 CAPSULE	TWO TO BE TAKEN ON THE FIRST DAY THEN ONE TO BE TAKEN EACH DAY FOR 4 DAYS	-	13-Dec-2024	13-Dec-2024
Metformin Hydrochloride Tablets 500 mg	56	56 TABLET	INITIALLY ONE TO BE TAKEN EACH MORNING WITH BREAKFAST	-	13-Dec-2024	13-Dec-2024
Timodine Cream	30	30 gram	APPLY THREE TIMES DAILY	-	04-Dec-2024	04-Dec-2024
Fluconazole Capsules 50 mg	7	7 capsule	ONE DIALY FOR 7 DAYS	-	04-Dec-2024	04-Dec-2024
Fostair Nexthaler Dry Powder Inhaler 100 micrograms + 6 micrograms/dose	240	240 DOSE	TWO PUFFS TO BE USED TWICE DAILY	-	03-Dec-2024	03-Dec-2024
Nystatin Oral suspension 100,000 units/ml	30	30 ML	USE 1ML IN THE MOUTH FOUR TIMES DAILY AFTER FOOD FOR 7 DAYS CONTINUED FOR 48 HOURS AFTER LESIONS HEALED	-	25-Nov-2024	25-Nov-2024
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	25-Nov-2024	25-Nov-2024
Prednisolone Tablets 5 mg	40	40 TABLET	EIGHT TO BE TAKEN IN THE MORNING FOR 3 TO 5 DAYS	-	25-Nov-2024	13-Dec-2024
Tiogiva Inhalation Powder Capsules 18 micrograms	60	60 CAPSULE	ONE DOSE TO BE INHALED EACH DAY.	-	11-Oct-2024	15-Oct-2024
Fostair Nexthaler Dry Powder Inhaler 100 micrograms + 6 micrograms/dose	120	120 DOSE	TWO PUFFS TO BE USED TWICE DAILY	-	17-Sep-2024	21-Oct-2024
Tiogiva Inhalation Powder Capsules With Device 18 micrograms	30	30 CAPSULE	ONE DOSE TO BE INHALED EACH DAY	-	17-Sep-2024	17-Sep-2024
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	13-Sep-2024	13-Sep-2024
Piroxicam Gel 0.5 %	112	112 gram	Rub into the affected site three to four times daily	-	29-Aug-2024	29-Aug-2024
Diazepam Tablets 2 mg	8	8 tablet	ONE TABLET TWICE DAILY FOR 4 DAYS (TOTAL DAILY DOSE 8MG FOR 4 DAYS)	-	22-Aug-2024	29-Aug-2024
Morphine Sulfate Oral solution 10 mg/5 ml	100	100 ML	2.5ML TO 5ML TO BE TAKEN WHEN REQUIRED FOR BREAKTHROUGH PAIN.	-	21-Aug-2024	06-Sep-2024

Anoro Ellipta Dry Powder Inhaler 55 micrograms + 22 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	24-Nov-2022	22-Aug-2024

Blood Pressure

Date Recorded	Systolic	Diastolic
20-Dec-2024	108	68
11-Apr-2024	167	110
24-Aug-2023	125	78
25-Oct-2019	140	70
25-Oct-2019	140	70

Body Measurements

Date Recorded	Height	Weight	BMI
24-Aug-2023	155	72.05	29.99
02-Feb-2023	-	77.3	32.59
25-Oct-2019	154	74	31.2
02-Oct-2019	154	-	-
02-Sep-2019	-	70	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker, 20 Cigarettes/day:		04-Jul-2024
Ready to stop smoking:		14-Jun-2024
Current smoker:		14-Jun-2024
Current smoker:		24-Aug-2023
Not interested in stopping smoking:		25-Oct-2019
Alcohol consumption, 0 units/week:		24-Aug-2023
Alcohol consumption, 0 units/week:		25-Oct-2019
Alcohol consumption, 0 units/week:		02-Oct-2019
Alcohol consumption, 0 units/week:		29-Nov-2018
Stopped drinking alcohol:		29-Nov-2018
Avoids even trivial exercise:		25-Oct-2019
Avoids even trivial exercise:		29-Nov-2018
GPPAQ physcl act ind: inactive:		29-Nov-2018
Avoids even trivial exercise:		03-Aug-2017
GPPAQ physcl act ind: inactive:		03-Aug-2017

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

QFIT requested?:Result available

Is patient aware they are being referred under a suspicion of cancer pathway?:Yes

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances
Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

Letter to Patient:

NHS
Greater Glasgow and Clyde
Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
Main Switchboard: 0141 201 3000
Department: Gastroenterology
Contact Tel: 0141 201 6368
Enquiries to: Secretary

Theresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Letter Date: 20/04/2023
Reference: SB/MR
Dictated Date: 17/04/2023
Transcribed Date: 18/04/2023

Dear Ms Sinclair,

I have received the results of your MRI on the 4th of April (reported 12th of April). This shows an entirely normal liver. This is reassuring, and no further action is required. I have cancelled your clinic appointment. I hope the above is reassuring and satisfactory.

Yours sincerely,

Dr Stephen T Barclay

Consultant Physician & Hepatologist

Electronically Signed: Dr Stephen Barclay, Consultant

cc. Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
Glasgow
G66 7JJ

Letter to Patient:

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW
Main Switchboard: 0141 201 3000
Department: Gastroenterology
Contact Tel: 0141 201 6368
Enquiries to: Secretary

Theresa Sinclair
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Letter Date: 20/03/2023
Reference: SB/MR
Dictated Date: 15/03/2023
Transcribed Date: 16/03/2023

Dear Ms Sinclair,

Your GP has written regarding a possible abnormal area in the liver on ultrasound.

I have requested a MRI scan to look at this area in more detail. I have also listed you for a clinic appointment to discuss results if required, but if the MRI is satisfactory we will cancel this.

I trust the above is satisfactory.

Yours sincerely,

Dr S Barclay

Consultant Physician and Hepatologist

Electronically Signed: Dr Stephen Barclay, Consultant

cc. Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Glasgow
G66 7JJ

Hospital use only	Clinic	Day Date	Time	Hospital No.

REFERRAL LETTER
MEDICAL IN CONFIDENCE

Attachments
Gastroenterology - 09032023 Imaging Result - US Abdomen 353337

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gastroenterology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital 133 Balornock Road Glasgow G21 3UW	——	**Hospital** and **hospital address** Hospital location code. G207H Email address

Urgency of referral Urgent - Suspected Cancer
Date of referral 15-Mar-2023 **Date sent** 15-Mar-2023

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

Voice: 07754676886

101029034432P

Unique Care Pathway Number: 101029034432P

REGISTERED GP DETAILS

Name	Dr Rosalyn Wilson		
GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (18862)		
Practice code	43261		

Practice address

Lennoxtown Medical Practice
Lennoxtown HUB
46 Main St
Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300
E-mail: GG-UHB.gp43261clinical@nhs.net

REFERRING GP DETAILS

Name	Dr. Rosalyn Wilson

Practice address

Lennoxtown Hub

GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (43261)		
Practice code	43261		

46 Main Street
Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: ?Underlying Liver Cancer

Comment: Dear Dr,

Many thanks for seeing this 59 y/o lady with a 3x3 cm isoechoic focus seen on USS.
This lady has a history of alcohol excess and dependence however she has been teetotal for 6 years.
Deranged LFTs and raised GGT (which has been persistently raised) was picked up on routine bloods.
An USS in 2017 was found to be normal however she was referred for an updated USS which shows 3 x 3 cm isoechoic focus possible underlying sinister cause.
I've attached the report to this referral.

Theresa otherwise has a history of mental health problems, COPD and angina. She has a BMI of 32 and has been trying to lose weight.
I've spoke to Theresa about these findings and I have let her know that there might be an underlying cancer.
I'd be grateful of your input and consideration of further imaging in the first instance.

Many Thanks,
Dr Omar Amin
GPST3

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
Chronic obstructive pulmonary disease	Moderate on spirometry	17-Jan-2019	17-Jan-2019
New onset angina	-	15-Jul-2015	15-Jul-2015
Adhesive capsulitis of the shoulder	-	13-Aug-2014	13-Aug-2014
Overdose of drug	-	16-Apr-2011	16-Apr-2011
Overdose of drug	citalopram	16-Apr-2011	16-Apr-2011
Overdose of drug	-	16-Sep-2010	16-Sep-2010
[X]Intentional self-harm	overdose of drug	06-Jul-2009	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	21-Jun-2008	21-Jun-2008
Overdose of drug	-	02-Jul-2007	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	27-Oct-2003	27-Oct-2003
Suicide and selfinflicted injury	OVERDOSE	20-Feb-2000	20-Feb-2000
Single major depressive episode	-	20-Dec-1999	20-Dec-1999
Alcohol dependence syndrome	-	18-Jun-1999	18-Jun-1999
Suicide and selfinflicted injury	-	15-Jun-1999	15-Jun-1999
Haematemesis	Mild	14-Jan-1999	14-Jan-1999
Suicide and selfinflicted injury	-	10-Aug-1998	10-Aug-1998
Suicide and selfinflicted injury	-	29-May-1998	29-May-1998
Suicide and selfinflicted injury	-	01-Jan-1993	01-Jan-1993
Single major depressive episode	-	20-Oct-1990	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed	Date recorded
Mammography normal	15-Dec-2021	15-Dec-2021

Family conditions (All priorities)

Description	Comment	Date of Onset
FH: MI- Myocardial infarct <60 (Father, Sister)	07-Jul-2015	
No family history diabetes	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008

FH: Ischaemic heart dis. <60 Disease: SPICE Basic Health Values, priority=2 02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Anoro Ellipta Dry Powder Inhaler 55 micrograms + 22 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	24-Nov-2022	13-Feb-2023
Peppermint Oil E/c capsules 0.2 ml	84	84 capsule	ONE TO BE TAKEN THREE TIMES A DAY BEFORE FOOD	-	25-Feb-2020	24-Feb-2023
Salbutamol Breath-Actuated Inhaler (Cfc-Free) 100 micrograms/dose	1	1 inhaler	ONE OR TWO PUFFS TO BE INHALED WHEN REQUIRED	-	06-Feb-2019	08-Feb-2023
Fluoxetine Hydrochloride Capsules 20 mg	168	168 CAPSULE	3 DAILY DISP MONTHLY	-	17-Sep-2018	07-Mar-2023
Omeprazole Capsules (Gastro-Resistant) 20 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	02-Feb-2023
Bisoprolol Fumarate Tablets 1.25 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	24-Feb-2023
Isosorbide Mononitrate M/R capsules 25 mg	56	56 capsule	ONE TO BE TAKEN EACH DAY	-	06-Sep-2018	01-Feb-2023
Thiamine Tablets 50 mg	224	224 tablet	ONE TO BE TAKEN FOUR TIMES A DAY	-	23-Feb-2018	17-Feb-2023
Glyceryl Trinitrate Pump spray 400 micrograms/dose	200	200 dose	SPRAY ONE OR TWO DOSES UNDER THE TONGUE WHEN REQUIRED FOR CHEST PAIN AND THEN CLOSE MOUTH	-	31-Mar-2017	28-Nov-2022
Aspirin Dispersible tablets 75 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	24-Feb-2023
Simvastatin Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	09-Sep-2015	01-Feb-2023
Ramipril Capsules 2.5 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	17-Jan-2023
Diazepam Tablets 2 mg	56	56 TABLET	ONE TAB TWICE DAILY. DISP WEEKLY ON WEDNESDAY	-	03-Jun-2015	10-Mar-2023
Co-Dydramol 10/500 Tablets	120	120 TABLET	2 TABS UP TO 4 TIMES DAILY. MAX 8 TABS DAILY	-	27-Oct-2014	06-Mar-2023

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Dihydrocodeine Tablets 30 mg	28	28 tablet	ONE TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY	-	17-Feb-2023	17-Feb-2023
Doxycycline Hyclate Capsules 100 mg	6	6 CAPSULE	TWO TO BE TAKEN ON THE FIRST DAY THEN ONE TO BE TAKEN EACH DAY FOR 4 DAYS	-	08-Nov-2022	08-Nov-2022

Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY FOR 5 DAYS	-	31-Oct-2022	31-Oct-2022
Fluoxetine Hydrochloride Capsules 20 mg	28	28 CAPSULE	THREE TO BE TAKEN EACH DAY (TOTAL 60MG)	-	31-Oct-2022	31-Oct-2022
Dihydrocodeine Tablets 30 mg	28	28 tablet	ONE TO BE TAKEN EVERY FOUR TO SIX HOURS WHEN NECESSARY	-	31-Oct-2022	15-Dec-2022
Budesonide Aqueous nasal spray 64 micrograms/dose	1	1 SPRAY	TWO SPRAYS TO BE USED IN EACH NOSTRIL IN THE MORNING REDUCED TO ONE SPRAY IN EACH NOSTRIL IN THE MORNING WHEN CONTROL ACHIEVED	-	25-Oct-2022	25-Oct-2022
Incruse Ellipta Dry Powder Inhaler 55 micrograms/dose	60	60 DOSE	ONE DOSE TO BE INHALED ONCE DAILY	-	06-Feb-2019	10-Oct-2022

Blood Pressure

Date Recorded	Systolic	Diastolic
25-Oct-2019	140	70
25-Oct-2019	140	70
02-Oct-2019	143	85
29-Nov-2018	125	70
03-Aug-2017	120	60

Body Measurements

Date Recorded	Height	Weight	BMI
02-Feb-2023	-	77.3	32.59
25-Oct-2019	154	74	31.2
02-Oct-2019	154	-	-
02-Sep-2019	-	70	-
20-Mar-2019	-	70	-

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Not interested in stopping smoking:		25-Oct-2019
Cigarette smoker, 15 cigarettes/day:		25-Oct-2019
Cigarette smoker, 20 Cigarettes/day:		02-Oct-2019
Not interested in stopping smoking:		29-Nov-2018
Cigarette smoker, 20 cigarettes/day:		29-Nov-2018
Alcohol consumption, 0 units/week:		25-Oct-2019
Alcohol consumption, 0 units/week:		02-Oct-2019
Alcohol consumption, 0 units/week:		29-Nov-2018
Stopped drinking alcohol:		29-Nov-2018
Alcohol units per week 0 :		29-Nov-2018
Avoids even trivial exercise:		25-Oct-2019
Avoids even trivial exercise:		29-Nov-2018
GPPAQ physcl act ind: inactive:		29-Nov-2018
Avoids even trivial exercise:		03-Aug-2017
GPPAQ physcl act ind: inactive:		03-Aug-2017

Clinical warnings

Additional Support Needs
No known ASN requirements

Additional relevant information
Administrative information
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Referred By:Referring GP
Electronic Attachment Present:Yes

Social circumstances
Ethnic Origin: (White) Scottish

Gastroenterology - 09032023_Imaging Result - US Abdomen_353337

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gastroenterology GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital 133 Balornock Road Glasgow G21 3UW	——	**Hospital** and **hospital address** Hospital location code. G207H Email address -

Urgency of referral Routine
Date of referral 19-Jul-2018 **Date sent** 19-Jul-2018

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

Voice: 07754676886

1010165791875 | Unique Care Pathway Number: 1010165791875

REGISTERED GP DETAILS

Name	Dr Rosalyn Wilson		
GMC code	4696496	GP code	01406
Practice name	Lennoxtown Medical Practice (18862)		
Practice code	43261		

Practice address

Lennoxtown Medical Practice
Lennoxtown HUB
46 Main St
Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300
E-mail: c.gargano@nhs.net

REFERRING GP DETAILS

Name	Dr. Christopher Taylor

Practice address

Lennoxtown Hub
46 Main Street

GMC code	6071642	GP code	03581
Practice name	Lennoxtown Medical Practice (43261)		
Practice code	43261		

Lennoxtown
G66 7JJ

Contact number(s)

Voice: 01360 327300

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: persistent upper GI symptoms with mildly raised platelets of unknown origin

Comment: I would be grateful for your review of this 54 year old woman who has a long history of alcohol dependency but has been sober for 1 year now. She presented to us a couple of months ago with persistent tiredness aswell as upper GI symptoms consisting of bloating and acid reflux. She was found to have a positive helicobacter test and subsequently underwent eradication therapy. This gave her transient relief from her symptoms but they have since recurred. At that point she was also found to have a mildly raised platelet count which has persisted since then. Her last platelet count prior to this was July 2017. At which point it was normal.

Theresa admits she has a poor diet and undoubtedly some of her symptoms are probably due to this aswell as a degree of IBS. She says her appetite is not great but we have documented her weight is steady around the 65 kg mark. She smokes 20 cigs a day.

Examination of her abdomen was unremarkable.

I am concerned regarding her persistently raised platelet count given the recent information that has came out suggesting it could be an underlying marker for malignancy. My first thoughts were her lungs given her smoking history but a chest xray has been reported as normal. Given her GI symptoms I feel this does require further investigation and I would be grateful if you could review her and advise regarding this.

Dr Chris Taylor

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded
New onset angina	-	15-Jul-2015	15-Jul-2015
Adhesive capsulitis of the shoulder	-	13-Aug-2014	13-Aug-2014
Overdose of drug	-	16-Apr-2011	16-Apr-2011
Overdose of drug	citalopram	16-Apr-2011	16-Apr-2011
Overdose of drug	-	16-Sep-2010	16-Sep-2010
[X]Intentional self-harm	overdose of drug	06-Jul-2009	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	21-Jun-2008	21-Jun-2008
Overdose of drug	-	02-Jul-2007	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	27-Oct-2003	27-Oct-2003
Suicide and selfinflicted injury	OVERDOSE	20-Feb-2000	20-Feb-2000
Single major depressive episode	-	20-Dec-1999	20-Dec-1999
Alcohol dependence syndrome	-	18-Jun-1999	18-Jun-1999
Suicide and selfinflicted injury	-	15-Jun-1999	15-Jun-1999
Haematemesis	Mild	14-Jan-1999	14-Jan-1999
Suicide and selfinflicted injury	-	10-Aug-1998	10-Aug-1998
Suicide and selfinflicted injury	-	29-May-1998	29-May-1998
Suicide and selfinflicted injury	-	01-Jan-1993	01-Jan-1993
Single major depressive episode	-	20-Oct-1990	20-Oct-1990

Family conditions (All priorities)

Description	Comment	Date of Onset
FH: MI- Myocardial infarct <60 (Father, Sister)	07-Jul-2015	
No family history diabetes	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008
FH: Ischaemic heart dis. <60	Disease: SPICE Basic Health Values, priority=2	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Thiamine Tablets 50 mg	224	224 tablet	ONE TO BE TAKEN FOUR TIMES A DAY	-	23-Feb-2018	11-May-2018
Mebeverine Hydrochloride Tablets 135 mg	168	168 TABLET	ONE TO BE TAKEN THREE TIMES A DAY 20-30 MINS BEFORE MEALS	-	08-Jan-2016	06-Jun-2018
Aspirin Dispersible tablets 75 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	11-Jul-2018
Omeprazole Capsules (Gastro-Resistant) 20 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	25-Jun-2018
Simvastatin Tablets 40 mg	56	56 TABLET	ONE TO BE TAKEN AT NIGHT	-	09-Sep-2015	25-Jun-2018
Ramipril Capsules 2.5 mg	56	56 CAPSULE	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	11-Jul-2018
Bisoprolol Fumarate Tablets 2.5 mg	56	56 TABLET	ONE TO BE TAKEN EACH DAY	-	09-Sep-2015	11-Jul-2018
Diazepam Tablets 2 mg	56	56 TABLET	ONE TAB TWICE DAILY. DISP WEEKLY ON WEDNESDAY	-	03-Jun-2015	09-Jul-2018

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Amoxicillin Capsules 500 mg	28	28 capsule	2 CAP TWICE DAILY FOR 7 DAYS	-	16-May-2018	16-May-2018
Clarithromycin Tablets 500 mg	14	14 tablet	ONE TO BE TAKEN TWICE A DAY FOR 7 DAYS	-	16-May-2018	16-May-2018
Omeprazole Capsules (Gastro-Resistant) 20 mg	14	14 capsule	1 Cap Twice daily FOR 7 DAYS	-	16-May-2018	16-May-2018
Amoxicillin Capsules 500 mg	15	15 CAPSULE	ONE TO BE TAKEN THREE TIMES A DAY	-	23-Apr-2018	23-Apr-2018
Piroxicam Gel 0.5 %	112	112 gram	Rub into the affected site three to four times daily	-	23-Apr-2018	23-Apr-2018
Fluoxetine Hydrochloride Capsules 20 mg	56	56 CAPSULE	2 DAILY	-	02-Mar-2016	11-Jul-2018
Co-Dydramol 10/500 Tablets	100	100 tablet	2 TABS UP TO 4 TIMES DAILY. MAX 8 TABS DAILY	-	27-Oct-2014	11-Jul-2018

Blood Pressure

Date Recorded	Systolic	Diastolic
03-Aug-2017	120	60
14-Oct-2016	140	70
29-Feb-2016	140	70
29-Feb-2016	140	70
09-Sep-2015	121	68

Body Measurements

Date Recorded	Height	Weight	BMI
20-Nov-2017	-	65	-
03-Aug-2017	154	63	26.6
14-Oct-2016	154	58	24.46
29-Feb-2016	-	54	-

17-Feb-2016 154 54 -

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Cigarette smoker, 7 cigarettes/day:		03-Aug-2017
Current smoker:		03-Aug-2017
Heavy smoker - 20-39 cigs/day :	sober for 1 week,not sleeping ++.says she is hoping for detox soon-already on diazepam x1/day.coughing++.feels SOB.	20-Mar-2017
Heavy smoker - 20-39 cigs/day :	roll ups	14-Oct-2016
Cigarette smoker, 30 Cigarettes/day:		14-Oct-2016
Stopped drinking alcohol:		03-Aug-2017
Alcohol units per week 0 :		03-Aug-2017
Alcohol consumption, 40 units/week:		14-Oct-2016
Alcohol consumption, 40 units/week:		29-Feb-2016
Alcohol consumption, 60 units/week:		21-May-2013
Avoids even trivial exercise:		03-Aug-2017
GPPAQ physcl act ind: inactive:		03-Aug-2017
Aerobic exercise 0 times/week:		14-Oct-2016
Aerobic exercise 0 times/week:		29-Feb-2016
Aerobic exercise 0 times/week:		21-May-2013

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Referred By:Referring GP

Electronic Attachment Present:No

Social circumstances

Ethnic Origin: (White) Scottish

Signature of referring doctor (or other professional) **Date**

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Stobhill Hospital
133 Balornock Road
Glasgow
Lanarkshire
G21 3UW

Dept. Contact Details:
Tel:
Fax:
Email:

Date Completed: 27/12/2013

Consultant: Dr Neil Dignon

RM Wilson
Dr Rosalyn Wilson & Dr Christopher
Campsie Surgery lennoxtown clinic
103 Main Street
Lennoxtown
Glasgow
G66 7DA

Dear RM Wilson

Re: **Sinclair Theresa** DOB: **13/08/1963** CHI: **1308636407**
90a Main Street
Glasgow G66 7DA

Attended on: **27/12/2013 at 17:39 hrs.** Departed on: **at hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **3**

Presenting complaint
left arm inj

Nursing Assessment:

Investigations in ED:
1. XR Elbow Lt

Diagnosis:

Diagnosis	Side	Site
Contusion of elbow		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Followup :

Highly sensitive: N

Consent for sharing withheld: N

Yours sincerely,
Susannah McFarlane
Nurse

Copies to:

1. RM Wilson (GP)

School Address:

HOSPITAL INFORMATION MISSING



Dr JAMES HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET LENNOXTOWN

G66 7DA

Date : 13 Jan 2012

Dear Dr JAMES HENDERSON,

Re: TERESA SINCLAIR, 92 MAIN STREET, LENNOXTOWN, GLASGOW, G66 7DB
Date of Birth: 13/08/1963 CHI number: 1308636407

HOSPITAL INFORMATION MISSING Patient attended on the 13 Jan 2012.

The presenting complaint was:	**ASSAULTED**
Triage information:	**ADMITS ALCOHOL. C/O RIGHT HAND NUMBNESS. NO WEAKNESSES. ALSO C/O ABDO DISTENDED. STATES HAS STOPPED DRINKING FOR 6MONTHS AND HAS DRANK TONIGHT.**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**

At the conclusion of treatment the patient was:	**PATIENT LEFT BEFORE BEING TREATED**
Follow-up:	**NOT KNOWN**
Additional information:	**None**

Yours sincerely,

NONE ASSIGNED IN EDIS

NONE ASSIGNED IN EDIS

HOSPITAL INFORMATION MISSING



Dr JAMES HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET LENNOXTOWN

G66 7DA

Date : 28 Dec 2010

Dear Dr JAMES HENDERSON,

Re: TERESA SINCLAIR, 90A MAIN STREET, LENNOXTOWN, GLASGOW, G66 7DA
Date of Birth: 13/08/1963 CHI number: 1308636407

HOSPITAL INFORMATION MISSING Patient attended on the 28 Dec 2010.

The presenting complaint was:	**OD**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**NONE ASSIGNED IN EDIS**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**PATIENT REFUSED TREATMENT**

Follow-up: **NOT KNOWN**

Additional information: **None**

Yours sincerely,

NONE ASSIGNED IN EDIS

NONE ASSIGNED IN EDIS

HOSPITAL INFORMATION MISSING



Dr JAMES HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET LENNOXTOWN

G66 7DA

Date : 16 Sep 2010

Dear Dr JAMES HENDERSON,

Re: TERESA SINCLAIR, 90A MAIN STREET, LENNOXTOWN, GLASGOW, G66 7DA
Date of Birth: 13/08/1963 CHI number: 1308636407

HOSPITAL INFORMATION MISSING Patient attended on the 16 Sep 2010.

The presenting complaint was:	**MED CAS. OD**
Triage information:	**Not recorded**
The following investigations were carried out:	**None**
The A&E diagnosis was:	**INTENTIONAL SELF HARM - ANTI-DEPRESSANT**
The following treatment was given:	**None**
At the conclusion of treatment the patient was:	**ADMITTED**

Follow-up: **ADMITTED**

Additional information: **None**

Yours sincerely,

GURJEET MINHAS

EMERGENCY DEPARTMENT DOCTOR

Acute Services Division

Surgery and Anaesthetics Directorate

NHS
Greater Glasgow and Clyde

Department of General Surgery

Digestive Diseases Directorate
Surgical Division
Stobhill Hospital
133 Balornock Road
GLASGOW G21 3UW

Mr D Hansell
General Surgical Clinic
Symptomatic One Stop Breast Clinic
Combined Surgery/Oncology Breast Clinic
Breast Family History Clinic

Clinic	27/05/2010
Dictated	28/05/2010
Typed	
Our Ref	MR/LM
Clinic Co-ordinator	0141 201 3000 Page 4232
Secretary	0141 355 1506

Dr James Henderson
Campsie Surgery, Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

I reviewed this lady today at Mr Hansell's Clinic.

As you know she has been seen by Miss Sylvia Brown in March 2010. She had had a lump in her right breast. She had a Mirena IUS in situ and has since had that removed. She feels the pain has gone and she feels the lump is much less obvious.

On examination today there was nothing palpable in either breast. The area that the patient pointed to was at around 10-12 o'clock in the right breast. There was in fact some difficulty in finding this area again. This all felt like normal breast tissue. It was symmetrical and felt exactly the same as the left side. I could find no discrete areas of concern today. No axillary lymph nodes and no lymphadenopathy. I discussed this fully with her at the clinic. As you know she had a normal mammogram and ultrasound in March. There was nothing that could be biopsied and certainly I was not concerned about anything today. I have discussed this fully with her at the clinic. She was reassured by this. I understand that she has a court case pending and has recently had two grandchildren, one of whom has spina bifida and one has downs syndrome. She was obviously very anxious today but atytributed it to returning to the clinic and these three family concerns.

I have obviously asked her to keep an eye on things and to see her GP should there be any further concerns. She was quite happy to do this. I am happy to discharge her today.

Thank you for your help.

Yours sincerely

DR MARY ROUSE
Specialty Doctor

Acute Services Division

Surgery and Anaesthetics Directorate

Department of General Surgery

Mr D Hansell
General Surgical Clinic
Symptomatic One Stop Breast Clinic
Combined Surgery/Oncology Breast Clinic
Breast Family History Clinic

Clinic 09/03/2010
Dictated 09/03/2010
Typed 10/03/2010
Our Ref SB/MJS
Clinic Co-ordinator 0141 201 3000 Page 4232
Secretary 0141 355 1506

Digestive Diseases Directorate
Surgical Division
Stobhill Hospital
133 Balornock Road
GLASGOW G21 3UW

NHS Greater Glasgow and Clyde

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Thank you for referring this lady to the Breast Clinic.

She is 46 and has had a lump in her right breast for many months. Initially, it was sore and it is now not so painful. She has a Mirena coil in-situ and is pre-menopausal. She has no family history of breast cancer.

On examination she does have bilateral fibrocystic change locally at 12 o'clock in both breasts. In the right breast there is a small, 1cm lump within this area of fibrocystic change. Mammogram showed moderately dense breasts and the right breast ultrasound showed no real abnormality in this area. I do not think there is anything to be concerned about and I suspect that things could change in this area of fibrocystic change and the lump may become less prominent. I therefore think we should see her in the clinic in 2 months time and only perform a biopsy if the lump is still palpable.

I have reassured her thoroughly and we will see her in the clinic in due course.

Yours sincerely

Miss Sylvia Brown
ST4

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

General Surgery - Breast GGC General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital 133 Balornock Road Glasgow G21 3UW	——	**Hospital** and **hospital address** Hospital location code. G207H Email address -

Urgency of referral ROUTINE
Date of referral 01-Feb-2010 **Date sent** 02-Feb-2010

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

-

1010001597851

Unique Care Pathway Number: 1010001597851

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)

Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		

Practice address

103 MAIN STREET
LENNOXTOWN

Contact number(s)

Practice code	43261	Voice: 01360310357

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Breast Clinic

Comment: This lady, 46, has a small mobile lump above her (R) nipple. It has been present for approximately 6/12.

O/E - No skin tethering or nipple changes. No axillary lymphadenopathy. Small firm lump approximately 1 x 1 cm.

Thanks for seeing her.

Dr Jill Carmichael

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset
[X]Intentional self-harm	overdose of drug	-	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	-	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	-	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	OVERDOSE	-	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	-	Mild	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed
Introduction of Mirena coil	30-Aug-2009
Female sterilisation op.NOS	03-Sep-2001
CLO test negative	26-Aug-1998

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. <60	02-Apr-2008
No family history diabetes	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003	-

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Ferrous Sulphate	60	TABS 200MG	Half Tab	Twice daily	29-Dec-2009	-

Citalopram	28	TABS 20MG	1 Tab	In the morning	21-Dec-2009	-
Citalopram	28	TABS 20MG	1 Tab	In the morning	05-Nov-2009	-
Citalopram	28	TABS 20MG	1 Tab	In the morning	06-Oct-2009	-
Chlordiazepoxide	15	CAPS 5MG	1 Cap 3 times daily	dispense daily	25-Sep-2009	-
Chlordiazepoxide	15	CAPS 5MG	1 Cap 3 times daily	dispense daily	15-Sep-2009	-
Chlordiazepoxide	15	CAPS 5MG	1 Cap	3 times daily	10-Sep-2009	-
Temazepam	5	TABS 20MG	1 Tab nocte	dispense daily	31-Aug-2009	-
Temazepam	10	TABS 20MG	1 Tab nocte	dispense daily	20-Aug-2009	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		27-Jul-2009
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
Alcohol intake above recommended sensible limits:		27-Jul-2009
unknown:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Previous Surname:Jenkins

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-6 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Acute Services Division

Emergency Care and Medicine Services Directorate

Department of Respiratory Medicine

Dr Bucknall

Stobhill Hospital
Balornock Road
GLASGOW G21 3UW
Switchboard: 0141 201 3000
Direct Dial: 0141 201 3717

NHS Greater Glasgow and Clyde

Consultant Physicians:

Dr Robert Milroy — Robert.milroy@ggc.scot.nhs.uk
Dr Christine E Bucknall — Christine.bucknall@ggc.scot.nhs.uk
Dr Eric Livingston — Eric.livingston@ggc.scot.nhs.uk

Typed 17/07/2009
Dictated 16/07/2009
Your Ref
Our Ref LC/AMMCK

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Admitted 06.07.09 Irregular Discharge 06.07.09

Consultant: Dr C Bucknall

Diagnosis: Overdose of Temazepam and alcohol

Follow Up: Nil

This 45 year old lady was brought to Casualty via Ambulance with a GCS of 11 following an overdose of approximately 80mg Temazepam on a background of alcohol excess. I understand that her partner had recently had been killed in a RTA.

She required no specific treatment besides iv fluids and post observations. However by the early hours of the morning the patient had woken up and refused to stay in hospital for further assessment. She was assessed by the junior doctor prior to discharge and did not demonstrate any ongoing suicidal ideation.

Yours sincerely

LYN CORRY
SPR3

Dr C Bucknall
Consultant Physician and Gastroenterologist

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology G General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital	——	**Hospital** and **hospital address** Hospital location code. G207H Email address -

Urgency of referral ROUTINE
Date of referral 09-Jun-2009 **Date sent** 10-Jun-2009

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

-

**	Unique Care Pathway Number:

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)

Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		

Practice address

103 MAIN STREET
LENNOXTOWN

Contact number(s)

Practice code	43261	Voice: 01360310357

CLINICAL INFORMATION

History of presenting complaint

Presenting complaint

Description: heavy periods

Comment: This 45 year old lady has been troubled by heavy periods for several months. Clinical exam and smear are normal.
FBC.....Hb 116 g/dl
She has tried Tranexamic Acid without marked success. Could you see her and perhaps discuss Mirena IUS?
She missed a previous appointment but is keen to have your advice.

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset
Overdose of drug	DIAZEPAM AND ALCOHOL	-	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	-	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	OVERDOSE	-	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	-	Mild	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed
Female sterilisation op.NOS	03-Sep-2001
CLO test negative	26-Aug-1998

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. <60	02-Apr-2008
No family history diabetes	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003	-

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
teetotal:		02-Apr-2008
teetotal:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Previous Surname:Jenkins

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-21 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Hospital use only	Clinic	Day Date	Time	Hospital No.

	REFERRAL LETTER MEDICAL IN CONFIDENCE	**Attachments**

Additional Support Needs:
No known ASN requirements

REFERRAL TO

Gynaecology G General Referral	——	**Consultant / receiving practitioner** and/or **specialty clinic**
Stobhill Hospital	——	**Hospital** and **hospital address** Hospital location code. G207H Email address -

Urgency of referral ROUTINE
Date of referral 10-Dec-2008 **Date sent** 12-Dec-2008

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Area of Residence	-

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)
-

**	Unique Care Pathway Number:

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)
Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		

Practice address

103 MAIN STREET
LENNOXTOWN

Contact number(s)

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: heavy periods

Comment: This 45 year old lady has been troubled by heavy periods for several months. Clinical exam and smear are normal. FBC ..... Hb 116g/dl.
She has tried Tranexamic Acid without marked success. Could you see her and perhaps discuss Mirena IUS?

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history
Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset
Overdose of drug	DIAZEPAM AND ALCOHOL	-	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	-	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	OVERDOSE	-	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	-	Mild	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed
Female sterilisation op.NOS	03-Sep-2001
CLO test negative	26-Aug-1998

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. <60	02-Apr-2008
No family history diabetes	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003	-

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Chlordiazepoxide	21	CAPS 5MG	1 Cap	3 times daily	05-Dec-2008	-
Tranexamic Acid	60	TABS 500MG	2 Tabs	3 times daily	20-Nov-2008	-
Buscopan	56	TABS 10MG	1 or 2 Tabs	3 times daily	15-Oct-2008	-

Buscopan	56	TABS 10MG	1 or 2 Tabs	3 times daily	28-Jul-2008	-
Vapour-Permeable Adhesive Film Dressing With Absorbent Pad	20	Mepore Ultra 6cmx7cm	-	-	24-Jul-2008	-
Buscopan	56	TABS 10MG	1 or 2 Tabs	3 times daily	27-Jun-2008	-

Blood Pressure

No Blood Pressures Recorded

Body Measurements

No Body Measurements Recorded

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
teetotal:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Clinical warnings

Additional Support Needs

No known ASN requirements

Additional relevant information

Administrative information

Previous Surname:Jenkins

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-21 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

CHI: 1308636407

Stobhill Hospital

Total Att: **16**

12 Mth Att: **3**

Title: **MS**

SINCLAIR **Theresa**

DOB: **13/08/1963** Age: **50y** Sex: **Female**

90a Main Street
Lennoxtown
Glasgow
G66 7DA

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 310357

Attendance Date: **27/12/2013** Arrival Time: **17:39**

Registration Time: **17:39** Date of Incident: **27/12/2013**

Major Incident Desc:

Reason for Attendance: **left arm inj**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **27/12/2013 17:42** Nurse name: **Nurse Susannah McFarlane**

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

BM		mmol/L
PF		l/min
Expected PF		l/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:

Stobhill Hospital
27/12/13 E-28106290
SINCLAIR, Theresa
G207HMIU 13/08/1963

AccNo: G207H28639645

1308636407 13/08/1963
SINCLAIR
Theresa

1308636407 13/08/1963
SINCLAIR
Theresa

1308
SINC
Ther

3/08/1963

27/12/13 1755

Meds Co-codamol
Fluoxitine
Diazepam

PMH IBS
depression

allegies NIL

HPC Patient on antibiotics - for dental problem - started these today. fell in the house this am - injured left arm - fell against table + ashtray which broke.

O/E No wounds - scrape on left elbow. Lateral aspect of lower end of humerous, full range of movement circulation and sensation intact, slight tenderness olecranon, can full extend flex pronate supinate can raise arm to 180° no bony tenderness clavicle, Shoulder, humerous, wrist, hand or scaphoid no parasthesia, no heat, redness, slight swelling just above elbow, no bruising

Ix Cannula & Xray left elbow
NBI

Advice Re Xray checking system

discharge
Patient has own analgesia

ENP
Susan McFarlane

CHI: 1308636407

Stobhill Hospital

Total Att: **14**

12 Mth Att: **1**

Title: **MS**

SINCLAIR **Teresa**

DOB: **13/08/1963** Age: **50y** Sex: **Female**

908 Main Street
LENNOXTOWN
Glasgow
Lanarkshire
G66 7DB

Next of kin: **JENKINS, TERESA**
Relationship: **Daughter**
078876623809

GP: **RM Wilson**
01360 310357

Attendance Date: **04/10/2013** Arrival Time: **16:22**

Registration Time: **16:22** Date of Incident: **04/10/2013**

Major Incident Desc:

Reason for Attendance: **dog bite to face**

Nursing Assessment

Alerts: **Not Recorded** Allergies: **Not Recorded** Pain Score:

Triage Category: **0** Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **04/10/2013 16:26** Nurse name: **Nurse Sharon Walker**

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

BM		mmol/L
PF		l/min
Expected PF		l/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:

REVAXIS®
PA:544/35/1
PL:06745/0123
Batch: H7185-1
EXP: 09-2014

1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa
1308636407 13/08/1963 SINCLAIR Teresa

HPC: Dog Bite today on Nose.
Superficial wound side of nose.

C/O Dog Bite
Patient has been drinking ~~alot~~.
Patient states unsure if ever had any tetanus.
Went to phone G.P. practise - Patient left room, out into waiting area.
Contacted G.P. No record of any immunisation.
Patient called back into room.
ATT Booster given.

Audrey Mitchell

US Abdomen and pelvis

Performed	05-Dec-2025 11:16	Received	05-Dec-2025 12:10
Reported	05-Dec-2025 12:08	Order Number	G207H42914149
Status	Final	Source System	MiSys

US Abdomen and pelvis Final
Theresa Sinclair
Clinical History :
increased abdominal girth - PMH alcohol XS UE . LFTs normal, Ca125 awaited. right lower back pain, ? ovarian pathology

US Abdomen and pelvis :

The liver appears enlarged and echobright in keeping with fatty infiltration. There is evidence of focal fatty sparing adjacent to the gallbladder fossa.
No evidence of focal lesions. The portal vein is patent with normal flow direction.

Normal appearances of: gallbladder, CBD, both kidneys and spleen.
Pancreas and aorta not visualised.
No free fluid.

No PMB or HRT. Para 4.
Transabdominal scan performed.

Normal appearances of anteverted uterus with no focal myometrial lesions.
Normal endometrium.
As best seen normal right ovary.
Left ovary not visualised.
No adnexal masses or cysts.
No free fluid.
The bladder outlines normally.

Summary:
Fatty liver.

Scanned and reported by Emma Lawrie, Sonographer.

Reported by: Emma Lawrie (Sonographer)
Verified by: Emma Lawrie (Sonographer)

XR Chest

Performed	24-Nov-2025 12:25	Received	25-Nov-2025 13:19
Reported	25-Nov-2025 13:17	Order Number	G207H42925901
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

COPD, cough, SOB, serial CR cystic changes, third course antibiotics,

XR Chest :
Comparison is made with the previous film of 10/06/2025 and the CT of 25/03/2025, 25/09/2024, 23/05/2024 and 12/10/2015. Normal heart and mediastinal contour. No pleural effusions. No new focal lung pathology. There is a small faint ill-defined opacity projected between the anterior ends of the right first and second ribs in keeping with the more lateral right upper lobe abnormality seen on CT. The bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

US Kidney Both

Performed	23-Sep-2025 12:00	Received	23-Sep-2025 12:23
Reported	23-Sep-2025 12:21	Order Number	G207H42687766
Status	Final	Source System	MiSys

US Kidney Both Final
Theresa Sinclair
Clinical History :

haematuria ?rcc

US Kidney Both :
Examination performed by Angela Street, sonographer.

Both kidneys appear normal with no gross cortical scarring, renal calculi or hydronephroses seen, the right kidney measures 10.2 cm and the left kidney 9.9 cm.

Impression: No renal pathology seen.

Reported by: Angela Street (Sonographer)
Verified by: Angela Street (Sonographer)

XR Chest

Performed	23-Dec-2024 12:49	Received	23-Dec-2024 15:20
Reported	23-Dec-2024 15:18	Order Number	G207H41736291
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

worsening cough and SOB, CT - cystic abnormalities, smoker, chest seems clear

XR Chest :
Comparison is made with the previous film of 12/04/2024 and the CT of 25/09/2024.Normal heart and mediastinal contour. The lungs are clear and the bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

XR Pelvis

Performed	07-Jun-2024 13:51	Received	19-Jun-2024 16:34
Reported	19-Jun-2024 16:32	Order Number	G207H41034257
Status	Final	Source System	MiSys

XR Pelvis Final
Theresa Sinclair
Clinical History :

GP APP request PH53224 - In April had flare up L hip pain referring to the knee. Recent acute exacerbation again which kept her up for 2 nights. Settling a bit now on strong PKs from GP, but sore around posterior/lateral/anterior hip, thigh to knee at times. Please assess for osteoarthritis.

XR Pelvis :
There is minor degenerative change affecting the left hip joint predominately central with normal appearances of the right hip joint, SI joints and pubic symphysis.
Additional degenerative changes identified affecting the lower lumbar spine.
Presumed sterilisation clips projected over both sides of pelvis.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

XR Chest

Performed	08-Jan-2024 13:01	Received	09-Jan-2024 07:34
Reported	09-Jan-2024 07:32	Order Number	G207H40481093
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

Chronic cough - known COPD - brown sputum. SOBOE. Smoker - lifelong

XR Chest :
The heart is not enlarged. The lungs are clear of active disease. No significant focal lung lesion identified. There are coarse lung markings and emphysematous changes in keeping with the smoking history.

Reported by: Dr Sean Kelly
Verified by: Dr Sean Kelly

MRI Liver with contrast

Performed	04-Apr-2023 10:48	Received	12-Apr-2023 14:06
Reported	12-Apr-2023 14:04	Order Number	G207H39463508
Status	Final	Source System	MiSys

MRI Liver with contrast Final
Theresa Sinclair
Clinical History :

USOC referral 3cm isoechoic lesion left lobe liver - sonographer says unknown aetiology could be malignant normal lfts

MRI Liver with contrast :
Comparison is made with the ultrasound exam from March 2023. Standard sequences with Multihance contrast.

The liver is of normal morphological appearance. No focal abnormality is identified. The possible lesion identified on ultrasound is not visible on MR.

Reported by: Dr Stuart Ballantyne
Verified by: Dr Stuart Ballantyne

US Abdomen

Performed	09-Mar-2023 10:04	Received	09-Mar-2023 12:04
Reported	09-Mar-2023 12:02	Order Number	G207H38882998
Status	Final	Source System	MiSys

US Abdomen Final
Theresa Sinclair
Clinical History :
Prev alcohol excess. Raised GGT. Enlarged liver felt on exam. ?NAFLD.

US Abdomen :
Within the left lobe of liver there is a subtle isoechoic well circumscribed focus measuring 3x3cm, which distorts the contour of the liver. No vascularity identified.
Otherwise the remaining liver parenchyma appears marginally echobright suggestive of fatty infiltration. Patent portal vein. No ascitic free fluid.
The spleen is not enlarged.

The gallbladder appears thin walled with no evidence of gallstones. Normal calibre of common duct with no intrahepatic duct dilatation.

The pancreas, both kidneys and aorta appear grossly normal.

Comment: Within the left lobe of liver there is a subtle isoechoic focus measuring 3x3 cm which distorts the contour of the liver. Aetiology of this is unknown. A sinister cause cannot be excluded. Hepatology opinion would be advised with a view to further imaging for characterisation.

Performed and reported by Lynne Cassidy (sonographer).

Reported by: Lynne Cassidy (Sonographer)
Verified by: Lynne Cassidy (Sonographer)

XR Chest

Performed	13-Sep-2022 13:13	Received	28-Sep-2022 16:34
Reported	28-Sep-2022 16:32	Order Number	G207H38840761
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

Sweats. Ex-smoker. ?pulmonary pathology

(Information via Order Comms)

XR Chest :
The heart is not enlarged, the lungs are clear.

Reported by: Dr John Shand
Verified by: Dr John Shand

XR Chest

Performed	03-Jan-2019 16:09	Received	04-Jan-2019 10:02
Reported	04-Jan-2019 10:00	Order Number	G207H34628425
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :

Smoker. Persistent cough for >6 weeks. no haemoptysis or weight loss. chest clinically clear. ? underlying lung pathology

XR Chest :
Comparison made with the previous examination of 26/06/2018 and older previous chest x-rays.

The heart is not enlarged. Unchanged hilar and mediastinal contours. There is no evidence of focal active pulmonary disease with no new pulmonary abnormality seen on comparison with the previous examinations.

Reported by: Dr Fiona Bryden
Verified by: Dr Fiona Bryden

XR Chest

Performed	26-Jun-2018 16:14	Received	04-Jul-2018 10:04
Reported	04-Jul-2018 10:02	Order Number	G207H34008865
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :
Smoker with persistent thrombocytosis.

XR Chest :
No change when compared with the previous film of 30/06/2017. Normal heart and mediastinal contour. The lungs are clear and the bony thorax is intact.

Reported by: Dr Colin Noble
Verified by: Dr Colin Noble

US Abdomen

Performed	18-Sep-2017 18:21	Received	18-Sep-2017 18:34
Reported	18-Sep-2017 18:32	Order Number	G207H32955396
Status	Final	Source System	MiSys

US Abdomen Final
Theresa Sinclair
Clinical History :
Long history of alcohol misuse. Reports abdominal swelling. Ascites? LFTs normal.

US Abdomen :
The liver is normal in size shape and echogenicity. No evidence of intra or extrahepatic ductal dilatation, common bile duct measured 4 mm thin walled gallbladder; no evidence of calculi. The pancreas, spleen, aorta and both kidneys appear within normal limits. No free fluid. Examination performed and reported by Carine Stirling consultant Sonographer.

Reported by: Carine Stirling (Cons Sonographer)
Verified by: Carine Stirling (Cons Sonographer)

XR Chest

Performed	30-Jun-2017 15:42	Received	13-Jul-2017 11:51
Reported	13-Jul-2017 11:49	Order Number	G207H32805077
Status	Final	Source System	MiSys

XR Chest Final
Theresa Sinclair
Clinical History :
Recent ex-smoker. Productive cough. Fatigue. Chest clinically clear. Lung pathology?

XR Chest :
The heart is not enlarged. Normal hilar and mediastinal contours. There is no evidence of focal active pulmonary disease with no new abnormality seen on comparison with the previous examination of 16/04/2011.

Reported by: Dr Fiona Bryden
Verified by: Dr Fiona Bryden

US Abdomen

Performed	21-Jun-2016 16:58	Received	21-Jun-2016 17:14
Reported	21-Jun-2016 17:12	Order Number	G207H31325371
Status	Final	Source System	MiSys

US Abdomen Final
Theresa Sinclair
Clinical History :
History of alcohol dependence and right upper quadrant pain. LFTs normal. Liver/gallbladder pathology?.

US Abdomen :
No significant abnormality demonstrated in the liver or biliary tree. Common bile duct measured 4 mm. Thin walled gallbladder; no evidence of calculi. The pancreas, spleen, aorta and both kidneys appeared within normal limits. No free air fluid.
Examination performed and reported by Carine Stirling consultant Sonographer.

Reported by: Carine Stirling (Cons Sonographer)
Verified by: Carine Stirling (Cons Sonographer)

US Shoulder Rt

Performed	16-Aug-2014 10:52	Received	16-Aug-2014 11:31
Reported	16-Aug-2014 11:29	Order Number	G207H29299710
Status	Final	Source System	MiSys

US Shoulder Rt Final
Theresa Sinclair
Clinical History : large right shoulder weeks ago with pain and limited movement

The long head of biceps tendon is intact and appears normal. There is a small amount of fluid in the biceps sheath and there is soft tissue thickening in the proximal biceps sheath.

The subscapularis is intact and heterogeneous is showing some small mid substance splits and a small split is seen at the insertion of the tendon of the first articular surface.

The supraspinatus tendon is mildly thickened in appearance and heterogeneous. In the mid tendon region on the articular surface there is a small tendon split measuring 5 mm in diameter.

The infraspinatus tendon appears normal.

There is with mild bursal thickening. There is some soft tissue thickening in the rotator cuff interval region. Combined with the patient's poor arm abduction this appearance is suggestive of adhesive capsulitis.

Scanned and reported by Barbara Symes
Locum Sonographer

Reported by: Barbara Symes (Locum Sonographer)
Verified by: Barbara Symes (Locum Sonographer)

XR Elbow Lt

Performed	27-Dec-2013 18:11	Received	28-Dec-2013 15:11
Reported	28-Dec-2013 15:09	Order Number	G207H28639645
Status	Final	Source System	MiSys

XR Elbow Lt Final
Theresa Sinclair
Clinical History :
Fall. Injured left elbow. Tender olecranon. Fracture?

XR Elbow Lt :
No evidence of acute bony injury.

Code A: Agreement: No major discrepancy between the radiologist report and the referrer's 'sticky note' interpretation.

Reported by: Dr Catriona Turbet (SpR)
Verified by: Dr Catriona Turbet (SpR)

US Pelvis

Performed	30-Jul-2012 15:27	Received	30-Jul-2012 16:00
Reported	30-Jul-2012 15:38	Order Number	G207H27101260
Status	Final	Source System	MiSys

US Pelvis Final
Teresa Sinclair
Clinical History :
abdo swelling

The uterus is anteverted and of normal size. The endometrium is not thickened. No obvious uterine pathology is noted.

Both ovaries are of normal size and morphology.

No adnexal mass, no free fluid.

Reported by: Pei Chee Wong(locum)
Verified by: Pei Chee Wong(locum)

US Abdomen

Performed	05-Jan-2012 09:24	Received	12-Jan-2012 12:38
Reported	12-Jan-2012 12:16	Order Number	G207H26466339
Status	Final	Source System	MiSys

US Abdomen Final
Teresa Sinclair
Clinical History : Pain right upper quadrant and positive Murphy's sign.

US Abdomen : Unfortunately the patient has eaten prior to the examination but the gallbladder is well seen and appears distended and thin-walled with no calculi seen in the lumen. The common duct is of normal calibre. There is no intrahepatic biliary dilatation. The liver parenchyma appears of normal echogenicity with no focal lesion seen. The pancreas is partially obscured but no obvious masses or duct distension was seen.
Portal flow was antegrade and the spleen of normal size.
The kidneys and aorta are normal. There is no ascites.

Summary: No evidence of gallstones or biliary obstruction was seen.

Reported by: Elliot Craig (Sonographer)
Verified by: Elliot Craig (Sonographer)

XR Mammogram Both

Performed	09-Mar-2010 09:53	Received	11-Mar-2010 16:44
Reported	11-Mar-2010 16:24	Order Number	G207H13616856
Status	Final	Source System	MiSys

XR Mammogram Both Final
Teresa Sinclair
Clinical History : Patient complaining of right breast lump. On examination today at approximately 12 o'clock within the right breast there is a 1 x 1 cm lobular breast tissue. This is graded P2. It is within an area of P2 fibrocystic change.

XR Mammogram Both :
There is a moderately dense breast parenchyma. No significant abnormality demonstrated in either breast. R1.

US Breast Rt :
NAD - U1.

Reported by: LINDSEY LEEN (Radiog) and DR NF DAWSON
Verified by: LINDSEY LEEN (Radiog)

US Breast Rt

Performed	09-Mar-2010 09:53	Received	11-Mar-2010 16:44
Reported	11-Mar-2010 16:24	Order Number	G207H13617993
Status	Final	Source System	MiSys

XR Mammogram Both Final
Teresa Sinclair
Clinical History : Patient complaining of right breast lump. On examination today at approximately 12 o'clock within the right breast there is a 1 x 1 cm lobular breast tissue. This is graded P2. It is within an area of P2 fibrocystic change.

XR Mammogram Both :
There is a moderately dense breast parenchyma. No significant abnormality demonstrated in either breast. R1.

US Breast Rt :
NAD - U1.

Reported by: LINDSEY LEEN (Radiog) and DR NF DAWSON
Verified by: LINDSEY LEEN (Radiog)

XR Chest

Performed	06-Jul-2009 04:50	Received	08-Jul-2009 17:29
Reported	08-Jul-2009 08:25	Order Number	G207H13059365
Status	Final	Source System	MiSys

XR Chest Final
Teresa Sinclair
Clinical History : Hypoxia.

XR Chest : The film was taken in an AP erect position. The film was also rotated. There are thought to be increased markings in the mid and lower zones. There may also be some slight upper zone pulmonary venous congestion. The appearances seen are non specific and may represent CCF and/or infection and follow up is advised.

Reported by: DR IA MACLEOD and BLANK RADIOL
Verified by: DR IA MACLEOD

Colonoscopy report

Performed	11-Feb-2025 14:06	Received	11-Feb-2025 14:11
Reported	11-Feb-2025 14:11	Order Number	UNI360749-1308636407
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
COLONOSCOPY REPORT

Name: **Theresa SINCLAIR (F)**
Date of birth: **13/08/1963**
NHS No: **1308636407**
Case Note No: **1308636407**

Address: **90a Main Street**
Lennoxtown
Glasgow
G66 7DA

GP: **WILSON, ROSALYN**
Lennoxtown Medical Practice
Lennoxtown Hub
46 Main Street
Lennoxtown
G66 7JJ

Procedure date: **11th February 2025 (14:06)**
Attachments:
Ileocecal valve_1
Appendiceal orifice_1
Terminal ileum_1
Distal sigmoid_1
Anal margin_1
Anal margin_2
Distal sigmoid_2

Elective
Outpatient/NHS
STO ACH
Ward - Not specified
GP (Direct Access)

Priority:
Status:
Hospital:
Ward:
Referring Cons:

Indications
Qfit 36, alternating bowel habit,.

Consultant/Endosc
Sister EMMA MA

Report
Bowel preparation with 2 moviprep was satisfactory. A digital rectal examination was performed.
The colonoscope was inserted via the anus to the terminal ileum. The caecum was identified positively by the ileocecal valve, the appendicular orifice, the tri-radiate caecal fold and ileal intubation. The scope was retroflexed in the rectum. There were no peri-operative complications.

Site d: An area extending from the proximal descending to the distal sigmoid

Instrur
SCANT

Premedica
Fentanyl (IV) 5
Midazolam (IV)

Diverticula: a few scattered with mucosal inflammation.
Site e: Distal sigmoid
Lesions: 1 sessile polyp (IIa, pit type IIIs) (3mm) excised (removed using partial snare), retrieved and sent to labs.Injection: Isoflex:Adrenaline:indigo carmine.Specimens: Polyps.

Diagnoses

Diverticulosis, diverticulitis and colonic polyp.

Advice/Comments

Scope passed to TI.
Scattered diverticulosis with some very small scattered patches of congestion in left colon.
Small SSL removed as above.
Will write out with histology.

Follow up

Awaiting pathology results.

Sister EMMA MAGUIRE
Colorectal Nurse Endoscopist
c.c. GP (Direct Access)

Produced by Unisoft's GI Reporting Tool Compiled on 11/02/2025 at

Department of Respiratory Medicine
Stobhill ACH
Pulmonary Function Report

NHS Greater Glasgow and Clyde

CHI:	**1308636407**				
Last Name:	**Sinclair**	**Height:**	**153 cm**	**Physician:**	**Dr Maclay J**
First Name:	**Theresa**	**Weight:**	**77.2 kg**	**Ward:**	**GRI Lab 1**
Date of Birth:	**13/08/1963**	**BMI:**	**33 kg/m²**	**Smoking status:**	**Smoker**
Age:	**62 Years**	**Race:**	**Caucasian**	**Smoking pk-yrs:**	
Gender:	**female**	**Pred. Module:**	**GLI_ECCS**	**Physiologist:**	**Speake L**
Visit date:	**08/04/2026**	**Indication:**	**NCU**		

Note GLI ethnic correction only adjusts for spirometry.

***SR Range** Normal +/- 1.64 to 1.64 Mild +/- 1.65 to 2.50 Moderate +/- 2.51 to 3.99 Severe +/- >4.00*

Spirometry

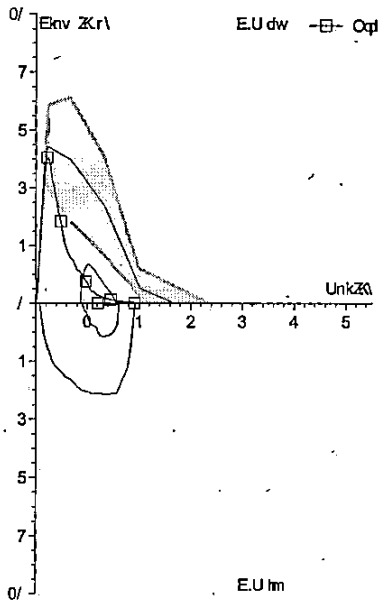
		Pred	Best Pre	% Pred	SR	Best Post	% Pred	SR	% Chg	%Pred Chg
FVC	L	2.69	1.91	71.1	-1.92					
FEV 1	L	2.13	1.20	56.3	-2.81					
FEV 1 % FVC	%	80	63		-2.15					
FEV 1 % VC MAX	%	80	62		-2.23					
PEF	L/s	5.45	5.05	92.7	-0.44					
MMEF 75/25	L/s	1.98	0.43	21.8	-3.01					

Bodyplethysmography

		Pred	Best	% Pred	SR	SR Graph
FRCpleth	L	2.33				
TLC	L	4.44				
VC	L	2.91				
IC	L	2.14				
ERV	L	0.68				
RV	L	1.56				
RV % TLC	%	35				
FRCpl% TLC	%	55				

Transfer Factor

		Pred	Meas	% Pred	SR	SR Graph
Hb	g(Hb)/dL		11.80			
DLCO_SB	mmol/(min*kPa)	5.93	3.82	64	-2.63	
DLCOcSB	mmol/(min*kPa)	5.93	4.03	68	-2.32	
VA_SB	L	4.08	3.53	87	-1.13	
KCO_SB	mmol/(min*kPa*L)	1.46	1.08	74	-1.89	
KCOc_SB	mmol/(min*kPa*L)	1.46	1.14	78	-1.57	



Comments

Reported to ERS/ATS 2021 and ARTP 2020 guidelines unless otherwise stated.

Qdr t ksr ` qd ` bbt q` sd ` mc qloqnct bhakd-

L ncdq` sd ` kqknv nar sq` bsnmnmqlct bdc cxm` l kb k mf unkt l dr-
BN sq` mr edqe bsnql khclk qlct bdc- U` ` mc J bn ` qd v ksghmsgd mnq ` kkk ksr - ZGa\ bnqqlbsdc odqOnqs kc` sdc 16-/ 2-15-

Qdonqsdc ax9 K Rod` j d
Qdonqsudqekdc ax9 E V kj kd

Department of Respiratory Medicine
Stobhill ACH
Pulmonary Function Report

NHS Greater Glasgow and Clyde

CHI:	**1308636407**				
Last Name:	**Sinclair**	**Height:**	**154 cm**	**Physician:**	**Dr McClay**
First Name:	**Theresa**	**Weight:**	**73.1 kg**	**Ward:**	**–**
Date of Birth:	**13/08/1963**	**BMI:**	**31 kg/m²**	**Smoking status:**	
Age:	**60 Years**	**Race:**	**Caucasian**	**Smoking pk-yrs:**	
Gender:	**female**	**Pred. Module:**	**GLI_ECCS**	**Physiologist:**	**Vaughn R**
Visit date:	**13/06/2024**	**Indication:**			

Note GLI ethnic correction only adjusts for spirometry.

SR Range Normal +/- 1.64 to 1.64 Mild +/- 1.65 to 2.50 Moderate +/- 2.51 to 4.00 Severe +/- >4.00

Spirometry

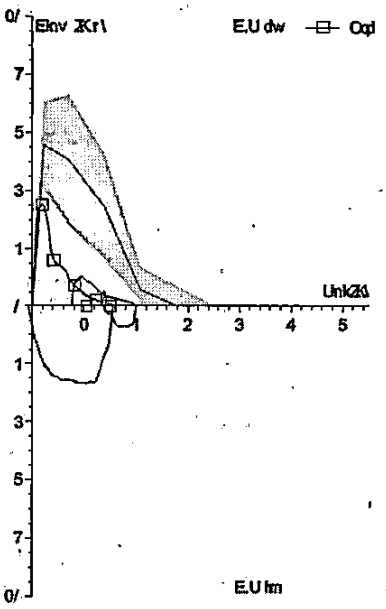
		Pred	Best Pre	% Pred	SR	Best Post	% Pred	SR	% Chg	%Pred Chg
FVC	L	2.78	1.52	54.8	-3.12					
FEV 1	L	2.21	1.06	48.0	-3.38					
FEV 1 % FVC	%	80	70		-1.39					
FEV 1 % VC MAX	%	80	64		-2.02					
PEF	L/s	5.56	3.49	62.8	-2.30					
MMEF 75/25	L/s	2.07	0.54	25.9	-2.83					

Slow Spirometry

		Pred	Best Pre	% Pred	SR	SR Graph
VC EX	L	3.01	1.63	54	-3.50	

Transfer Factor

		Pred	Meas	% Pred	SR	SR Graph
Hb	g(Hb)/dL		12.50			
DLCO_SB	mmol/(min*kPa)	6.04	3.02	50	-4.07	
DLCOcSB	mmol/(min*kPa)	6.04	3.11	51	-3.91	
VA_SB	L	4.16	3.11	75	-2.20	
KCO_SB	mmol/(min*kPa*L)	1.46	0.97	66	-2.51	
KCOc_SB	mmol/(min*kPa*L)	1.46	1.00	68	-2.35	



Comments *Reported to ERS/ATS 2021 and ARTP 2020 guidelines unless otherwise stated.*

L llc ` lqknv nar sq bsnmnmcxm l lb sdr smf -' qlct bdc EDU0$ UB l ` w(- Ga bnqqlbsdc eqnl 00./ 3.1/ 13- Bnqqlbsdc CKBN lr l ncdq sdkx qlct bdc- U' ` mc J BN ` qd ` lkn qlct bdc-

Qdonqdc ax Q U' t f gm
Qdonqsudqddc ax B V nnc

Direct Access Spirometry Report

OUTREACH SPIROMETRY SERVICE

Pre vs. Post Report

Patient Information

Name: Sinclair, Theresa	**ID: 1308636407**	Birthdate: 13/08/1963
Height at test (cm): 153.0	Sex: Female	Smoking history (pk-yrs): 30
Weight at test (kg): 71.0	Age at test: 55	Predicted set: ECCS 1983/93, Polgar(Peds)197

Comments: 43261, MRC - 3, SpO2 - 96%

Diagnosis:

Interpreted by:

Interpretation

Moderate obstructive pulmonary impairment. Bronchodilator produces no significant response. Post bronchodilator results reveal airflow obstruction that is consistent with QOF COPD Stage 2 (NICE).
F.Wilkie

Site: KoKo457631

Physician:

Technician: L. Gillan

Effort protocol: ATS/ERS 2005

Bronchodilator:

Test date/time: 17/01/19 15:21:35

Pre-BD Number of efforts performed: 5

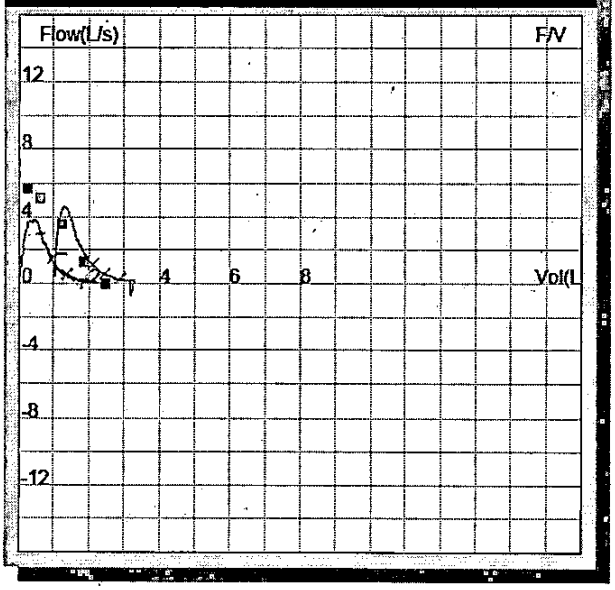
Post-BD Number of efforts performed: 4

Results

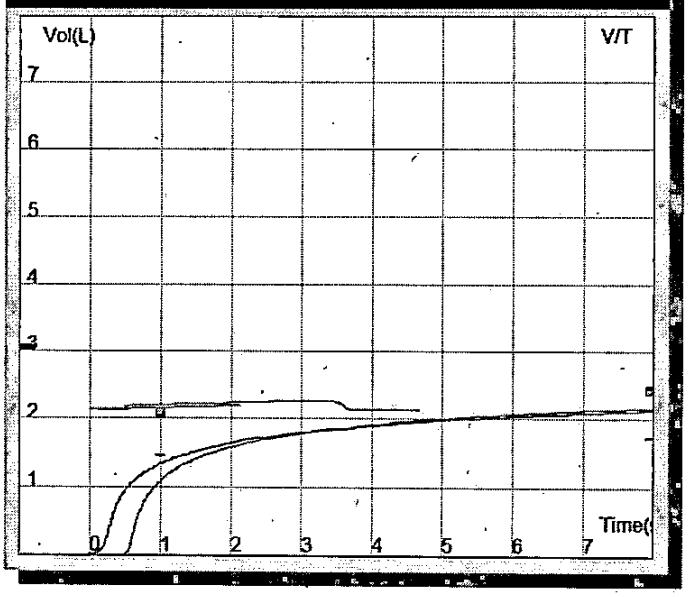
Result	Pred	Pre	%Prd	Post	%Prd	%Chg
FVC (L)	2.45	2.20	90%	2.26	92%	3%
FEV1 (L)	2.07	¤1.41	68%	¤1.43	69%	1%
FEV1/FVC	0.79	¤0.64		¤0.63		-1%
FEF25-75% (L/s)	2.97	¤0.67	23%	¤0.65	22%	-4%
PEFR (L/s)	5.66	¤3.77	67%	4.50	79%	19%
Vext %	—	3.60	—	2.24	—	-38%

Comments: 43261, MRC - 3, SpO2 - 96%

FVC Flow vs. Volume



FVC Volume vs. Time



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: 09-Oct-2025 10:06	**Created By:** Urology Nurse Practitioner - Carol OConnell2	**Role:** Nurse - GGC
Specialty: Urology	**Organisation:**	Sensitive
Note: Flexible cystoscopy. Urinalysis leucocytes+. Verbal consent. Healthy bladder		

Greater Glasgow & Clyde

Endoscopy Care Plan

1308636407
SINCLAIR | F
Theresa | 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Date: 28/8/18 **Consultant / Endoscopist:** SR Beck

Patient liked to be known as: .....

Procedure

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

Discharge Arrangements

Name of Escort /contact Annemarie Relationship Daughter Contact tel no 07496641808	**Escort Required** Yes ☑ No ☐ **Escort to be contacted** Yes ☑ No ☐	**Overnight supervision arranged** Yes ☑ No ☐ **Overnight stay in ward** Yes ☐ No ☐

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	✓		
Hypertension	✓		
Myocardial Infarction		✓	Date:
Artificial valves		✓	
Pacemaker		✓	
CABG		✓	
Coronary artery stent		✓	
Stroke/TIA		✓	
Asthma		✓	
COPD		✓	
Epilepsy		✓	
Liver disease		✓	
Arthritis		✓	
Orthopaedic implants		✓	Specify:
Glaucoma		✓	
Anaemia		✓	
Recent surgery		✓	
Previous endoscopy	✓		
CJD/VCJD risk		✓	
Other			

1308636407
SINCLAIR F
Theresa 13/08/1963 el
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Presenting complaint	Yes	No	Detail other illness or complaint
Reflux	✓		Bloating
Dysphagia			
Barretts			
Oesphageal/Gastric Varices			
Gastric ulcer			
Altered bowel habit			
PR bleeding			
Crohns disease			
Ulcerative colitis			
Surveillance colonoscopy			
Screening programme			
Other:			Persistent tiredness

Mobility Assessment

Independent Yes ☑ No ☐ If No, complete all questions

Aids and/ or assistance required Yes ☐ No ☐

Walking stick ☐ Zimmer ☐ Wheelchair ☐ Other ☐ Specify .....

Sight impairment Yes ☐ No ☑ if yes specify ..... Wears Glasses .....

Communication Needs (answer only applicable question)

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 ☑ Language .....

Interpreter 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)

Aspirin		Omeprazole			
Bisoprolol		Ramipril			
Diazepam		Simvastatin			
GTN Spray		Thiamine			
Mebeverine					

ANTICOAGULANT THERAPY Yes ☐ No ☐ If yes current medication ..... Aspirin .....

When was this medication last taken Specify ..... not taken Nus Any .....

INR Result .....

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Admission Observations

BP 144/82 Pulse 71 Oxygen Saturation 97%

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

Fasted since food 27/8/18 fluids 27/8/18

Bowel Prep	Klean Prep	Moviprep	Picolax	Enema / home	Enema / dept	Other
No of sachets						
Result- Good / Poor						

Patient Requests

Throat Spray ☐ IV Sedation ☒ No Sedation ☐ Not Applicable ☐

IV Cannulation

R Hand	L Hand	R Arm	L Arm	Other	Time	Inserted by (please print)
		✓				Emartin

Dentures removed (if applicable) Yes ☑ No ☐ OUT

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 ..... Nil known .....

Name of Admission Nurse (Print) ..... Elaine martin .....

Signature of Admission Nurse ..... Elaine martin .....

Patient's Declaration

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

Patient's signature .....

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Intra Procedure

Endoscopist (print) Sr. Beck

Endoscopy Room Nurses (print) ANDERSON, FERGUSON, St/N BURNS-

Surgical Pause carried out Yes ☑ No ☐

Medication Administered Pre, Intra and Post Procedure

Drug	Yes	No	Time	Dose	Route	Given/Sign/Dr/Nurse
Xylocaine spray						
Midazolam	✓		0828.	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		

Prescribed by .....

Endoscopist Signature .....

Start Time 0828 Finish Time 0834

Patient position Left Lateral ☑ Supine ☐ Prone ☐ All ☐

Oxygen therapy Yes ☑ No ☐ nasal sponge ☐ cannula ☐ mask ☐ rate 21

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7DA

Observations during procedure

Time						
Pulse						
SpO2						
BP						
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			

Other .....

Sedation score	Tick	Comfort Score	Tick
Asleep		None, resting comfortably	
Drowsy		One or two episodes of mild discomfort, well tolerated	✓
Awake	✓	More than two episodes of discomfort, adequately tolerated.	
		Significant discomfort experienced several times	
		Extreme discomfort frequently during procedure	

Comments Patient reassured.

Specimens Yes ☐ No ☐

Pathology ☐ No of pots ..... H.pylori test ☑ bacteriology ☐ cytology ☐ mytology ☐

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7D

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 via ..... until ..... ☐

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

To be seen by endoscopist before discharge ☐

Further Instructions .....

.....

Endoscopy Room Nurse Signature N Burns (St/N) / [illegible] SN

Recovery care

Post endoscopy observations

Time	0840	0855								
Blood pressure	132/82	116/78								
Pulse	74	68								
O2 Saturation	96%	95%								
Respiratory Rate	Neg	Neg								
Sedation score	0	0								
Pain score	0	0								
Oxygen	AIR	AIR								
IV Cannula	INSITU	INSITU								
BM	✓	✓								
Nurse initials	NB	NB								

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

Sedation score A - Asleep 0 - Alert 1 - Responds to verbal command

2 - Responds to painful stimuli 3 - Unresponsive

1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
F
13/08/1963
G66 7D

Nurses notes

In recovery 0840 hrs

1308636407
SINCLAIR F
P Theresa 13/08/1963
90a Main Street
Lennoxtown
Glasgow
G66 7DA

Discharge Criteria	Yes	No
Stable vital signs	☑	☐
Alert and Orientated	☑	☐
Pain score is 2 or below	☑	☐
Diet and fluids taken	☑	☐
IV Cannula removed	☑	☐
Received written instructions regarding sedation	☑	☐
Received verbal and written aftercare instructions	☑	☐
Patient Advice Leaflet given (if applicable)	☐	☑

Received Endoscopy Report/ Patient letter Yes ☑ No ☐

If no

Verbal report by endoscopist ☐

Follow up appointment indicated on report Yes ☐ No ☑

Follow up appointment (if given in department) .....time .....

Comments..... NO follow up .....

.....

.....

I confirm patient is satisfactory for discharge

Print Name LORNA McGRATTAN Signature .....

Discharged at 0940 to care of DAUGHTER

Irregular discharge Reason .....

.....

Patients' Signature ..... Nurses Signature .....

Consent Form

Patient agreement to endoscopic investigation or treatment

Pati
1308636407
SINCLAIR
Theresa
90a Main Street
Lennoxtown
Glasgow
G66 7DA
F
13/08/1963

Name of Procedure

Gastroscopy/ Endoscopy/ Oesophago-gastro-duodenoscopy

Inspection of the upper gastrointestinal tract with a flexible endoscope (with or without biopsy and photography)

Biopsy specimens will be retained.

Statement of Patient

You have the right to change your mind at any time, including after you have signed this form.

I have read and understood the information in this booklet including the benefits and any risks.

I agree to the procedure described in this booklet and on the form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however have appropriate experience.

Where a trainee performs this examination, this will be undertaken under supervision by a fully qualified practitioner.

I understand that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I would like to have: **local anaesthetic throat spray** ☐
or sedation ☑ (Please tick box)

Have you ever been notified that you are at an increased risk of CJD/VCJD for public health purposes:

☐ Yes ☑ No

Consent Signature

Signed T Sinclair Date 28-8-18.

Name (print in capitals) THERESA SINCLAIR

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signed _____ Date _____

Staff Only

Confirmation of consent (to be completed by a health care professional when the patient is admitted for the procedure)

I have confirmed that the patient understands what the procedure involves including any risks.

I have confirmed that the patient has no further questions and wishes the procedure to go ahead.

Signed Elaine Martin Date 28.8.18

Name (print in capitals) Elaine martin

Job Title Charge Nurse

MANUAL PATIENT RECORDS

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 (PART 1)	☑		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

FINAL DISCHARGE LETTER

NHS Greater Glasgow

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone : 0141 - 201 - 3000

First Issued: 22/09/2010 16:04
Printed: 22/09/2010 16:04

Admitted: 16/09/2010 **Discharged:** 16/09/2010
Discharged to: Home
Ward: 14a
Consultant: DR ERIC LIVINGSTON, General Medicine
Hospital No: 23004807E **Date of birth:** 13/08/1963
CHI: 1308636407

REGISTERED GP

Dr JAMES HENDERSON
CAMPSIE SURGERY, LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN
G66 7DA

PATIENT

TERESA SINCLAIR
90A MAIN STREET
LENNOXTOWN
GLASGOW
G66 7DA

DIAGNOSES	ICD10	PROCEDURES	OPCS4
1. Self-poisoning with antidepressant, 16/09/2010	T432		

MEDICATION

No medication has been prescribed for this patient

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
No arrangements made		

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

Dear Doctor,
This lady was admitted to ward 14a of Stobhill on the 16/9/2010. She had been drinking with friends when the police had attended with an outstanding warrant for her arrest, and she had told them she had taken an overdose of 12 citalopram tablets. She denied any ongoing suicidal ideation or any true suicidal intent.

On admission to A and E she had been intoxicated but otherwise examination had been normal. ECG showed a sinus tachycardia. Bloods were normal. She was admitted to the ward overnight as citalopram can prolong the QRS complex and Q interval.

Cardiac monitoring was carried out overnight and repeat ECG in the morning showed no changes. She was reviewed by addiction liason services prior to discharge, who are already aware of her.

She was discharged without follow up.

Kind reagrds

Mhairi Little
FY1 Medicine

Final Discharge Letter - Dr C Kennedy, GPST1

Nil to add.

Signed: _____ **Designation:** _____

NHS
Greater Glasgow and Clyde

DEPARTMENT OF GYNAECOLOGY

Dr S Mathew

GLASOW ROYAL INFIRMARY
CASTLE STREET
GLASGOW, G4 OSF

TEL NO: 211 4000

Dr J H Kennedy Dr H Lyall
Dr A M Mathers Dr R Jamieson
Dr R W S Yates Dr P Owen
Dr M. Perera Dr. M. Rodger
Dr J E Norman Dr. M. Deeny

Enquires: Catherine Donaghy (Secretary)
Direct: 0141 211 4755
Fax: 0141 800 1973
E-Mail: Catherine.Donaghy@northglasgow.scot.nhs.uk

Clinic &
Dictated 30/08/2009
Typed 01/09/2009
Your Ref
Our Ref SM/MC

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CHI: 1308636407 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Thank you for referring this 46 year old lady to my Gynaecology Clinic today. She is a para 4 who was referred with a history suggestive of heavy periods. She says her periods last for up to seven days and are quite heavy with dysmenorrhoea. She has had three normal deliveries and a forceps delivery in the past and was sterilised about 8 years ago. Her last smear was negative. There are no bowel or bladder disturbances.

On examination her cervix was hypertrophic, anteverted and parous size and mobile. There was no adnexal mass felt. I have carried out a Pipelle endometrial biopsy and we discussed a Mirena IUS insertion which she was keen to get done today. I have inserted a Mirena IUS under aseptic precautions without any complications. I have suggested we will review her in four months' time and in case she is well and does not want to see us she can always call and cancel the appointment.

Yours sincerely

Dr Sarju Mathew
Consultant Gynaecologist & Obstetrician

NHS
Greater Glasgow and Clyde

DEPARTMENT OF GYNAECOLOGY

Dr S Mathew

GLASOW ROYAL INFIRMARY
CASTLE STREET
GLASGOW, G4 OSF

TEL NO: 211 4000

Dr J H Kennedy Dr H Lyall
Dr A M Mathers Dr R Jamieson
Dr R W S Yates Dr P Owen
Dr M. Perera Dr. M. Rodger
Dr J E Norman Dr. M. Deeny

Enquires: Catherine Donaghy (Secretary)
Direct: 0141 211 4755
Fax: 0141 800 1973
E-Mail: Catherine.Donaghy@northglasgow.scot.nhs.uk

Clinic &
Dictated: 06/07/2009
Typed 08/07/2009
Our Ref SM/CK

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CHI: 1308636407 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

This lady has failed to attend our clinic and another appointment has been sent.

Yours sincerely

Dr Sarju Mathew
Consultant Gynaecologist & Obstetrician

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology F2
G General Referral

Consultant / receiving practitioner and/or **specialty clinic**

Stobhill Hospital

Hospital and **hospital address**

Hospital location code: G207H

Email address: -

Urgency of referral ROUTINE
Date of referral 09-Jun-2009 **Date sent** 10-Jun-2009

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s): -

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)

Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		
Practice code	43261		

Practice address

103 MAIN STREET
LENNOXTOWN

Contact number(s)

Voice: 01360310357

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: heavy periods

Comment: This 45 year old lady has been troubled by heavy periods for several months. Clinical exam and smear are normal. FBC.....Hb 116 g/dl
She has tried Tranexamic Acid without marked success. Could you see her and perhaps discuss Mirena IUS?
She missed a previous appointment but is keen to have your advice.

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
teetotal:		02-Apr-2008
teetotal:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Modifier	Extension	Date of onset
Overdose of drug	-	DIAZEPAM AND ALCOHOL	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	-	LIBRIUM AND ALCOHOL	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	-	OVERDOSE	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	Mild	-	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Modifier	Date performed
Female sterilisation op.NOS	-	03-Sep-2001
CLO test negative	-	26-Aug-1998

Family conditions (All priorities)

Description	Modifier	Extension	Date Recorded
FH: Ischaemic heart dis. <60	-	-	02-Apr-2008
No family history diabetes	-	-	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration

Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003	2054 Days

Recent medication (Any medication issued within last 90 days not shown above)

No recent medications recorded

Clinical warnings

Additional relevant information

Administrative information

Previous Surname:Jenkins

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-21 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

Acute Services Division

Emergency Care and Medicine Services Directorate

Department of Respiratory Medicine

Dr Bucknall

Stobhill Hospital
Balornock Road
GLASGOW G21 3UW
Switchboard: 0141 201 3000
Direct Dial: 0141 201 3717

Consultant Physicians:

Dr Robert Milroy — Robert.milroy@ggc.scot.nhs.uk
Dr Christine E Bucknall — Christine.bucknall@ggc.scot.nhs.uk
Dr Eric Livingston — Eric.livingston@ggc.scot.nhs.uk

Typed 17/07/2009
Dictated 16/07/2009
Your Ref
Our Ref LC/AMMCK

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Admitted 06.07.09 Irregular Discharge 06.07.09

Consultant: Dr C Bucknall

Diagnosis: Overdose of Temazepam and alcohol

Follow Up: Nil

This 45 year old lady was brought to Casualty via Ambulance with a GCS of 11 following an overdose of approximately 80mg Temazepam on a background of alcohol excess. I understand that her partner had recently had been killed in a RTA.

She required no specific treatment besides iv fluids and post observations. However by the early hours of the morning the patient had woken up and refused to stay in hospital for further assessment. She was assessed by the junior doctor prior to discharge and did not demonstrate any ongoing suicidal ideation.

Yours sincerely

LYN CORRY
SPR3

Dr C Bucknall
Consultant Physician and Gastroenterologist

STOBHILL HOSPITAL

OUTPATIENT CHART

SURNAME	UNIT NUMBER	PAT	MARITAL STATUS
	23004807E	Dr. J HENDERSON	(yrs) S W
DATE OF BIRTH	SINCLAIR F TERESA 13/08/1963	WARD/DEPT	RE 103 MAIN STREET E
ADDRESS	90A MAIN STREET LENNOXTOWN GLASGOW G66 7DA CHI-1308636407	GJ G66 7DA	
TEL. No. 31 AUG 2005		TEL No.	
DATE	SPECIALITY- GYNAECOLOGY	CONSULTANTS NAME	DR MATHEW

COMPLAINT & DURATION — Hx — Heavy periods

PREVIOUS HISTORY Omeprazole / Tamazepam 46

PREVIOUS OBSTETRIC HISTORY (Summary of pregnancies and deliveries)

P4 —
Stillbirth —
3 SVDs 8yrs
1 Fem

Years Married

Gynaecological History	Contraception	F.P.M.	L.P.M.
Cycle	Loss	Clots	Regularly
Dysmenorrhoea		Backache	
Dyspareunia			
Discharge	Quantity	Regular — Colour ?	
Micturition-Dysuria			
Frequency-Day		Night	7 days / 3 nights
Stress Incontinence		Urgency — dysuria	
Bowels		No dyspareunia	

History of Present Condition

Smear — 2 years

Bleed
Bladder ✓

Abdomen

Breasts

Pelvic Examination

— Cx — Hypertrophy
— Utx — AV — Parous

Pap Smear

Mobile

Diagnosis

No adnexal mass. Pelvic ✓

Suggested Treatment

Ult Colposcopy — 8 cm

Waiting List		Priority	
Seen by	Midwife	For letter YES/NO	Date
		Return	2 months

Hx — Recur 4/12
— Will — Repeat appt
— Right Breast for

AW/FORM 3

Patient's name Theresa Sinclair Age 46 Date of Birth

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 6/7/09 Time Triage Nurse PC

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) 2140
HR: 100
BP: 95/56
RR: 20
SaO_2: 90% on RA
Temp: 35.7
G.C.S:
Signed CA/JM

INITIAL MANAGEMENT

Nurse

Oxygen started %: Signed ECG: Signed

Signed

Other Namebnd

Treatment 95% on 4Lit

NEUROLOGICAL OBSERVATIONS

TIME		hrs	NVB	5	04	04	04	04	
RESPONSIVENESS	EYES OPEN	spontaneously 4	1						eye closed by swelling =C
		to speech 3	C	C					
		to pain 2	-			•	•		
		none 1			A				
	BEST VERBAL RESPONSE	orientated 5	C						Endotracheal tube or Tracheostomy = E Dysphalsa=D
		confused 4							
		inappropriate words 3							
		incomprehensible sounds 2				C	C		
		none 1			C	=			
	BEST MOTOR RESPONSE	obey commands 6	C						Record the best arm response
		localises pain 5	C	•	C		C	C	
		normal flexion to pain 4							Paralysed =P
		abnormal flexion to pain 3							
		extention to pain 2							
		none 1							
		COMA SCORE 15	14			8	9		
PUPILS	RIGHT	size (mm)	3	4	2	2	2		+= Reacts - =No Reaction C= Eye closed SL= sluggish pupil
		Reaction	+	+	-	+	+		
	LEFT	size (mm)	3	4	2	2	2		
		Reaction	+	+	-	+	+		
LIMB MOVEMENT	ARMS	Normal power	1	1					Record right (R) and left (L) seperatly if there is a difference between the two sides Fractured limb = #
		Mild weakness							
		Severe weakness							
		Extention							
		No response							
	LEGS	Normal power	1	1					
		Mild weakness							
		Severe weakness							
		Extention							
		No response							

BLOOD PRESSURE mm Hg: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 — 35/56

37 Temp C° 36 35 34 33 32 31 30

PULSE RATE: 88 86 88 88 91 59 61 61 65

PUPIL SCALE (mm): 1 2 3 4 5 6 7

RESPIRATORY RATE	20	20	21	24	24	23	
SaO_2	95	95	94	96	96	96	
NURSE INITIALS	C	C	RH	RH	RF	RF	

287 · 95 · 24 · 25

BLOOD GLUCOSE	Time	2140
BM STIX	BM	5.7
PEAK FLOW	Time	
	PF	
VISUAL ACUITY	R. eye aided/unaided	
	L. eye aided/unaided	
	pH L. eye	R. eye

Signed:

URINALYSIS

Urobilinogen µmol/L	Normal 3 16	33	66	131			
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg			Positive			
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve			- ve			

Signed:

Date

0/E $E_2 M_5 V_4 = 11$. Maintaining own airway
HR 100 BP 95/56 RR 20. Sats 90% on A, T 35?
pulse reg, good volume
HS 1+11+0
chest clear
abdomen soft nontender
moving all 4 limbs
no facial droop
pupils variable - range dilated to small (not pinpoint) - equal & reactive

ECG - ST 102 bpm, nil acute

ABG on 28% O_2 - Hct 45, pH ~~7.~~ PCO_2 6.6, PO_2 9
HCO_3 27. Sats 93.7%.

Na 145, K 4.4, urea 1.7 creat 73
Bil 3, AST 29, ALT 18, GGT 37 Alk phos 88
T prot 67 albumin 36, globulin 31
glucose 5.6
CRP 1.2
osmolality 347
Hb 11.7, WBC 8.4, MCV 90, Plts 436

Imp, alcohol intoxication
+ temazepam overdose
↓ GCS but maintaining own airway

Plan, refer medics --> paracetamol & salicylate added to initial bloods

(W) Wallace
FY2 ED

5/4/19
04:25 MEDICAL ST3

(45) OVERDOSE.
F

NO hx from pt. Hx from above
Planning healthy today + took temazepam

Date

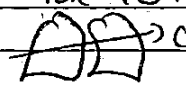
~80mg at ~1am
shared them w her daughter who phoned ambulance.
Became drowsy in ambulance + remains drowsy.

Partner recently kicked

PMH-?
DH-?
SH-alcohol xs?
smokes. -tobacco in pocket

O/E E- 2 10
M- 3
V- 5

A- maintaining

B- SOBs= 96% on 28% O_2
RR=10.

clear.

C- BP=80/47 HS 1+1+0
P= 90
warm peripheries

D- GCS as above

BM=5-7
Pale.

SNT 2 spider naevi neck.
marks

ECG- sinus tachy
(N) ACS.

Imps Overdose temazepam | alcohol

Plan→ → ITU
Regular neuro obs
IV fluids to maintain BP.
If BP drops - head down tilt.
not for permanent at present
Bloods ✓ CXR ✓ ECG ✓ MRI ✓

Stobhill Hospital Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR TERESA	13.08.63	F	STOB

Specimen R,09.0170031.Z Type BLOOD
Collected 06.07.09 03:42 A.Diag OVERDOSE

FBC	
WBC	8.42
RBC	4.08
Hgb	117
HCT	0.369
MCV	90
MCH	28.7
PLT	436
NEUT	2.71
LYMPH	4.82
MONO	0.69
EOSIN	0.09
BASO	0.11

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR TERESA	13.08.63	F	STOB

Specimen N,09.0130082.F Type Specimen
Collected 06.07.09 03:00 A.Diag

U&E		LFTs		Glucose		CRP	
Sodium	145	AST	29				
Potassium	4.4	ALT	18			CRP	1.2
Chloride	107	G-GT	37				
Urea	1.7	A Phos	88				
Creat	73	T Prot	67				
eGFR	>90	Alb	36				
		Globulin	31				
		Bili	3	Glucose	+ 5.6		

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatme
200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700
>280mg/L if under 5 years.

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR TERESA	13.08.63	F	STOB

Specimen N,09.0130082.F Type Specimen
Collected 06.07.09 03:00 A.Diag

Bone		Osmolal		Parac'mol		Salicylate	
A Phos	88	Osmol	+ 347	Pmol mg/L	<15	Salic mg/L	<40
T Prot	67						
Alb	36						
Globulin	31						
Calcium	2.36						
Ad Cal	2.38						
Phos	+ 1.46						

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatme
200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700
>280mg/L if under 5 years.

6/7/09 FYI Robertson
0730 Patient has become aggressive & abusive to staff.
Wants to sign herself out.
Lucid, orientated.
Patient states she did not try to kill herself & does not have suicidal ideation currently.

EN
1025.

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
6/7	NSaline	500	Stat	✓	—	1	[signature]			JM	CA	
6/7	NSaline	500ml	Stat				[signature]		0450	CA	RF	09C25TSR 02/20

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I [redacted] wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* [redacted] Signature [redacted]

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date 6/7/09 [redacted] Signature [redacted] E. ROBERTSON

(Medical Practitioner)

FY1.

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

STOBHILL

PATIENT PROGRESS / EVALUATION

23004807E F
SINCLAIR 13/08/1963
TERESA
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

AFFIX DATA LABEL

All entries must be signed

Date	No.	Progress/ Evaluation
07/07	SCBU	45 yr old female admitted with overdose temazepam with Alcohol o/e: very drowsy unable get details BP: 98/64 pulse: 84/m SpO2: 97% on 4L/min Temp: 36.5c Prob: Alcohol excess ? anything else Imp: overdose Temazepam / Alcohol plan - 14 a. Regular neurobs 1/hr fluids If BP drops head down tilt not for removal of drips Bloods / CXR
	SCBU	patient refused to take off her jeans off. 1/hr fluids commenced as prescribed
07/07		Patient Noke became aggressive & abusive to staff. Wants to sign herself out. Irregular d/c taken. Venflon removed ☑ Did not want NOK informed.

00599/3

STOBHILL

PATIENT PROGRESS / EVALUATION

23004807E F
SINCLAIR 13/08/1963
TERESA
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

AFFIX DATA LABEL

All entries must be signed

Date	No.	Progress/ Evaluation	
07/07	5am	45 yrs old female admitted with overdose temazepam with alcohol.	
		o/e: very drowsy unable get details BP: 98/64 pulse: 84/mt SpO2: 97% on 4Ltrs Temp: 36.5c Poss: Alcohol excess ? anything else Imp: overdose Temazepam / alcohol plan - 14 g. Regular neurobs 1/r fluids if BP drops bring down with not for paracetamol or panadol Bloods / CXR	GD
	8am	patient refused to have bed jeans off. 1/r fluids commenced as prescribed	GD
	07th	Patient woke became aggressive & abusive to staff. Wants to sign herself out. Irregular dlc taken. Venflon removed ☑. Did not want NOK informed.	JC

PATIENT PROGRESS / EVALUATION

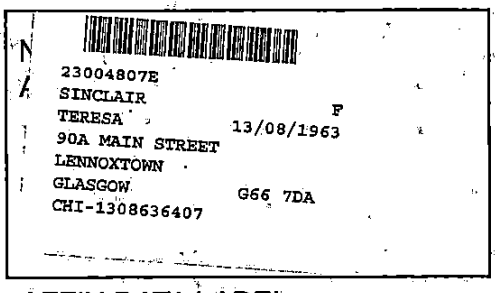
(Continued)

Date	No.	Progress/ Evaluation	***All entries must be signed***

STOBHILL

NURSING ASSESSMENT

WARD



AFFIX DATA LABEL

Maintaining Safe Environment

Communication

Hearing Aid Y/ N

Spectacles Y / N

Breathing / Circulation

Resps 20/- B.P. 98/64

Pulse 84/m Smoker Y/ N

Sp02 97 %.on 28/.02.

Eating / Drinking

Dentures

Elimination

Urinalysis Rsult

Personal Cleansing / Dressing

CONTINUED OVER /

NURSING ASSESSMENT

(Continued)

Controlling Body Temperature	Temp.
Mobilisation	Weight Waterlow - score
Expressing Sexuality	
Sleeping	
Pain	
Socialization	
Dying	Minister / priest

Signature of Assessment Nurse _____ Date _____ Time _____

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL PATIENT PROFILE

Ward

Type / source of admission

NAME
ADDRES

D.O.B.
UNIT No.

23004807E
SINCLAIR
TERESA F
90A MAIN STREET 13/08/1963
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

AFFIX DATA LABEL

Religion

Alliergies

Next of kin informed

Medical reasons for admission

Patient's understanding of admission

Relative's understanding of admission

General condition on admission

Very drowsy

00599/1

PATIENT PROFILE

(Continued)

Social circumstances

unable to get details as patient very drowsy.

Lives alone
Smoker.

Occupation

Hobbies / interests

Medical history

Alcohol excess ? anything else.

Medication list

See Kardex

Valuables / belongings

Clothes in Locker.

Dr. J HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN

G66 7DA

Signature of Assessment Nurse _____ Date 6/7/04 Time 5.30 am.

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL HOSPITAL
24 HOUR FLUID CHART

NHS Greater Glasgow and Clyde

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Theresa	Sinclair	

DATE 6/7/09

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
MgCl(A/E) Admitted		500ml	5 a.m.	NUP				
(N) Saline		500	6 a.m.	NUP				
			7 a.m.					
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon					
			1 p.m.					
			2 p.m.					
			3 p.m.					
			4 p.m.					
			5 p.m.					
			6 p.m.					
			7 p.m.					
			8 p.m.					
			9 p.m.					
			10 p.m.					
			11 p.m.					
TOTALS								
TOTAL INTAKE						TOTAL OUTPUT		

INSTRUCTIONS

PARENTERAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum: Urea	
Sodium	
Polassium	
Chloride	
Bicarbonate	

No. 00260

I.V. THERAPY

STOBHILL HOSPITAL

PATIENT ID LABEL

PRESCRIPTION SHEET

MS T SINCLAIR

90A MAIN STREET
LENNOXTOWN
GLASGOW
G66 7DA

DATE presc	ADDITIVE DRUG	dose	duration of admin	signature	Date administered	infusion comm	infusion end	Serial No Exp date	Nurse Signature
6/7	(N) SALINE	500	1°	[illegible]	6/7/19	5[th] 950	0615	09C12T SY 02/12	[illegible]
6/7	(N) SALINE	500	1°	[illegible]	6/7/19	0615	0715	09C12 TSY 02/12	JA
6/7	(N) SALINE	500	2°	[illegible]	6/7/19	0715		09C2T SY 02/12	JA

All fields must be completed

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	MS T SINCLAIR
Addre	90A MAIN STREET LENNOXTOWN GLASGOW.
Hospit	G66 7DA.
DOB	

Admitted Date 6/7/05 Ward CCU

Transferred Date _____ Ward _____

Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immédiate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

DATE																			
Time			06 30																TEMP X
BP ^ v and Pulse •	240																		
	230																		
	220																		40°C
	210																		
	200																		39°C
	190																		
	180																		38°C
	170																		
	160																		37°C
	150																		
	140																		36°C
	130																		
	120																		35°C
	110			108															
	100		98	^															
	90																		
	80																		
	70			v															
	60		64	78															
	50																		
	40																		
Resp. Rate			84	89															
Inspiration O_2%			20	16															
SpO_2%			46	28															
Pain Score			97	95															
Sedation Score																			
Nausea Score																			
Blood Glucose																			

MEWS																			
	Resp. Rate		0	0															
	Pulse		0	0															
	Systolic BP		1	0															
	GCS / AVPU			2															
	Urine Output			—															
	Temp.		0	0															
	SpO_2%		0	0															
	TOTAL			2															

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

DATE																		TEMP X
Time																		
BP ^ v and Pulse •	240																	40°C
	230																	
	220																	39°C
	210																	
	200																	38°C
	190																	
	180																	37°C
	170																	
	160																	36°C
	150																	
	140																	35°C
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
	50																	
	40																	
Resp. Rate																		
Inspiration O_2%																		
SpO_2%																		
Pain Score																		
Sedation Score																		
Nausea Score																		
Blood Glucose																		
MEWS	Resp. Rate																	
	Pulse																	
	Systolic BP																	
	GCS / AVPU																	
	Urine Output																	
	Temp.																	
	SpO_2%																	
	TOTAL																	

Calling Criteria

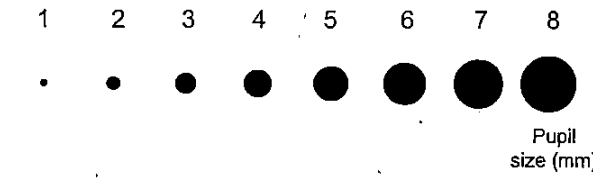
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

DATE				6/7																		
Time				5/M3	06 30																	
COMA SCALE	E Eyes open	Spontaneously	4																			Eyes closed by dwelling = C
		To speech	3																			
		To pain	2		0																	
		None	1	✓																		
	V Best verbal response	Orientated	5																			Endotracheal tube or tracheostomy = T
		Confused	4		9																	
		Inappropropriate 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		3/3	11/15																	
PUPILS	R	Size		2	2																	= reacts —no reaction c. eyes closed
		Reaction		+	=																	
	L	Size		2	2																	
		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																				
		No response																				
	LEGS	Normal power		✓	o																	
		Mild weakness																				
		Severe weakness																				
		Extension																				
		No response																				

Glasgow Coma Scale



DATE																						
Time																						
COMA SCALE	E Eyes open	Spontaneously	4																			Eyes closed by dwelling = C
		To speech	3																			
		To pain	2																			
		None	1																			
	V Best verbal response	Orientated	5																			Endotracheal tube or tracheostomy = T
		Confused	4																			
		Inappropropriate 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																				
		No response																				
	LEGS	Normal power																				
		Mild weakness																				
		Severe weakness																				
		Extension																				
		No response																				

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

Acute Services Division

NHS Greater Glasgow and Clyde

CIWA-AR SCORE CHART

If score greater than 10 and rising give 20mg diazepam (unless elderly, frail, history of falls, suspected head injury, hepatic/renal or respiratory disease) score 1hrly whilst rising, wake patient if sleeping. Monitor respiratory rate, pulse, BP

If score greater than 10 and falling give 20mg diazepam (unless elderly, frail, history of falls, suspected head injury, hepatic/renal or respiratory disease) score 2hrly whilst falling, and wake patient if sleeping. Monitor respiratory rate, pulse, BP

If score less than 10 on 3 separate occasions (2hrly in duration) discontinue. If less than 24hrs since last drink then continue to observe/monitor

Do not administer more than 120mg of diazepam in a 24hr period without contacting FY2 or above to review patient

Surname: 23004807E SINCLAIR Forename: TERESA DOB: CHI-1308636407	CHI Number: Hospital Number:
Ward:	Date:

Date										
Time										
Blood Pressure										
Pulse										
Respiratory Rate										
SaO2%										
FiO2										
GCS										
Nausea + vomiting										
Tremor										
Paroxysmal sweats										
Anxiety										
Agitation										
Tactile disturbance										
Auditory disturbance										
Visual dist										
Headache /fullness										
Orientation /clouding										
Total score										
Time of admin										
Route of admin										
Given by										

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

Management of Alcohol Withdrawal Guidance

SEVERE WITHDRAWAL (aggressive / uncontrollable/ dangerous behaviour)

Intravenous diazemuls up to 40mg over first 30 minutes
Adjunctive therapy with Haloperidol 5-10mg IV or IM
(smaller doses unlikely to be effective)
These patients require close monitoring ideally with one-to-one nursing care
Consultation regarding intensive care support may be necessary in extreme situations

PATIENTS UNABLE TO TOLERATE ORAL MEDICATION

Patients unable to tolerate oral medication may receive intravenous therapy (diazemuls or lorazepam) as an alternative at 50% of the oral dose in the first instance
It is recommended that this intravenous treatment is given by a member of the medical staff and that patients are closely monitored (P, BP, RR, GCS)

APPROXIMATE BENZODIAZEPINE EQUIVALENCE

40mg Diazepam = 4mg Lorazepam = 120mg Chlordiazepoxide (BNF 56 Sep 2008)

Patients should not be discharged on regular benzodiazepine unless there is a confirmed rrangement with the community addiction services. Chlordiazepoxide is the recommended benzodiazepine for community use

REFER TO PABRINEX GUIDELINES ON REVERSE
(ALSO INCLUDED WITHIN THE THERAPEUTICS HANDBOOK FOR PRESCRIBERS AUG 2008)

Score Chart

NAUSEA AND VOMITING

Ask "do you feel sick to your stomach? Have you vomited?"

OBSERVATION:

0 No nausea and no vomiting
1
2
3
4 Intermittent nausea and dry heaves
5
6
7 Constant nausea, frequently heaves and vomiting

TACTILE DISTURBANCES

Ask "Have you any itching, pins and needles, any burning, numbness or do you feel bugs crawling on or under your skin"

OBSERVATION:

0 None
1 Very mild itching, pins & needles, burning or numbness
2 Mild itching, pins & needles, burning or numbness
3 Moderate itching, pins & needles, burning or numbness
4 Moderate severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

TREMOR

Arms extended and fingers spread apart

OBSERVATION:

0 No tremor
1 Not viable, but can be felt fingertip to fingertip
2
3
4 Moderate, with patient's arms extended
5
6
7 Severe, even with arms not extended

AUDITORY DISTURBANCES

Ask "Are you more aware of sounds around you? Are they harsh?. Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things that you know are not there?"

OBSERVATION:

0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability to frighten
3 Moderate harshness or ability to frighten
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

PAROXYSMAL SWEATS

OBSERVATION:

0 No sweat viable
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

VISUAL DISTURBANCES

Ask "Does light appear too bright? Is colour different? Does it hurt your eyes? Are you seeing anything that is disturbing you? Are you seeing things that you know are not there?"

1 Not present
2 Very mild sensitivity
3 Moderate sensitivity
4 Moderate severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

ANXIETY

OBSERVATION:

0 No anxiety, at ease
1 Mildly anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reaction

HEADACHE, FULLNESS IN HEAD

Ask "Does your head feel different? Does it feel like there is a band around your head?"

OBSERVATION:

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

AGITATION

OBSERVATION:

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview or constantly thrashes about

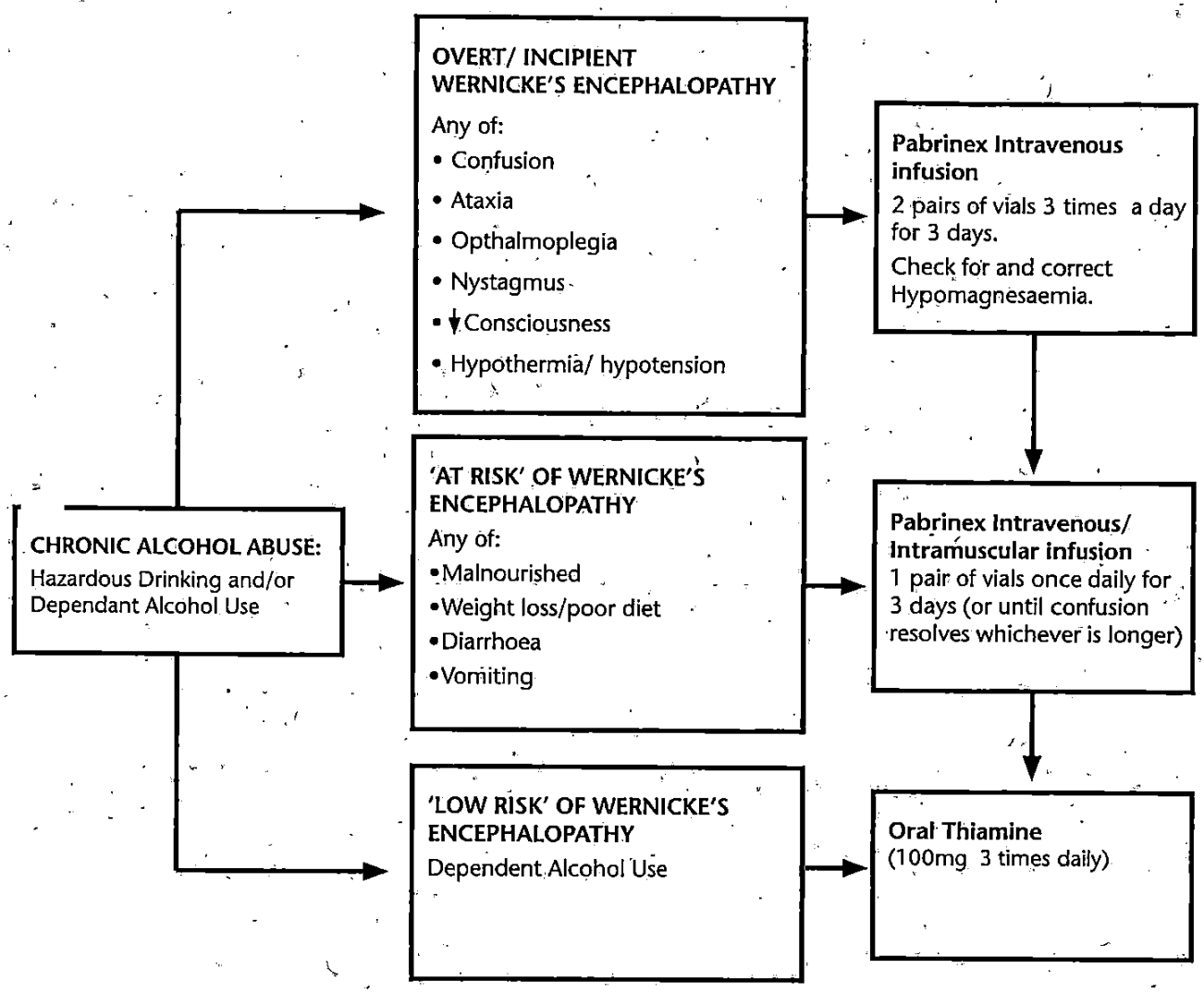
ORIENTATION AND CLOUDING OF SENSORIUM

Ask "What day is it? Where are you? Who am I?"

OBSERVATION:

0 Orientated and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disorientated for date by no more than 2 calendar days
3 Disorientated for date by more than 2 calendar days
4 Disorientated for and / or person

VITAMIN PROPHYLAXIS AND TREATMENT OF WERNICKE-KORSAKOFF SYNDROME



Patients with overt/ incipient Wernicke's Encephalopathy or 'At Risk' of Wernicke's Encephalopathy MUST be given Pabrinex BEFORE the administration of dextrose or nutritional support

Intravenous Pabrinex should be administered over 30 minutes

Anaphylaxis is a rare complication of Pabrinex administration, and even more uncommon with intramuscular administration. Patients should be monitored for wheeze, tachycardia, breathlessness and skin rash. Facilities for the administration of adrenalin and other resuscitation should be available

Further vitamin supplementation (ie Forceval, folic acid) at discretion of responsible medical team in the context of a general nutritional assessment

CARE PLAN WARD 14A

NHS Greater Glasgow and Clyde

MS T SINCLAIR

90A MAIN STREET
LENNOXTOWN
GLASGOW
G66 7DA

UNIT NO:

DATE OF ADMISSION :

NURSE :

PROVISIONAL DIAGNOSIS :

Signs

BP	Pulse	Temp.	Resp.	Colour	Peak Flow	CNS	CVP	Fluid Balance	Urine Volume
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly	— hrly	— hrly	— hrly	— hrly	— hrly	

Monitoring / Recording of Observations

IV Cannula	IV Infusion	Chest Drain	Telemetry	Cardiac Monitoring	BM Stix	ECG during Pain
☐	☐	☐	☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly	— hrly		

Medications (Prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 therapy
☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly

via syringe Drive	via O_2	O_2 %	via Infusion Pump	Nebuliser Compressor Pump	Flow Rate
☐	☐	☐	☐	☐	☐

Hygiene

Bed bath (2 Nurses)	Assisted wash (1 Nurse)	Shower bath (Independent)	Ambu / Shower (Supervised)	Independent but on bed rest
☐	☐	☐	☐	☐

Mouth Care	Eye Care	Nasal Care	Catheter Care	Wound Care
☐	☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly	— hrly

Bladder and Bowel Care

Offer Commode / Urinal	Wheel to toilet	Self Care	Catheter Care	Continence Aids
☐	☐	☐	☐	☐

Stool Specimen for : CS ☐ FOB ☐

Mobilisation Ambulant

Bed Rest ☐ Independent ☐ Supervised ☐ Positional Change ☐ — hrly Specialised Bed ☐

Passive Limb Exercise ☐ — hrly No. of Staff required for M & H ☐ — specify Moving & Handling Aid ☐ — hrly

DIET

Normal diet ☐ Light diet ☐ Special Diet ☐ ——— specify Nasagastric / Gastronomy feeding. Use in conjunction with feeding chart. ☐

Requires help with feeding ☐ Restricted Fluids ☐ Fasting ☐ Dietetic Advice ☐ Ice to suck ☐ Fluids only ☐

Paramedic Services to be Involved

Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Liaison Services to be Involved

Cardiac ☐ Respiratory ☐ Diabetic ☐ Stoma ☐ Social Work ☐

putum Specimen for :

CS ☐

AAFB ☐

Pathology ☐

Urine Specimen for :

RSOU ☐ Wound Swab ☐

MSSU ☐ Specify

EMU ☐

Urinalysis	Colour	A.G.	Reaction	Sugar	Blood	Protein	Ketones	Bile	Others

Weight: Unable to

FALLS RISK ASSESSMENT A.M.R.U.
WARD 14 A

SEX	MALE 1	FEMALE 2				
AGE	0-70 1	71-80 2	81+ 3			
GAIT	Steady 1	Hesitant 1	Poor Transfers 3	Unsteady 3		
SENSORY DEFICIT	Sight 2	Hearing 1	Balance 2			
FALLS HISTORY	None 0	At Home 2	In Ward 1	Both 3		
MEDICINE	Hypnotics 1	Seditives 1	Hypotensives 1			
MEDICAL HISTORY	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Unable to 1	
MOBILITY	Fully Mobile 1	Uses Aid 2	Restricted 3	Bed Bound 1		
TOTAL						

Score 3-8 LOW RISK Score 9-12 MEDIUM RISK Score 13+ HIGH RISK

PATIENT MANAGEMENT

LOW RISK

1. Explain to patient the importance of asking for help when walking.
2. Ensure nurse call buzzer is at hand.
3. Ensure patient's footwear has been assessed as being appropriate.
4. Ensure variable height bed is left in a low position and the brakes are on.
5. Orientate to environment and ensure the area is hazard free.
6. If walking aid is used, ensure it is within easy reach of the patient.
7. If patient has had previous falls, speak to patient and family and offer advice to avoid reoccurence.
8. Initiate Multi-disciplinary falls assessment.

MEDIUM RISK

9. If possible ensure bed is in an area of close supervision.
10. Ensure patient, staff and relatives are aware of the risk of falling and precautions being taken.
11. Refer to Physiotherapist, Occupational Therapist and Podiatry.
12. Highlight risk in nursing notes.

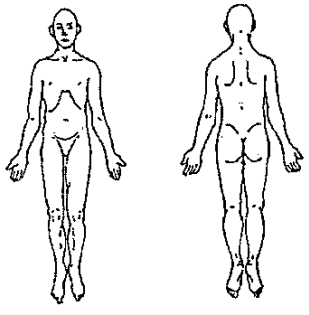
HIGH RISK

As for low and medium risk

13. Ensure maximum supervision at all times.
14. One to one supervision if required.

Signature: ..... Designation: ..... Date: .....

Waterflow Risk Assessment	Initials:													
	Date:													
	No.	1	2	3	4	5	6	7	8	9	10	11	12	13
Body weight for height:														
Average	0													
Above average	1													
Obese	2													
BelowAverage	3													
Continence:														
Completely catheterised	0													
Occasionally incontinent	1													
Cath. Incontinence of faeces	2													
Doubly Incontinent	3													
Skin Type-Visual Risk Areas:														
Healthy	0													
Tissue paper/Dry	1													
Oedematous/Clammy (Temp.)	1													
Discoloured	2													
Broken spot	3													
Mobility:														
Fully	0													
Restless/Fiidgety	1													
Apathetic	2													
Restricted	3													
Inert/Traction	4													
Chairbound	5													
Age/Sex:														
MaleFemale	1/2													
14-49	1													
50-64	2													
65-74	3													
75-80	4													
80+	5													
Appetite:														
Average	0													
Poor	1													
N.G. Tubes/Fluids only	2													
nbm - anorexic	3													
Special Risks - Tissue Malnutrition:														
e.g. Terminal Cachexia	8													
Cardiac Failure	5													
Peripheral Vascular Disease	5													
Anaemia	2													
Smoking	1													
Neurological Deficit:														
e.g. Diabetes, MS., CVA														
Motor-sensory Paraplegia	4-6													
Major Surgery/Trauma:														
Orthopaedic														
Below waist, Spinal	5													
On table > 2 hours	5													
Medication:														
Cytotoxics, Highdose steroids	4													
Anti-inflammatory														
TOTAL SCORE														
SCORE: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ - very high risk.												4		



MIS 115449

Acute Services Division

Hospital / Department

NHS
Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient nam MS T SINCLAIR .....

Ward: ..... 90A MAIN STREET .....
LENNOXTOWN

CHI numbe GLASGOW .....Unit/Hospital number .....
G66 7DA

Contents

1. Canard 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.

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0									
Sex	Male 1	Female 2										
Age	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 bound 1								
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3								
				TOTAL SCORE								
				ACTION(S) TAKEN Enter action code(s)								
SCORE 2 - 8 = LOW, 9 – 12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE								

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Action code	**LOW, MODERATE AND HIGH RISK**							
1	Prevention and general safety precautions discussed with patient and family.							
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE							

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

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 (Heminevin), antidepressants.

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

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

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

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.

Cat. No. 41328

VI MEDICAL ILLUSTRATION • DME • 10469

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: / /
Address: MS T SINCLAIR 90A MAIN STREET LENNOXTOWN GLASGOW	Time:
DoB: G66 7DA	HOSPITAL:
CHI number:	Ward:
Affix patient data label	

To be recorded within 24 hours of admission*

Height: m/ft Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☐

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

Please state:

Profile completed by: Name (PRINT): Signature: Date:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date										
Initials										
Height (see page 1) _____ Weight										
Oedema or ascites present Y/N										
BMI										

'MUST'

Step 1: BMI Score (refer to chart on page 4)										
>20 (>30 = Obese) 0										
18.5 - 20 1										
<18.5 2										
Step 2: Weight Loss Score										
Unplanned weight loss in past 3-6 months:										
<5% 0										
5-10% 1										
>10% 2										
Step 3: Acute Disease Effect Score										
If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2										
Not applicable ..... Score 0										
Step 4: Overall Risk of Malnutrition Total:										

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

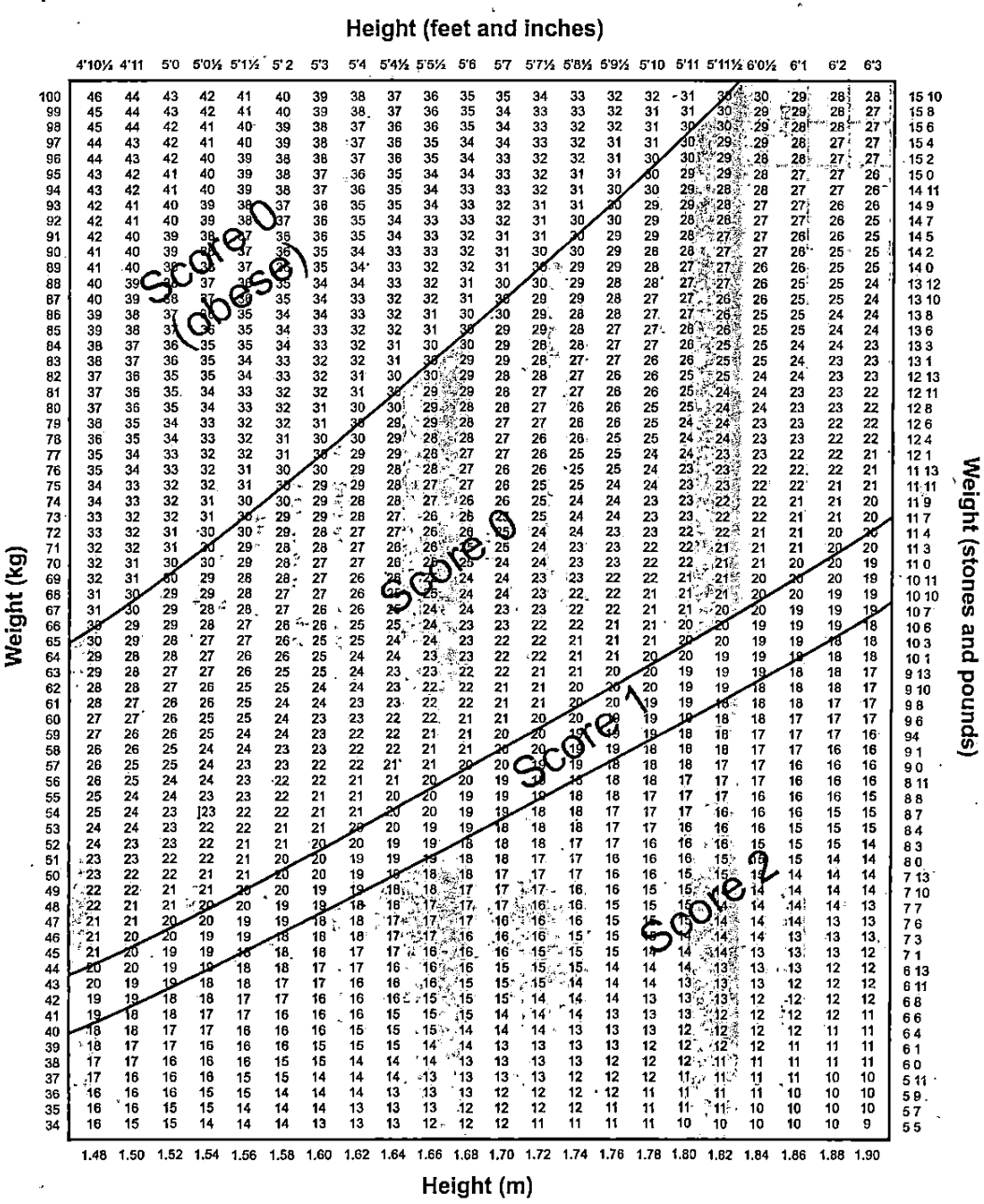
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 Wt loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't Loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08
STORES ORDER CODE 41850

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name:	Ward:
Unit number:	Discharge destination:
CHI number:	Estimated Discharge Date (1) / /
	Estimated Discharge Date (2) / /
Apply addressograph label	Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed				
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature:	Designation:			Date: / /

FORM NUMBER 0005752

VI MEDICAL ILLUSTRATION • DISCHARGE • 12410/14.01.08

E-Pacer PATIENT REPORT

Time 02:19 Date 06/07/2009

PATIENT AND INCIDENT DETAILS

Incident number	PA003023847 001
Name	THERESA SINCLAIR
Age	46
Gender	Female
Incident location	[illegible] MAINSTREET ENNISKEOWN
	ENNISKEOWN
Incident post code	[illegible]
Incident type	EMC
Call received	[illegible]
Call passed	[illegible]

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway [illegible]	[illegible]

BREATHING

Breathing [illegible]	Normal
Respiratory rate	
Oxygen given	[illegible]%

CIRCULATION

[illegible] rate	[illegible]
[illegible] peripheral pulse found	Radial
Cap refill rate	
Skin colour	Normal
Skin [illegible]	Dry

C SPINE INJURY

Suspected [illegible]	[illegible] of spine injury

AMPDS

Dispatch code	[illegible]
	Priority [illegible]
Final code	[illegible]
	Without Priority Symptom

GCS

Final [illegible] opening	Spontaneous
Final [illegible] response	Orientated
Final [illegible] response	Obeys commands

VITAL SIGNS

Time hr : min	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill secs	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	Pain score	ECG
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

AMPLE

Past history	[illegible]
	[illegible]
	[illegible]
	[illegible]
Last meal	[illegible]
	[illegible]
	[illegible]
	KILLED
Report ID	[illegible]
	[illegible]

Patient Sample Report

Status: **NOT VALIDATED**
Analyzed: 06.07.2009 03:40:04
Sample Type: **Arterial**
Account Number:
Clinician:
Operator: RHONA BRIGGS0

Patient

ID: 23004807E
SINCLAIR, TERESA
Female, 45 years
Birth Date: 13.08.1963

Analyzer

Model: GEM Premier 4000
Area: STOCAS
Name: SPARE
S/N: 06100188

Measured (37.0°C)

cH	↑ 44.5	nmol/L
pCO_2	↑ 6.6	kPa
pO_2	↓ 9.0	kPa
Na^+	144	mmol/L
K^+	3.6	mmol/L
Ca^{++}	↓ 1.09	mmol/L
Glu	↑ 5.9	mmol/L
Lac	incalculable	

CO-Oximetry

tHb	↓ 10.2	g/dL
O_2Hb	↓ 88.8	%
COHb	↑ 4.9	%
MetHb	0.3	%
HHb	↑ 6.0	%
sO_2	↓ 93.7	%

Derived

BE(B)	1.0	mmol/L
HCO_3^-(c)	27.1	mmol/L

O_2 and Vent Settings

FIO_2		%

↑ ↓ Outside Reference Range

TOXBASE .org
UK NPIS 0844 892 0111
Ireland NPIC (01) 809 2566
mailto: mail@toxbase.org

Search
Product search | Advanced search
For help with searching click here

NPIS National Poisons Information Service
A service commission Protection /

News General Info Specialist areas Chemicals Poisons Index A-Z Dosage Calculato

Temazepam Revised 09/2008

Type of Product

A benzodiazepine.

Ingredients

Temazepam
Tablets - 10 mg, 20 mg
Oral solution - 10 mg/5 mL
Gel-filled capsules - 10 mg, 15 mg 20 mg, 30 mg - discontinued

Toxicity

Serious toxicity in children or adults is rare. An elderly patient developed coma and respiratory depress following an estimated overdose of 7 tablets of unknown strength (Verghese et al 1999).

The therapeutic elimination half life of temazepam is reported to be 8-15 hours (Martindale 2007).

When co-ingested with alcohol and other central nervous system depressants, the effects of benzodiaze potentially more severe.

Adults and children ingesting greater than 2 mg/kg require medical assessment.

Benzodiazepine - features and management Updated 03/2009

Features

Benzodiazepines commonly cause drowsiness, ataxia, dysarthria and nystagmus. Coma, hypotension, b and respiratory depression occasionally occur but are seldom serious if these drugs are taken alone. Co lasts only a few hours but may be prolonged in elderly patients.

Benzodiazepine respiratory depressant effects are more serious in patients with severe chronic obstruct airways disease. Severe effects in overdose also include rhabdomyolysis and hypothermia.

Co-ingestion of alcohol and other central nervous system depressants potentiates the effects of benzodi and can increase toxicity.

Management

Flumazenil (Anexate), a benzodiazepine antagonist, is not advised as a routine diagnostic test in patien reduced conscious level. It may sometimes be used as an alternative to ventilation in children who are benzodiazepines, or in patients with COPD to avoid the need for ventilation. It is not necessary or appr cases of poisoning to fully reverse the benzodiazepine effect. Flumazenil has a short half-life (about an in this situation an infusion may therefore be required.

Flumazenil is contraindicated when patients have ingested multiple medicines, especially after co-ingest benzodiazepine and a tricyclic antidepressant or any other drug that causes seizures. This is because th benzodiazepine may be suppressing seizures induced by the second drug; its antagonism by flumazenil

reveal severe status epilepticus that is very difficult to control.

Contraindications to the use of flumazenil include features suggestive of a tricyclic antidepressant inges including a wide QRS, or large pupils. Use in patients post-cardiac arrest is also contraindicated.

It should be used with caution in patients with a history of seizures, head injury, or chronic benzodiazep

1. Maintain a clear airway and adequate ventilation if indicated.

2. The benefit of gastric decontamination is uncertain. Consider activated charcoal (50 g for an adult, 1 child) in adults or children who have taken more than a potentially toxic amount within 1 hour, provide airway can be protected.

3. Patients who are asymptomatic at 4 hours are unlikely to develop severe toxicity.

4. Monitor level of consciousness, respiratory rate, pulse oximetry and blood pressure in symptomatic p

5. Consider arterial blood gas analysis in patients who have a reduced level of consciousness (GCS < 8; scale P or U) or have reduced oxygen saturations on pulse oximetry.

6. Correct hypotension by raising the foot of the bed and by giving an appropriate fluid challenge. Wher hypotension is thought mainly due to decreased systemic vascular resistance, drugs with alpha-adrener activity such as noradrenaline or high dose dopamine (10-30 micrograms/kg/min) may be beneficial. Th inotrope should be titrated against blood pressure.

If severe hypotension persists despite the above measures, then central venous pressure monitoring sh considered.

If severe hypotension persists despite the above measures discuss with your local poisons information s the UK NPIS 0844 892 0111, in Ireland NPIC (01) 809 2566.

7. Supportive measures as indicated by the patient's clinical state.

8. Flumazenil (Anexate), a benzodiazepine antagonist, is available but should rarely be required. It may required in children who are naive to benzos or patients with COPD as an alternative to ventilation. Flur has a short half-life (about an hour) and in this situation an infusion may therefore be required.

Flumazenil should not normally be used in patients with a history of seizures, head injury, chronic benz use, co-ingestion of a benzodiazepine and tricyclic antidepressant or other proconvulsant - Instructions follow.

Activated Charcoal
Flumazenil Doses, Cautions and Adverse Effects
Drugs of abuse - time limits for detection
References

Nursing guide - benzodiazepines

Contact Page | sitemap

© Crown copyright 1983-2009

NPIS Nursing Guide to Care Plan
Benzodiazepines

Chlordiazepoxide, diazepam, lorazepam, nitrazepam and temazepam

Note This guide is intended to assist nursing staff caring for patients with benzodiazepine poisoning. It is based on nursing experience in the NPIS clinical units throughout the UK. For full clinical details and management refer to full TOXBASE entry for that benzodiazepine

Key Clinical Features

(Slow onset 4 – 6 hours post ingestion and long lasting)

Decreased conscious level
Respiratory depression
Hypotension

Warning: Co-ingestion with opiates, other sedative drugs or ethanol is potentially hazardous

Initial Assessment

- Admission Observations:
  - TPR, B/P, SaO_2 (oxygen saturation) and GCS (or AVPU*)
- Laboratory tests:
  - Creatinine, U&Es and LFTs

Asymptomatic Patients

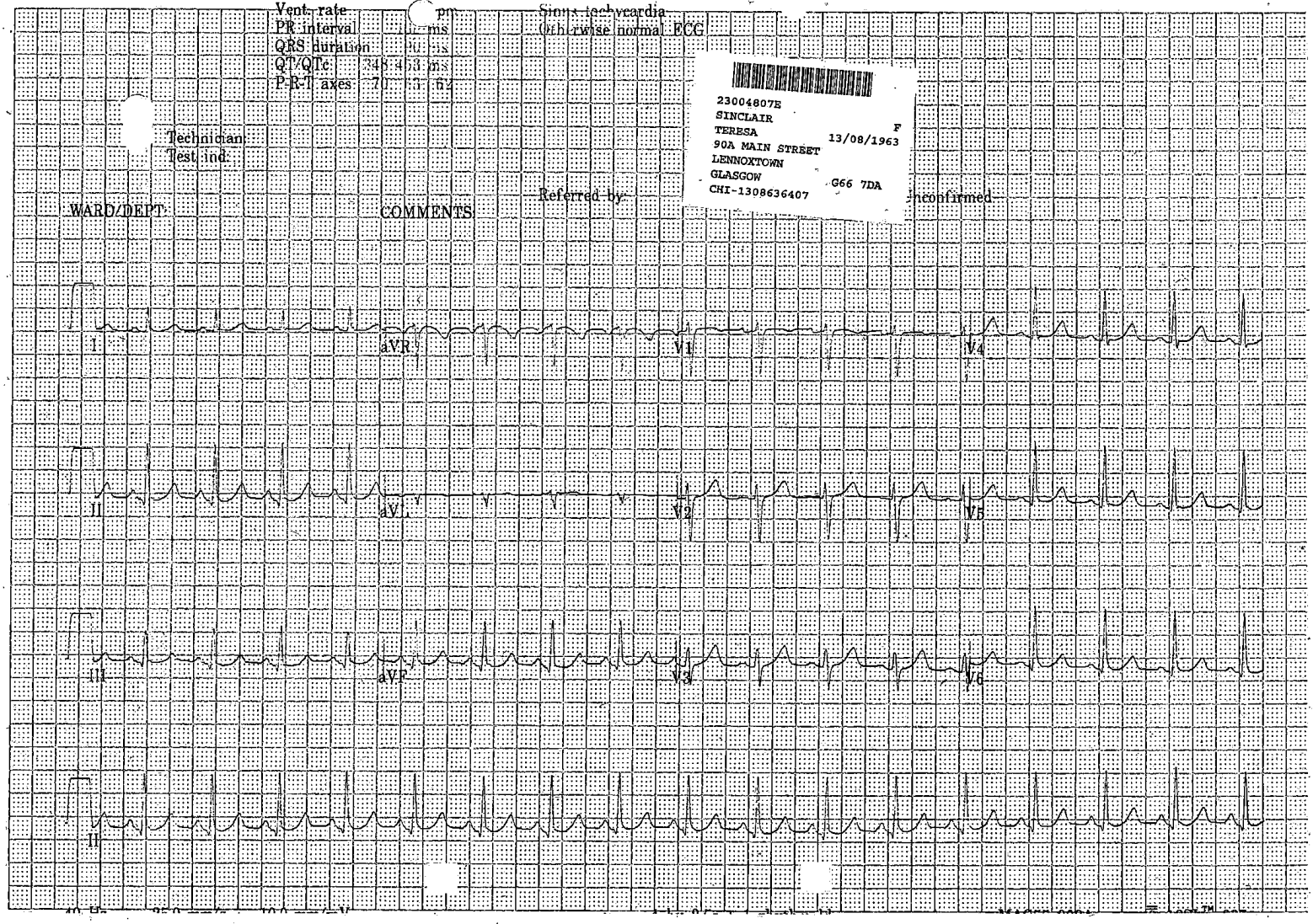
- Observe for 4 hours post ingestion

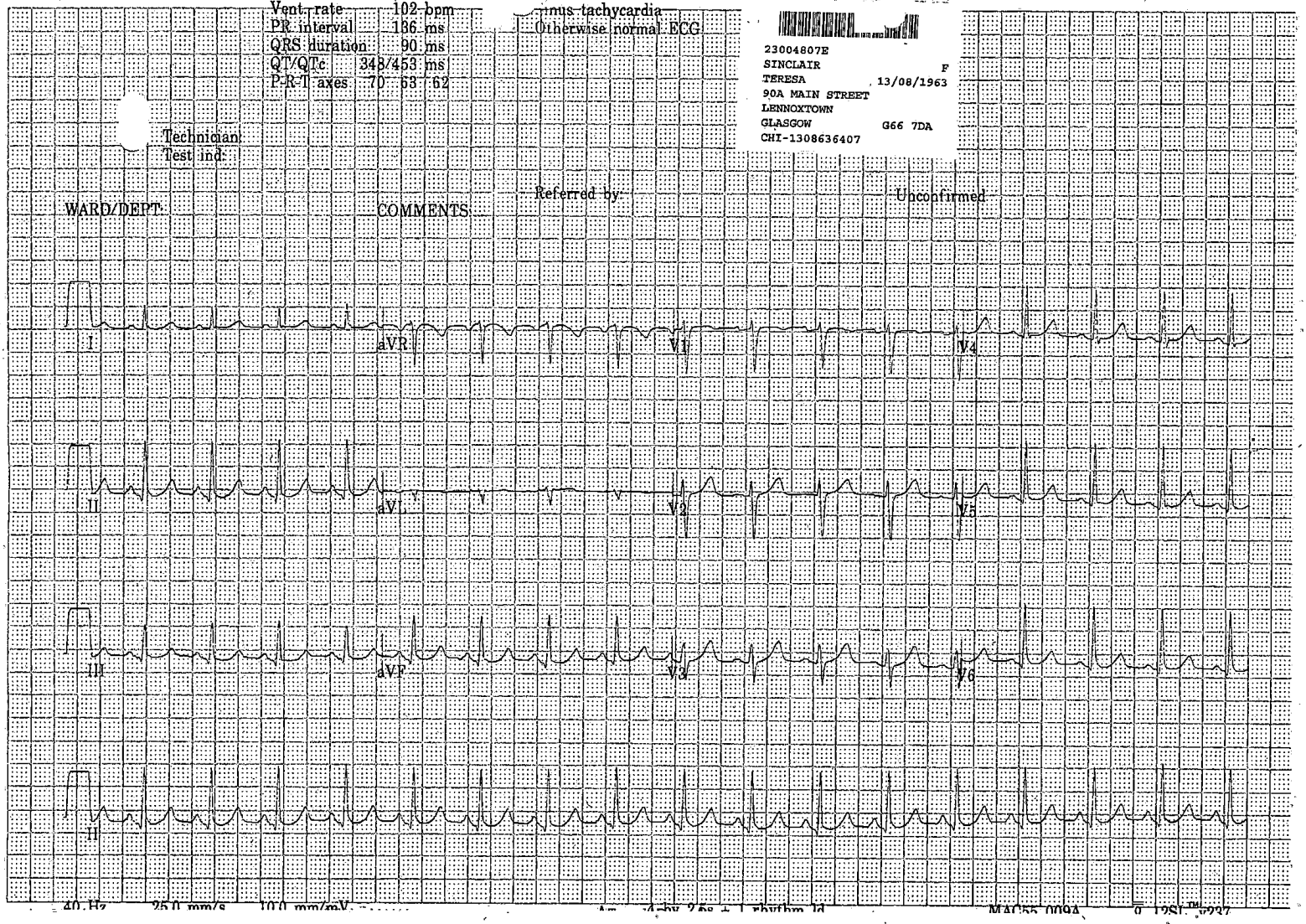
Symptomatic Patients

- Monitor every 15 minutes including respiratory rate SaO_2 (oxygen saturation) and GCS (or AVPU*) while symptomatic
- Hourly observations should be sufficient if patient is stable and 4 hours have passed
- Supportive measures as required

AVPU*
A simple assessment of conscious level for use in poisoning (Kelly et al, 2004)
A – Alert V – Responsive to voice P – Responsive to pain U – Unresponsive

SINCLAIR, TERESA ID: 6-Jul-2009 1:40:49 STOBHILL HOSPITAL




Vent. rate 102 bpm
PR interval 136 ms
QRS duration 90 ms
QT/QTc 348/453 ms
P-R-T axes 70 63 62
Sinus tachycardia
Otherwise normal ECG
23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407
Technician:
Test ind:
Referred by:
Unconfirmed
WARD/DEPT:
COMMENTS:
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
40 Hz
25.0 mm/s
10.0 mm/mV

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

Name: TERESA SINCLAIR	Height:
CHI No:	Weight:
Hospital Number: 2305048076	Surface area:
DOB: 13/8/63	Date of writing discharge prescription: __/__/__
Date of Admission: 6/7/9	Ward: 14a
Consultant Name: BUCHANAN	
Date and time this form prepared: __/__/__ Time:_____	Sheet No ..... / 2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

NKDA

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin	☐	TPN:	☐
PCA and other infusions	☐	Enteral Nutrition:	☐
Anticoagulants: Heparin	☐	Oxygen Therapy:	☐
Oral	☐	Other:	
Topical:	☐		

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

A DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
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.

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

PATIENT'S NAME:

Oral and Other Drugs: Regular Prescriptions

ADMINISTRATION

DATE →

MONTH →

Other time																															
0700-0900																															
1200-1400																															
1600-1800																															
2200-2400																															
Other time																															

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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 Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

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

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 Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

NN DRUG

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

PP DRUG

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN BY	

RR DRUG

DOSE | ROUTE | INDICATION

SIGNATURE OF PRESCRIBER | MAX.FREQUENCY | DATE:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

STOPPED DATE: INITIALS:

DATE	
TIME	
DOSE	
GIVEN 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.

| | | |

Nurse/Midwife Administration by Protocol - 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.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

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 indelible (black ink is recommended).

3. Sign your full name clearly against each prescription entry.

4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.

5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

6. 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).

7. 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	= nasojejunostomy	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
(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

Cat No.00548 Ver 8, 01/2009

Accident and Emergency Department
Stobhill Hospital


23004807E

A&E No. 10000021284

Surname	SINCLAIR	**Forename**	TERESA	**Title:** MS
Address:	90A MAIN STREET LENNOXTOWN GLASGOW	**Postcode** **Telephone:**	G66 7DA 077866 01685	**CHI No:**1308636407
Date of Birth:	13.08.63	**Sex:**	F	**Age:** 47 yrs


CHI Number: 1308636407

GP Name:	HENDERSON JAMES		
Address:	LENNOXTOWN CLINIC 103 MAIN STREET LENNOXTOWN	**Postcode** **Telephone:**	G66 7DA 01360310357

Next of Kin	MICHAEL		
Relationship:	OTHER		
Address:		**Postcode**	
		Telephone:	078876623809
Primary Carer:			

Date of Attendance: 16.09.10 01:58
Date of Incident:
Presenting Complaint: MED CAS. OD

Triage **Tetanus Cover:**

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=**

PF= **GCS=** E: M: V: Total:

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

© iSOFT Group Limited

Theresa
Patient I.D. Label
Sinclair 47

Patient handover information

From 14A

To Medical ward

NHS Greater Glasgow and Clyde

Presenting Complaint / Condition
?O/D Citalopram

Past Medical History
Depression A1c dependance

Current Management (Immediate handover details)		
for c/monitoring P+S levels.	IV Access	✓
	Iv Abs	
	Iv Fluids	
	Oxygen	%

Investigation Results	Investigations Pending

Is Patient Orientated	Yes		
	No		GCS?

Is patient in Pain	yes	
	no	

Mobility	Independent	
	Assistance of 1	
	Assistance of 2	
	Fully Dependant	

Diet	Normal		
	Special		?
	Referred to Dietician		
	Fasting / Nil by mouth		

Skin	Intact		
	Other		?
	Waterlow Score		
	Special Bed		

Infection Risk	Yes		?
	No		

Any other Issues

Patient's name Teresa Sinclair Age _____ Date of Birth 13/8/63

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 6/9/10 Time 01 55 Triage Nurse Mac PC Med Cas

2 Hours

has not vomited Overdose

Police

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) 0200
HR: 104
BP: 96/67
RR: 17
SaO_2: 97%
Temp: 36
G.C.S:
Signed Ar

INITIAL MANAGEMENT

Nurse Amanda.

Oxygen started _____ %: Signed _____ ECG: Signed Ar

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

905 Mac 8L Lithium

RESPONSIVENESS	TIME	hrs								1
	EYES OPEN	spontaneously 4								eye closed by swelling =C
		to speech 3								
		to pain 2								
		none 1								
	BEST VERBAL RESPONSE	orientated 5								Endotracheal tube or Tracheostomy = E Dysphaisa=D
		confused 4								
		inappropriate words 3								
		incomprehensible sounds 2								
		none 1								
	BEST MOTOR RESPONSE	obey commands 6								Record the best arm response Paralysed =P
		localises pain 5								
		normal flexion to pain 4								
		abnormal flexion to pain 3								
		extention to pain 2								
		none 1								
		COMA SCORE 15								
	PUPILS	RIGHT size (mm)								2 += Reacts -=No Recaction C= Eye closed SL= sluggish pupil
		RIGHT Reaction								
		LEFT size (mm)								
		LEFT Reaction								
MOVEMENT	ARMS	Normal power								3 Record right (R) and left (L) seperatly if there is a difference between the two sides Fractured limb = #
		Mild weakness								
		Severe weakness								
		Extention								
		No response								
	LEGS	Normal power								
		Mild weakness								
		Severe weakness								
		Extention								
		No response								
	PUPIL SCALE (mm) 1 2 3 4 5 6 7	230								4 40
		220								39
		210								38
		BLOOD PRESSURE mm Hg 200								37 Temp C°
		190								36
		180								35
		170								34
		160								33
		150								32
		140								31
		130								30
		120								
		110								
		100								
		90								
		PULSE RATE 80								
		70								
		60								
		50								
		40								
		30								
		RESPIRATORY RATE								5
		SaO_2								
		NURSE INITIALS								6

BLOOD GLUCOSE	Time				
BM STIX	BM				
PEAK FLOW	Time				
	PF				
VISUAL ACUITY	R. eye aided/unaided				
	L. eye aided/unaided				
	pH L. eye	R. eye			

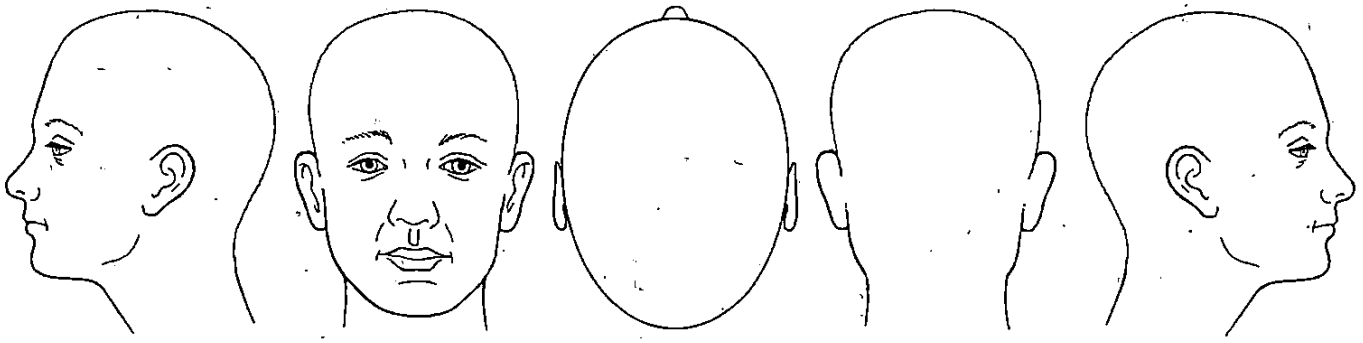
Signed: _____

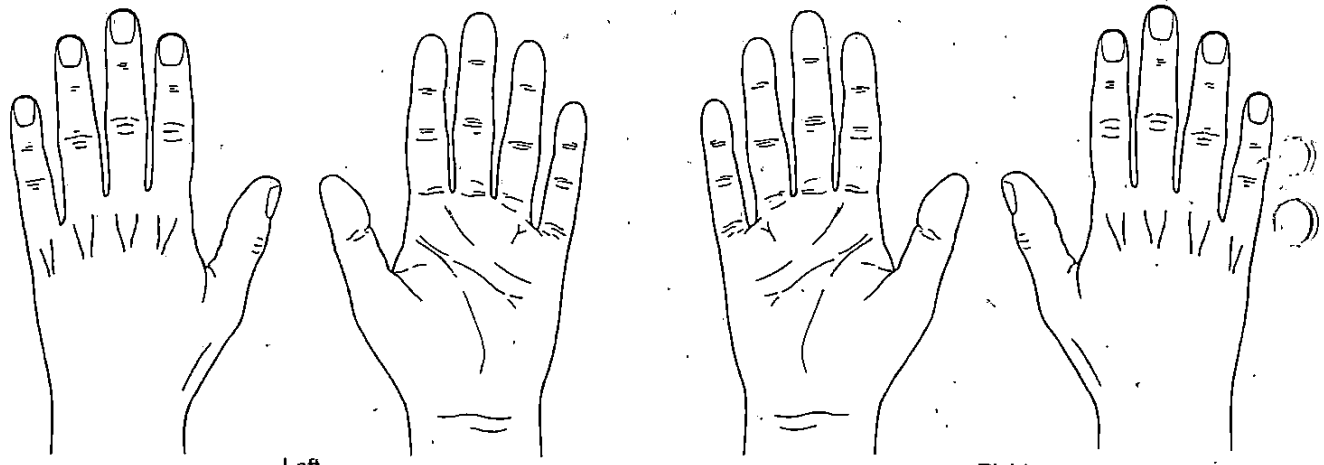
URINALYSIS

Urobilinogen µmol/L	Normal 3 16	33	66	131			
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Signed: _____

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds





Dorsal

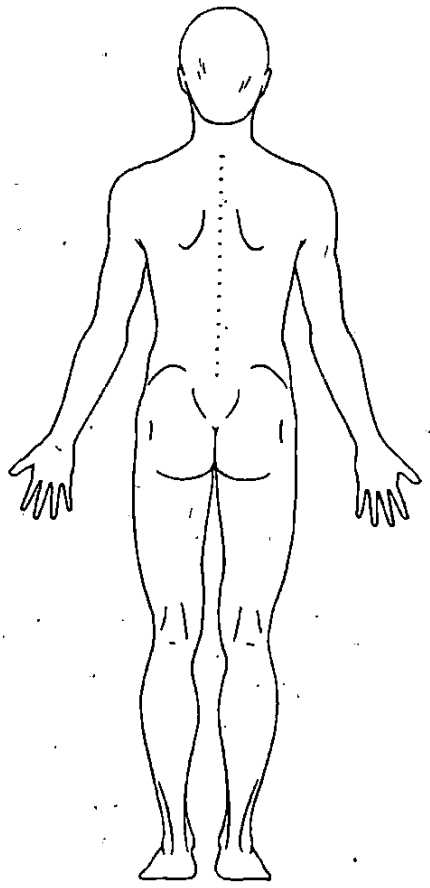
Left

Palmar

Palmar

Right

Dorsal





Left Dorsal



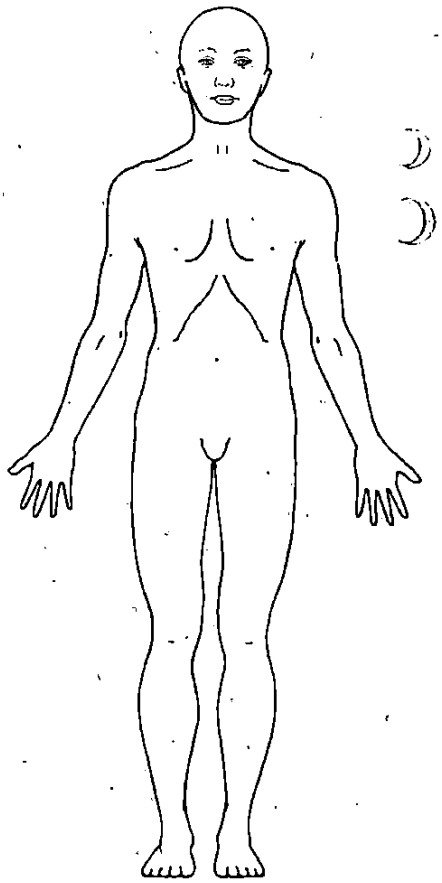
Right Dorsal



Left Plantar



Right Plantar



Signed _____

NURSING NOTES

Signature: [illegible] Time: 0200

History: pt presented @ Con dep OD of unknown substance. Taken friends medications.

PMH/ Depression

DH

Allergies: No / Yes

NKDA

Initial Management

02 Y/N Litres Per Min

ECG Y/N X-ray Y/N

Urinalysis:

βHCG +ve -ve

Cannula Y/N

Bloods	Y/N
U & Es	☐
FBC	☐
GL	☐
Amyl	☐
Coag	☐
Group	☐
D. Dimers	☐

Other:

Social History: lives alone.

NOK Daughter Tressa Jenkins

Not / present

Keys / valuables

Social Services

Not / contacted

MEDICAL NOTES - HISTORY and EXAMINATION

Consultant _____ Seen by _____

Grade: SpR SHO SHO3 JHO Clin Assist ENP SG AS *(Please circle)* At (time) _____

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

Date	
16/9/16	G.MINHAS CPST 0230
	(47) F Background - Depression Alcohol dependent
	Drinking with friends this evening, police attended for Noise disturbance.
	They then attempted to arrest her as she has an outstanding warrant for arrest
	She then told officers that she has taken an OD of what could be 12x 20mg Citalopram tablets (am) but is unsure.
	intoxicated, in dept
	P104 96/67 rr 12 97% RA 36°C
	Cheste clear
	Varied response to questions regarding suicidal ideation
	P.T.O

Date

Chest clear

PERCA
neurologically grossly intact

Bloods. FBC (N)
Coag (N)
UTE (N)
paracetamol <15
CRP 3.4

ECG. Sinus tachy 110.

Imp/- ? intentional OD ? citalopram
-? Told police she took an overdose to avoid going into the cells overnight

D/w CPN - No formal psych Hx
is known to CAT for alcohol dependence

Toxbox - Can prolong QT / QRS
Need to observe for minimum 6hr

(P) - refer medics
- need observation +/- cardiac monitor

psych input when sober.

G. Mannan
GPST1

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

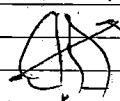
Date

16/9/10 KENNEDY GPST1 MEDICINE.

PC - Citalopram OD - ? 240mg.

HPC - Drunk at party when police tried to arrest her and she announced had taken OD of ~~[illegible]~~ her medication.
Police searched house and could only find half her citalopram supply (one box missing).
Pt very vague about what she's taken. Says it came out of a bottle and she took a handful.

O/E Pt intoxicated.



Chest clear
HS I+II+0



Abdo soft, non tender
BS present
No masses

DH- Citalopram NKDA.
Omeprazole
buscopan

PMH- Depression
Irritable bowel
Alcohol dependence

Bloods - normal
ECG - sinus tachy

SH - smokes 50 roll ups a day.
binge drinks.
lives alone. - boyfriend killed in RTA last yr.

Impression - unclear history but possible citalopram OD

Plan - cardiac monitor for 6 hrs, if no QT/QRS prolongation can be d/c.

CK

GPST1 ~~HHSS~~.

16/9/10 Addiction Liaison Tel [illegible]
Thank you for referral. Reporting history of binge drinking. Yesterday consumed ~~[illegible]~~ greater than 15 units of alcohol. Unclear of actual amounts. No alcohol 7 days previous to that. Currently seeing Denise at East Dunbartonshire CAT. Reports binges better controlled. No alcohol withdrawals previously DTs. Please continue CIWA but pabs not required. Discharge when medically fit. Contact East Dun CAT re admission.

Gill Wilson.

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.
23004807E	SINCLAIR TERESA	13.08.(

Specimen N,10.0206150.E Type Specimen
Collected 16.09.10 02:20 A.Diag

.....U&E.....		AST	17	Ca 2.26
Sodium	144	ALT	10	
Potassium	4.4	G-GT	20	AdCa 2.36
Chloride	+ 111	A Phos	67	
Urea	3.6	T Prot	69	Phos 1.47
Creat	69	Alb	37	
eGFR	>60	Globulin	32	Glu 5.4
.....LFTs.....		.....Bone.....		
Bili	2	A Phos	67	

Parac'mol Refer to BNF diagram for paracetamol overdos
200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Les
Salicylate Salicylate intoxication >350mg/L, severe to>
>280mg/L if under 5 years.

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.
23004807E	SINCLAIR TERESA	13.08.(

Specimen N,10.0206150.E Type Specimen
Collected 16.09.10 02:20 A.Diag

.....CRP.....	
CRP	3.4
.....Parac'mol.....	
Pmol mg/L	<15
.....Salicylate.....	
Salic mg/L	<50
.....Chol.....	
Chol	+ 5.30

Parac'mol Refer to BNF diagram for paracetamol overdos
200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Les
Salicylate Salicylate intoxication >350mg/L, severe to>
>280mg/L if under 5 years.

Quit \ Earlier req \ Later req \ ED \ LD \ Prev res
Back \ PHoned comment <B>

Glasgow Royal Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.
23004807E	SINCLAIR THERESA	13.08.(

Specimen R,10.2130925.S Type Citrate/El
Collected 16.09.10 02:43 A.Diag

.....FBC.....		.....C/Screen.....	
WBC	8.3	PT	11
Hb	125	PT C Ratio	0.9
Hct	0.374	APTT	32
MCV	91.9	APTT Ratio	1.1
Plts	454	TCT	16
NEUT	2.6	TCT Ratio	1.1
LYMPH	4.8		
MONO	0.7		
EOS	0.05		
BASO	0.10		

C/Screen This report does not include any comment on

Quit \ Earlier req \ Later req \ LD
Back \ PHoned comment <B>

PM

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug *(BLOCK CAPITALS)*	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no

IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record (Part B)

NHS Greater Glasgow and Clyde

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Date 16/9/10 Consultant DL Livingstone Ward 14A

PRE-ADMISSION	ON ADMISSION
Sleeping	
☑ No problems sleeping ☐ Problems with sleeping specify: ☐ Use of night sedation specify:	
Communication/Sensory Impairment	
☑ No Problems Communicating ☐ Specify Any Problems ☐ (e.g. Dysphasia, use of hearing aids / glasses):	alert, orientated laughing
Nutrition	
☑ Normal Diet ☐ Special Diet specify: ☐ Appetite specify: ☐ Recent Weight Changes specify: ☐ No Problems Swallowing ☐ Swallowing Difficulties specify:	☐ **Nutrition Risk Score=** **(If greater than 10 refer to Dietician.)**

Waterlow Chart

Circle scores in table. Add total. Several scores per catagory can be used.

Build/Weight for Height		Skin Type: Visual Risk Area		Sex: Age	
Average	(0)	Healthy	(0)	Male	1
Above Average	1	Tissue Paper / Dry	1	Female	(2)
Obese	2	Oedematous	1	14 - 49	(1)
Below Average	3	Clammy (Temp)	1	50 - 64	2
		Discoloured	2	65 - 74	3
		Broken/ Spot	3	75 - 80	4
				81+	5
Continence		**Mobility**		**Appetite**	
Complete/ Catheter	(0)	Fully	(0)	Average	(0)
Occ. Incontinence/ Cath/ Incontinent	1	Restless/ Fidgety	1	Poor	1
		Apathetic	2	NG Tub/ Fluids Only	2
Faecally Incontinent	2	Restricted	3	NBM/ Anorexic	3
Doubly Incontinent	3	Inert/ Traction	4		
		Chairbound	5		
SPECIAL RISKS					
Tissue Malnutrition		**Neurological Deficit**		**Medication**	
Terminal Cachexia	8	Diabetes MS, CVA,		Cytotoxics	
Cardiac Failure	5	Motor Sensory Paraplegia	4 - 6	High Dose Steroids	4
PVD	5				
Anaemia	2				
Smoker	(1)				

SCORE	10+ = AT RISK	15+ = HIGH RISK	20+ = VERY HIGH RISK

Pressure Areas	specify:	Skin condition: intact Waterlow score: 4 Torrance score:

Clinical Notes

Police Custody

Emergency admission re arrest of a 47yrs old lady
c overdose of citalopram + alcohol
PMH depression, IBS, Alcohol dependency
Impression ? Overdose citalopram
Plan - Cardiac monitoring for QTc if no QT/QRS prolongation can be d/c.
No Telemetry available :- c/o Cardiac monitor Rhys

liaison Psychiatry 16/9
Thanks, assessed on ward today. Impulsive o.d. of ? Citalopram whilst very intoxicated. Was aware she was to present to police station c/o outstanding warrant, decided to become intoxicated prior to having spend night in cell. little or no suicidal ideation intent. No ongoing thoughts, regrets actions. Can be discharged to police custody when medically fit.

c/o
C. McLaughlin

16/9/10
washed. Independently Hx
Am Seen by CPN
and Cat for discharge
when medically fit
Await medical F/U
S.N. Cusack

16/9/10 ECG - no QRS or QT prolongation. N Whittle FY1 (1030)

Discharge - Police custody
- Veller out.
- Indent discharge letter given

Lsm

Clinical Notes

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.
23004807E	SINCLAIR TERESA	13.08.(

Specimen N,10.0206196.R Type Specimen
Collected 16.09.10 08:00 A.Diag

U&E			
Sodium	141	T Prot	66
Potassium	4.4	Alb	36
Chloride	108	Globulin	30
Urea	3.3	CRP	
Creat	65	CRP	3.0
eGFR	>60		
LFTs			
Bili	2		
AST	18		
ALT	8		
G-GT	20		
A Phos	71		

Glasgow Royal Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.
23004807E	SINCLAIR THERESA	13.08.(

Specimen R,10.2130969.A Type Citrate/El
Collected 16.09.10 08:00 A.Diag

FBC	
WBC	7.7
Hb	127
Hct	0.387
MCV	92.8
Plts	481
NEUT	2.3
LYMPH	4.5
MONO	0.8
EOS	0.06
BASO	0.08

Quit \ Earlier req \ Later req \ ED \ LD
Back \ PHoned comment <B> ..

Clinical Notes

Gl... Unita... nit... nary... (Part B)

Acute Medical Unit (14a) Stobhill Unitary Patient Record

NHS Greater Glasgow and Clyde

230048807E F
SINCLAIR 13/08/1963
TERESA
90A MAIN STREET
LENNOXTOWN G66 7DA
GLASGOW
CHI-1308636407

Date

Ward

Ward Review

Please complete where appropriate:

AMT (if >65 years)

CURB Score (if <65 years)

SIRS

DVT Prophylaxis
- indicated ☐
- not indicated ☐

01927

Medicine Reconciliation Form

Source of Information: Patient ☐ Relative/ carer ☐ GP surg ☐ GP computer printout/letter ☐ Patient's own drugs ☐ Other (specify) .....

Admission Medicines (including OTC, herbal, homeopathic)				Plan for medicines (unless indicated to stop or hold, medication should be continued on drug kardex)				
Name	Dose	Freq	Route	Amend	Withhold	Stop	Continue	Reason for alteration
Diclofenac								
Omeprazole								
Ruscapen								
Allergies/adverse events	None known							

List obtained by ..... Designation .....

Recently altered/discontinued medicines prioir to admission and reasons why .....

.....

Compliance aid? Y ☐ N ☐ Type..... If, Y Community Pharmacy ..... Phone .....

Senior Medical staff review: Sign ..... Title ..... Date and Time .....

Reviewed by pharmacist ..... Date and Time .....

Comments

Acute Medicine Unit
Glasgow Royal Infirmary
Unitary Patient Record (Part B)

NHS
Greater Glasgow and Clyde

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Date	Consultant	Ward

Consultant Review

16/9/10 ? Sandy alcohol abuse in
? ↓ ↑ ↑ abdo pain (in
police custody)
LFTs ⊖
No CXR
CTs Not dressed & clipped
HIV ⊖
No ag GCS drips

Needs full Rx PA
CAT/CMV to K/V
RNTECG 12 noon
EDD 16/9/10

Rubby

Estimated Discharge Date

Print Name Designation

Signature Date and Time

Pink Varfed

Social Circumstances

Name (print): R Lyons	Signature: R Lyons	Time: 0450	Named Nurse: M Murphy

Religion/Spiritual Belief:	—	**Occupation:** —	**Rm/B:** 8 -

Domestic Arrangements: (please circle)	**Lives;** (Alone) Family Partner House Bound
Housing: (please circle)	Sheltered Residential Nursing House Bungalow (Flat) position) **Stairs;** Internal / External
Carers: (please circle)	Cared for by partner / Other Carer for partner / Other Family issues.
Services: (please circle)	Meals on wheels District Nurse Home Carers CPN Day Hospital
Personal Belongings: (please circle)	Clothing Listed Dentures - Top/Bottom Prosthetics Policy Explained **Any Valuables** If yes - With Patient ☐ Deed Box ☐ Finance Dept ☐

Smoking History Tobacco.

Alcohol Screen ☐ Vodka 1/4 gal AS much as site Conger FAST +ve ☐ -ve ☐

Observations	Temp. 35°C	BP. 105/64	P. 85	RR. 18	SPO2. 95% RA	MEWS. 1

Functional Assessment

PRE-ADMISSION	ON ADMISSION
Breathing ☑ Breathing Problems Resp Problem Specify: ☐ Domiciliary Oxygen ☐ Domiciliary NEB Breathless On Exertion	no problem ASAT 95% RA
Circulation ☑ No circulatory problems ☐ Problem with circulation (e.g. PVD) specify:	no problems
Safety and Comfort ☑ No Problems with pain ☐ Chronic pain specify: ☐ Risks to safety (e.g. self harm) specify:	State orientation / conscious level: alert + oriented 15/15 - euphoric / laughing Pain on admission: panadol
Mobility ☑ Mobile Independently ☐ Problems with mobility specify:	Moving and Handling Requirements specify: independent
Personal Hygiene ☑ Independent ☐ Requires Assistance/Aids specify:	independent
Elimination ☑ No problems ☐ Problems with elimination specify:	independent

Cardiac Monitor Chart ward 14a Stobhill

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Date :- 16/9/10

Time	Rhythm	Rate	Comments
11:00			
12:00			
13:00			
14:00			
15:00			
16:00			
17:00			
18:00			
19:00			
20:00			
21:00			
22:00			
23:00			
00:00			
01:00			
02:00			
03:00	✓		
04:00	Admitted		
05:00	SR	85.	Commenced.
06:00	SR	80	
07:00			
08:00	SR	81	
09:00			
10:00			
11:00			

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	23004807E SINCLAIR F TERESA 13/08/1963
Address	90A MAIN STREET LENNOXTOWN GLASGOW G66 7DA
Hospital No.	CHI-1308636407
DOB	

Admitted	Date 16/9/10	Ward 14c
Transferred	Date _____	Ward _____
Transferred	Date _____	Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

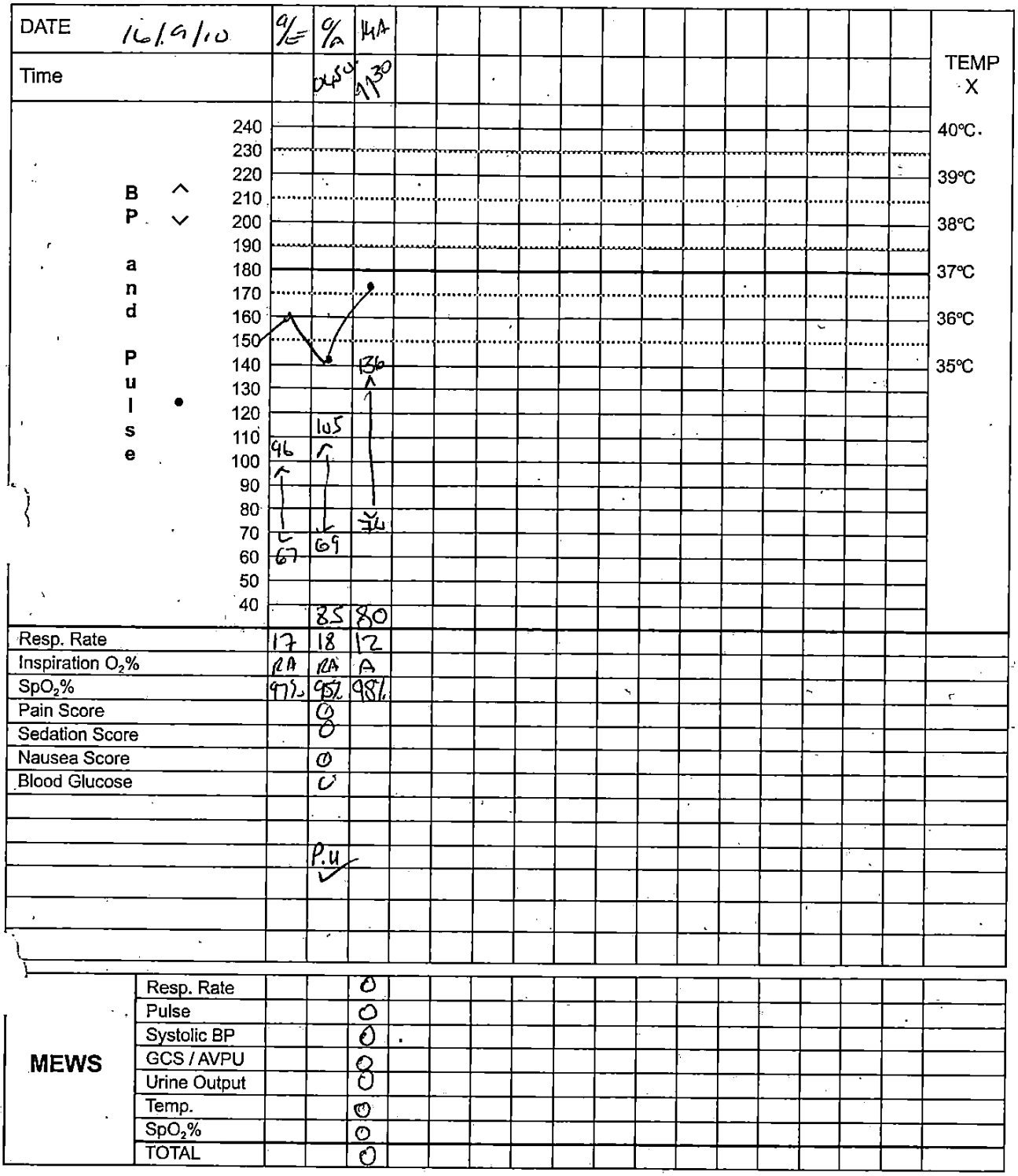
Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

Teresa Sinclair



Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO2%	≤87	88-91	92-94	95-100			

DATE																	
Time																	TEMP X
BP ^ v and Pulse •	240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40																40°C 39°C 38°C 37°C 36°C 35°C
Resp. Rate																	
Inspiration O_2%																	
SpO_2%																	
Pain Score																	
Sedation Score																	
Nausea Score																	
Blood Glucose																	

MEWS																		
	Resp. Rate																	
	Pulse																	
	Systolic BP																	
	GCS / AVPU																	
	Urine Output																	
	Temp.																	
	SpO_2%																	
	TOTAL																	

Calling Criteria

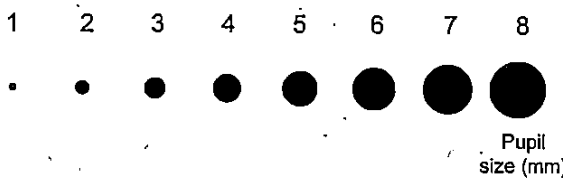
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

DATE																					
Time																					
COMA SCALE	E Eyes open	Spontaneously	4																		Eyes closed by dwelling = C
		To speech	3																		
		To pain	2																		
		None	1																		
	V Best verbal response	Orientated	5																		Endotracheal tube or tracheostomy = T
		Confused	4																		
		Inappropropriate 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																			
		No response																			
	LEGS	Normal power																			
		Mild weakness																			
		Severe weakness																			
		Extension																			
		No response																			

Glasgow Coma Scale



DATE																					
Time																					
COMA SCALE	E Eyes open	Spontaneously	4																		Eyes closed by dwelling = C
		To speech	3																		
		To pain	2																		
		None	1																		
	V Best verbal response	Orientated	5																		Endotracheal tube or tracheostomy = T
		Confused	4																		
		Inappropropriate 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																			
		No response																			
	LEGS	Normal power																			
		Mild weakness																			
		Severe weakness																			
		Extension																			
		No response																			

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

Acute Services Division

Hospital / Department

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient nam

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Ward: .....

CHI number .....Unit/Hospital number .....

Contents

1. Canard 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: 6/5 Ward: 45	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0 ✓			0						
Sex	Male 1	Female 2 ✓				2						
Age	13-59 0 ✓	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0 ✓		0						
Medication type	Drugs for mental illness 1 ✓	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
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		1						
Gait	Steady 1 ✓	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		3						
				ACTION(S) TAKEN *Enter action code(s) from Care Plan below		1						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves				NURSE SIGNATURE								

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / Ward:	Date: / 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.							

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-amilofruse.

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

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

CA RD 14A

NHS Greater Glasgow and Clyde

23004807E
NAM SINCLAIR F
TERESA 13/08/1963
ADD 90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
SIGN CHI-1308636407

UNIT NO:

DATE OF ADMISSION : 16/9/10

PROVISIONAL DIAGNOSIS : Please see Notes

Recording of Vital Signs

BP	Pulse	Temp.	Resp.	Colour	Peak Flow	CNS	CVP	Fluid Balance	Urine Volume
☑ 4	☑ 4	☑ 4	☑ 4	☑ Cont	☐ —	☐ —	☐ —	☐ —	☐
hrly	hrly	hrly	hrly	hrly	hrly	hrly	hrly	hrly	

Monitoring / Recording of Observations

IV Cannula	IV Infusion	Chest Drain	Telemetry	Cardiac Monitoring	BM Stix	ECG during Pain
☑	☐	☐	☐	☑	☐	☐
— hrly	— hrly	— hrly	— hrly	Cont — hrly		

Medications (Prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 therapy
☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly

via syringe Drive	via O_2	O_2 %	via Infusion Pump	Nebuliser Compressor Pump	Flow Rate
☐	☐	☐	☐	☐	☐

Hygiene

Bed bath (2 Nurses)	Assisted wash (1 Nurse)	Shower bath (Independent)	Ambu / Shower (Supervised)	Independent but on bed rest
☐	☐	☐	☑	☐

Mouth Care	Eye Care	Nasal Care	Catheter Care	Wound Care
☐	☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly	— hrly

Bladder and Bowel Care

Offer Commode / Urinal	Wheel to toilet	Self Care	Catheter Care	Continence Aids
☐	☐	☑	☐	☐

Stool Specimen for : CS ☐ FOB ☐

Mobilisation Ambulant

Bed Rest ☐ Independent ☑ Supervised ☐ Positional Change ☐ — hrly Specialised Bed ☐

Passive Limb Exercise ☐ — hrly

No. of Staff required for M & H ☐ — specify

Moving & Handling Aid ☐ — hrly

DIET

Normal diet ☑ Light diet ☐ Special Diet ☐ ——— specify

Nasagastric / Gastronomy feeding. Use in conjunction with feeding chart. ☐

Requires help with feeding ☐ Restricted Fluids ☐ Fasting ☐ Dietetic Advice ☐ Ice to suck ☐ Fluids only ☐

Paramedic Services to be Involved

Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Liaison Services to be Involved

Cardiac ☐ Respiratory ☐ Diabetic ☐ Stoma ☐ Social Work ☐

Sputum Specimen for :

CS ☐

AAFB ☐

Pathology ☐

Urine Specimen for :

RSOU ☑ Wound Swab ☐

MSSU ☐ Specify

EMU ☐

Urinalysis	Colour	A.G. Reaction	Sugar	Blood	Protein	Ketones	Bile	Others	

Weight:

23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407

Adult Intravenous (IV) Cannulation Care Plan

NHS Greater Glasgow and Clyde

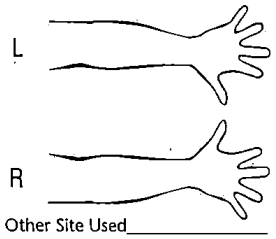
Potential Complications of IV Cannulation

1. Redness, pain or inflammation at insertion site due to phlebitis or local infection
2. Local oedema due to infiltration
3. Bloodstream infection
4. Extravasation

Required Nursing Actions

1. **Hand hygiene must be performed before and after IV cannula insertion or manipulation is undertaken.**
2. Decontaminate the patients' skin for at least 30 seconds and allow to dry before inserting the IV cannula. Non-sterile gloves must be worn and the insertion site should never be directly touched.
3. **Document the date, time**, gauge and **site of IV cannula insertion below.** Use the date strip contained within the IV dressing to label the date of insertion on the cannula dressing.
4. Assess and document the reasons for insertion and removal of IV cannulae below. **The IV cannula site and ongoing clinical need should be assessed at least once per shift and must be documented in the Monitoring and Recording Chart overleaf.** When the IV cannula is not in use, maintain patency by flushing with 0.9% sodium chloride every 24 hours.
5. **The IV cannula should be changed every 72 hours or immediately if indicated by VIP score of 2 or more. If the patient has poor venous access, a risk assessment should be carried out using VIP scoring tool overleaf. If score is less than or equal to 1 then the decision can be documented by nursing staff in the chart overleaf to retain cannula up to a maximum of 96 hours. If the cannula has to remain in situ for longer than this, then this decision must be made and documented by medical staff.**
6. **Check IV cannula dressing is dry and intact and that site of insertion can be easily observed. Replace dressing immediately if indicated and document procedure overleaf.**
7. Ensure IV cannula has a needle-free access system with integrated extension. This must be decontaminated for at least 30 seconds and allowed to dry before and after use.
8. If there has been a breach in aseptic technique during insertion (e.g. cannula was inserted during an emergency) then the cannula must be replaced within 24 hours of insertion *. If the cannula has to remain insitu for longer than this, then this decision must be documented overleaf.

Please mark successful cannulation with a number e.g. ① and failed cannulation with an Ⓕ



Other Site Used_____

Insertion Reason Codes: Emergency IV Access = E; Routine IV Access = R; Radiological Procedure = RP; Nil by Mouth = NBM; Chemotherapy = C; IV Fluids / IV Medicine Administration = IV; Blood = B; Other (Please state)

Removal Reason Codes: Not Required = NR; Phlebitis = P; Infiltration= I; Extravasation = E; Other (Please state)

Cannula Number	Date and Time	Inserted by (print name)	Insertion Reason Code	Gauge	Was aseptic technique breached?	Removed by (print name)	Date and Time	Removal Reason Code
①	16/9/10	Pink Venflon (R) arm	ate access		Yes*/No			
					Yes*/No			
					Yes*/No			
					Yes*/No			

IV site appears healthy	**0**	No phlebitis **OBSERVE CANNULA**
One of the following is evident: • Slight pain or redness near IV site	**1**	Possible first signs **OBSERVE CANNULA**
Two of the following are evident: • Pain • Erythema • Swelling	**2**	Early stage of phlebitis **RESITE CANNULA**
All of the following are evident: • Pain along the path of the cannula • Erythema • Induration	**3**	Mid-stage phlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along the path of cannula Erythema • Induration • Palpable venous cord	**4**	Advanced stage of phlebitis or start of thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**
All of the following are evident and extensive: • Pain along path of cannula • Erythema • Induration • Pyrexia • Palpable venous cord	**5**	Advanced thrombophlebitis **RESITE CANNULA and SEEK FURTHER ADVICE**

IV Cannula Monitoring & Recording Chart

(Based on the HPS PVC Care Bundle)

		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		
		Yes / No*	Yes* / No	Yes / No*		Yes / No*		

NHS Greater Glasgow and Clyde

Alcohol Screening & Assessment Tool

NHS Greater Glasgow and Clyde

Ple

CHI 23004807E F
SINCLAIR 13/08/1963
Nam TERESA
90A MAIN STREET
Addi LENNOXTOWN G66 7DA
GLASGOW
CHI-1308636407

Postcode _____

Drink / Type	Units
Wine 12% (175 ml glass)	2.1 Units
Wine 12% (750ml bottle)	9.0 Units
Beer/Lager 4.5% (440ml can/bottle)	2.0 Units
Beer/Lager 4.5% (500ml can/bottle)	2.2 Units
Spirtis 40% (25ml measure)	1.0 Units
Spirits 40% (1/4 bottle 175ml)	7.0 Units
Spirits 40% (700 ml bottle)	28.0 Units
Cider 4% (300ml glass)	1.2 Units
Cider 4% (1 litre bottle)	4.0 Units
Strong/White Cider 8% (300ml glass)	2.4 Units
Strong/White Cider 8% (1 litre bottle)	8.0 Units
Alcopops 5% (275ml bottle)	1.4 Units

Number of Units = ABV (%) x Volume (litres)

eg A bottle of wine (750mls) which is 12% ABV = 12 x 0.75 = 9 Units
A glass of wine (200mls) which is 12% ABV = 12 x 0.2 = 2.4 Units

Fast Alcohol Screening Tool - FAST:

1. **MEN: How often do you have EIGHT or more drinks on one occasion?**
   WOMEN: How often do you have SIX or more drinks on one occasion?

   Note : 1 drink = 1 unit of alcohol (refer to table above)

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☑4

2. **How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

   ever ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

3. **How often during the last year have you failed to do what was normally expected of you because of drinking?**

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. **In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?**

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☐4

Total ☐

Score of 3 or more: FAST Positive

FAST Positive?

Yes ☐ No ☐

FAST 0-2:	**Negative: No action required**
FAST 3-8:	**Hazardous Drinking: Advise regarding safe drinking levels and offer information leaflet and referral to GP for follow up/BI**
FAST 9-16:	**Probable Dependent Drinking: Advice as above, offer information leaflet and consider referral to specialist alcohol support service.**

Acute Services Division

Discharge Ch[illegible]st

NHS Greater Glasgow and Clyde

Pati[illegible]

Unit

CHI n

23004807E F
SINCLAIR 13/08/1963
TERESA
90A MAIN STREET
LENNOXTOWN G66 7DA
GLASGOW
CHI-1308636407

[illegible] addressograph label

Ward: 16A

Discharge destination: Home

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed		NA		
Others informed: Care Home		NA		
Transport arranged				
Own transport (preferred option)				
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed	-			
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				

[illegible]me of Discharge:

[illegible]se's signature:

Designation:

Date: / /

[illegible] NUMBER 0005752

Nutrition Profile

NHS Greater Glasgow and Clyde

Nam	Date of admission: / /
Addr: 23004807E SINCLAIR F TERESA 13/08/1963 90A MAIN STREET LENNOXTOWN GLASGOW G66 7DA CHI-1308636407	Time:
DoB:	HOSPITAL:
CHI number:	Ward:
Affix patient data label	

To be recorded within 24 hours of admission*

Height: m/ft Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: kg/stones Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☐

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

Please state:

Profile completed by: Name (PRINT): Signature: Date:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date										
Initials										
Height (see page 1)		Weight								
Oedema or ascites present Y/N										
BMI										

'MUST'

Step 1: BMI Score (refer to chart on page 4)										
?0 (>30 = Obese) 0										
18.5 - 20 1										
<18.5 2										
Step 2: Weight Loss Score										
Unplanned weight loss in past 3-6 months:										
<5% 0										
5-10% 1										
>10% 2										
Step 3: Acute Disease Effect Score										
If patient is acutely ill and there has been or is likely to be no or virtually no food intake for > 5 days..... Score 2										
Not applicable..... Score 0										
Step 4: Overall Risk of Malnutrition Total:										

ep 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score

Height (feet and inches)

Weight (kg)	4'10½	4'11	5'0	5'0½	5'1½	5'2	5'3	5'4	5'4½	5'5½	5'6	5'7	5'7½	5'8½	5'9½	5'10	5'11	5'11½	6'0½	6'1	6'2	6'3	Weight (stones and pounds)
100	46	44	43	42	41	40	39	38	37	36	35	34	34	33	32	32	31	30	30	29	28	28	15 10
99	45	44	43	42	41	40	39	38	37	36	35	34	33	33	32	31	31	30	29	29	28	27	15 8
98	45	44	42	41	40	39	38	37	36	36	35	34	33	32	32	31	30	30	29	28	28	27	15 6
97	44	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	28	27	27	15 4
96	44	43	42	40	39	38	38	37	36	35	34	33	32	32	31	30	30	29	28	28	27	27	15 2
95	43	42	41	40	39	38	37	36	35	34	34	33	32	31	31	30	29	29	28	27	27	26	15 0
94	43	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	14 11
93	42	41	40	39	38	37	36	35	35	34	33	32	31	31	30	29	29	28	27	27	26	26	14 9
92	42	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	14 7
91	42	40	39	38	37	36	36	35	34	33	32	31	31	30	29	29	28	27	27	26	26	25	14 5
90	41	40	39	38	37	36	35	34	33	33	32	31	30	30	29	28	28	27	27	26	25	25	14 2
89	41	40	38	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	14 0
88	40	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	13 12
87	40	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	13 10
86	39	38	37	36	35	34	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	13 8
85	39	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	13 6
84	38	37	36	35	35	34	33	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	13 3
83	38	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	23	23	13 1
82	37	36	35	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	12 13
81	37	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	12 11
80	37	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	12 8
79	36	35	34	33	32	32	31	30	29	29	28	27	27	26	26	25	24	24	23	23	22	22	12 6
78	36	35	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	12 4
77	35	34	33	32	32	31	30	29	29	28	28	27	27	26	25	25	24	24	23	23	22	22	12 1
76	35	34	33	32	31	30	30	29	29	28	28	27	26	26	25	25	24	23	23	22	22	22	11 13
75	34	33	32	32	31	30	29	29	28	27	27	26	26	25	25	24	24	23	23	22	22	21	11 11
74	34	33	32	31	30	30	29	28	28	27	26	26	25	25	24	24	23	23	22	22	21	21	11 9
73	33	32	32	31	30	29	29	28	27	26	26	25	25	24	24	23	23	22	22	21	21	20	11 7
72	33	32	31	30	30	29	28	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	11 4
71	32	32	31	30	29	29	28	28	27	26	26	25	25	24	23	23	22	22	21	21	21	20	11 3
70	32	31	30	30	29	28	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	11 0
69	32	31	30	29	29	28	28	27	26	26	25	24	24	23	23	22	22	21	21	20	20	20	10 11
68	31	30	29	29	28	28	27	27	26	25	25	24	24	23	22	22	21	21	21	20	20	19	10 10
67	31	30	29	28	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	10 7
66	30	29	29	28	27	27	26	26	25	25	24	23	23	22	22	21	21	20	20	19	19	19	10 6
65	30	29	28	28	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	19	19	18	10 3
64	29	29	28	27	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	10 1
63	29	28	27	27	26	26	25	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	9 13
62	28	28	27	26	26	25	25	24	24	23	23	22	22	21	21	20	20	20	19	19	18	18	9 10
61	28	27	26	26	25	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	9 8
60	27	27	26	25	25	24	24	23	23	22	22	21	21	20	20	20	19	19	18	18	17	17	9 6
59	27	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	19	18	18	17	17	17	9 4
58	26	26	25	24	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	9 1
57	26	25	25	24	23	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	9 0
56	26	25	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	17	16	16	16	8 11
55	25	24	24	23	23	22	21	21	20	20	19	19	18	18	18	17	17	17	16	16	16	15	8 8
54	25	24	23	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	8 7
53	24	24	23	22	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	8 4
52	24	23	23	22	21	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	8 3
51	23	23	22	22	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	8 0
50	23	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	7 13
49	22	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	7 10
48	22	21	21	20	20	19	19	18	18	17	17	17	16	16	15	15	15	14	14	14	14	13	7 7
47	21	21	20	20	19	19	18	18	17	17	17	16	16	16	15	15	15	14	14	14	13	13	7 6
46	21	20	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	7 3
45	21	20	19	19	18	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	7 1
44	20	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	6 13
43	20	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	6 11
42	19	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	6 8
41	19	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	6 6
40	18	18	17	17	16	16	16	15	15	15	14	14	14	13	13	13	12	12	12	12	11	11	6 4
39	18	17	17	16	16	16	15	15	15	14	14	13	13	13	13	12	12	12	12	11	11	11	6 1
38	17	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	11	6 0
37	17	16	16	16	15	15	14	14	14	13	13	13	13	12	12	12	11	11	11	11	10	10	5 11
36	16	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	5 9
35	16	16	15	15	14	14	14	13	13	13	12	12	12	12	11	11	11	11	10	10	10	10	5 7
34	16	15	15	14	14	14	13	13	13	12	12	12	11	11	11	11	10	10	10	10	10	9	5 5
	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.62	1.64	1.66	1.68	1.70	1.72	1.74	1.76	1.78	1.80	1.82	1.84	1.86	1.88	1.90	

Height (m)

Score 0 (obese)

Score 0

Score 1

Score 2

Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 Wt loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08

STORES ORDER CODE 41850

MANUAL PATIENT RECORDS

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 (PART 2.)	☑		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

GREATER GLASGOW HEALTH BOARD

STOBHILL HOSPITAL

UNIT NUMBER 313693

SURNAME	D.O.B.	SEX	MARITAL STATE	RELIGION
JENKINS	13·8·63	F	~~M~~ Sep	R.C

FIRST NAMES: THERESA

OCCUPATION: —

ADDRESS:
23004807E
SINCLAIR F
TERESA 13/08/1963
90A MAIN STREET
LENNOXTOWN
GLASGOW G66 7DA
CHI-1308636407
CRES
POST CODE

NEXT OF KIN (NAME & ADDRESS): ~~HUSBAND~~ CHRISTOPHER S/A
MOTHER MARET SINCLAIR
90A Main St
Lenoxtown.
POST CODE TEL. No. —

CHANGE OF ADDRESS
POST CODE TEL. No.

NAME & ADDRESS
Dr. J HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN
M
POST CODE G66 7DA
43261
SON
XTOWN.
No. 431 0588
01360
310357

CHANGE OF ADDRESS
POST CODE TEL. No.

NAME &
POST CODE TEL. No.

INDEX OF ATTENDANCES

Every NEW out-patient attendance, and EACH in-patient admission must be noted below

DATE	CLINIC/WARD	DOCTOR	DIAGNOSIS/OPERATION	CODED	DISCH. DATE
1.2.91	A/N. O/P.	Dr STILL			
20-8-91	29B			✓	21-8-91
27/12/92	adm 12B	MCROY		✓	
7.10.93	Adm 6.	MR HANSELL		✓	10.10.93
20/12/94	Adm 5	Mr Hansell		✓	22.12.94
26/8/96	adm 14A.	Smith			
16/6/97	Gyn.	Dr Row			
17/7/98	MEDICAL.	DR MANESH			
25·12·96	ADM 14A	DR FORREST		✓	
9.9.99	Medical	DR Danesh			
24/4/01	GYN	MACKENZIE			

USE RED INK FOR NOTIFICATION OF DEATH - ALL OTHER ENTRIES IN BLACK

GYNAECOLOGY

PLEASE PRESS FIRMLY WITH A FINE TIPPED BALL-POINT PEN

NEONATAL RECORD (Revised 1.1.87)

SMR11 (ABBREVIATED)

Hospital of Birth (Name or Code No.). STOBHILL E207 1

Case Reference No. 313493 6

Maternal Reference No. 313693 16

Surname JENKINS 26

Infant Forenames 1

Telephone No. 1

Home Address 38 BENGLOICH CRES 1

Post Code G657NB 38

Ward 11 Paediatrician or G.P. 1123921 47

Family Doctor 1

Address 1

1 Telephone No. 1

BIRTH RECORD

Spe Place 1. Hospital 2. Home 8. Other 9. N/K 1 55

E.D.D. 1/1/11 Sure Not Sure N/K

Gestation (by dates) 56

Time 11 Hrs. 35 Date of Birth 20089 1 58

Apgar Score 1 min./5 min. (for 9 and 10 enter 9, N/K=0) 99 64

Resuscitation
1. Nil (with clear airway, funnel O_2)
2. Mask, IPPV (no drugs)
3. Mask, IPPV (with drugs)
4. Intubation, IPPV (no drugs)
5. Intubation, IPPV (with drugs)
6. Drugs only
Specify:
8. Other 9. N/K

Birth Weight (g) 2250 71

Number of births this pregnancy 1 75

Birth Order 1 76

Sex 1. Male 2. Female 9. N/K 2 77

O.F.C. cm. 999 78

Transfers within hospital (2 only)
0. None 1. Post Natal Cot 2. SCBU 8. Other 9. N/K
1st 90
2nd 91

Number of days in SCBU 92

Jaundice (bilirubin mg%; µmol/l)
1. Absent
2. Mild (5–11.9; 86–204) or not measured
3. Moderate (12.0–19.9; 205–340)
4. Severe (20.0+; 342+)
9. N/K 4 116

Absent 1	Present 2	N/K 9	
Significant Hypotonia			1 118
Convulsions			1 121
Recurrent Apnoea			1 122
Assisted Ventilation after 30 mins.			1 123
Feeding Difficulty			1 124

TRANSFER BETWEEN HOSPITALS (Neonatal Only)

TRANSFER 1

Receiving Hospital Code No. 127

Case Reference No. 132

Paediatrician or G.P. 142

Date of Admission 149

Admitted to 1. Post Natal Cot 2. SCBU 8. Other 155

Number of days in SCBU 156

TRANSFER 2

Receiving Hospital Code No. 158

Case Reference No. 163

Paediatrician or G.P. 173

Date of Admission 180

Admitted to 1. Post Natal Cot 2. SCBU 8. Other 186

Number of days in SCBU 187

DISCHARGE RECORD

Condition 1. Normal 2. Doubtful 3. Cong. Abn. 4. Dead 5. Dead P.M. 6. Cong. Abn. & Other 8. Other 9. N/K 1 190

Discharge (Final)
1. Home with Mother
2. Home after Mother
3. To care of relative
4. To other ward or Hospital (Medical or Surgical).
5. Transfer to Residential/Foster Care
6. Dead
8. Other
9. N/K 191

Age (Days) 1 Weight at Discharge 9991 192

Date of Discharge 21 11 91 196

DIAGNOSIS

- V3 202
208
214
220
226
232
238
244
250
256

Operations (2 only) 1. 262
2. 266

FOLLOW UP 1. None 2. This Hospital 3. Elsewhere 4. Multiple 270

Local Option 271
281

PLEASE NOTE: COMPLETION OF SHADED BOXES IS OPTIONAL

NEONATAL RECORD–SMR11 (ABBREVIATED) FOR FURTHER DETAILS SEE MANUAL

Notes for completion of this form.

General

1. This form should be completed for every newborn infant discharged or transferred from hospital. The top copy should be sent in monthly batches to Room 8020, Information and Statistics Division, Trinity Park House, South Trinity Road, Edinburgh EH5 3SQ. The second copy may be sent to the General Practitioner and the back copy may be retained in the Hospital Case Records.
2. Use legible block capitals. A fine tipped ball point pen should be used.
3. In those instances where the key to the code is not given on the form, you may write comments in the spaces provided in addition to coding.
4. The use of separate temperature and weight charts will be necessary.
5. Items which do not have numbered coding boxes will not be included on the computer record. Shaded boxes need not be filled.

Administrative and Clinical Data — Coding Instructions

Box	Item	Instructions
1	Hospital of Birth	Enter the 5-digit official code
6	Case Reference No.	Enter a unique number. All numbers should have a minimum of 6 digits. Preceeding zeros should be entered to make the number up to 6 digits. e.g. 12345 = 0 1 2 3 4 5
16	Maternal Reference No.	
26	Surname	Enter the current surname, starting with the left-hand box. Apostrophes and hyphens should be placed in separate boxes. Names containing more than 12 letters should be entered as follows: D U R H A M - R O B E R T S O N
38	Postcode	Enter postcode if available.
47	Paediatric Consultant or G.P.	Enter appropriate 7-digit code.
55	Specify Place	Enter appropriate code.
56	Gestation	Enter the number of weeks (min. =20, max. =45). If not known, enter "99".
58	Date of Birth	Enter a 6-digit date, e.g. 010182 for 1st January 1982.
64	Apgar Scores (at 1 and 5 minutes)	Each box must contain a number in the range 0-9, where "0" means not done. For scores of 9 or 10 enter code "9". If resuscitation is in progress at 1 or 5 minutes, enter 'R'.
70	Resuscitation	Enter appropriate code.
71	Birth Weight	Enter the weight in grams, e.g. '0980' (min. =0200, max. =7500). If not known enter 9999.
75	Number of Births this Pregnancy	Enter in box 74 if the child was a singleton (1), a twin (2) or a triplet (3).
76	Birth Order	Enter in box 75 the order this child was born, e.g. the second child born in triplets=2
77	Sex	Enter appropriate code.
78	O.F.C.	Enter the measurement in cm. (preferably measured on third day of life). Min. =10.0, max. =49.9. If not known enter "99.9".
90-91	Transfers within hospital	Enter appropriate code. Both boxes should be completed.
92	Number of days in SCBU	Number of days = day of discharge minus day of admission to SCBU.
1	Jaundice	Enter appropriate code.
2	Findings — Any Age	Enter appropriate code.
	Transfer between Hospitals	(i.e. discharge from one hospital and admission to another) For further details see manual.
	Transfer 1 and 2 (if appropriate)	
117	Receiving Hospital Code No.	Enter the 5-digit code if known. Otherwise write name of hospital.
122	Case Reference No.	Enter a unique 10-digit code. All numbers should have a minimum of 6 digits. Preceeding zeros should be entered to make the number up to 6 digits. e.g. 12345 = 0 1 2 3 4 5
132	Paediatric Consultant or GP.	Enter appropriate 7-digit code.
139	Date of Admission	Enter a 6-digit date e.g. 070282 for 7th February 1982.
145	Admitted to	Enter appropriate code.
146	Number of days in SCBU	Number of days = day of discharge minus day of admission to SCBU.
180	Condition	Enter appropriate code.
181	Discharge (Final)	This applies to discharge from the neonatal service. Enter appropriate code.
182	Weight on Discharge or Death	Enter the weight in grams, e.g. '0980' (min. =0200, max. =7500). If greater than 9998 gm. enter 9998. If not known enter 9999.
186	Date of Discharge or Death	Enter a 6-digit date e.g. 090282 for 9th February 1982.
192-246	Diagnosis	The first diagnosis, Classification of infant, Single twin, etc., must be completed. The codes to be used are in the range V30 to V39 with 0, 1 and 2 used to indicate place of birth. The - V 3 have been preprinted leaving the remaining two digits to be filled in. The other diagnoses may be left blank but if filled in should be coded to the BPA supplement.
252-256	Operations	Enter code in accordance with the Office of Population Censuses and Surveys Code of Operations.
260	Follow up	Enter appropriate code.
271	Local Option	These boxes are for local use only. The code entered in each box should be in the range 0-9 Unused boxes should be left blank.

List of Abbreviations

EDD	- Estimated date of delivery	Cong. Abn.	- Congenital Abnormality
IPPV	- Intermittent positive pressure ventilation	N/K	- Not known
SCBU	- Special Care Baby Unit		

AL IN CONFIDENCE 2+0

SCOTLAND MATERNITY DISCHARGE SHEET

SMR2
Revised 1.1.87

GENERAL INFORMATION

Hospital Code * S Z 0 7 H 1–5

Hospital Case Reference Number * 3 1 3 6 9 3 6–15

Surname * J E N K I N S 16–27

Forename * T H E R E S A 28

Second Initial * 29

Maiden Name * S I N C L A I R 30–41

Age 28 Date of Birth * 1 3 0 8 1 9 6 3 42–49

Marital State MARRIED * 2 50

Home Address 38 BENCLOICH CRESCENT
LENNOXTOWN

Post Code * G 6 5 7 N B 51–57

Occupation
– Patient H/W 58–60
– Husband U/E 61–63

Date of Marriage 0 0 0 0 8 64–69

Obstetrician DR R.M. STILL * 0 4 6 4 7 8 70–76

Family Doctor DR HENDERSON 77–83

Type of Antenatal Care 84

2. PREVIOUS PREGNANCIES

Total Number	2 85	Spontaneous Abortions (Miscarriages)	86
Therapeutic Abortions	0 87	Caesarean Sections	0 88
Perinatal Deaths	0 89	Children now Living	2 90

3. CURRENT PREGNANCY

Date of Admission * 2 9 0 8 9 1 91–96

Admitted From abnormal address 1 97

Number of Previous Admissions to Any Hospital in this Pregnancy 1 98

Type of Admission Booked. * 3 99

Date of Booking 0 4 0 2 1 1 100/105

Original Booking for Delivery 2 106

Blood Group O Rh Pos 2 107

Height ft 1.57m ins 1 5 7 108/110

Type of Abortion 111

Management of Abortion 112

Sterilisation after Abortion 113

Principal Complication of Abortion 114

Last Menstrual Period * 0 2 1 1 9 0 115/120

Estimated Gestation at Abortion or Delivery 4 1 121/122

Certainty of Gestation based on LMP 2 123

4. MATERNAL DISCHARGE DATA

Date of Discharge * 124/129

Condition on Discharge * 130

Discharged To * 131

Category of Patient * 132

Unit on Discharge * 133

* THESE FIELDS MUST BE COMPLETED WHEN CONDITION ON DISCHARGE = 1 OR 4

5. RECORD OF LABOUR

Method of Induction of Labour 134

Presentation at Delivery or start of Operative Delivery — Baby 1 135 / Baby 2 136

Mode of Delivery — Baby 1 137 / Baby 2 138

Duration of Labour (In Hours) 0 3 139/14

Sterilisation after Delivery 141

Date of Delivery 2 0 0 8 9 142/14

Number of Births this Pregnancy 14

Outcome of Pregnancy — Baby 1 14 / Baby 2 15

Birthweight (GMS) — Baby 1 3 3 9 0 151/15 / Baby 2 155/15

Apgar Score at 5 mins — Baby 1 9 15 / Baby 2 16

Sex — Baby 1 2 16 / Baby 2 16

6. POSTNATAL RECORD OF INFANT(S)

Special Care Baby Unit — Baby 1 0 16 / Baby 2 16

Baby Discharged To — Baby 1 16 / Baby 2 1 16

Case Record No. in this Hospital — Baby 1 16/1 / Baby 2 17/1

To be specified by Clinician

Underlying Cause of Stillbirth or Baby Death

Baby 1 187/190

Baby 2 191/194

7. MAIN CONDITION

* 195

8. OTHER CONDITIONS

200

200

201

201

202

9. OPERATION

231

CT 2

National Use 2 0 0 8 23

Local Use 24

KEY TO CODED ITEMS

SMR.

Marital State [50]
1 = Never married (Single)
2 = Married
3 = Widowed
4 = Divorced
5 = Separated
8 = Other
9 = Not Known

Type of Antenatal Care [84]
0 = None
1 = GP Only
2 = GP care with specialist consultation
3 = Hospital Only
4 = GP and Hospital Shared
8 = Other
9 = Not Known

Admitted from [97]
0 = Not admitted
1 = Home
2 = Other hospital
3 = GP unit outwith this hospital
4 = Other speciality in this hospital

Type of Admission [99]
0 = Domiciliary (Not Admitted)
1 = Abortion (includes threatened abortion and ectopic pregnancy)
2 = Pregnant but not in labour
3 = In Labour
4 = Born before arrival
5 = Admitted after delivery at home
6 = Admitted after delivery in any hospital
8 = Other (e.g. doubtfully pregnant)

Original Booking for Delivery [106]
0 = Not booked prior to this admission
1 = Booked for Home delivery
2 = This Hospital (Consultant Unit)
3 = This Hospital (GP Unit)
4 = Other Hospital (Consultant Unit)
5 = Other Hospital (GP Unit)
9 = Not Known

Blood Group [107]
1 = O Rh −ve
2 = O Rh +ve
3 = A Rh −ve
4 = A Rh +ve
5 = B Rh −ve
6 = B Rh +ve
7 = AB Rh −ve
8 = AB Rh +ve
9 = Not Known

Type of Abortion [111]
0 = Threatened Abortion (still pregnant on discharge)
1 = Spontaneous or incomplete abortion
2 = Missed abortion
3 = Hydatidiform mole
4 = Therapeutic Abortion
5 = Suspected illegal abortion
6 = Failed therapeutic abortion
7 = Ectopic Pregnancy
8 = Unspecified abortion

Management of Abortion [112]
0 = Not operative (i.e. management of threatened or spontaneous complete abortion)
1 = D+C
2 = Vacuum aspiration
3 = Hysterotomy
4 = Prostaglandin (all forms)
5 = Amniotic infusion (other than Prostaglandin)
8 = Other (including ectopic pregnancy)
9 = Not stated

Sterilisation after Abortion [113]
0 = None
1 = Laparoscopy
2 = Laparotomy
3 = Laparoscopy Other hospital
4 = Laparotomy Other hospital
8 = Other
9 = Not stated

Principal Complication of Abortion [114]
0 = None
1 = Haemorrhage
2 = Sepsis
3 = Trauma to Cervix or uterus
4 = Damage to bowel
5 = Retained products requiring re-evacuation
8 = Other
9 = Not stated

Certainty of Gestation [123]
0 = Not applicable
1 = Certain
2 = Uncertain
9 = Not known

FULL INSTRUCTIONS FOR COMPLETING THIS FORM ARE CONTAINED IN THE SMR 2 MANUAL.

Condition on Discharge [130]
0 = Domiciliary Delivery
1 = Still pregnant
2 = Aborted (all types of completed abortion)
3 = Delivered
4 = Post natal care only
5 = Pregnancy not confirmed
8 = Other (e.g. known missed abortion)

Discharged to [131]
0 = Domiciliary Delivery
1 = Home Care
2 = Other hospital - GP maternity unit
3 = Other hospital - specialist maternity unit
4 = Other hospital or institution
5 = Other unit in this hospital
6 = Died (PM)
7 = Died (No PM)
8 = Other

Category of Patient [132]
1 = Amenity
2 = Paying
3 = NHS
7 = Special arrangement (see manual)

Unit on Discharge [133]
1 = Obstetric (Consultant)
2 = Obstetric (General Practitioner)
3 = Home or Other confinement not admitted to hospital
4 = Day Case (for definition see manual)
9 = Other or Not Known

Method of Induction of labour [134]
0 = None
1 = ARM
2 = Oxytocics
3 = ARM + Oxytocics
4 = Prostaglandins
5 = ARM + Prostaglandins
6 = Prostaglandins + Oxytocics
7 = Prostaglandins + ARM + Oxytocics
8 = Other
9 = Not Known

Presentation at Delivery or start of Operative Delivery (Baby 1 and Baby 2) [135], [136]
1 = Occipito - anterior
2 = Occipito - posterior
3 = Occipito - lateral
4 = Breech
5 = Face/brow
6 = Shoulder
7 = Cord
8 = Other
9 = Not Known

Mode of Delivery (Baby 1 and Baby 2) [137], [138]
0 = Normal, spontaneous vertex, vaginal delivery, occipito - anterior.
1 = Cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation.
2 = Forceps, low application, without manipulation, forceps delivery NOS
3 = Other forceps delivery. Forceps with manipulation. High forceps. Mid forceps
4 = Vacuum extraction ventouse.
5 = Breech delivery, spontaneous assisted or unspecified partial breech extraction
6 = Breech extraction. Breech extraction: NOS or Total or Version with breech extraction.
7 = Elective (planned) Caesarean Section.
8 = Emergency, other and unspecified Caesarean Section
9 = Other and unspecified method of delivery

Sterilisation after Delivery [141]
0 = None
1 = Laparoscopy
2 = Laparotomy
3 = Laparoscopy other hospital
4 = Laparotomy other hospital
8 = Other
9 = Not stated

Outcome of Pregnancy (Baby 1 and Baby 2) [149], [150]
1 = Live birth
2 = Still birth
3 = Live birth died < 7 days
4 = Live birth died 7-28 days
5 = Live birth died after 28 days

Sex (Baby 1 and Baby 2) [161], [162]
1 = Male
2 = Female
8 = Other or Not Known

Special Care Baby Unit (Baby 1 and Baby 2) [163], [164]
0 = Not Admitted
1 = Admitted for up to 48 hours
2 = Admitted for more than 48 hours
9 = Not known

Baby Discharged to (Baby 1 and Baby 2) [165], [166]
1 = Home
2 = Remaining in Special Care Baby Unit
3 = Special Care Baby Unit but home with mother
4 = Transfer to Other Hospital
5 = Other Unit in same hospital
6 = Foster Home
7 = Local Authority Care
8 = Healthy baby remaining in unit after mother's discharge
9 = Dead

MEDICAL IN CONFIDENCE

SCOTLAND MATERNITY DISCHARGE SHEET

SMR2
Revised 1.1.87

1. GENERAL INFORMATION

Hospital Code * S207H 1–5
Hospital Case Reference Number * 313693 6–15
Surname * FINK INS 16–27
Forename * THERESIA 28
Second Initial * C 29
Maiden Name * O'NEILL 30–41
Age 21 Date of Birth * 130819 42–49
Marital State _____ * 2 50
Home Address 38 DONCLOICH RD.
Post Code * G53 7NL 51–57
Occupation
– Patient H/W 58–60
– Husband U/E. 61–63
Date of Marriage 000088 64–69
Obstetrician DR STILL * 70–76
Family Doctor DR HENDERSON 2335801 77–83
Type of Antenatal Care 4 84

2. PREVIOUS PREGNANCIES

Total Number 2 85
Spontaneous Abortions (Miscarriages) 86
Therapeutic Abortions 0 87
Caesarean Sections 0 88
Perinatal Deaths 0 89
Children now Living 2 90

3. CURRENT PREGNANCY

Date of Admission * 150891 91–96
Admitted From 1 97
Number of Previous Admissions to Any Hospital in this Pregnancy 98
Type of Admission * 99
Date of Booking 090491 100–105
Original Booking for Delivery 2 106
Blood Group _____ Rh _____ 2 107
Height _____ ft _____ ins 5 7 108–110
Type of Abortion _____ 111
Management of Abortion _____ 112
Sterilisation after Abortion _____ 113
Principal Complication of Abortion _____ 114
Last Menstrual Period * 020190 115–120
Estimated Gestation at Abortion or Delivery 121–122
Certainty of Gestation based on LMP 0 123

4. MATERNAL DISCHARGE DATA

Date of Discharge * 150864 124–129
Condition on Discharge _____ * 1 130
Discharged To _____ * 1 131
Category of Patient _____ * 3 132
Unit on Discharge _____ * 4 133

* THESE FIELDS MUST BE COMPLETED WHEN CONDITION ON DISCHARGE = 1 OR 4

5. RECORD OF LABOUR

Method of Induction of Labour _____ 134
Presentation at Delivery or start of Operative Delivery _____ Baby 1 135
_____ Baby 2 136
Mode of Delivery _____ Baby 1 137
_____ Baby 2 138
Duration of Labour (In Hours) 139–140
Sterilisation after Delivery _____ 141
Date of Delivery 142–147
Number of Births this Pregnancy 148
Outcome of Pregnancy _____ Baby 1 149
_____ Baby 2 150
Birthweight (GMS) Baby 1 151–154
Baby 2 155–158
Apgar Score at 5 mins Baby 1 159
Baby 2 160
Sex _____ Baby 1 161
_____ Baby 2 162

6. POSTNATAL RECORD OF INFANT(S)

Special Care Baby Unit _____ Baby 1 163
_____ Baby 2 164
Baby Discharged To _____ Baby 1 165
_____ Baby 2 166
Case Record No. in this Hospital Baby 1 167–172
Baby 2 173–178

To be specified by Clinician

Underlying Cause of Stillbirth or Baby Death
_____ Baby 1 187–190
_____ Baby 2 191–194

7. MAIN CONDITION

_____ * 195–199

8. OTHER CONDITIONS

BLEEDING – UTS 200–204
_____ 205–209
_____ 210–214
_____ 215–219
_____ 220–224

9. OPERATION

_____ 231–235

CT 2

National Use 236–241
Local Use 242–247

KEY TO CODED ITEMS

SMR2

Marital State [50]
1 = Never married (Single)
2 = Married
3 = Widowed
4 = Divorced
5 = Separated
8 = Other
9 = Not Known

Type of Antenatal Care [84]
0 = None
1 = GP Only
2 = GP care with specialist consultation
3 = Hospital Only
4 = GP and Hospital Shared
8 = Other
9 = Not Known

Admitted from [97]
0 = Not admitted
1 = Home
2 = Other hospital
3 = GP unit outwith this hospital
4 = Other speciality in this hospital

Type of Admission [99]
0 = Domiciliary (Not Admitted)
1 = Abortion (includes threatened abortion and ectopic pregnancy)
2 = Pregnant but not in labour
3 = In Labour
4 = Born before arrival
5 = Admitted after delivery at home
6 = Admitted after delivery in any hospital
8 = Other (e.g. doubtfully pregnant)

Original Booking for Delivery [106]
0 = Not booked prior to this admission
1 = Booked for Home delivery
2 = This Hospital (Consultant Unit)
3 = This Hospital (GP Unit)
4 = Other Hospital (Consultant Unit)
5 = Other Hospital (GP Unit)
9 = Not Known

Blood Group [107]
1 = O Rh –ve
2 = O Rh +ve
3 = A Rh –ve
4 = A Rh +ve
5 = B Rh –ve
6 = B Rh +ve
7 = AB Rh –ve
8 = AB Rh +ve
9 = Not Known

Type of Abortion [111]
0 = Threatened Abortion (still pregnant on discharge)
1 = Spontaneous or incomplete abortion
2 = Missed abortion
3 = Hydatidiform mole
4 = Therapeutic Abortion
5 = Suspected illegal abortion
6 = Failed therapeutic abortion
7 = Ectopic Pregnancy
8 = Unspecified abortion

Management of Abortion [112]
0 = Not operative (i.e. management of threatened or spontaneous complete abortion)
1 = D+C
2 = Vacuum aspiration
3 = Hysterotomy
4 = Prostaglandin (all forms)
5 = Amniotic infusion (other than Prostaglandin)
8 = Other (including ectopic pregnancy)
9 = Not stated

Sterilisation after Abortion [113]
0 = None
1 = Laparoscopy
2 = Laparotomy
3 = Laparoscopy Other hospital
4 = Laparotomy Other hospital
8 = Other
9 = Not stated

Principal Complication of Abortion [114]
0 = None
1 = Haemorrhage
2 = Sepsis
3 = Trauma to Cervix or uterus
4 = Damage to bowel
5 = Retained products requiring re-evacuation
8 = Other
9 = Not stated

Certainty of Gestation [123]
0 = Not applicable
1 = Certain
2 = Uncertain
9 = Not known

FULL INSTRUCTIONS FOR COMPLETING THIS FORM ARE CONTAINED IN THE SMR 2 MANUAL

Condition on Discharge [130]
0 = Domiciliary Delivery
1 = Still pregnant
2 = Aborted (all types of completed abortion)
3 = Delivered
4 = Post natal care only
5 = Pregnancy not confirmed
8 = Other (e.g. known missed abortion)

Discharged to [131]
0 = Domiciliary Delivery
1 = Home Care
2 = Other hospital - GP maternity unit
3 = Other hospital - specialist maternity unit
4 = Other hospital or institution
5 = Other unit in this hospital
6 = Died (PM)
7 = Died (No PM)
8 = Other

Category of Patient [132]
1 = Amenity
2 = Paying
3 = NHS
7 = Special arrangement (see manual)

Unit on Discharge [133]
1 = Obstetric (Consultant)
2 = Obstetric (General Practitioner)
3 = Home or Other confinement not admitted to hospital
4 = Day Case (for definition see manual)
9 = Other or Not Known

Method of Induction of labour [134]
0 = None
1 = ARM
2 = Oxytocics
3 = ARM + Oxytocics
4 = Prostaglandins
5 = ARM + Prostaglandins
6 = Prostaglandins + Oxytocics
7 = Prostaglandins + ARM + Oxytocics
8 = Other
9 = Not Known

Presentation at Delivery or start of Operative Delivery (Baby 1 and Baby 2) [135], [136]
1 = Occipito - anterior
2 = Occipito - posterior
3 = Occipito - lateral
4 = Breech
5 = Face/brow
6 = Shoulder
7 = Cord
8 = Other
9 = Not Known

Mode of Delivery (Baby 1 and Baby 2) [137], [138]
0 = Normal, spontaneous vertex, vaginal delivery, occipito - anterior.
1 = Cephalic vaginal delivery with abnormal presentation of head at delivery, without instruments, with or without manipulation.
2 = Forceps, low application, without manipulation, forceps delivery NOS
3 = Other forceps delivery. Forceps with manipulation. High forceps. Mid forceps
4 = Vacuum extraction ventouse.
5 = Breech delivery, spontaneous assisted or unspecified partial breech extraction
6 = Breech extraction. Breech extraction: NOS or Total or Version with breech extraction.
7 = Elective (planned) Caesarean Section.
8 = Emergency, other and unspecified Caesarean Section
9 = Other and unspecified method of delivery

Sterilisation after Delivery [141]
0 = None
1 = Laparoscopy
2 = Laparotomy
3 = Laparoscopy other hospital
4 = Laparotomy other hospital
8 = Other
9 = Not stated

Outcome of Pregnancy (Baby 1 and Baby 2) [149], [150]
1 = Live birth
2 = Still birth
3 = Live birth died < 7 days
4 = Live birth died 7-28 days
5 = Live birth died after 28 days

Sex (Baby 1 and Baby 2) [161], [162]
1 = Male
2 = Female
8 = Other or Not Known

Special Care Baby Unit (Baby 1 and Baby 2) [163], [164]
0 = Not Admitted
1 = Admitted for up to 48 hours
2 = Admitted for more than 48 hours
9 = Not known

Baby Discharged to (Baby 1 and Baby 2) [165], [166]
1 = Home
2 = Remaining in Special Care Baby Unit
3 = Special Care Baby Unit but home with mother
4 = Transfer to Other Hospital
5 = Other Unit in same hospital
6 = Foster Home
7 = Local Authority Care
8 = Healthy baby remaining in unit after mother's discharge
9 = Dead

MAT. 1.

G.G.H.B. **STOBHILL GENERAL HOSPITAL** PCW OUTPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
JENKINS	THERESA	313693	H/W.	(M). S. W.

DATE OF BIRTH	AGE	WARD/DEPT	RELIGION	MAIDEN NAME
13-8-63	27	OPD.	R/C	SINCLAIR

ADDRESS: 38. BENCLOICH CRES. HENNOXTOWN G65 7NB

G.P.'S NAME & ADDRESS: DR. HENDERSON H/C. MAIN ST. HENNOXTOWN

DATE 27 FEB 1967 SPECIALITY – OBSTETRICS

CONSULTANT'S NAME: DR. R. M. STILL

CHANGE OF ADDRESS

LENGTH OF TIME IN U.K.

NATIONALITY: BRITISH

Location

Tel. No. 31106.

Size of House: 2apt.

Husband's Name: Onrisophor.

Husband's Age: 27.

Husband's Occupation: UE.

Next of Kin: husband

Years Married: 3YES.

Ring Appropriate number

0 — Not booked prior to this admission
1 — Home delivery
2 — This hospital (consultant unit)
3 — This hospital (G.P. unit)
4 — Other hospital (consultant unit)
5 — Other hospital (G.P. unit)
6 — Not Known

Number of previous admissions anywhere this pregnancy

Antenatal care by:— 1 — Hospital 2 — L.A. Clinic 3 —G.P.

Date of first antenatal visit anywhere this pregnancy

Principal reason for Antenatal admission
0 — Social
1 — False Labour
2 — Toxaemia
3 — A.P.H.
4 — Hyperemesis
5 — Prev. Section
6 — Bad Obstetric History
7 — Multiple Pregnancy
8 — Diabetes
9 — Other/Not known

SUMMARY: DIAGNOSES SHOULD BE RECORDED IN ORDER OF IMPORTANCE

	1st Admission	2nd Admission	3rd Admission
DIAGNOSIS 1			
2			
3			
4			
5			
6			
7			
Initials / Letter / Date			
Mode of Delivery			
Other Operative Procedures			

Stopped oc. 1 yr ago.

CLINICAL DETAILS

Sure ☑ EDD 9/8/91 Dates

Not Sure ☐

Not known ☐ EDD 9.8.91. U/S

Mestrual Cycle irregular 5 2/3/4 mths LMP 2/11/90

MEDICAL HISTORY

Rheumatic Fever
Diabetes
Pneumonia, Pleurisy
T.B.
} none.

Urinary Tract Infection – prone.

Other (specify) Nov/Dec 90 Pelvic Inflammatory Disease.

Previous & Current Medication antibiotics ? type.

OPERATIONS none.

FAMILY HISTORY T.B. none

Twins mother is a twin Hypertension none

Diabetes none. Others husband mother had asthma

Gravida 3. OBSTETRIC HISTORY Para 2+0

Date	Place	Maturity in weeks	Labour: Spont. or Induced	Labour: Duration	Delivery: Spont.	Delivery: Operative	Infant: Alive S/B Miscar	Infant: Died 1st month	Infant: Died 1 mth to 1 yr	Infant: Sex	Infant: Weight	Complications
Jan 1981	S'Hill T.		Spont.		forceps.		Alive.			Girl.	7lb 9oz (Theresa)	No
4 Feb 1985	S'Hill T.		Spont.		SVD.		Alive			Girl.	7lb 14oz (Annemarie)	No.

ANTENATAL RECORD

Date	Maturity	Fundus	U.S	Presentation	1/5 ths Palpable	F.H.	WT. LBS; KGS	B.P.	Urine: Alb.	Urine: Sugar	Oedema	Blood: Haemoglobin	Blood: Antibodies
12/91	13+5	N.P.	13+5				54	110/60	No spec		nil.	12.4	
25	28	33	28	?breech	free	FMF FHH	58.150	100/60	no spec.		nil	10.8	
/7	35+	35+	36+	Br.	free	FHH	60.	120/60	C	C	–	11-0	
7.	36			Ceph	7/5	FHH		105/60	—	—	—		
5/7	37+6	38		Ceph	4/5	FHH	58	100/60					
5/8		37cm	Light	Ceph	3/5	FHH	60	95/50	neg	neg	Slight fungal		

MAT. 2.

WANEO

Blood Group O Rhesus POS. Unit No. 313693

A.F.P. Does not wish Rubella IMMUNE Height 1.57m Shoe size 5

Problems

Active | Inactive

Smoked 40 cigs/day. Occasional alcohol. Does not wish parentag Birth plan..

Drs. Signature

Present Pregnancy Happy about pregnancy. Planned

History Vomiting

Refer. Med. Specialist

Haematologist

Other

General Condition satisfactory. No pallor, Or oedema

Varicosities none.

Vag. Discharge none.

Breasts and Nipples comfortable

CVS HS I + II + 0'

Teeth and Gums attends occasional

Lungs chest clear

Remarks

Skeletal or other abnormalities None

Share A.N.C. Yes / No

Date Vaginal Examination

Attitude to Breast Feeding

Yes ☐

No ☑

Undecided ☐

Date Pelvic Assessment

Declines

Unsure about smear.

ANTENATAL RECORD

REMARKS	Return	Initials
Scan MSSU. Bloods ✓ ✓		
Advice re: cutting down on smoking given. well.	(14)	
Tired. Given iron tablets. LGA. ? ↑ AFV. For USS please	(8)	
Well. Active baby. U/S for AFW & Presentation Community Visit.	(2)	
Well. Plenty FMF U/S – Cephl.	(5)	
Some vague uterine activity over last few days CTG -	Plenty FM ✓ smoke 10c/day. EDC: 22/8/91	

GREATER GLASGOW HEALTH BOARD

CONSENT TO OPERATION CHART

SURNAME	CHRISTIAN/FORENAMES	UNIT NUMBER

NORMAL CONFINEMENTS

PERMISSION FOR ANAESTHETIC/OPERATION

I _____ hereby sanction the giving of an anaesthetic to my _____ and leave the decision of the nature and extent of the obstetric procedure to the Surgeon in charge.

Signed _____

Relationship _____

Date _____

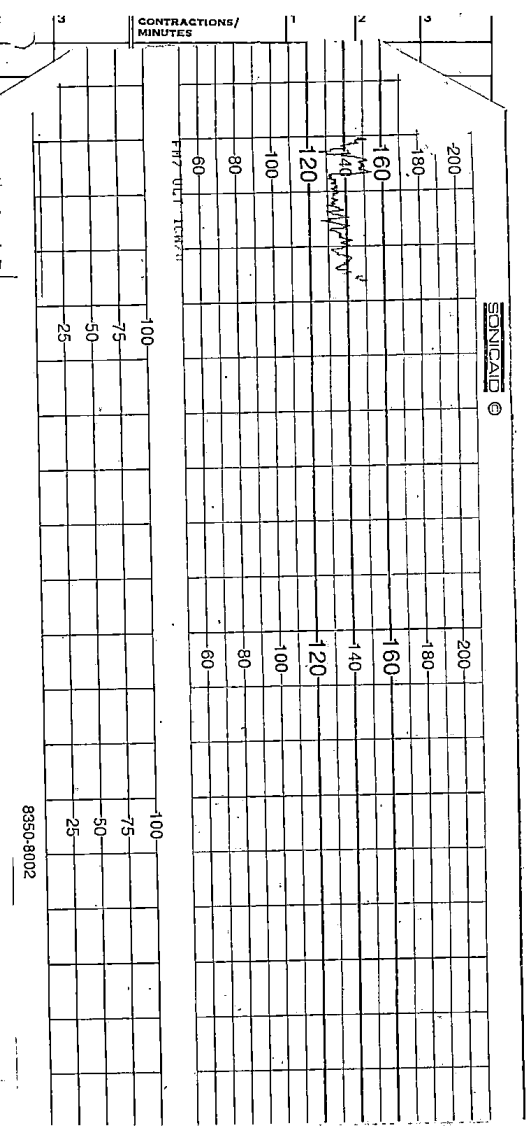
Witness Dr/Mr. _____

NON-STRESS TEST • PATIENT RECORD COROMETRICS MEDICAL SYSTEMS, INC.

PATIENT NAME	DATE
PATIENT NO. EDC	
INDICATION FOR TESTING	
OTHER ANTEPARTUM TESTS	
PERTINENT MATERNAL HISTORY	
MEDICATION	

	1	2	3
TEST NUMBER			
DATE			
FHR TECHNIQUE (ULTRASOUND OR PHONO)			
MATERNAL HEART RATE (bpm)			
MATERNAL BLOOD PRESSURE(mmHg)			
FHR BASELINE (bpm)			
FHR VARIABILITY (Note if absent)			

INTERPRETATIONS: R—REACTIVE(NST) NR—NON-REACTIVE (NST) POS—POSITIVE (spontaneous CST



PROBLEM SOLVING Patient's Name _____ Unit No: _____

PROBLEM / NEEDS	DESIRED OBJECTIVE	PROPOSED ACTIONS	Date Reviewed	Date Resolved
40wk+6 for CTG		observations stable at ANC CTG: satisfactory Has date for IOL 21.8.91. Reviewed at DCA 19.8.91	SOW	15891
41+3 – CTG.	Monitor & maintain maternal & fetal wellbeing.	Urinalysis. B/P. O/P. DNA: phoned pt – didn't come as probs at home – Com visit.		

PROBLEM SOLVING

Patient's Name _____ Unit No: _____

PROBLEM / NEEDS	DESIRED OBJECTIVE	PROPOSED ACTIONS	Date Reviewed	Date Resolved

G.G.H.B.

STOBHILL GENERAL HOSPITAL

ANTENATAL INPATIENT CHART

MAT. 3.

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
JENKINS	THERESA.	313693	H/W.	(M) S.

DATE OF BIRTH	AGE	SEX	WARD/DEPT	RELIGION	MAIDEN NAME
13.6.63	28	F			SINCLAIR

ADDRESS	G.P.'S NAME & ADDRESS
38 BENCLOCH CRESCENT LENNOXTOWN	DR. HENDERSON MAIN ST. LENNOXTOWN

DATE 20/8/91 CONSULTANT'S NAME DR STILL

HISTORY

Contracting 1:10 mins since 6am
More frequent since 08:30 and becoming stronger.
Show passed yesterday. No SRM.

GENERAL EXAMINATION ON ADMISSION (heart, lungs, deformities etc.)

V/E: Cervix 4cm dilated, almost fully effaced. Vx 0-2.
Bulging membranes. ARM - clear liquor.
FH

ABDOMINAL EXAMINATION T. 36.4°c P. 80 BP 110/75

Height of Fundus	Term	Lie of Foetus	Longitudinal
Foetal Heart	130 bpm		
Frequency and Character of Contractions	1:5 mod/strong		
Membranes Intact/Ruptured		Liquor	
Examined by Nurse:	SI Yule	Doctor:	

Presentation	Cephy
Position	LOA
1/5 ths Palpable	3/5HL

INSTRUCTIONS

CTG.
Analgesia.

DATE	ANTENATAL INPATIENT NOTES

PARTOGRAM FOR ESTABLISHED LABOUR

NAME Theresa Jenkins
DATE 20/8/91
Admitted to Labour Ward at:

From: Home
EDD 9/8/91
PARITY 2+0
Special Consideration

RH Pos Hb

Time Started 10:30 11:15 12:25 13:35

0 2 4 6 8

10 9 8 7 0–3 6 0–2 5 0–1 4 0 3 0+1 2 0+2 1 0

X CERVICAL DILATION cms

0 DESCENT

Position R L R L R L R L R L

Effacement 6/10

Moulding –

Caput –

AMNIOTIC FLUID Clear

SCALP BLOOD pH

SIGNATURE BH BH BH

200 180 160 140 120 100 80 60

FOETAL HEART

Contractions per 10 mins

30 secs

30-50 secs

50 secs

SVD Girl 11.35hr

I.V. Syntocinon MU per min

I.V. FLUIDS

DRUGS DOSAGE

ZANTAC ✓

EPIDURAL

220 200 180 160 140 120 100 80 60

B.P. BLUE

PULSE RED X

URINE PROTEIN KETONES VOLUME

TEMPERATURE

GREATER GLASGOW HEALTH BOARD

NEWBORN INFANT INPATIENT CHART

SURNAME	CHRISTIAN OR FORENAME	UNIT NUMBER	BORN DATE	BORN TIME	WEIGHT	LENGTH	HEAD CIRC.
JENKINS			20/8/91	11.35 HR	3.390		

RELIGION	SEX	WARD	GESTATION	MOTHER'S UNIT NO.	MOTHERS AGE
	GIRL		40+ WKS	318693	28

ADDRESS: 38 BENCLOICH CRES. LENNOXTOWN

(G.P.'s NAME & ADDRESS): DR H HENDERSON MAIN ST. LENNOXTOWN

SPECIALTY - MEDICAL PAEDIATRICS

CONSULTANT: (DR STILL)

MOTHER'S PREVIOUS HEALTH (Including Tuberculosis)

PAST PREGNANCIES

1981 1 STOBHILL T. FORCEPS female 7lbs 9.

1985 2 STOBHILL T. S.V.D female 7lbs 14.

3 _____ 6 _____

MOTHER'S HEALTH IN THIS PREGNANCY

HISTORY OF LABOUR

DURATION OF 1st STAGE: 2h 30min 2nd STAGE: 35min

MEMBRANES RUPTURED SPONTANEOUSLY/ARTIFICIALLY ON 20/8/91 AT 09.20 HK

BLOOD GROUP: O. Pos.

DRUGS: ANAESTHETICS

KAHN: 7.2.91 Neg

PLACENTAL WEIGHT: 650 gms

APPEARANCE: Healthy

TYPE OF DELIVERY: SVD

E.D.D.: 9.8.91

CONDITION AT BIRTH

Gasped & cried. Suction only

NO. OF CORD VESSELS: 3

APGAR SCORE AT ONE MINUTE

SCORE	0	1	2	
HEART RATE	ABSENT	UNDER 100	OVER 100	
RESP. EFFORT	ABSENT	SLOW. IRREG.	GOOD. CRYING	
MUSCLE TONE	LIMP	FLEXION OF LIMBS	ACTIVE MOVEMENT	
CATHETER IN NOSTRIL	NO RESPONSE	GRIMACE	SNEEZE OR COUGH	
COLOUR	BLUE PALE	BODY PINK EXTREMS. BLUE	ALL PINK	

9/1 10/5

DATE	INITIAL EXAMINATION AND PROGRESS
21/8/91	OFC 34cm. Good colour + tone Fontanelles ✓ eyes ✓ PEARL ✓ reflexes ✓ HS I+II+ nil chest clear ✓ Abdo ✓ Anus ✓ feeding ok. Hips (R) normal (L) normal. Genitalia normal ♀. IMD Rt for home.

DEXTROSTIX

ROUTINE EXAMINATION (TICK IF NORMAL)

HEART | NERVOUS SYSTEM | HIPS

CHEST | PALATE

ABDOMEN | GENITALIA | ANUS

DATE OF DISMISSAL	CONDITION	FEEDING	BCG	WEIGHT
			GUTHRIE	

Form 13

Notes on Delivery

STOBHILL GENERAL HOSPITAL

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
JENKINS	THERESA	313693	H/W	M. S. W.

DATE OF BIRTH	AGE	WARD/DEPT	RELIGION	MAIDEN NAME
13.8.63	28			SINCLAIR.

ADDRESS: 38 BENCLOUCH CRESCENT LENNOXTOWN

G.P.'S NAME & ADDRESS: DR. HENDERSON MAIN ST. LENNOXTOWN

Spontaneous Vertex Delivery — Face to Pubis — Spontaneous Face Delivery

Forceps Delivery — Breech Delivery — Vacuum Extraction

Caesarean Section

CONDUCTED BY

DELIVERED BY Sr Yule
St. Nurse Barker

IV/IM Ergometrine — Pudendal Block

Syntometrine — Spinal/Epidural Anaesthesia

IV Syntocinon — General Anaesthesia

Maternal T P BP

REPORT ON LABOUR — Spontaneous / Induced

Contractions Began

Membranes Ruptured

Spontaneously / Artificial 09.20 HR

Child Born at 11.35 a.m. p.m. DATE 20/8/91

Duration 1st stage 2 hrs. 30 mins.

2nd stage hrs. 35 mins.

3rd stage hrs. 5 mins.

Placenta Delivered at 11.40 a.m. p.m. Weight

Expelled Spont. CCT 650g

Expressed by

Manually Removed by

Placenta complete/incomplete

Membranes complete/incomplete Ragged

Condition of Placenta Healthy

Blood loss 150 mls

Episiotomy/Lacerations Labial - no sutures required. REPAIRED BY

Local Anaesthetic used mls.

Sutures Vagina

Perineum

INFANT EXAMINATION T. 36.5°C

Alive — Mature — Male — Weight 3.390kg lbs/gms 7lb 7½oz Ward

Stillborn — Premature — Female — Special Care Nursery

Small for Gestational age — LENGTH — CIRCUMFERENCE

Condition of Child at Brith Gasped & cried
Suction only

APGAR SCORE	1 Min.	3 Min.	5 Min.
	9		10

Special Remarks

GREATER GLASGOW HEALTH BOARD — **HOSPITAL PRESCRIPTION SHEET No.**

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED Date	DISCONTINUED Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H 20/8/91	Codydramol	2tabs		4-6hly				PRN						V		
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS — **DIET**

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES	1.

MAT. 8.

GREATER GLASGOW HEALTH BOARD

OBSTETRIC CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER

DATE

CONSULTANT

DATE																			
	C																		
PULSE 130	39.3																		
120	38.7																		
110	38.2																		
100	37.6																		
90	37.1																		
	36.8																		
80	36.5																		
70	36																		
60	35.5																		
BLOOD	A.M.																		
PRESSURE	P.M.																		
OEDEMA	FACE																		
	HANDS																		
	ANKLES																		
	BACK																		
	ABDOMEN																		
HAEMOGLOBIN																			
FOETAL HEART RATE																			
GIRTH cms																			
LOCHIA																			
BOWEL FUNCTION																			
URINE	SUGAR																		
	KETONES																		
	PROTEIN																		
	ESBACH READING																		
		DRUG TREATMENT																	

FUNDUS

CMS	INS
12	6
10	5
8	4
6	3
4	2
2	1

TEMPERATURE

MAT. 6.

SURNAME	CHRISTIAN/FORENAMES	UNIT NUMBER
JENKINS	THERESA	313693

POSTNATAL INPATIENT NOTES

POST DELIVERY HAEMOGLOBIN — POST NATAL PELVIMETRY

ANTI-D GAMMA GLOBULIN — RUBELLA VACC.

FAMILY PLANNING ADVICE — METHOD

— REFER D.O.M. F.P.

DATE	
20/8/91	Well No problems Bowels Bd Micturition Lochia — Home if already Baby Well ok Wants to go home tomorrow

DATE	POSTNATAL INPATIENT NOTES

GREATER GLASGOW HEALTH BOARD

ULTRASONICS

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	Morag	313693

DATE	WARD DEPT.	MATURITY BY DATES	REPORT, DATE AND SIGNATURE
7/2/91	ANC	14/52	Single foetus. FHtve. BPD = 26mm = 13 weeks 5 days. P Gray.
16/5/91	OP	27+	Single Breech FHtve BPD 7.6 = 29 wks. AC 229 EFW 1.16 kgs Anterior placenta not low. Plenty of liquor. FHtt. Infusion
29.7.91	ANC	37+	Single fetus FH +ve Cephalic presentation EFW = 333 mm = 3.22 Kg A Donaldson.

	MSAFP SCREENING		
	Maternal Serum	U/S	Amnio
Not done			
Done			
Refused			
Failed			
	Box 56	Box 57	Box 58

STOBHILL HOSPITAL

OUTPATIENT CHART

SURNAME	GP Prac : 432611 JENKINS 313693 THERESA 13/08/1963	UNIT NUMBER	PATIENT Dr. J HENDERSON
DATE OF BIRTH	90 Main Street F	WARD/DEPT	RELIGION LENNOXTOWN CLINIC 103 MAIN STREET
ADDRESS	Lennoxtown GLASGOW G66 7DA		G.P's NAME & ADDRESS LENNOXTOWN G65 7DD
TEL No.			TEL No.

TAL STATE S. W.

DATE 24 APR 2001 SPECIALITY-GYNAECOLOGY CONSULTANT'S NAME

Complaint & Duration 37 yo Para 2 : Requests Sterilisation.

DH :- Antidepressants - Nil else. NKDA

Previous History Depression. ETOH abuse.

Previous Obstetric History (Summary of pregnancies and deliveries)

P2+0 < 20 ♀ Miscarriage
16 ♀ SVD
7 ♀ SVD
8lbs 2 SVD.

Vaginale.
Smokes - 10/7 ago.
No ETOH, 7/7 ago.

Years Married

Gynaecological History Contraception POP F.M.P. L.M.P. 21/04/01.

Cycle Regular 4-5/28 Loss Clots Regularity ✓

Dysmenorrhoea Nil. Backache ✓

Dyspareunia Nil.

Discharge Nil. Quantity Colour

Micturition-Dysuria Nil.

Frequency-Day Night

Stress Incontinence Urgency

Bowels Nil. Recent episode diarrhoea.

History of Present condition Currently using POP. COC → not suitable. Wishes something more permanent. Is certain family complete. Partner not consenting Vasectomy. Well at present.

Abdomen NAD Breasts

Info re Mirena / Implanon - declined.

Pelvic Examination

→ Lmp 8wks.

Pap Smear 2000

Diagnosis Fothe Rete ∠1°, Infertility

Suggested Treatment Estipic Laparotomy.

Waiting List Priority

Seen by Mr Mason For Letter Yes/No

Return 2/52

JMcC/492368

STOBHILL
NHS TRUST

MEDICAL IN CONFIDENCE

CASE RECORD

ADMISSION FORM V3

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
STO	STOBHILL HOSPITAL	313693

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
03 Sep 01	07:30	11	1K	12	2	24 Apr 01	TB	3

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
DSS*STO	11	GYNAECOLOGY	DR F MACKENZIE		

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MRS JENKINS	THERESA		38	13 Aug 1963	F	0

ADDRESS: 90 Main Street
Lennoxtown
GLASGOW

POSTCODE: G66 7DA TELEPHONE No.: 01236 827479

ALT./PREV. SURNAME:

OCCUPATION:

C.H.I. NUMBER: 1308636407

OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE:

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR? Y

G.P.

NAME: J HENDERSON
G.P. CODE: 2335801
CONTRACT No.:
GPRACTICE: 432611
PRACTICE:
FH STATUS:

ADDRESS: LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN
TEL No.: 01360310357
POSTCODE: G65 7DD

REF. P.

NAME: J HENDERSON
CONTRACT No.: 2335801
PRACTICE: 432611
FH STATUS:

ADDRESS: LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN
TEL No.: 01360310357
POSTCODE: G65 7DD

NEXT OF KIN

NAME: MARGARET SINCLAIR
RELATIONSHIP: MOTHER

ADDRESS: 103 MAIN STREET
LENNOXTOWN
01360310357
G65 7DD

DAY PHONE No.:
NIGHT PHONE No.:

MISC.

RELIGION:
VISIT REQ. BY CHAPLAIN YES/NO:
PENSION BOOK No.: NA

Admission

DIAGNOSIS							SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)							
OTHER CONDITIONS (D.G.3)							

IR04 SMR50

STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DIAGNOSES

MAIN DIAGNOSIS							SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)							
(D.G.3)							
(D.G.4)							
(D.G.5)							
(D.G.6)							

AND OPERATIO

	CODE	DATE
MAIN OPERATION	Lap Ster	
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

STOBHILL

OPERATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	THERESA	313693
13 08 63	WARD: DSU	

DATE OF OPERATION 03 09 01

SURGEON'S NOTES

DR F MacKENZIE

OPERATION PERFORMED

SURGEON _____

PROCEDURE: LAPAROSCOPIC STERILISATION

FINDINGS: Routine laparoscopy via open technique under video control.

Adipose ++

Retroverted mobile uterus

Normal tubes and ovaries

One Filshie clip applied to each side (small haematoma developed after left clip applie approximately .5 cms in diameter - gas tension released and observed for a number o minutes with no increase in size).

Position of clips checked

Gas expelled

Dexon to skin 1 subrapubic and 2 subumbilical (sutures need to be removed)

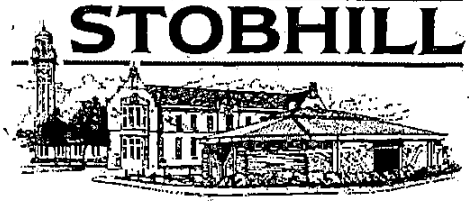
SPECIAL INSTRUCTIONS

FORM 7A

FM/AK/DICTATED & TYPED - 03 09 01

DATE 3/9/01 SIGNATURE fm

STOBHILL



HOSPITAL

Day Surgery

ASSESSMENT/ADMISSION PACK

Date of Assessment 24/4/01

Date of Admission 18/06/01

Consultant MACKENZIE.

Unit No. GP Prac : 432611
JENKINS 313693
Name THERESA 13/08/1963
Address 90 Main Street F
Lennoxtown
GLASGOW G66 7DA

DOB

ASSESSMENT

TELEPHONE NO. HOME 01236 827479

WORK

PROCEDURE LAPAROSCOPIC STERILISATION

Height; 5'2" Weight: 62KG =BMI 26

Refer to nomogram if patient appears obese. If result is more than 30 patient not suitable.

B.P. 120/78 P. 92.

Will you :-	YES	NO	
be able to be driven home by private car	✓		1
have easy access to your home (stairs, ..)	✓		2
have someone to take you home	✓		3
have a telephone at home	✓		4
have easy access to a lavatory	✓		5
have someone at home able to look after you for 24 hours	✓		6
do you have any dependents	✓		7

Have you ever suffered from any of the following :-	YES	NO	
chest pain on exercise or at night		✓	8
breathlessness		✓	9
asthma or bronchitis		✓	10
high blood pressure		✓	11
heart murmur		✓	12
fainting easily		✓	13
convulsions or fits		✓	14
jaundice (yellowness)	✓	✓	15
indigestion or heartburn PREVIOUSLY ON LOSEC.	✓		16
kidney or urinary trouble		✓	17
anaemia or other blood problems			18
excessive bleeding or bruising		✓	19
arthritis		✓	20
muscle disease or progressive weakness			21
diabetes		✓	22

have you ever had:	YES	NO	
a serious illness		✓	23
allergy or reaction to medicines, Elastoplast, etc		✓	24

Do you :-

	YES	NO	
take any medicines (tablets, patches, injections, inhalers) MICROVAL (PROGESTERONE ONLY PILL)	✓		25
smoke 50g TOBACCO / WEEK	✓		26
drink more than 1½ pints of beer or 3 shorts a day		✓	27
or have you ever used intravenous drugs		✓	28
If a woman, are you pregnant or taking the "pill" AS ABOVE			29
Is there anything else the surgeon / anaesthetist should know		✓	30

What operations have you had before if any (please list)? 31

NONE ENDOSCOPY

Did you have any anaesthetic or surgical complications (please list)? 32

✓

When was your last general anaesthetic ? —

Has any member of your family had problems with anaesthetics ? (please tick box) ..... YES ☐ NO ☑ 33

How long will it take you to travel home : .....hrs 25 mins 34

Do you have any Prosthesis UPPER BRIDGE & 1 DENTURE 35

HAVE YOU ANY QUESTIONS ABOUT THE PROCEDURE ..... YES ☐ NO ☑ 36

COMMENTS: .....

FURTHER INVESTIGATIONS CARRIED OUT (PLEASE TICK BOX)

U & E s - ☐ **HAEMOGLOBIN** - ☐ **E.C.G** - ☐ **CXR** - ☐

REQUIRES ANAESTHETIC OPINION : ..... YES ☐ NO ☑

REASON : .....

NURSES SIGNATURE : Lynn Tedman

ANAESTHETIC DETAILS

DR..... DATE.....

ANAESTHETISTS COMMENTS : .....

ADMISSION

GP Prac : 432611
JENKINS 313693
THERESA 13/08/1963
90 Main Street F
Lennoxtown
GLASGOW G66 7DA

CARE PLAN - Any changes in health since assessment: Details

NONE
* PREGNANCY TEST - NEGATIVE 03/09/01 *

PRE-OPERATIVE PREPARATION — Tick

1.	LAST TIME PATIENT ATE OR DRANK 12 MIDNIGHT	✓
2.	CONSENT SIGNED	✓
3.	IDENTITY BAND	✓
4.	CASE NOTES, X-RAYS, DRUG KARDEX	✓
5.	OPERATION SITE PREPARED AND MARKED	✓
6.	TEETH - DENTURES REMOVED, CROWNS/CAPS/BRIDGE UPPER DENTURE/BRIDGE	✓
7.	PROSTHESIS REMOVED - CONTACT LENS, GLASSES NONE	✓
8.	REMOVED - MAKE-UP, NAIL VARNISH, UNDERWEAR, JEWELLERY (TAPED/REMOVED)	✓
9.	ALLERGIES NONE KNOWN	✓
10.	VOIDED URINE	✓
11.	BASELINE OBSERVATIONS P: 82bpm BP: 117/68	✓

PROBLEMS/NEEDS	INTERVENTION	OUTCOME
INDIGESTION L.M.P. BLEEDING EVERY 2/52.	BLEEDING AT PRESENT ? PERIOD.	BOYFRIEND COLLECTING PT AND STAYING OVERNIGHT.

Signature - Claire Gaffney

THEATRE

OPERATION PERFORMED hep sks

DIATHERMY	BIPOLAR/MONOPOLOR	☐	
HEEL RESTS		☐	
FLOWTRON BOOTS		☐	
SHEEPSKIN HEEL PADS/MAT		☐	
HEATED WATER BED		☐	
ARM BOARDS		☐	

PATIENT POSITION

LATERAL RIGHT	☐	TRENDELENBURG	☐
LATERAL LEFT	☐	REVERSE	☐
SUPINE	☐	LITHOTOMY	☑
PRONE	☐	LLOYD DAVIS	☐

TOURNIQUET TIME ON OFF

SPECIMENS: PATH BACT OTHER
DRAINS
CATHETER

COUNTS CORRECT

SWABS -	FIRST	☑
-	FINAL	☑
INSTRUMENTS		☐
SHARPS -	NEEDLES	☑
-	BLADES	☑
THROAT PACK OUT		☐
PACK IN SITU		☐

INSTRUCTION FOR REMOVAL

SPECIAL COMMENTS

Name of Scrub Nurse: SR Anderson

Signature of Circulating Nurse: K Gaffney

POST OPERATIVE RECOVERY ROOM INSTRUCTIONS

THERESA JENKINS

ROUTINE - Pulse & B.P. ✓	PLEASE ISSUE TO TAKE HOME
- Oxygen/recovery ✓	KAPAKE ✓ / COCODAMOL ✓ AL
SPECIAL Information/Instructions	DICLOFENAC / PARACETAMOL
	CO-DYDRAMOL / METOCLOPRAMIDE ✓
ONCE ONLY PRESCRIPTIONS	

Date Given	Time	Medicine (Block Capitals)	Dose	Route	Signature	Given By	Time
3/9/07	9.45	Diamorphine	2.5mgs	I.V	Cowan	Cowan	
		Cyclizine	50mgs	I.V			

POST OPERATIVE OBSERVATIONS

Signature: Cowan

TIME	9.35	10.00	10.20			2nd Stage																
PULSE	75	93	97	✓																		
BLOOD PRESSURE	105/64	136/64	103/74																			
SATURATION (SaO^2)	92	95	92																			
RESPIRATORY RATE	N18	L	R																			
AIRWAY	W	OUT	✓																			
OXYGEN	4L	WS	OUT	100																		
PAIN SCORE	0	0																				
SEDATION SCORE	3	0/1																				
PONV SCORE	0	0																				
TEMPERATURE																						
WOUND	Dry																					
VENFLON (L) hand	✓	✓																				
	AM	AM																				

PAIN SCORE -
Assess using visual analogue scale ruler (VAS) ✓

0 — 5 — 10
No pain — Worst pain ever

SEDATION SCORE

S = Normal sleep
0 = Alert
1 = Responds to verbal command
2 = Responds to painful stimuli
3 = Unresponsive and unrousable

PONV SCORE

0 = No symptoms
1 = Nausea
2 = Vomiting
3 = Persistent symptoms despite treatment

FLUID BALANCE

Time	Input	Volume	Initial	Time	Output	Volume	Initial

NURSING NOTES

DISCHARGE MEDICATION

30 KAPAKE TABLETS
Take TWO tablets every FOUR to SIX hours
if required for pain relief
Warning this may cause drowsiness
If affected do not drive or use machinery
Warning avoid alcoholic drink
BN:050601(SH) EXPIRES:31/03/03
NAME: T Jenkins DATE:

Pharmacy Dept. Stobhill Hospital | KEEP ALL MEDICINES OUT OF REACH OF CHILDREN | Dispensed by..... Checked by.....

4 METOCLOPRAMIDE 10mg TABLETS
Take ONE tablet every SIX to EIGHT hours
if required for relief of nausea or
vomiting
Do not take more then 3 in 24 hours
BN:140501(SH) EXPIRES:29/02/04
NAME: T Jenkins DATE:

Pharmacy Dept. Stobhill Hospital | KEEP ALL MEDICINES OUT OF REACH OF CHILDREN | Dispensed by..... Checked by.....

GP Prac : 432611
JENKINS 313693
THERESA 13/08/1963
90 Main Street F
Lennoxtown
GLASGOW G66 7DA

CONSENT BY PATIENT/PARENT FO

I _____

hereby consent to

* submission of _____ to the

operation of LAPAROSCOPIC STERILISATION

the nature and effect of which have been explained to me by:

Dr/Mr ANTONY WILSON

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.

No assurance has been given to me that the operation will be performed by a particular surgeon.

Date 24/04/01 (Signed) X T Jenkins

* Relationship to Patient _____

I confirm that I have explained the nature and effect of this operation to the patient, parent, relative or guardian.

Date 24/04/01 Signed _____

(Doctor's Signature)

* Delete if not applicable

SPECIAL CONSENT FORM FOR STERILISATION AND JEHOVAH'S WITNESSES MUST BE USED.

DISCHARGE CRITERIA	Yes	No
1. Venflon Removed	☑	☐
2. Stable Vital Signs - Respiration, Pulse, B.P.	☑	☐
3. Alert and orientated	☑	☐
4. Able to dress, sit and walk unaided	☑	☐
5. Tolerating food and fluids	☑	☐
6. Information given regarding		
* Post anaesthetic instructions	☑	☐
* Procedure	☑	☐

* Discharged at 3.30 to Partners care

POST SURGICAL INSTRUCTIONS

* Follow-up appointment NFU

* Special instructions _____

NURSES SIGNATURE A Mac

ADDITIONAL INFORMATION

3 | 9/07 POP. LMP 4/7 ago. - Irregular Bleeding past 4/52

for Lap Sterl

Irreg

not 100%. ectopic

Method, laparotomy

Mirena (LNG)

Stobhill NHS Trust

STERILIZATION

CONSENT BY PATIENT

GP Prac : 432611
JENKINS 313693
THERESA 13/08/1963
90 Main Street F
Lennoxtown
GLASGOW G66 7DA

I, ... of .....
(name and address of patient)

hereby consent to undergo the operation of .....

LAPAROSCOPIC STERILISATION

the nature and purpose of which have been explained to me by Dr./~~Mr./~~Ms. ANTONY NEAL

I have been told that the intention of the operation is to render me sterile and incapable of further parenthood. I understand that there is a possibility that I may not become or remain sterile.

I also consent to the administration of general, local or other anaesthetic.

No assurance has been given to me that the operation will be performed by any particular surgeon.

Date 24/04/01 Signature ..... J Jenkins
Patient

I confirm that I have explained to the patient the nature and purpose of this operation.

Date 24/04/01 Signature .....
Medical Practitioner

JOINT CO-ORDINATING COMMITTEE
The Medical Protection Society The Medical and Dental Defence Union of Scotland The Medical Defence Union

No. 0180539 Form 5B

Medical Defense Union

STOBHILL NHS TRUST **ANAESTHETIC RECORD**

DATE & TIME	PREMEDICATION		WEIGHT:
TIME GIVEN:	ORDERED BY:	GIVEN BY:	Kg. AGE:

Name JENKINS THERESA 313693
Addres 90 Main Street 13/08/1963
Lennoxtown F
GLASGOW
G66 7DA
GP Prac : 432611
D.O.E
Unit No.

Affix data label

PRE-OPERATIVE ASSESSMENT

CVS
Exercise Tolerance.
BP
Pulse
RS.
c.p.d. Smokes
airway
Other. C_2H_5OH no excess

Previous Operation
Previous GA
No problems

Allergies. None
CXR
ECG.
Haematology
Biochemistry.

Contraceptive Pill

ANAESTHETIST Walsh / May — TRAINEE CON SpR SHO

OPERATOR McKenzie — CON ✓ SpR SHO

PROCEDURE Laparoscopic Sterilisation — DURATION 1 2 3 4 10 20 30 40 50 5

CLASSIFICATION — OPERATION ASA: DAY CASE I ✓ | ELECTIVE II | SCHEDULE III | URGENT IV | EMERGENCY V

CURRENT DRUGS

PREV. ANAESTH. | COMPLICATIONS | FAMILY HISTORY

PREMEDICATION — Benzo | Antiemetic | NSAID | Opiate | H_2Antag | Antacid | Antichol | Other | Normal Drugs

INDUCTION — Prop ✓ | STP | Etom | Ket | Opiate ✓ | Benzo | Inhalation | Other | Rapid Sequence | Anti emetic ✓

RELAXANT — Sux / Miv | Vec / Atrac | Panc / Roc | Infusion / Other | Glyco / Atropine | Neost / Other

MAINTENANCE — N_2O / Air ✓ | Ethrane / Isoflu ✓ | Sevo / Desflu ✓ | Morphine / Fentanyl | Alfent / Pethidine | Haloth / NSAID | Drop / Other

TECHNIQUE — Spont / IPPV ✓ | Mask ✓ / LMA | ETT ✓ / A'way | Oral / Nasal | Cuff / Pack | Tracheos / Jet | Circle / Map A | Map D / Map E | Other / TCI

V / A ACCESS — Peripheral ✓ 20G | Central | Arterial

MONITORING — ECG ✓ / SpO_2 ✓ | NIBP ✓ / IABP | FIO_2 ✓ / Et CO_2 ✓ | Vent Alm / Volatile ✓ | PNS / CVP | Temp / Other

POSITION — Supine | Lithotomy ✓ | Lateral | Prone | Other | Hd Up | Hd down

REG. ANALGESIA — Spinal / Priloc | Epidural / Cocaine | Caudal / Bupivac | Brach Plex / Lignoc | Bier / Adren | Voc Cord / Sub-Tenon | Infilt / Other

COMPLICATIONS

SIGNIFICANT BLOOD LOSS | Volume (ml) | Volume Expander | Blood Products (not PPS)

Fentanyl	100 µgs				
Droperidol	0.5mgs				
Propofol	200mgs				
Atracurium	8mgs				

TIME	9.00 - 30	10.00			
V					
BP					
Λ					
• PULSE					
○ TEMP					
Sp 02	97%				
Et C02					
Et AA					
Paw					
CVP					
BLOOD LOSS					
URINE VOLUME					

38 200
180
36
140
34
100
60
20
0

C.E.T.T. SIZE GRADE INTUBATION - (circle) EASY AWKWARD DIFFICULT

Time	Fluid	Volume

Signature : _____

STOBHILL HOSPITAL

CONTINUATION CHART

SU 313693
JENKINS
THERESA

CHRISTIAN/FORENAME	UNIT NUMBER

7/9/02 Lay Stvi

Normal Pelvis

~0.5cm laceration by ⓛ clip.

Hand.

NP fu fm (cont.)

F3

STOBHILL HOSPITAL

OUTPATIENT CHART

SURNAME	[redacted] T NUMBER 23004807E	PATIENTS	STATUS Dr. J HENDERSON LENNOXTOWN CLINIC S W
DATE OF BIRTH	SINCLAIR F TERESA 13/08/1963 RD/DEPT	RELIGION	103 MAIN STREET LENNOXTOWN
ADDRESS	90A MAIN STREET LENNOXTOWN GLASGOW G66 7DA CHI-1308636407	G.P'S NAME	G66 7DA
TEL. No.		TEL No.	
DATE	SPECIALITY- GYNAECOLOGY	CONSULTANTS NAME	DEENY

COMPLAINT & DURATION

PREVIOUS HISTORY

PREVIOUS OBSTETRIC HISTORY (Summary of pregnancies and deliveries)

Years Married

Gynaecological History	Contraception	F.P.M.	L.P.M.
Cycle	Loss	Clots	Regularly
Dysmenorrhoea		Backache	
Dyspareunia			
Discharge	Quantity		Colour
Micturition-Dysuria			
	Frequency-Day	Night	
Stress Incontinence		Urgency	
Bowels			

History of Present Condition

Abdomen — Breasts

Pelvic Examination

Pap Smear

Diagnosis

Suggested Treatment

Waiting List		Priority	

Seen by — For letter YES/NO

Return

AW/FORM 3

General Surgical

Dr. Allan J. Rae, MB, ChB
The Clinic
Main Street
Lennoxtown
Glasgow
G65 7DD

7/10/93

Dear Dirk,

Re: Terence JENKINS (13-8-63)
38 Birchwood Cres
Lennoxtown

The above is c/o nervous vomiting + abd pain since 2am today.
The pain was central but is now localised in the (R) IF.
There is no vomit in bowel upset.
On O/E. - Tenderness - guarding 6/12
Temp 97.8 P. 80/min/reg
tiny
Abd. tender in both iliac fossa but much more guarding in (R) IF
A: P.I.D
: Appendicitis

82. (RS) WARD COPY

G.G.P.B. STOBHILL GENERAL HOSPITAL — ACCIDENT/EMERGENCY DEPT.

DATE 7.10.93

UNIT 9 TIME 6.47 AM/PM — REF. BY G.P. YES/NO — AMB/CAS./OTHER

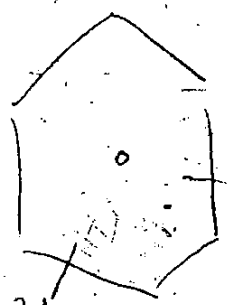
SURNAME	FIRST NAME(S)	M. S.W.	AGE	DATE OF BIRTH
Jenkins	Theresa		30	18-8-63

ADDRESS	NEXT OF KIN	PLACE OF INJUR
38 Berelodi Cres. Kennoxtown. G65	Husband S/A.	WORK ☐ SCHOOL ☐ HOME (indoors) ☐ R.T.A. ☐ OTHER ROAD ☐ OTHER ✓
TELEPHONE No.	TELEPHONE No.	
NAME AND ADDRESS OF FAMILY DOCTOR Dr. Rae Kennoxtown G65	OCCUPATION	
	DATE & TIME OF INJURY	TIME SEEN a.m./p.m.

DRUG HISTORY (anti-coagulants, insulin, A.T.T. steroids, allergic reactions etc.) — Ranitidine + Diclo + Keflex

BP 105/75 P 111 T 36.3°C. SURG PEND

R/F pain since this morning - initially central.
- colicky in nature
- vomited x 2 - clear liquid
- loss of appetite
- urinary symptoms
- ? change in bowel habit



mild tenderness, rebound

soft
guarding
clicks/mass
BS ✓

X-RAY AXR's - E + S

DIAGNOSIS ? UTI ? appendix

TREATMENT Admit Hd 6

SIGNATURE [signature]

DISPOSAL RETURN TO CASUALTY ☐ G.P. ☐ WARD ☐ O.P. CLINIC ☐ OTHER CLINIC ☐

STOBHILL GENERAL HOSPITAL UNIT

MEDICAL IN CONFIDENCE

CASE RECORD

ADMISSION FORM V2

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G207H	STOBHILL	S/H|313693

SSION TAILS

DATE	TIME	TYPE	SOURCE	INPAT/DAYCASE	DATE ON W.L.	PATIENT CATEGORY
07/10/93	19:26	8 EM-OT	1 HOME	Inpatient		3 NHS

WARD	SPECIALTY	CONSULTANT
WD 6	GENERAL SURGERY	MR DT HANSELL

PATIENT

TITLE/SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MRS JENKINS	TERESA		30	13/08/1963	F	M

ADDRESS 38 BENCLOICH CRES
LENNOXTOWN

ALT/PREV SURNAME

OCCUPATION

POSTCODE G65 7NB

TELEPHONE No.

OCCUPATION (HUSBAND/FATHER)

REF. G.P.

NAME HENDERSON J

G.P. CODE 2335801 PRACTICE 43261|1

CONTRACT No.

ADDRESS MAIN STREET
LENNOXTOWN,
431 0588

TELEPHONE No.

POSTCODE G65 7DD

NEXT OF KIN

NAME JENKINS RELATIONSHIP HUSBAND

ADDRESS SAME

DAY PHONE No.

NIGHT PHONE No.

AND / OR

NAME

RELATIONSHIP

ADDRESS

DAY PHONE No.

NIGHT PHONE No.

MISC.

RELIGION	VISIT REQ. BY CHAPLAIN YES/NO	PENSION BOOK No.

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
11/10/93					Surgery	Hansell	

HOSPITAL	CODE	WARD	SPECIALTY	CONSULTANT	CODE
DISCHARGED/ TRANSFERRED TO					

DIAGNOSES

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Acute abdominal pain	-7890	
OTHER CONDITIONS (D.G,2)			
(D.G,3)			
(D.G,4)			
(D.G,5)			
(D.G,6)			

AND OPERATIONS

		CODE	DATE
MAIN OPERATION	Nil - spontaneous resolution		
OTHER OPERATION (O.P,2)			
(O.P,3)			
(O.P,4)			

LOCAL USE			NATIONAL USE	

SHIFT COMPLETED

IRENE ROYLE 07/10/93 19:27

PATIENT PROFILE

Surname JENKINS Hosp. No. 313693
Forenames THERESA Sex F
D. of B. 13.8.63
Address 38 BENCLOICH LENORTOWN.
Ward/Dept 6C

AGE 30yrs
RELIGION: RC.
date
Seen by minister/priest:

Date of admission: 7.10.93. Time: 8 pm.
Type of admission: EMERGENCY
Accompanied by: HUSBAND
From where: HOME.
PATIENTS OCCUPATION: HOUSEWIFE.
MARITAL STATUS: MARRIED
Children: 3 Ages: 12, 8, 2.
Other dependants: NONE.
living alone? No.
(1) NO—with whom? HUSBAND CHILDREN
(2) YES—any supportive help?

NEXT OF KIN: CHRISTOPHER JENKINS.
Relationship: HUSBAND
Address: S/A.
Home phone no: —
Work phone no:
ALTERNATIVE NEXT OF KIN: MRS SINCLAIR
Relationship: MOTHER.
Address: 3 BENCLOICH CRES.
Phone No: —

VISITING PROBLEMS
NONE

SPECIAL PROBLEMS AT HOME
(a) With housing? NONE.
(b) Social:
(c) Other:

REASON FOR THIS ADMISSION
ABDO PAIN.

PAST MEDICAL HISTORY
NONE.

PATIENT'S UNDERSTANDING OF ILLNESS

INFORMATION GIVEN TO PATIENT RE ILLNESS (date and by whom)

CURRENT DRUG THERAPY AT HOME
NONE

INFORMATION GIVEN TO RELATIVES (date and by whom)

ALLERGIES NONE.

PATIENT'S PROPERTY
Checked Not Checked
VALUABLES IN HOSPITAL SAFE:
Description:

ANY FACTORS WITHIN PATIENT'S LIFESTYLE WHICH ENDANGER RECURRENCE OF THIS ILLNESS

DAILY LIVING

SLEEP
Pattern: VARIES
How many pillows? 3
Sedation? NONE
What else helps?

MOBILITY
Remarks: GOOD

Assistance needed? NONE

DIET
Appetite:
Special diet: NONE
Dislikes:
Fluid preferences: TEA.

URINARY
Any problems? NONE.
Special needs:

BOWELS
Frequency: 1 DAILY
Any problems?
What helps?

MENSTRUATION 'Pill' ✓ IUCD
LMP:
Cycle:
Any problems?

HEARING
Any problems? NONE.
Hearing aid? Battery Type?

VISION
Any problems? NO
Glasses? Contact lenses?

LANGUAGE BARRIER/SPEECH DIFFICULTY
Remark: SPEAKS CLEARLY.

RECREATIONAL INTERESTS
BINGO

SMOKING (type and amount)
30 DAILY.

SOCIAL DRINKING (type and amount)
SOCIALLY.

PROSTHESIS/APPLIANCE Type:
Help needed:

NURSING ASSESSMENT

GENERAL APPEARANCE/CONDITION
NEAT & TIDY.

GENERAL OBSERVATIONS
T 36°8 P 83 R B/P 110/80
Height: Weight: Norton Score:
Urine:
SKIN INSPECTION CLEAR

ORAL INSPECTION
Condition of mouth: GOOD
Condition of teeth: GOOD
Dentures: Upper Lower Partial
Crown?
Any problems? NO

ADDITIONAL SIGNIFICANT GENERAL INFORMATION

DISCHARGE/FUTURE PLANS	Date ordered	Date given	Sign
Education of condition/ limitations/rehabilitation (a) Patient ...			
(b) Relatives ...			
Discharge medications ...			
Wafarin/Steroid/Tetanus card			
Transport home ...			
Out-patient appointments...			
Walking stick/crutches ...			
Dressings: ...			
Other: ...			
Community Nursing ...			
Home help ...			
Meals on wheels ...			
Social worker ...			
Physiotherapy ...			
Occupational therapy ...			
Speech therapy ...			
Geriatric waiting list ...			
Sheltered housing ...			
Other: ...			

GGH.B
STOBHILL GENERAL HOSPITAL

NURSING NOTES

Surname Jenkins Hospital No 313693
Forenames THERESA Sex F
DoB 13.8.63
Address 38 BANCHAICH CRES

Ward / Dept 6C

R.I. Foss

Date		Signature
	EA to ward ? R.I. Foss p.r.n.	
7.10.93	Not distressed — Apyrexial — Resting	B Wallace
8.10.93	c/d pain. Pethidine 100mg IM @ 9.50pm. Continues to fast. Slept well. Awaiting MSSU. urinalysis shows + protein Contin. on I.V. infusion S.T.B.J. Dr. for U/S Tomorrow.	A C Marshall.
pm.	Ultrasound negative. I.V. fluids to continue. More settled. Apyrexial. MSSU sent ✓ Remains nil by mouth. To be reviewed later.	A Calder.
9/10/93	Settled and slept well. — I.V. infusion running as charted	E Bennett
am.	To commence on antibiotics for UTI. Can eat & drink. Apyrexial. I.V. infusion discontinued.	C Calder.
pm	self caring, apyrexial. Tolerating fluids + diet.	E Reilly
10.10.93	Comfortable overnight. Oral analgesia taken ½ effect. Self caring. Seen by medical staff. discharged home. Return appointment SOPD 8/52.	A C Marshall E Reilly.

JMcC/912353

Date	NURSING NOTES	Signature

GREATER GLASGOW HEALTH BOARD — INPATIENT CHART

SURNAME / FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
D 313693 JENKINS THERESA A 38 BENCLOICH CRES LENNOXTOWN 13/08/63 G65 7NB G.P.Prac.43 TEL. NO.	WARD/DEPT.	RELIGION / MAIDEN NAME G.P.'S NAME & ADDRESS TEL. NO.	M. S. W.

DATE 7/10/03 SPECIALTY CONSULTANT'S NAME

PC ≡/A seen GP

HPC Acute onset central colicky abdominal pain last night
Gradually worsening throughout today and moved → RIF
Vomited ×2 Nausea ++
↓ appetite ↓ fluids
° urinary symptoms

PMH nil of note

DH nil NKA

FH nil

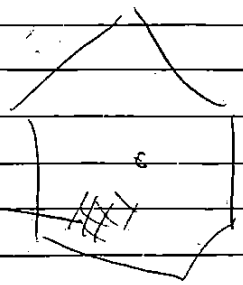
SH Lives ≤ husband
Unemployed
Smokes ~30 roll ups/day
Alcohol occ

CVS NAD

Resp NAD

CNS NAD

O/E Healthy looking 30yr. Not ill
Undistressed Apyrexial
°JACCOS Lymphadenopathy
Pulse 80 reg BP 110/86
RS I + II + 0
BS ves + 0 bowel ↓ nml pres.



Abdo soft
0 clicks / masses
BS ✓

CNS grossly intact SL (JMC)

ORM 2 JMcC/911628

DATE

URINE

Reaction | Albumin | Sugar | Ketones

WEIGHT (in Kilogrammes)

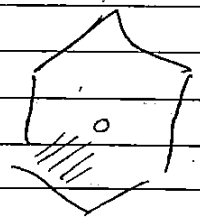
PHYSICAL EXAMINATION

Hb 12·3
WCC 19·5
plat. 421.

7/10/93 30 ♀ E/A via GP with R.I.F. pain

Woken by pain at 3am with generalised abdo pain. Since then it has moved to R.I.F. + ↑ in severity. Vomited ×1. ° blood.
No diarrhoea.
Last ate yesterday - doesn't feel hungry.
On O.C.P. Last withdrawal bleed 2/52 ago.
Para 1+0.

o/E Apyrexial 36·8°C ~~jaundiced~~
BP 110/70 pulse 88 reg.
Abdo
Soft
Tender R.I.F.
° guarding.
Some rebound
Tender (R) renal angle.
° masses / ~~LKKS~~
BSv
P.R. Soft stool FOB -ve. Non-tender



INVESTIGATIONS

Note WCC of 19·5.

Imp ? appendicitis.
? UTI.

MSSU + microscopy in am. + review

P/A.
(SHO).

GREATER GLASGOW HEALTH BOARD

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	THERESA	

few polymorphs. mod.

8.10.93 U/S abdo — Normal liver, spleen, kidneys & pancreas. Gallbladder normal. Patent to duodenum to gallbladder → now in RIF. No ultrasonic abnormality seen in this area

F Bright

8/10/93 Had been S/B Mr Hansell this am. he felt pain more RUQ + with sister's Hx of cholecystitis → U/S. Result above. Still tender, apyrexial not toxic clinically. MSSU sent - Direct microscopy - a few polymorphs + a "moderate" amount of bacteria. For review this evening by Dr Hiew (SHO) Started on trimethoprim 200mg b.d.

8/10/93 8.00pm. Undistressed. ○ Abd pain now. OE Pulse 90/m, apyrexial still. Abd ○ Soft. ○ Tender (R) IF + Rebound. ○ Masses. BS ✓.

FORM 3 JMcC 911630

Ate bowl of soup! at 500 pm. Advised NBM for now.

Ti D/W Reg. LUTHER (SHO)

8/10/93 FBC ND

Hgb 12.6

WCC 14.6

Platelets 441

D Nellis (SHO).

/10/93 Discharge summary

DOA 7/10/93 DOD 10/10/93

Dx: acute abdominal pain

Ex: U/S abdo & pelvis – (N)

urine microscopy – polymorphs + moderate bacteria

OPA 2/52

Leon Roe Sinclair 1006

(SHO)

THIS DOCUMENT MUST BE RETAINED

GREATER GLASGOW HEALTH BOARD

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6 hr = 22 Drops/min.
4 hr = 30 Drops/min. 8 hr = 15 Drops/min.

SURNAME	FORENAME	Unit Number
JENKINS	THERESA	313693

DATE 7·10·93

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	SERIAL No / BATCH No.	Given by
N SAL. N.G. 0·9%	500		4hr	3.0 10/-	L Marshall		
DEXTROSE 5%	500	3.0 10/-	4hr	5 3.0 p.m.	L Marshall	93G 29/5/95	
Dextrose 5% + 20mM KCl	500	5.50 A.M.	4hr	4.30pm	L Marshall	93F 28/5/95	
(N) Saline	500	5 p.m	4.	11.50 p.m.	S Dalgleish	93H 16 BP	~~D.C~~
Dextrose 5%	500	11.50 p.m.	4	5a.m.	S Dalgleish	93G 28/5/95	
Dextrose 5% + 10mmol KCl	500	5am	4		S Dalgleish	93F2 8BH.	EB

Form 75a

JMcC/920694

GREATER GLASGOW HEALTH BOARD

24 HOUR FLUID CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	THERESA	313693

DATE 7.10.93

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
			5 a.m.					
			6 a.m.					
			7 a.m.					
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon					
			1 p.m.					
			2 p.m.					
			3 p.m.					
			4 p.m.					
			5 p.m.					
			6 p.m.					
			7 p.m.					
			8 p.m.					
			9 p.m.					
N-SALINE 0-9%		500	10 p.m.					
			11 p.m.					
TOTALS								
TOTAL INTAKE		500				TOTAL OUTPUT		

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time	
Serum: Urea Sodium Potassium Chloride Bicarbonate Creatinine		
Urine: Urea		

FORM 9A

GREATER GLASGOW HEALTH BOARD

24 HOUR FLUID CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
THOMSON	JOHN A.	

DATE 8/10/93

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
DEXTROSE 5%		500.	5 a.m.					
			6 a.m.					
			7 a.m.					
			8 a.m.	UTT				
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon	UTT				
			1 p.m.					
Tea	180		2 p.m.					
Water	30		3 p.m.					
Lucozade	180		4 p.m.	UTT				
DEXTROSE Kcl Tea	180	500.	5 p.m.					
SOUP	180.		6 p.m.					
			7 p.m.					
			8 p.m.					
			9 p.m.					
			10 p.m.					
N-SALINE 0-9%		500.	11 p.m.					
TOTALS	750	1500.						
TOTAL INTAKE	2250			PASSING URINE SATISFACTORILY		TOTAL OUTPUT		

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum: Urea	
Sodium	
Potassium	
Chloride	
Bicarbonate	
Creatinine	
Urine: Urea	
Chloride	

FORM 9A

GREATER GLASGOW HEALTH BOARD

24 HOUR FLUID CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	THERESA.	

DATE 9/10/93

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
DEXTROSE		500	5 a.m.					
			6 a.m.					
			7 a.m.					
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
TEA	150		12 noon					
TEA	150		1 p.m.					
TEA	150		2 p.m.					
TEA	150		3 p.m.					
			4 p.m.					
TEA	150		5 p.m.					
TEA	150		6 p.m.					
TEA	150		7 p.m.					
TEA	150		8 p.m.					
			9 p.m.					
			10 p.m.					
			11 p.m.					
TOTALS	1240	500						
TOTAL INTAKE		1740				TOTAL OUTPUT		

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum: Urea	
Sodium	
Potassium	
Chloride	
Bicarbonate	
Creatinine	
Urine: Urea	

FORM 9A

GREATER GLASGOW HEALTH BOARD

24 HOUR FLUID CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Jenkins	Theresa.	

DATE 10.10.93

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
			5 a.m.					
			6 a.m.					
			7 a.m.					
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon					
			1 p.m.					
			2 p.m.					
			3 p.m.					
			4 p.m.					
			5 p.m.					
			6 p.m.					
			7 p.m.					
			8 p.m.					
			9 p.m.					
			10 p.m.					
			11 p.m.					
TOTALS								
TOTAL INTAKE						TOTAL OUTPUT		

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum: Urea Sodium Potassium Chloride Bicarbonate. Creatinine	
Urine: Urea	

FORM 9A

GREATER GLASGOW HEALTH BOARD

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	~~TRIMETHOPRIM~~	~~200~~														
	J 9/10/93	TRIMETHOPRIM	200mg	ORAL	✓							✓			P		
	K 9/10/93	CODDAMOL	2 TABS	ORAL			4-6 hrly				prn	prn					
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
9/10/93	9.50 p.m.	PETHIDINE	100mg	IM	[signature]	[signature]	9.50

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
6C	THERESA JENKINS	30			313693	MR Hansell

KNOWN MEDICINE SENSITIVITIES 1.

GREATER GLASGOW HEALTH BOARD

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6 p.m.			10 p.m.			12 m.n.			OTHER TIMES			
			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial	
8/10/93																													
9/10/93										K												JK							
10/10/93																													

NAME: THERESA JENKINS.

UNIT NUMBER: 313693

WARD: 6C

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

GREATER GLASGOW HEALTH BOARD

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
DATE	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6 p.m.			10 p.m.			12 m.n.			OTHER TIMES			
			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial	

NAME	UNIT NUMBER	WARD	KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED CODE LETTER SCORED E.G. X = PATIENT ABSENT
		6C	

STOBHILL GENERAL HOSPITAL

NAME JENKINS THERESA

HAEMATOLOGY

UNIT NO. 313693

SURNAME JENKINS

AGE 13.8.63

FORENAME Theresa

SEX F

ADDRESS 38 Bencloich Cres

WARD ANC

DR STILL

CONSULTANT/G.P.

J.McC/893735

7/ 2/91	
1	
10.55	WBC x10⁹/l
4.19	RBC x10¹²/l
124	Hb g/l
0.386	HCT RATIO
92.1	MCV fl
29.6	MCH pg
32.1	MCHC g/l
13.2	RDW-CV
362	PLATS x10⁹/l
6.35	NEUT x10⁹/l
3.45	LYMPH x10⁹/l
0.50	MONO x10⁹/l
0.14	EOS x10⁹/l
0.08	BASO x10⁹/l
mm in 1hr.	ESR
%	RETICS

JB-E1600

INITIALS	INITIALS	INITIALS	INITIALS	INITIALS

STOBHILL GENERAL HOSPITAL

HAEMATOLOGY

UNIT NO: 313693

SURNAME: JENKINS
AGE: 13.8.63
FORENAME: Theresa
SEX: F
ADDRESS: 38 Bencloick cres
WARD: ANC
DR STILL
CONSULTANT/G.P.

11/7/91

1	
13.48	WBC ×10⁹/l
3.80	RBC ×10¹²/l
110	Hb g/l
0.329	HCT RATIO
86.6	MCV fl
28.9	MCH pg
33.4	MCHC g/l
14.7	RDW.-CV
343	PLATS ×10⁹/l
7.95	NEUT ×10⁹/l
4.23	LYMPH ×10⁹/l
0.90	MONO ×10⁹/l
0.27	EOS ×10⁹/l
0.13	BASO ×10⁹/l
mm in 1hr.	ESR
%	RETICS

JB-E1600

STOBHILL GENERAL HOSPITAL

NAME

HAEMATOLOGY

UNIT NO. 313693

SURNAME JENKINS

FORENAME Theresa

ADDRESS 38 Bencloick cres

AGE 13.8.63

SEX F

WARD 29b

CONSULTANT/G.P. DR STILL

11/ 7/9	21/ 8/91	
13.40	17.16	WBC ×10⁹/l
3.80	3.60	RBC ×10¹²/l
110	103	Hb g/l
0.329	0.311	HCT RATIO
86.6	86.4	MCV fl
28.9	28.6	MCH pg
33.4	33.1	MCHC g/l
14.7	15.7	RDW-CV
343	303	PLATS ×10⁹/l
7.95	11.55	NEUT ×10⁹/l
4.23	4.53	LYMPH ×10⁹/l
0.90	0.83	MONO ×10⁹/l
0.27	0.18	EOS ×10⁹/l
0.13	---.--	BASO ×10⁹/l
mm in 1hr.	mm in 1hr.	ESR
%	%	RETICS

JB E1600

JB E1600

Ind.

GREATER GLASGOW HEALTH BOARD

TPR CHART

SURNAME CHRISTIAN/FORENAME	UNIT NUMBER
Jenkins Theresa	

92.

Date	27/12													
Post Op Date														

TEMPERATURE °C: 42 41 40 39 38 37 36 35 34

PULSE: 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20 10

RESPIRATION

GREATER GLASGOW HEALTH BOARD

BLOOD PRESSURE CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Jenkins	Theresa	

21/12/72

28/12.

Date	8		2		10	/																					Date
300		10		6		/																					300
290						/																					290
280						/																					280
270						/																					270
260						/																					260
250						/																					250
240						/																					240
230						/																					230
220						/																					220
210						/																					210
200						/																					200
190						/																					190
180						/																					180
170						/																					170
160						/																					160
150						/																					150
140						/																					140
130						/																					130
120	1	4				/																					120
110	1	1				/																					110
100	1	1				/																					100
90	1	1				/																					90
80	V	⊻				/																					80
70						/																					70
60						/																					60
50						/																					50
40	100	96				/																					40

THERAPY

Form 44

GREATER GLASGOW HEALTH BOARD

24 HOUR FLUID CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Jenkins	Theresa	

DATE 27/12/92

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
			5 a.m.					
Admitted.			6 a.m.					
Dextrose 5% + Pardex		250	7 a.m.	450				
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon					
			1 p.m.					
			2 p.m.					
			3 p.m.					
			4 p.m.					
			5 p.m.					
			6 p.m.					
			7 p.m.					
			8 p.m.					
			9 p.m.					
			10 p.m.					
			11 p.m.					
TOTALS								
TOTAL INTAKE							TOTAL OUTPUT	

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum: Urea, Sodium, Potassium, Chloride, Bicarbonate, Creatinine	
Urine: Urea, Chloride	

FORM 9A

THIS DOCUMENT MUST BE RETAINED

GREATER GLASGOW HEALTH BOARD

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6 hr = 22 Drops/min.
4 hr = 30 Drops/min. 8 hr = 15 Drops/min.

SURNAME	FORENAME	Unit Number
Jenkins	Teresa	

DATE 27/11

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	SERIAL No / BATCH No.	Given by
200ml 5% Dex	200ml	6.40 am	15 min	7am	Allen	92D 16 BJ	OT.
+50m +52.5M Pamoles							
5% Dex Pamoles	500ml 17.5m	7am	4Hr	1pm	Allen	92 J 05 BJ	OT.
5% Dex Pamoles	500ml 17.5m	1pm	8Hr		Allen	92J 05BJ	FM'E
5% Dex Pamoles	500ml 17.5m		8Hr		Allen		

Form 75a

Patient's Name: Theresa Jenkins

Address: 38 Bencloich Cres Lennoxtown

Contact Tel.No:

GREATER GLASGOW HEALTH BOARD
STOBHILL MATERNITY UNIT
HISTORY SHEET/COMMUNITY LIAISON

313693

G.P. Dr Henderson

Address: Main St Lenzie

Consultant: Dr Still

PRENATAL: Parity: 2+0 E.D.D.: 9/8/91 Scan:

Past Obstetric History: 1981 F/D Well
1985 SVD Well.

Obstetric Problems:

Medical History/Drug Allergies:

Blood Group/Rhesus Factor: RO5 Anti-D: Rubella: Immune.

Options of Care/Wishes:

Social Services:

Parenthood: Yes/No

Birth Plan: Yes/No

Special Needs:

BABY: Live/S.B./N.N.D. Boy/Girl Name:- CHRISTINA

Gestation: Term Apgar Score: 9/1 10/5

Weight: Birth: 3.390kg 7lb 7½ Discharge:

Feeding: Breast/Artificial - Type: SMA

Admission to Paed. Dept. Yes/No/Short Stay

Reason:

Transfer/Home/Other: 21/8/91 Date:

Discharge Summary: Feeding well.

Additional Information:

DELIVERY: SVD/FORCEPS/LUSCS/BREECH/VENTOUSE Spontaneous/Induced GA/Spinal/Epidural

Reasons:

DATE: 20/8/91 Perineum Intact/Episiotomy/Tear 1° 2° 3°

TIME: 11.35 HR Length of Labour: 3L 10 min

Blood Loss: 150 mls. Sutures: Yes/No Type:

Placenta: complete/Incomplete Membranes: Complete/Incomplete/Ragged

Cord/Maternal Blood taken: Yes/No

Additional Information: Wishes early discharge.

POSTNATAL Inpatient: Mother

Hb: Taken 21/8/91.

Anti-D: ✓

Kleihaur: ✓

Almavax: ✓ F.P. O/C Appointment:

Transfer/Home/Other: 21/8/91 Date:

Discharge Summary:

Additional Information:
In. S.S.M. 21/8/91 ✓
G/P 6/52.

Signature: P. Rankin.

COMMUNITY: Discharge Summary: Mother well. Temp. 36°. ~~abd~~ observation normal. Carries well with baby

Feeding: Bottle

H.V./G.P. Contacted: Yes/No

Signature: S. Kerr

Discharge Summary: Baby Temp 36° ~~abd~~ Eyes. mouth skin clear. Bottle fed - advised. Put 2lb. Bottle feeding well.

Feeding: Bottle. Cord: On/Off 26/8/91 Guthrie Test: 26/8/91 ✓

Signature: S Kerr.

AUGUST 1991

(Hospital Sticker)

GREATER GLASGOW HEALTH BOARD
STOBHILL MATERNITY UNIT

THERESA JENKINS

MATERNAL OBSERVATIONS:

Breasts: }
Fundus: }
Lochia: } DAILY
Perineum: }

Abdominal Wound: –
Legs: DAILY
Micturition: DAILY
Temperature: DAILY
Pulse: DAILY
B.P.:

MIDWIFERY ADVICE:

Sleep:
Diet:
Hygiene:
Physiotherapy:
Family Planning:
Social Services:
Pre-Pregnancy Care:
Other:

INVESTIGATIONS:

M.S.S.U.:
Haematology: 21·8·91
Pelvimetry:
Other:

PARENTHOOD:

Registration Card: 20·8·91 to mother
Equipment Sterilisation:
Bathing:
Bath by Mother:

BABY OBSERVATIONS:

2 Name Bands: DAILY
Sex: DAILY
Temperature: DAILY
Weight: ON 4th P/N discharge
Skin: }
Eyes: }
Mouth: }
Cord: } DAILY.
Buttocks: }
Urine: }
Stools: }

INVESTIGATIONS:

Medical Examination: 21·8·91
Paediatric Examination 21·8·91
Guthrie Test:
S.B.R.:
Other:

Date	Post-Natal Day	POSTNATAL CHECKS COMPLETED BY:-		
		Maternal Check	Baby Check	Shift Midwife
	0			
20·8·91	1	C Muat	C Muat	E Hothold R. Mac Lennan
21/8/91	2	P. Rankin.		
	3			
	4			
24 8 91	5	M Ceiran	M Ceiran	
	6			
26 8 91.	7	S. Kerr.	S. Kerr	
	8			
28-8-91.	9	S Kerr.	S. Kerr.	
29-8 91	10	S. Kerr	S. Kerr	

GREATER GLASGOW HEALTH BOARD

FORM NO. 12

SURNAME	JENKINS	CHRISTIAN/FORENAMES	THERESA.	UNIT NUMBER 313693

WARD | TRANSFERRED TO WARD | DATE OF ADMISSION

NEXT OF KIN & ADDRESS (Give Phone No.) | RELATIONSHIP | AGE

CHRISTOPHER JENKINS — HUSBAND — 28.
38 BENCLOICH CRESCENT LENNOXTOWN

NURSING REPORT

Para 2+0 — Exs. 9.8.91 — O. P05

DATE		SIGNATURE
20/8/91	Admitted from home with history of regular contractions since 06.00 hr.	
09.00	No show or SRM. Had show last week. Well during Pregnancy.	B. Yule
	Palpation: Term fundus, longitudinal lie, cephalic presentation 3/5th palpable. FH ✓ LOA position. T. 36.4° P. 80 BP. 110/75.	
09.20	V/E: Cervix 4 cm dilated, almost fully effaced. Membranes bulging. Vx 0-2.	
	ARM. clear liquor draining. Head ↓ 0-1 following ARM	B. Yule
09.40	CTG commenced in lounge. FH 130 bpm.	
	Quite uncomfortable. Entonox given.	B. Yule
10.00	CTG discontinued. Mobilising. Zantac 150mgs orally.	
11.00	Becoming very uncomfortable. To cubicle 3. V/E Cervix fully dilated. Vx 0+1.	
11.20	Organised pushing commenced. CTG in progress.	
11.35	SVD girl. Routine Syntometrine 1ml. Baby gasped & cried.	
	MOTHER: Placenta and membranes by CCT. BABY: Apgars 9/1 10/5. Suction only required	B. Yule
	To GP for PIN. discuss forms to fill	

Name	Religion	Consultant
THERESA JENKINS	R.C.	DR STILL.

DATE	Mother — NURSING REPORT — Baby	SIGNATURE
	Small labial laceration sustained. No sutures required.	No obvious abnormalities detected. Temp 36.5°C. Bathed. Identibands checked and applied. Konakion 1mg IM	B Yule
	T. [illegible] P. 73 BP. 122/75. Fundus firm, lochia minimal. Immersion bath taken. Tea and toast. Wishes to go home discharge. Will wait till morning.	Weight 3.390kg 7lb 7½oz
		12.30 1st Milk feed. SMA 40 mls taken.
13.10	From L/W Temp 36 P. 70 BP 120/70 Fundus firm 1FB ↓ umbilicus Lochia rubra + not excessive. Still to void urine	ID x 2 checked + correct. R temp 37°C. NAD. Has passed meconium but no urine	C. Hunt.
21/8/91.	Discharged on day 3 following SVD. To GP for P/N & O/C.	Discharged by Paed.	P. Rankin.
22.8.91. 3.	Temp. 36° Pulse. 80. Complaining of after pains taking Paracetamol. All other observations normal. Coping well with baby	Baby Christina Temp 37. Eyes, mouth, skin, buttocks clean. Clamp Removed. Dri Bib. Bottle feeding taking 2.2kgs. SMA Nipple Cap. Drinks of Water given between feeds.	S Keogh

23.8.91.	Temp. 36°. Pulse 78. Fundus firm 6 FBS	Baby Christina Temp. 36°. all	
4.	½ umbilicus lochia Rubra average, Coping	observation normal. Cord	
	well with baby uncomplaining	separating. Pri Bfd. Bottle feeding	S Kerr
		taking 3oz. 4 hourly. Content	
24 8 91	Post natally well	All observations satisfactory	
5		Taking 3oz 4 hourly PU 90 content	M Canavan
25 8 91	No visit		
6			M canavan
26.8.91.	Temp. 36 Pulse 80. Resp. natal observations	Baby Christina Temp 36°.	
7.	normal Coping well with baby	Cord OFF. all observation	
		normal. Bottle feeding taking	S Kerr
		4 oz SMA whilst cup PKW.	
24 8.91.	No. VISIT. Has phone. NO		
8			
28-8-91.	Temp. 36°. Pulse 72. Fundus firm 6 FBS ½	Baby. Christina Temp. 36°.	
9.	umbilicus Lochia minimal but mum said	observations normal. Bottle	S. Kerr
	her lochia was Red and heavy Yesterday, advised	feeding taking 4oz. 4 hourly	
	all other observations normal.		
29.8.91	mum post natally well, observations normal.	Baby Christina Temp 36.4	
10	Discharged.	All observations normal.	
	No. visits 6.	Bottle feeding well: Content	
	To GP for PIN. Diarrhoea form to H/V		

Name	Religion	Consultant
THERESA JENKINS	R.C.	M. STILL.

Patients Name	Unit Number	Ward
Teresa Jenkins		12B

NURSING CARE PRESCRIPTION

HOSPITAL Stobhill

Code	Date	PROBLEM	PLAN OF CARE	DATE OF EVALUATION	Times of Administration 2	4	6	8	10	12	2	4	6	8	10	12	Sign	Discontinued Date	Discontinued Intl.
A	26/12	Mobility	Bed rest initially		←											→			
B																			
C	"	Elimination	Offer commode						4s	Regd.									
D																			
E	"	P/hygiene	Bed bath / Asst basin						✓		✓		✓						
F			Reg mw.						✓		✓		✓						
G	"	Diet	Light					✓		✓		✓							
H																			
I																			
J																			
K																			
L																			
M																			

	Observations	Times	Initials	Special Treatment/Therapy	Sign	Discontinued Date	Discontinued Intl.
27/12	BP	10, 6, 10	FM	RSOU			
"	Temp	10+6	FM	IV fluids	"		
"	Fluid balance	24	FM				

LS5

Patients Name	Unit Number	Ward

NURSING CARE PRESCRIPTION

HOSPITAL _____

Code	Date	PROBLEM	PLAN OF CARE	DATE OF EVALUATION	Times of Administration												Sign	Discontinued	
					2	4	6	8	10	12	2	4	6	8	10	12		Date	Intl.
A																			
B																			
C																			
D																			
E																			
F																			
G																			
H																			
I																			
J																			
K																			
L																			
M																			

		Observations	Times	Initials	Special Treatment/Therapy	Sign	Discontinued	
							Date	Intl.

LS 5

HOSPITAL ROBHILL

NURSING CARE — RECORDING

| DATE 27/12 | | |

GREATER GLASGOW HEALTH BOARD

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A 23/9	PARVOLEX	1 V	I/V Infusion													
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H 23/9																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
J7.1	Theresa Jenkins					Mulmy

KNOWN MEDICINE SENSITIVITIES 1.

MEDICAL IN CONFIDENCE

GREATER GLASGOW HEALTH BOARD

CASE RECORD

ADMISSION FORM V2

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G207H	STOBHILL	

DATE	TIME	TYPE	SOURCE	INPAT/DAYCASE	DATE ON W.L.	PATIENT CATEGORY
27-12-92	5.10 AM	84	1	I		3

WARD	SPECIALTY	CONSULTANT
12B	16	MILROY

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
JENKINS	TERESA		29	13.8.63	F	M

ADDRESS: 38 BENCLOICH CRES. LENNOXTOWN

ALT/PREV SURNAME:

OCCUPATION:

POSTCODE: G65 7DS.

TELEPHONE No.:

OCCUPATION (HUSBAND/FATHER):

NAME	ADDRESS
HENDERSON	MAIN ST. LENNOXTOWN

G.P. CODE: PRACTICE:

CONTRACT No.:

TELEPHONE No.: POSTCODE:

NAME	RELATIONSHIP		NAME	RELATIONSHIP
	HUSBAND	AND / OR		
ADDRESS	S.A.		ADDRESS	
DAY PHONE No.	NIGHT PHONE No.		DAY PHONE No.	NIGHT PHONE No.

RELIGION	VISIT REQ. BY CHAPLAIN YES/NO	PENSION BOOK No.
R.C.		

DISCHARGE SUMMARY

DATE	TIME	DISCH CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE
29/12/92		1	3	1	16	DR MILROY	

HOSPITAL	CODE	WARD	SPECIALTY	CONSULTANT	CODE
DISCHARGED/ TRANSFERRED TO					

	CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS: Paracetamol O/D.	-9654	
ER CONDITIONS (D.G,2)	E9500	
(D.G,3)		
(D.G,4)		
(D.G,5)		
(D.G,6)		

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P,2)		
(O.P,3)		
(O.P,4)		

LOCAL USE			NATIONAL USE	

CHART COMPLETED

122 Yr. YES / REC R.C. E|12. WARD COPY

G.G.H.B. STOBHILL GENERAL HOSPITAL ACCIDENT/EMERGENCY DEPT.

DATE 27-12-92

UNIT 6 TIME 3.10 AM/PM REF. BY G.P. YES/NO AMB/CAS./OTHER

SURNAME	FIRST NAME(S)	M. S.W.	AGE	DATE OF BIRTH
JENKINS	TERESA		29	13.8.6

ADDRESS	NEXT OF KIN	PLACE OF INJUR
38 BENCLOICH TERR G65	HUSBAND S.A	WORK ☐ SCHOOL ☐
TELEPHONE No. IRVINE 211768	TELEPHONE No. N.A	HOME (indoors) ☐
NAME AND ADDRESS OF FAMILY DOCTOR DR HENDERSON 8 MAIN ST LENNOXTOWN	OCCUPATION	R.T.A. ☐ OTHER ROAD ☐
	DATE & TIME OF INJURY O/D	TIME SEEN a.m./p.m. OTHER ☐

DRUG HISTORY (anti-coagulants, insulin, A.T.T. steroids, allergic reactions etc.)

D' [illegible] PBT

d. precac 30 mg give 3.35 = IVM

~~given 12 hourly~~

given precac → vomited multiple times

late → haematemesis

E950 Hb 13.1

WC 11.2

Plat 364

PT 13/12

PTT 33/32

TT 92/11

21

plan Admit 12B

CT.

1.45am FBC, G&C

5.30am U&E's, ABG [illegible] (Salvage)

X-RAY

DIAGNOSIS Na 143 K 4.2 Cl 104

TREATMENT Hb 21 U 2.3 Ca 2.2

Ca 6.3

Par 0.8 Sal -ve

Grey cross

SIGNATURE

DISPOSAL RETURN TO CASUALTY ☐ G.P. ☐ WARD ☐ O.P. CLINIC ☐ OTHER CLINIC ☐

GREATER GLASGOW HEALTH BOARD

INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
Jewthun	Theresa			M. S. W.

DATE OF BIRTH	AGE	SEX	WARD/DEPT.	RELIGION	MAIDEN NAME

ADDRESS	G.P.'S NAME & ADDRESS
TEL. NO.	TEL. NO.

DATE | SPECIALTY Gen Med | CONSULTANT'S NAME Milroy

E/A c/o CAS

24 y/o ♀

PC Last week father died
Trying to cope w/ this
Now the fact that she felt as if she had to cope w/ everything
started drinking
Early this am took bottle of paracetamol & subsequent vomiting ~1:30am
→ Casualty Spec. → Vomiting delayed haemeteisis
RM/H/H Was in a care home as child as too unruly for parents

PMH/H Varicose veins 0/d 13 y/o
~~Asthma~~
~~Allergy/Tx/Dm/Gp/RS/Asthma~~

OA N.K.

F/Sm Married 3 kids Works in butcher
Heavy smoker Occ light drinker

S/E Tended to answer Yes to every question & believed ~~that~~ ~~every~~ this was significant

CVS Chest pain: Tight, central assoc'd w/ vomiting

Resp Cough: haemoptysis: ? ? months
? night sweats hoarseness

GIT Dyspepsia
Blood PR
Loose stool

~~GUS~~ GUS } N.A.D
CNS

DATE

URINE

Reaction | Albumin | Sugar | Ketones

WEIGHT (In Kilogrammes)

PHYSICAL EXAMINATION

O/E In good spirits but tenderness over abdomen ° JAUNDICE

CVS P 107 Reg
BP 140/80
JVP ~
HS: I+II+0

Chest Tr ⊿ clear clear

Abdo soft
yesterday

CNS PERLA CNs: Intact
Peripheral Sensation intact

Imp Unfortunate o/d. Phoned friend to tell of o/d
not really serious
ERC Coma GCS 6 UEOs Glu Paracet Salic level
ABGs Cleared but fractured
Hb 13.1 WC 11.2 Plat 316
PT 13/11 PTT 33/32 TT 12/11

INVESTIGATIONS Na 143 K 4.2 U 109
Bu 2.1 Cr 23 Cr 82
Glu 6.3
Panc. tested Glu positive 0.8 : Urine dipsi
Sal -ve

(P) → Panadol R/

Arthur JMO

GREATER GLASGOW HEALTH BOARD

CLINICAL NOTES

SURNAME CHRISTIAN/FORENAME	UNIT No

DATE	CLINICAL NOTES	Initials
07-12-98	29 year old woman.	
	- Paracetamol O/D - Uncooperative. Unwilling to answer questions. - NO past hx of O/D	
	Paracetamol level = 0.8 at 4h. Salicylate (-) → commenced on Parcolex	
	U&Es Glucose, FBC ~ (N). (ucc ↑ 11.2) + Coag.	
	O/E - Pale incisors BP = 140/80 pulse = ~~80~~ 90/reg ↑vol HS - I + II + 0 Chest - clear Abdomen - (soft Tender epigastrium to deep palpation ↑ BKS CNS - PERLA - sluggish Uncooperative Alert plan as bb	
	Re-check level + Coag + U&Es & LFTs to-day	
	NHagerty	

FORM 39

JMcC/912436

DATE	CLINICAL NOTES	Initials

N.B. D/C - Dr Haggerty

~~Fate~~
Teresa Jenkins

Date of Admission: 27/12/92.

Date of Discharge: 27/12/92

Diagnosis: Paracetamol O/D.

Results awaited: patient signed irreg discharge book + left.

Drugs on discharge: —

Follow-up: nil. Arranged Yes/No

Other arrangements to be made:

Arranged Yes/No

Arranged Yes/No

GENERAL

UNIT NORTH 1

HOSPITAL: STOBHILL | UNIT NUMBER | WARD 12B

TEL. NO.
AGE 29
RELIGION R.C.

NEXT OF KIN Husband
NAME
ADDRESS S/A

TEL. NO. DAY | TEL. NO. NIGHT
NEIGHBOUR WILLING TO BE CONTACTED
NAME
ADDRESS
TEL. NO.

REASON FOR ADMISSION Self poisoning Paracetamol.

REASON GIVEN TO PATIENT S/A

SLEEP PATTERN

WHAT HELPS YOU TO SLEEP

APPETITE — GOOD/POOR

ANY DIFFICULTIES EATING OR SWALLOWING YES ☐ NO ☐

DISPOSAL OF VALUABLES

RELATIVES AWARE OF ADMISSION YES ☑ NO ☐

VISITORS EXPECTED YES ☑ NO ☐

PROBLEMS WITH VISITING — IDENTIFY e.g. TRANSPORT, BABY SITTING

BLADDER — NORMAL ☑ NOCTURIA ☐ INCONTINENT ☐
FREQUENCY ☐ DYSURIA ☐

ANY PROBLEMS AT HOME WHILST IN HOSPITAL — IDENTIFY

SIGHT — GOOD ☑ BLIND ☐ LENSES ☐
POOR ☐ GLASSES ☐

HEARING — GOOD ☑ DEAF ☐
POOR ☐ HEARING AID ☐ (R) (L)

UNDER CARE OF
DISTRICT NURSE ☐
SOCIAL WORKER ☐
OTHER — SPECIFY ☐

TEETH — OWN ☐ DENTURE ☐ PARTIAL ☐ UPPER ☐
FULL ☐ LOWER ☐

LS 1

Name	Age	Unit No./Address	Consultant/G.P.
Theresa Jenkins	29	38 Bencloich Cres, Lennoxtown	DR Milroy

Date	Progress/Evaluation	Signature

DIET — SPECIAL DIET

SPECIAL LIKES AND DISLIKES

MOBILITY — MOBILE WITHOUT ANY HELP ☑

NEEDS HELP WITH ☐

WALKING	☐	STANDING	☐
IN/OUT BED	☐	BATHING	☐
IN/OUT CHAIR	☐	FEEDING	☐

NEURO-SENSORY LEVEL —

EUPHORIC	☐	ANXIOUS	☐
AGGRESIVE	☐	DISTRESSED	☐
WITHDRAWN	☐	CONFUSED	☐
ORIENTATED	☑		

FEMALE PATIENTS — MENSTUATION

REGULAR	☐	AMENORRHOEA	☐
IRREGULAR	☐	DYSMENORRHOEA	☐

DO YOU SMOKE? (YES) NO

ANY SPEECH/ LANGUAGE DIFFICULTY

CONDITION OF PRESSURE AREAS — DESCRIBE

CURRENT HEALTH PROBLEMS — DESCRIBE

ANY ALLERGIES YES NO

NORTON SCORE —

CHECK LIST 0 - 48 HOURS

PATIENT SPOKEN TO BY —

RELATIVES SPOKEN TO BY —

MEDICAL CERTIFICATE —

SOCIAL WORKER —

SEEN BY PRIEST —

SEEN BY MINISTER —

HISTORY OBTAINED FROM:—

HISTORY OBTAINED BY:—

DATE: TIME:

Date	Progress/Evaluation	Signature
27/12/02	E/A via casualty at 6am presenting with self poisoning of paracetamol ? amount. "bottle". drinking also? given ipecac in casualty vomitted several times. Haemetemesis.	
	PMH. Valium o/d 13yrs dd.	SH. Married 3 children. chain smoker. works in kitchen. light drinker.
	OH. Nil	
	O/A Paracetamol level 0.87 for parvolex. Required persuading to accept this + put nightchess on. Told "no smoking" lit cigarette despite this then was sick. BP 130/80 P100 T.36.5. Commenced Parvolex 6.40am.	
am	S/E Dr Milroy - patient is not keen to stay in hospital. Advised to stay meantime.	CMerrick
12noon	- Pulled out Venflon - wishing to go home. - Dr Hassan informed. Irregular discharge taken.	CMerrick

Name	Age	Unit No./Address	Consultant/G.P.
Thieresa Jenkins	29	38 Bencloich Cres, Lennoxtown	DR MILROY.

Date	Progress/Evaluation	Signature

Name	Age	Unit No./Address	Consultant/G.P.

MEDICAL IN CONFIDENCE

STOBHILL
NHS TRUST

CASE RECORD

ADMISSION FORM V2

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G207H	STOBHILL HOSPITAL	S/H-313693

DATE	TIME	TYPE	SOURCE	INPAT./DAYCASE	DATE ON W.L.	PATIENT CATEGORY
20/12/94	01:30	8 EM-OT 1	HOME	Inpatient		3 NHS

WARD	SPECIALTY	CONSULTANT
WD 5	GENERAL SURGERY	MR DT HANSELL

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MRS JENKINS	THERESA		31	13/08/1963	F	M

ADDRESS
38 BENCLOICH CRES
LENNOXTOWN

ALT./PREV. SURNAME

OCCUPATION

POSTCODE
G65 7NB

TELEPHONE No.

OCCUPATION (HUSBAND/FATHER)

NAME
HENDERSON J
G.P. CODE 2335801 PRACTICE 43261 1
CONTRACT No.

ADDRESS
MAIN STREET
LENNOXTOWN
TELEPHONE No. 431 0588 POSTCODE G65 7DD

NAME
RELATIONSHIP
HUSBAND
ADDRESS
SA
DAY PHONE No.
NIGHT PHONE No.

AND / OR

NAME
RELATIONSHIP
ADDRESS
DAY PHONE No.
NIGHT PHONE No.

RELIGION	VISIT REQ. BY CHAPLAIN YES/NO	PENSION BOOK No.
Roman Catholic	Y	

DISCHARGE SUMMARY

DATE	TIME	DISCH. CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT	CODE

DISCHARGED/ TRANSFERRED TO	HOSPITAL	CODE	WARD	SPECIALTY	CONSULTANT	CODE

MAIN DIAGNOSIS	CODE	SPECIAL WARNINGS
	7890	
OTHER CONDITIONS (D.G,2)		
(D.G,3)		
(D.G,4)		
(D.G,5)		
(D.G,6)		

MAIN OPERATION	CODE	DATE
OTHER OPERATION (O.P,2)		
(O.P,3)		
(O.P,4)		

LOCAL USE			NATIONAL USE	

GREATER GLASGOW HEALTH BOARD — INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
JENNINS	THERESA			M. S. W.

DATE OF BIRTH	AGE	SEX	WARD/DEPT.	RELIGION	MAIDEN NAME

ADDRESS	G.P.'S NAME & ADDRESS
TEL. NO.	TEL. NO.

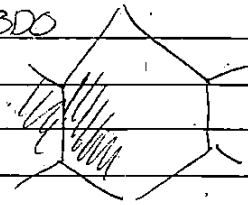
DATE	SPECIALTY	CONSULTANT'S NAME
20/11/91	E/A via casualty with abdo pain	HANSELL

HPC - Sudden onset of generalised abdo pain 18hrs ago now settling in RLQ + (R) loin
- pain was constant but is now easing
- vomit NAD - foodstuffs
- bowels have moved but only a small amount
- some abdo distension - now settling.
- ?? shivering
feels need to pass urine but only passing small amounts. - 0 other urinary symps.

PMHx - ?TB, DM, jaund, epil, IHD, TBP asthma, allergies
- no prev ops.

DHx OCP
NKDA

S/E CVS
RESP
CNS
} nil of note

O/E - comfortable ?JACCO not flushed
CVS - pulse 97 HS I + II +0
RESP - trachea ↓
- good AE 0 added sounds
- resonant to percussion
ABDO  tender at (R) side + in (R) loin
slight rebound tenderness in RIF
-ve murphys
0 masses
BS ✓
CNS - Grossly intact

FORM 2 JMcC/911628

DATE

URINE

Reaction | Albumin | Sugar | Ketones

WEIGHT (In Kilogrammes)

PHYSICAL EXAMINATION

RESULTS. - Hb-13 | Na 138 | Urea 2.0
WCC 18.3 | K 4.1 | Cr 75
PCS 381 | Cl 104 | Gluc 5.4
HCO_3 26 | Amy 85

Given IV cefuroxime 750mg
NBM
IV fluids

9) Gordon

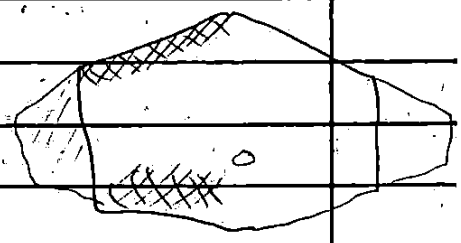
INVESTIGATIONS

GREATER GLASGOW HEALTH BOARD

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	TERESA	

19/12/94	SHO
	Hx → Vague history → Sudden onset generalised abdo pain today after eating roll → as day progressed ↑ Rt side but c/o bilat "side" pain → anorexic ± vomiting + ? slight distension → bowel ° change ? = ? → °GUS complaint ⇒ Prev episode UTI - similar to above
	°E, Unclistressed, Apyrexial °S°A°C °C °O °V=
	Abdo → soft tender abdo, ? slightly distended → tender MF + Rt hypochondrium + Rt renal → °masses → °bruits → ± Murphy's sign → °evidence peritonism → BS ↓ → PR → soft faeces °masses



FORM 3 JMcC:911630

Imp -> 31 ♀ c ? Appendicitis
? UTI
? Acute Cholecystitis.

Plan -> Admit 5
- i.v. Fluids / NBM
- FBC, U+E, Glucose, Amy
- i.v. ceftriaxone
- NSSU
- U/S Upper + lower abdo. now.

(SHO)

US
uterus: ovary (Rt) seen
fluid in pouch of R/F ?? abnormality.
- OBs & RV seen

26/12/94 Reviewed 6am and 12pm.
Well - Feeling better.
O/E: Mild tenderness on DEEP palpation
Not guarding
Imp: Not requiring appendicectomy
tonight

TOBIN

27/12 WIR Dr Brown
Drop down
to continue IV antibiotics

SJS

GREATER GLASGOW HEALTH BOARD INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
				M. S. W.

DATE OF BIRTH	AGE	SEX	WARD/DEPT.	RELIGION	MAIDEN NAME

ADDRESS	G.P.'S NAME & ADDRESS
TEL. NO.	TEL. NO.

DATE	SPECIALTY	CONSULTANT'S NAME

22/12/94. Doing well - Pain settled
Home today. F/U at OPD in 3/12.

Discharge Summary:

DOA. 20/12/94.
DOD: 22/12/94.
Dx - E/A ↓ abdo pain. settled on NBM + IV. Cefuroxime + flagyl.
? aetiology.
F/U - OPD in 3/12.

MMASP(SR)
(JHO)

D.N.A. 20 FEB 1995
NEW APPOINTMENT SOON
NEW APPOINTMENT (Not Urgent) ✓
LETTER TO DOCTOR
NO FURTHER ACTION

ND 4/4 11.35

D.N.A. 04 APR 1995
NEW APPOINTMENT SOON
NEW APPOINTMENT (Not Urgent) ✓
LETTER TO DOCTOR
NO FURTHER ACTION

FORM 2 JMcC/911628

DATE	URINE			
	Reaction	Albumin	Sugar	Ketones
	WEIGHT (In Kilogrammes)			
	PHYSICAL EXAMINATION			

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	mid 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
Sc	Lorraine Cannon	09/05/			455237	Mr. Hansell

KNOWN MEDICINE 1.

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION

REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
DATE	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6.p.m.			10 p.m.			12 m.n.			OTHER TIMES			
			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial		

NAME: Lorraine Canavan

UNIT NUMBER: 455237

WARD: SC

KEY: CODE LETTER CIRCLED E.G. Ⓐ = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	mid 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A 20/12/94	~~CEFUROXIME~~	~~750mg~~	~~IV~~		✓			✓			✓					
	B 20/12/94	PETHIDINE	75mg	IM	4-6 hrly for pain												
	C 20/12/94	STEMETIL	12.5mg	IM	6-8 hrly for pain												
	D 20/12/94	~~METRONIDAZOLE~~	~~500mg~~	~~IV~~		✓			✓			✓				21/12	KAG
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

| | | | | | | | | | | | | | | | |

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

DATE	REGULAR PRESCRIPTIONS: 6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
20/4	Initial	A Initial	Initial	Initial	A Initial	Initial	Initial	A Initial	Initial	Initial	A at 1.30am Bat 1.10pm. H given at 6.40 pm J given at 7.25pm
21/4	Initial	Co-trim Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	

NAME: THERESA JENKINS

UNIT NUMBER:

WARD:

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	

NAME

UNIT NUMBER

WARD

KEY: CODE LETTER CIRCLED E.G. Ⓐ = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. ✗ = PATIENT ABSENT

THIS DOCUMENT MUST BE RETAINED

GREATER GLASGOW HEALTH BOARD

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6 hr = 22 Drops/min.
4 hr = 30 Drops/min. 8 hr = 15 Drops/min.

SURNAME	FORENAME	Unit Number
JENKINS	THERESA	

DATE 20/12/94

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	SERIAL No / BATCH No.	Given by
N-SALINE	500	1PM	4	5.30 PM	[signature]	94J 17BL	AR
DEXTROSE	500	5.30 AM	4	2.30	[signature]	94K 03BE	AR
DEXTROSE	500	12	4	4.55 PM	[signature]	94K 03BE	LP
N Saline	500	4.55 PM	4	9.10 PM	[signature]	94J 21BD EXP 10/96	VM
5% Dextrose	500	9.10 PM	4	12.10	[signature]	94K 03BE EXP 11/96	VM
5% Dextrose	500	12.10	4	5.50 am.	[signature]	94K 03BE	[signature]
N-SALINE	500	5.50	4		[signature]	94J 17BL	[signature]
5% DEXTROSE	500	[signature]	4		[signature]		
5% DEXTROSE	500		4		[signature]		

Form 75a

JMcC/920694

STOBHILL NHS TRUST

TPR CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	~~[illegible]~~ Theresa	

Date	29/12	21/2	23/2											
Post Op Date														

TEMPERATURE °C: 42 41 40 39 38 37 36 35 34

PULSE: 180 170 160 150 140 130 120 110 100 90 80 70 60

RESPIRATION: 50 40 30 20 10

No. of Stools

FORM 10B

STOBHILL PATIENT PROFILE

WARD

Type / source of admission

Emergency

NAME Theresa ~~[illegible]~~ JENKINS.
ADDRESS 38 Benclaich Cres
Lenzie
D.O.B. 13/8/63 31 yrs
UNIT No.

AFFIX DATA LABEL

Religion R. C.

Allergies NONE

Next of kin informed YES
Christopher Jenkins

Medical reasons for admission

Abdominal Pain

Patient's understanding of admission

FULLY UNDERSTAND

Relative's understanding of admission

FULLY UNDERSTAND

General condition on admission

CLEAN NOT UNWELL LOOKING

PATIENT PROFILE
(continued)

Social circumstances

LIVES WITH HUSBAND AND THREE DAUGHTERS

Occupation: HOUSEWIFE.

Hobbies / interests

Medical history

NONE.

Medication list

BIRTH PILL

Valuables / belongings

Other information

Signature of Assessment Nurse Ann Reilly Date 20-12-94 Time 2AM

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

NAME
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

NURSING ASSESSMENT

WARD

Maintaining Safe Environment

Communication

FLUENT

Hearing Aid Y/(N)

Spectacles Y/(N)

Breathing / Circulation

Resps

B.P. 120/80

Pulse 80

Smoker (Y)/N

Eating / Drinking

NIL ORALLY MEANTIME

Dentures 2 TOP PARTIAL PLATE

Elimination

Urinalysis

Personal Cleansing / Dressing

SEE TO OWN PERSONAL HYGIENE

JMcC/933380

CONTINUED OVER

NURSING ASSESSMENT
CONTINUED

Controlling Body Temperature

Temp 36.1°C

Mobilisation

UP AND ABOUT AS ABLE

Weight 8 ST.

Waterlow - score

Expressing Sexuality

NOT DISCUSSED

Sleeping

GOOD SLEEPER.

Pain

ABDOMINAL PAIN.

Socialization

GOES FOR A DRINK SOMETIMES.

Dying

NOT DISCUSSED

Minister / priest

Signature of Assessment Nurse Ann Reilly Date 20/12/96 Time 2 AM

Signature of Named Nurse Date Time

JMcC/933380

STOBHILL **CARE PLAN** WARD 5C

NAME T Jenkins
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

Date	No.	Problem/Need	Patient Goal/ Nursing Outcome	Intervention	Evaluation Date
21/12/94	1.	Venflon	Close: To prevent if possible infection	1a Observe site for inflammation/m	23/12/94

JMcC/933380

All entries must be signed

STOBHILL **CARE PLAN** WARD

Date	No.	Problem/Need	Patient Goal/ Nursing Outcome	Intervention	Evaluation Date

JMcC/933380

All entries must be signed

STOBHILL

PATIENT PROGRESS / EVALUATION

WARD

NAME THERESA JENKINS
ADDRESS
38 BENCLOICH CRES

D.O.B. 13.8.63 Age 31
UNIT No.

AFFIX DATA LABEL

All entries must be signed.

Date	No.	Progress / Evaluation	
20/12/94		C/A via casualty presenting	
		1/c 24hr H/o abd pain	
		RLQ & (R) loin WCC 18·3.	
		Impression ? UTI ? Appendicitis	
		? cholecystitis.	
		MSSU to be obtained	
		U/S to be arranged, commenced	
		on IV fluids & antibiotics.	
		Nil orally meantime Apyrexial	A McLeod
		I.V maintained IM analgesia given	
		U/S Took some dinner; told to	
		fast till reviewed by Dr	MR &
		Apyrexial.	
	pm	Vomited x 2 hrs ago - oral analgesia	
		and antiemetic as before with settling effect	
		~~[illegible]~~ - Free fluids only	
21/12/94		Settled night	
		IV fluids continue No further	
		vomiting	
		Urine this am by pussy away of	
		yellow colour	Yorke
	am	Settled, IV discontinued, tolerating	
		free fluids and diet, IV antibiotics	
		to continue, no nausea or vomiting	
		Apyrexial. No complaints.	VMorrison
	pm	Self caring. Tolerating	
		fluids + diet. NO nausea	
		or vomiting this pm. ?home-am	E Reilly
22/12/94		Slept well No complaints of pain	
		?home this AM.	A Reilly
	am	Seen by Mr Morrell. Discharged home	

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress / Evaluation	***All entries must be signed.***
		For 3/12 OPA.	Cancelled

STOBHILL

DISCHARGE PLAN

WARD

NAME ADDRESS   D.O.B. UNIT No.

AFFIX DATA LABEL

Discharge date 22.12.94	
Patient informed Yes	Relative informed
Transport arrangements family	Clothing requested for discharge
Medication / G.P.'s letter given to patient	
Out-patients appointment 3/12	Ambulance required No
Social services: Social worker Home help Meals on wheels Other	N/A
District nurse N/A	
Aids and equipment	
Other needs	
Discharge summary / comments Admitted with ab. pain. Settled and discharged home	

Signature of Discharge Nurse C McCready Date 22.12.94 Time 3 pm

Signature of Named Nurse Date Time

JMcC/933380

STOBHILL

NAME
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

SPECIMEN / INVESTIGATIONS

WARD

DATE ORDERED	SPECIMEN	DATE OBTAINED

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL

JMcC/933380

STOBHILL HOSPITAL, GLASGOW CASUALTY DEPARTMENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	THERESA	31	13 8 63	19.12.94	1140	77

Address	Sex	Religion	Date of Inc	Time
38 BENLOICH CRES	F	R/C		

PC G65 7NA	Tel —	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
		M			

Name: DR RAE Address: MAIN ST G66

Referred by: GP.

Name: Address:

Relat. HUSBAND S/A

Tel No.

Complaint: SUR/Pain

CLINICAL NOTES

B.P: 124/84
PULSE: 97
TEMP: 37
TIME:

- 24 hr h/o of abdo pain
- Initially all over abdo + both loins. Now settled in RLQ + (R) loin
- pain now settling
- abdoc NTU
- some abdo distension - passing wind but any small amounts of faeces.
- occas shivering + feeling warm
- feels the need to pass urine but only passing small amounts - ? other UTI symptoms

Urine: NAD
Bloods - WFG

PMHx - nil of note
DHx - OCP NKDA
OE - comfortable not flushed afebrile
- tender in (R) loin and RLQ
some rebound tenderness in (R) LQ
no murphys sign
BS -

Hb - 13
WCC - 18.3
pts 381

ALLERGIES:

TREATMENT PRESCRIBED:

- FBC/F/S/G/U/C done

Examining Doctor: G Gordon
(Signature)
PRINT NAME GORDON

estigations	X-Ray	Lab	ECG	Cross Match	Bact
		✓			

atment	Dressing	Suture	Tet Tox	Antibiotic	Analg

	Pop	Resusc	Nurse's Signature

Diagnosis

	Pat Group	Diag	Anat Sit
1			
2			
3			
FD			

Research

sposal Time	Home	Admit	A/E Clinic	Irreg Dis
12:35 pm		5		

	DOA	GP	Transfer	Other Clinic	DNW

STOBHILL NHS TRUST, GLASGOW CASUALTY DEPARTMENT

Form 5

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	THERESA	33	13/08/1963	26/08/96	13:27	020620

Address	Sex	Religion	Date of Inc	Time
38 BENCLOICH CRES LENNOXTOWN	FEMALE		NOT KNOWN	

PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
G657NA		MARRIED		EMERG.	WALK/OT

Name	Address	Referred by
HENDERSON	MAIN STREET LENNOXTOWN G65 7DD	

Name	Address	Complaint
NOT STATED		MED/CAS
Relat. HUSBAND		
Tel No.	SA	

CLINICAL NOTES

B.P: 99/68

PULSE: 121

TEMP: 36.6

TIME: 13:40

ALLERGIES:

TREATMENT PRESCRIBED:

Examining Doctor: (Signature)

PRINT NAME

Investigations	X-Ray	Lab	ECG	Cross Match	Bact

Treatment	Dressing	Suture	Tet Tox	Antibiotic	Analg

	Pop	Resusc	Nurse's Signature

Diagnosis			
	Pat Group	Diag	Anat Sit
1			
2			
3			
FD			

Research

Disposal Time	Home	Admit	A/E Clinic	Irreg Dis
		RD		

DOA	GP	Transfer	Other Clinic	DNW

MEDICAL IN CONFIDENCE

STOBHILL
NHS TRUST

NOT ON COMP.

CASE RECOR

ADMISSION FORM V2

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
	STOBHILL	313693

ADMISSION DETAILS

DATE	TIME	TYPE	SOURCE	INPAT./DAYCASE	DATE ON W.L.	PATIENT CATEGORY
26/8/96	13:27	8	1	I		3

WARD	SPECIALTY	CONSULTANT
14A	16.	SMITH (3286616)

PATIENT

TITLE SURNAME	FORENAME	INITIALS	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
JENKINS	THERESA		33	13/8/63	F	M

ADDRESS: 38 BENCLOICH CRES
LENNOXTOWN

ALT./PREV. SURNAME:

OCCUPATION:

POSTCODE: G65 7NA

TELEPHONE No.:

OCCUPATION (HUSBAND/FATHER):

REF. G.P.

NAME: HENDERSON

G.P. CODE:

PRACTICE:

ADDRESS: MAIN ST
LENNOXTOWN.

CONTRACT No.:

TELEPHONE No.:

POSTCODE: G65 7DN

NEXT OF KIN

NAME:

RELATIONSHIP: HUSBAND

ADDRESS: S/A.

DAY PHONE No.:

NIGHT PHONE No.:

AND / OR

NAME:

RELATIONSHIP:

ADDRESS:

DAY PHONE No.:

NIGHT PHONE No.:

MISC.

RELIGION:

VISIT REQ. BY CHAPLAIN YES/NO:

PENSION BOOK No.:

DISCHARGE SUMMARY

DISCHARGE DETAILS

DATE	TIME	DISCH. CODE	PATIENT CATEGORY	TYPE FACILITY	SPECIALTY	CONSULTANT CODE
29/8/96		8			16	DRAOSMITH

HOSPITAL CODE	WARD	SPECIALTY	CONSULTANT CODE

DISCHARGED/TRANSFERRED TO: none

DIAGNOSES

	CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	R073	
OTHER CONDITIONS (D.G,2)		
(D.G,3)		
(D.G,4)		
(D.G,5)		
(D.G,6)		

AND OPERATIONS

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P,2)		
(O.P,3)		
(O.P,4)		

SMR1 COMPLETED

LOCAL USE			NATIONAL USE	

GREATER GLASGOW HEALTH BOARD — INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
Jenkins	Theresa			M. S. W.

DATE OF BIRTH	AGE	SEX	WARD/DEPT.	RELIGION	MAIDEN NAME
	33	F			

ADDRESS	G.P.'S NAME & ADDRESS
TEL. NO.	TEL. NO.

DATE | SPECIALTY | CONSULTANT'S NAME Dr A. Smith

26/8/96
4.30 pm

33 yr. old female generally fit

Woke up 5.00 am this morning feeling unwell, sore throat & chest pain (pleuritic in nature more on the (Rt) side ant. & posteriorly.)
Mild cough → unproductive, no haemoptysis.
H/o Dysuria (only last micturation)

PMH Nil

D.H Nil

S/H Married, lives w husband & 3 children
Heavy smoker 40 cpd.
Alcohol +

O/E looks unwell
Pyrexial; Temp 38°c
P 100/min
BP 100/70
JVP →
No oedema

CVS: HS I + II + 0
Chest: clear
Abd } NAD
CNS }

Na	136	Urea 2.9	Hb
K	H	Creat 73	WCC 18
Cl	105	gl. 6.4	Plt.
Bic	21		

FORM 2 JMcC/911628

DATE

URINE

Reaction | Albumin | Sugar | Ketones

WEIGHT (in Kilogrammes)

PHYSICAL EXAMINATION

Arterial BG on Air

H^+

~~PCO_2~~ CO_2 4.7

Bic 22

PO_2 7.8

CXR: Diffuse B/L shadowing

ECG: SR, nil acute

Impression

33 yr. ♀ Pleuritic chest pain
hypoxia + B/L shadow on CXR

Δ Atypical pneumonia

Plan - Blood cultures

- I.V A/B } as charted.
- I.V fluids }

TG

INVESTIGATIONS

STOBHILL NHS TRUST

CONTINUATION CHART

SURNAME	CHRISTIAN / FORENAME	UNIT NUMBER
JENKINS	T	

26.8.96. Although one's tempted to believe that she has a atypical lower respiratory tract infection, she has no syndrome whatever. Really only system which appears affected is the urinary tract. She has a high fever, & severe hypoxia.

Hb 16.3
WC 18.0
P. 377

Please give N. fluids + Ab as charted, together O2 & 02, by humidifier if necessary.

27.8.96 0955 There has been considerable improvement. However please continue therapeutic measures as discussed, for a few days. Review chest

(10d)

28/8/96 Well - keen to home.
Appraisal
Chest clear
⇒ if she remains apyrexial tomorrow → change to oral A/B

FC

0176932

29/8/96.
1 am Asked to resite venflon due to painful left arm into which Clarithromycin + Cefotaxime was being administered IV.
Patient refused another venflon and requested the IV antibiotics be discontinued.
Against advise the IV drugs were withdrawn and the patient was ~~not~~ prescribed:
Erythromycin 500mg ~~qid~~ qds
Amoxycillin 250mg tid

SHO (JHO)

9.8.96 She would ~~go~~ home today to take antibiotics for ~~through~~ until 2.9.96, and ~~c~~ FU today with ~~Dr~~ — so that IVR may be regulated.
Please ~~do~~ bloods charted.
(i/c amoxycillin 500mg tds.
Rest — as.

AK
SHO

10 SEP 1996
Generally well
No resp. symptoms
CXR → Normal.
Note c/o amenorrhoea since April (5 months)
Not preg. (preg. test — ve on 27/8)
Not lactating not on any med.

STOBHILL NHS TRUST

CONTINUATION CHART

SURNAME	CHRISTIAN / FORENAME	UNIT NUMBER
Jenkins	Theresa	

⇒ S. Prolactin

⇒ FBC., TFTs

[signature] 2/12

0176932

STOBHILL PATIENT PROFILE

WARD 14A

Type / source of admission

33yrs

F/A VIA A+E

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

Religion

R. C.

Allergies

N/K KNOWN

Next of kin informed ✓ (HUSBAND)

CHRISTOPHER JENKINS

Medical reasons for admission

P C of C. PAIN
SINCE YESTERDAY / SHARP
WORSE on INSPIRATION

Patient's understanding of admission

UNDERSTANDS C. PAIN

Relative's understanding of admission

General condition on admission

S.O.B / AGITATED / C. PAIN

PATIENT PROFILE
(continued)

Social circumstances

LIVES WITH HUSBAND (3 CHILDREN)
OCCASIONAL ALCOHOL

Occupation: DOESN'T WORK

Hobbies / interests READING

Medical history

ABDO PAIN

Medication list

Valuables / belongings

WARD POLICY EXPLAINED

Other information

Signature of Assessment Nurse [signature] Date 26.8.96 Time 1530 HRS

Signature of Named Nurse [signature] Date 27/8 Time

JMcC/933380

STOBHILL

NURSING ASSESSMENT

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261
AFFIX DATA LABEL

WARD 14A

Maintaining Safe Environment

c/o O2 THERAPY

Communication

Hearing Aid Y/(N)

NORMAL

Spectacles (Y)/N

Breathing / Circulation

Resps B.P.

SOB / NORMAL
O/A

Pulse Smoker (Y)/N
40

Eating / Drinking

APPETITE NORMAL Dentures

POOR LAST FED DAYS YES

Elimination

BOWELS REGULAR
C. URINARY PROBLEMS

Urinalysis ~~awaited~~
Blood + Protein +

Personal Cleansing / Dressing

SELF CARE

JMcC/933380

CONTINUED OVER

NURSING ASSESSMENT

CONTINUED

Controlling Body Temperature

Temp

36.6°c

Mobilisation

Normal

Weight 9st 2lb

Ht 5'2"

Waterlow - score

Expressing Sexuality

Not menstruating

Sleeping

Normal

Pain

C. Pain

Socialization

—

Dying

—

Minister / priest

Signature of Assessment Nurse [signature] Date 26.8.96 Time 1530 hrs

Signature of Named Nurse [signature] Date 27/8 Time

JMcC/933380

STOBHILL CARE PLAN WARD

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

Title:
Nursing care of breathless patient.

Date	No.	Problem/Need	Patient Goal (PG)/ Nursing Outcome (NO)	Intervention	Eval Date
8/8/96	(1)	Dyspnoea caused by * . . . . . Pneumonia	Facilitate ventilation.	a) Administer oxygen as prescribed, via * Venti. Mask rate * . 40% . . . litres. b) Encourage patient to adopt a comfortable position which allows for maximum lung expansion. c) Give reassurance and support. d) Liaise with medical staff re-need for physiotherapy. e) Observe and record * . . . . hourly: i) Temperature. ii) Pulse. iii) Respirations. f) Encourage patient to rest. g) Allow patient time to complete activities at own pace. h) Observe for evidence of respiratory distress i.e i) Increased respiratory rate. ii) Anxiety. iii) Sweating. iv) Restlessness. Report to medical staff. i) Carry out oral hygiene * . . . hourly. Method * . . . . . Please specify where * . . . occurrs. MB	29/8/96

All entries must be signed

Title: Care of a patient with Intravenous (ula.

ADDRESS

D.O.B
UNIT No.
AFFIX DATA LABEL

ate	No.	Problem/Need	Patient Goal/(PG) Nursing Outcome(NO)	Intervention	Eval Date
28/8/96	(2)	Observation of complications of: 1) Pain. 2) Infection (local) Thrombophlebitis. 3) Extravasation. 4) Haematoma. 5) Blocked Cannula. 6) Dislodged Cannula.	maintain venous access, and prevent complications.	a) Observe cannula site *. 4. .hourly for signs of complications ie: i) Swelling/ inflammation ii) Pain. iii) Redness. b) Maintain asepsis when wocking with cannula. c) Cover with clear adhesive dressing. d) Change dressing if blood or fluid trapped. e) Inform medical staff if complications arise. Please specify where * . . . occurs.	29/8/96

All entries must be sign

\wp51\ccp\intcannula.ccp

STOBHILL

PATIENT PROGRESS / EVALUATION

313693
JENKINS THERESA (33)
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

33 yr

WARD 14A IMPRESSION - C. PAIN ? CAUSE

All entries must be signed.

Date	No.	Progress / Evaluation	
26.8.96		O/A SOB, C. PAIN, ACTIVITIES	
		OF. PLAN: BLOODS, CXR, ECHO REVIEW	
		N. PLAN: AS CHARTED.	
		Seen by Dr. Smith Imp: Pneumonia commenced	
		IV antibiotics, IV fluids, Pethadine 50mgs +	
		Stemetil 12.5mg @ 6.10pm. MSSU + Sputum	
		for C+S, Physiotherapy referral.	Allison
10pm		O_2 Sat 89%. Encouraged to keep	
		O_2 therapy insitu	
		IV Antibiotics as prescribed	
27.8.96.		I.V. Fluids continue	
		Settled for short spells	E Kane
	8 SE	S/B Dr Smith	
		- For atypical pneumonia screen.	
		- Please collect MSSU.	
		- Continue with present management	
		- O_2 via nasal cannulae - 4 litres.	
		- continue 2 IV fluids as charted.	
		- trans 10B.	Hay SE
am		Transferred from 14A - NO IV	
		fluids. fully mobile and	
		walked to smoking room -	
		against nursing advice.	
		Taking fluids & diet well	
		No C/O pain. or breathlessness.	
pm		Continues to mobilise smoke.	
		and not req O_2 therapy.	
		Patient informed nursing staff	
		she has not consulted for	

JMcC/933380

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress / Evaluation	All entries must be signed.
		over 2 months ? pregnant. –	
		Latex test to be carried on	
		Ward in AM.	
		Continue IV antibiotics as	
		prescribed	JM Thompatrick
28/8/96		Slept for intervals.	
		C/o pain at venflon site	
		no evidence of swelling or	
		Redness, ? to be rested	
		in am.	M Bunton
am.		Complaining of pain at venflon site during	
		antibiotic therapy added to 250 mls bag of	
		N. Saline but required to have extra fluid added	
		due to discomfort. Dr Williams will review	
		for evening dose.	L Henderson
		Observations satisfactory this am.	R Henderson
pm		Seen by Dr Gaman. To continue I.V. antibiotics	
		to tomorrow if patient remains apyrexical	
		then discontinue tomorrow, change to oral.	
		Patient had earlier spoke of going home as family	
		had visited and upset patient. When Dr Gaman	
		spoke to her, patient stated she would stay.	
		if had just been that family had upset her.	
		Fine this evening, no mention of going home	R Henderson
29/8/96		continues to c/o pain at	
		venflon site. Refused IV antibiotics	
		Dr informed commenced	
		oral antibiotics	
		ISF 118. 60 mgs given for pain	
		with good effect	M. Bunton
am		Seen by Dr Smith for discharge home. To	
		attend Med Clinic next Thursday, to have CXR at	
		this appointment. Patient will contact husband re	
		discharge	R Henderson

STOBHILL

PATIENT PROGRESS / EVALUATION

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

WARD 106

All entries must be signed.

Date	No.	Progress / Evaluation	
29/5	2pm	Discharged home -	R Henderson

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress / Evaluation	***All entries must be signed.***

STOBHILL

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

SPECIMEN / INVESTIGATIONS

WARD 14B

DATE ORDERED	SPECIMEN	DATE OBTAINED
26.8.96	URINE (LEAD ROUTINE)	26/8/96
27/8/96	MSU for C&S	28/8/96
27/8/96	Latex etc.	28/8/96

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL
CXR.	26/8/96	✓		
CXR	28/8/96			

JMcC/933380

STOBHILL

Date Assessed 28/8/96

DISCHARGE PLAN

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

WARD 10b

Discharge date NOT KNOWN AS YET 29/8/96

Patient informed 29/8/96

Relative informed Patient will inform 29/8/96 ✓

Transport arrangements

Own

Clothing requested for discharge

Medication / G.P.'s letter Yes ✓

Out-patients appointment
THURSDAY 5th SEPT 1996
MEDICAL CLINIC

Ambulance required
No

Social services:

Social worker

Home help

Meals on wheels

Other

District nurse

Aids and equipment

Other needs

Discharge summary / comments

Signature of Discharge Nurse P Henderson Date 29/8/96 Time 2pm

Signature of Named Nurse Date Time

JMcC/933380

STOBHILL NHS TRUST

STOBHILL NHS TRUST

Ward 14A Care Plan

Name: THERESA JENKINS

Address: _____ Unit Number: _____

_____ Date of Admission: 26.8.96

Signature of Registered Nurse: _____

Provisional Diagnosis: SEE NOTES

Recording of Vital Signs

BP	Pulse	Temp	Resp	Colour	Peakflow	CNS	CVP	Fluid Balance
☑	☑	☑	☐	☐	☐	☐	☐	☐
6 hrly	6 hrly	6 hrly	____hrly	____hrly	____hrly	____hrly	____hrly	____hrly

Monitoring / Recording of Observations

IV Cannula	IV Infusion	Chest Drain	Urethral Catheter
☑	☐	☐	☐
6 hrly	_____hrly	_____hrly	_____hrly

Telemetry	Cardiac Monitor	BM Stix	ECG During Pain
☐	☐	☐	☐
_____hrly	_____hrly	_____hrly	_____hrly

Medications (prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 Therapy
☑	☐	☐	☐
As Req hrly	_____hrly	_____hrly	
	☐ Via Syringe Drive	☐ Via O_2	☐ Type of Mask
	☐ Via Infusion Pump	☐ Nebuliser Compressor Pump	☐ Flow Rate

Nursing Care Plan Ward 14A Continued

Name:_____ **Unit Number:**_____

Hygiene

Bed Bath (2 Nurses)	Assisted Wash (1 Nurse)	Shower / Bath (Independent)	Ambi/Shower (Supervised)	Basin (Independent but on bed rest)
☐	☑	☐	☐	☐
Mouth Care	**Eye Care**	**Nasal Care**	**Catheter Care**	**Wound Care**
☐	☐	☐	☐	☐
_____hrly	_____hrly	_____hrly	_____hrly	Specify on Information Sheet

Mobilisation

Bed Rest	Ambulant		Positional Change
	Independent	Supervised	
☑	☐	☐	☐
			_____hrly
Specialised Bed	**Passive Limb Exercise**	**Number of Staff Required for M & H**	**Moving and Handling Aid**
☐	☐	☐	☐
	_____hrly	_____specify	_____specify

Diet

Normal Diet	Special Diet	Nasogastric / Gastronomy Feeding Use in conjunction with feeding instruction chart
☑	☐	☐
	_____specify	
Fluids Only	**Restricted Fluids**	**Fasting**	**Dietetic Advice**
☐	☐	☐	☐
	_____specify		

Nursing Care Plan Ward 14A Continued

Name:_____ Unit Number:_____

Paramedic Services - To be involved

Physiotherapy	Occupational Therapy	Speech Therapy
☐	☐	☐

Liaison Services - To be Involved

Cardiac	Respiratory	Diabetic	Stoma	Social Work
☐	☐	☐	☐	☐

Bladder / Bowel Care

Offer Commode / Urinal	Wheel to Toilet	Self Care	Catheter Care	Continence Aids
☑	☑	☐	☐ _____hrly	☐

Specimen Collection –
Tick Box if Specimen Required. Enter Date on Line when Obtained (*Specify)

RSOU	MSSU	Sputum	Wound Swab	Blood Culture
☑ _____	☐ _____	☐ _____	☐ _____	☐ _____
Gases	**FOB**	**AAFB**	**Pathology**	* _____
☐ _____	☐ _____	☐ _____	☐ _____	☐ _____
* _____	* _____	* _____	* _____	* _____
☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

Other Information

BUILD/WEIGHT FOR HEIGHT

Average	(0)
Above Average	1
Obese	2
Below Average	3

THERESA JENKINS
O/P
1530 HRS
26.8.96

CONTINENCE

Complete/ Catheterised	(0)
Occasion Incont.	1
Cath/Incontinent of Faeces	2
Doubly Incont.	3

SKIN TYPE VISUAL RISK AREAS

Healthy	(0)
Tissue Paper	1
Dry	1
Oedematous	1
Clammy (Temp up)	1
Discoloured	2
Broken/Spot	3

MOBILITY

Fully	0
Restless/Fidgety	1
Apathetic	2
Restricted	(3)
Inert/Traction	4
Tiribound	5

SEX/AGE

Male	1
Female	(2)
14 - 49	1
50 - 64	2
65 - 74	3
75 - 80	4
81+	5

APPETITE

Average	(0)
Poor	1
NG Tube/Fluids only	2
NBM/Anorexic	3

SPECIAL RISKS

TISSUE MALNUTRITION

eg. Terminal Cachexia	8
Cardiac Failure	5
Peripheral Vascular Disease	5
Anaemia	2
Smoking	(1)

NEUROLOGICAL DEFICIT

eg. Diabetes M.S., CVA., Motor/Sensory Paraplegia	4-6

MAJOR SURGERY/TRAUMA

Orthopaedic - Below Waist Spinal	5
On table > 2 hours	5

MEDICATION

Steroids Cytotoxics High Dose Anti-Inflammatory	4

****
* SCORE: 10+ AT RISK 15+ HIGH RISK 20+ VERY HIGH RI
****

6. Not at Risk

DEPENDENCY SCORING **PATIENT NAME** Theresa Jenkins **MONTH AND YEAR** 8/96

PERSONAL HYGIENE		DATE	28/8	28											
Requires bath/bed bath with 2 or more nurses	**High**	**4**													
Requires 1 nurse to assist with personal hygiene	**Medium**	**3**													
Serving only	**General**	**2**	1	1											
Independent of nurses	**Low**	**1**													

DRESSING

Total dependence	**High**	**4**													
Requires help with most garments	**Medium**	**3**													
Minimal assistance (e.g. shoes and socks)	**General**	**2**	1	1											
Independent of nurses	**Low**	**1**													

FEEDING

Total dependence, Nasogastric,PEG.	**High**	**4**													
Full assistance with eating and drinking	**Medium**	**3**													
Some assistance	**General**	**2**	1	1											
Independent of nurses	**Low**	**1**													

CONTINENCE

Incontinent of urine/faeces and/or uses aids	**High**	**4**													
Frequent toileting/ occasional incontinence	**Medium**	**3**													
Requires facilities at bedside / assistance to toilet	**General**	**2**	1	1											
Independent of nurses	**Low**	**1**													

MOBILITY

Bed rest and/ or 2 nurses to walk/ transfer	**High**	**4**													
Requires 1 nurse to encourage/ enable walk/ trans	**Medium**	**3**													
Requires supervision of 1 nurse and/or walking aid	**General**	**2**	1	1											
Independent of nurses	**Low**	**1**													

RING SCORES IN TABLE, ADD TOTAL. SEVERAL SCORES PER CATEGORY CAN BE USED.

BUILD/WEIGHT FOR HEIGHT

Average	(0)
Above Average	1
Obese	2
Below Average	3

CONTINENCE

Complete/ Catheterised	(0)
Occasion Incont.	1
Cath/Incontinent of Faeces	2
Doubly Incont.	3

SKIN TYPE VISUAL RISK AREAS

IF PATIENT HAS DISCLOSED OR BROKEN SKIN ON PRESSURE AREA, MARK SITE + GRADE OF SORE IN PRESSURE SORE 1 OR 2 CORE CARE PLAN.

Healthy	(0)
Tissue Paper	1
Dry	1
Oedematous	1
Clammy (Temp up)	1
Discoloured	2
Broken/Spot	3

MOBILITY

Fully	(0)
Restless/Fidgety	1
Apathetic	2
Restricted	3
Inert/Traction	4
Chairbound	5

SEX/AGE

Male	1
Female	(2)
14 - 49	(1)
50 - 64	2
65 - 74	3
75 - 80	4
81+	5

APPETITE

Average	(0)
Poor	1
NG Tube/Fluids only	2
NBM/Anorexic	3

SPECIAL RISKS

TISSUE MALNUTRITION

eg. Terminal Cachexia	8
Cardiac Failure	5
Peripheral Vascular Disease	5
Anaemia	2
Smoking	(1)

NEUROLOGICAL DEFICIT

eg. Diabetes M.S., CVA., Motor/Sensory Paraplegia	4-6

MAJOR SURGERY/TRAUMA

Orthopaedic - Below Waist Spinal	5
On table > 2 hours	5

MEDICATION

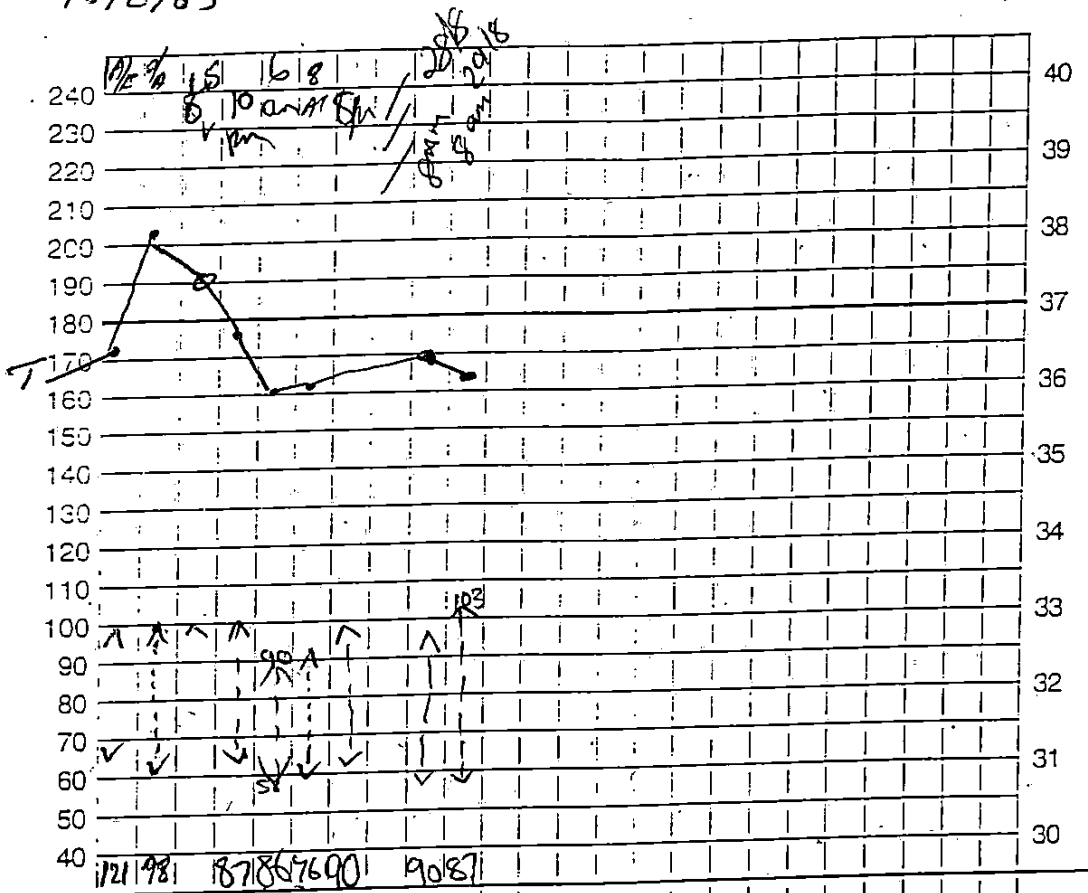
Steroids Cytotoxics High Dose Anti-Inflammatory	4

313693
JENKINS THERESA F
38 BENCLOICH CRES M
LENNOXTOWN 13/08/1963
G65 7NB G.P.Prac.43261

* SCORE: 10+ AT RISK 15+ HIGH RISK 20+ VERY HIGH RI

DATE	SCORE	MATTRESS	CUSHION	DATE NEXT DUE	IN
27/8/96	4	Softfoam	N/A	✓	JF

13/8/63



Blood Pressure and Pulse Rate

Pulse

Respiration Rate/min

Regular/irregular

0.2 Sat

BM Stix

Oral

Peak Flow

Weight

Bowel

Cumulative Totals

Size

Urinalysis	Colour	S.G.	Reaction	Sugar	Blood	Protein	Esoach g/l	Bile	Others
	Amber		pH5		+1	+1			+1 Keytones

Comments

STOBHILL NHS TRUST

24 HOUR FLUID CHART

DATE 26/8/96

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	THERESA	

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
			5 a.m.					
			6 a.m.					
			7 a.m.					
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon					
			1 p.m.					
			2 p.m.					
			3 p.m.					
			4 p.m.					
			5 p.m.					
COMM			6 p.m.					
			7 p.m.	50				
Hot Chocolate	100	IV Fluid. 500	8 p.m.					
			9 p.m.					
			10 p.m.					
			11 p.m.					
TOTALS								
TOTAL INTAKE							TOTAL OUTPUT	

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time	
Serum: Urea		
Sodium		
Potassium		
Chloride		
Bicarbonate		
Creatinine		
Urine: Urea		
Chloride		

FORM 9A

THIS DOCUMENT MUST BE RETAINED

GREATER GLASGOW HEALTH BOARD

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6 hr = 22 Drops/min.
4 hr = 30 Drops/min. 8 hr = 15 Drops/min.

DATE 26.8.96

SURNAME	FORENAME	Unit Number
JENKINS	T	

FLUID / ADDITIVE DRUG	VOL / DOSE	Commence	Duration	Finish	SIGNATURE	SERIAL No / BATCH No.	Given by
N/S Saline	500	6/5 pm STOPPED FOR ANTIBIOTIC				964 628	
5% Glucose	500	10.30pm	1 hour	12 SS		96F 668 BG ✗ 6/98	
N/S 0.9% NaCl 500ml		12 SS	2 hour	2		96F GG BS	
5% Dextrose	500ml	2	2 hour	3.40am		96F GG BS	
N/S 0.9% NaCl 500ml		3.40am	3 hour	6.50		96G 048G	
5% Dextrose	500ml	6.50	3 hour	10 am.		96F GG BS 69	
N-Saline 20 mmol KCl	500		3 hour				
5% Dextrose	500		3 hour				
N SALINE 20 mmol KCl	500		3 hour				

Review

Form 75a

JMcC/920694

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use		Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
26/8/96	A	28.6.96	HEPARIN	5000 u	s/c		✓		~				✓					
N 250ml	B	28.6.96	GENTAMYCIN	200 mg	IV		✓						✓					
	C	28.6.96	CEFOTAXIME	1g	IV		✓			✓			✓				29/8	
..	D	28.6.96	PETHIDINE	50mg	IM	6		8	hourly									
—	E	28.6.96	METOCLOPRAMIDE	10mg	IM		6-8	hourly										
	F																	
	G																	

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	28.6.96	OXYGEN	40%	INH	CONTINUOUS											
	I	28.6.96	CODEINE	60mg	ORAL	4-6 hourly											
	J	26.8.96	AMOXYCILLIN	500mg	ORAL												
	K	28.6.96	LACTULOSE	10ml	ORAL		✓			✓			✓				
	L	28.8.96	ERYTHROMYCIN	500mg	ORAL		✓			✓			✓				
	N		CEFOTAXIME														
	O	28.8.96	AMOXYCILLIN	250mg	ORAL		✓			✓			✓			29/8	
	P	29.8.96	TRIMETHOPRIM	200mg	ORAL		✓			✓			✓				
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DIET

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
26/8/96	6.40pm	Clarithromycin	500 mg	I.V	FG		6.40 pm
26/8/96	6.40pm	Cefotaxime	1gm	I.V	FG		6.40 pm

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE 1.

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
11	[illegible]					[illegible]

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS																								COMMENTS ON DISCREPANCIES
DATE	6 a.m.			8 a.m.			10 a.m.			12 m.d.			2 p.m.			4 p.m.			6 p.m.			10 p.m.			12 m.n.			OTHER TIMES			
			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial			Initial	

NAME

UNIT NUMBER

WARD

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMI

CODE LETTER SCORED E.G. X = PATIENT ABSENT

FORM MR 1.10

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
26/8/96	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	K at 10.05pm QP
27/8/96		L A C			A	C	K	A K BC			K at 4.30am EB K at 12.15pm JF
28/8/96		L A DC JF			A			A K		12.55am K	
29/8/96					MP						

NAME: Theresa Tentiris

UNIT NUMBER:

WARD: 11

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

CONFIDENTIAL
IMMEDIATE DISCHARGE & MEDICINE PRESCRIPTION FORM
PATIENT AND GP LABELS MUST GO ON ALL FOUR COPIES

NUMBER 02071

STOBHILL NHS TRUST

STOBHILL NHS TRUST
GLASGOW G21 3UW
TELEPHONE 0141 201 3000

DR. JR J HENDERSON
MAIN STREET
LENNOXTOWN

G65 7DD
G.P. Prac. 43261

313693
JENKINS THERESA F
38 BENCLOICH CRES M
LENNOXTOWN
13/08/1963
G65 7NB G.P.Prac.43261

DATE OF ADMISSION 26.8.96
DATE OF DISCHARGE 29/8/96
WARD 10B
CONSULTANT SMITH

DIAGNOSIS
1 INFLUENZA
2
3
4

OPERATION / PROCEDURES
1
2
3

FOLLOW UP ARRANGEMENTS

OUTPATIENT APPOINTMENTS

CONSULTANT	CLINIC	WHEN	DATE GIVEN	INITIALS
REHAT CX12	MEDICAL	Dr GORDON	16/09/96	2451M
FU MDT		4/52	5/9/96	

OUTPATIENT INVESTIGATIONS N.B. (request cards must be provided)

	DATE GIVEN	INITIALS
15.8		
33.8		

COMMUNITY CARE ARRANGEMENTS

ARRANGED BY

AMBULANCE REQUIRED ~~YES~~ / NO
WALKING
2 HANDED SEAT
STRETCHER
ESCORT
Tick as necessary

OTHER NEEDS (SPECIFY)

DISCHARGE MEDICATION

Please TICK box if childproof containers are UNSUITABLE ☐

Medicine	Form	Dose	Times of Administration	Recommended Duration from discharge (Days)
ERYTHROMYCIN	CAPS	250mg	qds	5 days
AMOXICILLIN	CAPS	500mg	tds	5 days
Reduce if Diarrhoea.				
		100ml	1	24 hrly

PHARMACY USE ONLY

No. of Days Supplied	Quantity, Name Strength & Manufacturer Supplied
5	Abbott 250
5	Bencard 21

OTHER TREATMENT AND COMMENTS (including details of drug sensitivites, appliances etc.)

DISPENSED BY
CHECKED BY
DATE 29/8/96 CP CHECK

MEDICINES COLLECTED BY (MESSENGER)

WARD USE ONLY

RECEIVED ON WARD BY
ISSUED BY
DATE ISSUED
SIGNATURE OF RECIPIENT

DR.'s NAME IN BLOCK CAPITALS WILLIAMS DATE 29/8/96
SIGNATURE PAGER No. 1166

COPIES TO ; WHITE - GP , PINK- MEDICAL RECORDS , BLUE - PHARMACY , YELLOW - PATIENT

STOBHILL NHS TRUST

CLINICAL NOTES

SURNAME CHRISTIAN/FORENAME	UNIT No
Jenkins Theresa	313693

DATE	CLINICAL NOTES	Initials
12 NOV 1996	WT 59 Kgs	JF 3.00
	Bcm discharge in Sept.	
	PRL 95 Test. 3.2	
	TA 17.3	
	FSH 5.2	
	E2	
	USS	
	Discharge	

FORM 39

0181063

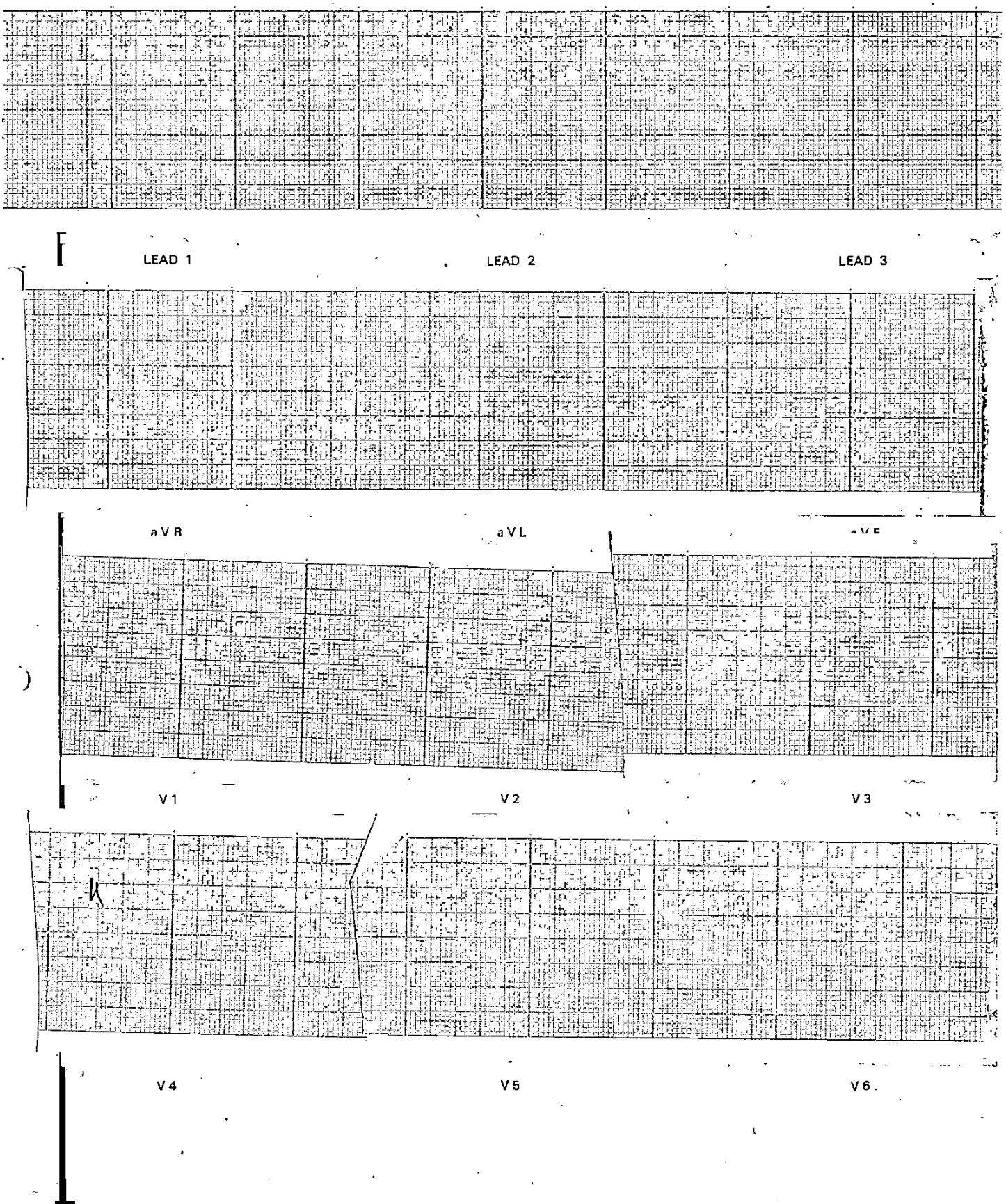
DATE	CLINICAL NOTES	Initials

E.C.G. CHART

SURNAME CHRISTIAN/FORENAME	UNIT No.
Jenkins THERESA	—

REPORT ON REVERSE SIDE

DATE	WARD	E.C.G. REF. No.	DOCTOR
26/8/90	A/E	96/9615	—



STOBHILL

NHS TRUST

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac:43261

INVESTIGATION FROM

	DATES OF INVESTIGATIONS														
	6/11/96			6/12/96			18/12/96			29/12/96			/ /		
DEPARTMENT	W'ted	Ord'd	Obt'd	W'ted	Ord'd	Obt'd	W'ted	Ord'd	Obt'd	W'ted	Ord'd	Obt'd	W'ted	Ord'd	Obt'd
BIOCHEMISTRY															
Full Screen				✓			✓								
Urea & Electolytes	✓														
Glucose															
Liver Function tests															
Cardiac Enzymes															
Amylase															
C. Reactive protein	✓			✓			✓								
Arterial blood gases	✓														
Thyroid function															
Cholesterol															
HAEMATOLOGY															
Full Blood Count	✓			✓			✓								
E.S.R.															
Coagulation/I.N.R.															
B12/Folate															
Ferritin															
RADIOLOGY															
X-ray	✓														
Ultrasound scan															
C.T.															
CARDIO/PULMONARY															
E.C.G.	✓														
Echo															
Exercise Test															
PFT's															
V/Q															
OTHERS															
Blood Cultures	✓			WAT											
PN ANTIGEN				✓											
ANTIBODY SCREEN				✓											

KEY (W'ted) = Investigation Required
(Ord'd) = Investigation Ordered
(Obt'd) = Result seen & signed

MEDICAL IN CONFIDENCE

STOBHILL
NHS TRUST

ADMISSION FORM V3

CASE RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G207H	STOBHILL HOSPITAL	S/H-313693

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
29/05/98	14:04	3	16	12 PR LR	IP		8	3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
WARD 14A	11	GENERAL MEDICINE	DR L ERWIN Dr. M. Claren		

PATIENT

MRS SURNAME JENKINS FORENAME (1) THERESA (2) AGE 34 DATE OF BIRTH 13/08/1963 SEX F MARITAL STATUS

ADDRESS 38 BENCLOICH CRES
LENNOXTOWN
G65 7NB

ALT./PREV. SURNAME

OCCUPATION

CHI NUMBER 1308636407

POSTCODE TELEPHONE No. Glasgow

OCCUPATION (HUSBAND/FATHER)

HEALTH BOARD OF RESIDENCE

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME HENDERSON J
G.P. CODE 2335801 PRACTICE 43261/1
SGC06 N
CONTRACT No. FH STATUS

ADDRESS MAIN STREET
LENNOXTOWN
01360 310357 G65 7DD
TEL No. POSTCODE

REG. G.P.

NAME HENDERSON J
G.P. CODE 2335801 PRACTICE 43261/1
SGC06 N
CONTRACT No. FH STATUS

ADDRESS MAIN STREET
LENNOXTOWN
01360 310357 G65 7DD
TEL No. S/A POSTCODE

NEXT OF KIN

NAME CHRISTOPHER JENKINS
RELATIONSHIP HUSBAND

ADDRESS
DAY PHONE No. NIGHT PHONE No.

MISC.

RELIGION Roman Catholic

VISIT REQ. BY CHAPLAIN YES/NO N

PENSION BOOK No.

Admission

MAIN DIAGNOSIS Drug overdose

SPECIAL WARNINGS

OTHER CONDITIONS (D.G.2)

OTHER CONDITIONS (D.G.3)

SMR SMR50

L STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
31.5.98		1	3	1	16	Dr. M. Claren

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE

SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

SMR1 COMPLETED

DIAGNOSES

		SPECIAL WARNINGS
MAIN DIAGNOSIS	T402	
OTHER CONDITIONS (D.G.2)	X620	
(D.G.3)	F100	
(D.G.4)		
(D.G.5)		
(D.G.6)		

OPERATIONS AND

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

JACQUELINE BOYD 29/05/98 14:04

STOBHILL NHS TRUST, GLASGOW CASUALTY DEPARTMENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	THERESA	34	13/08/1963	29/05/98	13:58	020285

Address	Sex	Religion	Date of Inc	Time
38 BENCLOICH CR LENNOXTOWN	FEMALE	CATHOLIC N	29/05/98	~

PC	Tel	Marital Status	Occupation/School	Type of Inc	Mode of Arrival
G657NA	NONE	MARRIED		EMERG.	WALK/OT

Name	Address	Referred by
HENDERSON	MAIN STREET LENNOXTOWN G65 7DD	GP REF.-LETTER-G.MED

Name	Address	Complaint
CHRISTOPHER		PENDING
Relat.: HUSBAND		MED
Tel No.:	S/A	

CLINICAL NOTES

OBS

ECG

CHARCOAL TO DRINK 14/9 L McA.

ADMIT WEYLA

B.P: 151/98

PULSE: 109

TEMP: 35.6°C

TIME: 16.08

ALLERGIES:

TREATMENT PRESCRIBED:

Examining Doctor:
(Signature) L 02
PRINT NAME

X620
Diagnosis

vestigations	X-Ray	Lab	ECG	Cross Match	Bact

eatment	Dressing	Suture	Tet Tox	Antibiotic	Analg

	Pop	Resusc	Nurse's Signature

sposal Time	Home	Admit	A/E Clinic	Irreg Dis

	DOA	GP	Transfer	Other Clinic	DNW

	Pat Group	Diag	Anat Sit
1			
2			
3			
FD			

Research

Dr. A.J. Rae
Dr. J.R. Henderson

Health Clinic
Main Street.
Lennoxtown
Glasgow. G65 7DD
Tel: (01360) 310357
Fax: (01360) 311740

29/5/98

Dear Dr

Theresa Jenkins

13.8.63

The above took 16 Codydramol last night and apparently was in Stobhill.
She took a further 10 on her return home (c. 0600 this am)
She had been drinking
She denies taking any other pills
She has long standing psychological problem

Yours faithfully

A Henderson

STOBHILL NHS TRUST — INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STAUS
JENKINS	THERESA			M S W

DATE OF BIRTH	AGE	SEX	WARD/DEPT	RELIGION	MAIDEN NAME
03/8/63					

ADDRESS	G.P'S NAME & ADDRESS
TEL. No.	TEL No.

DATE	SPECIALITY	CONSULTANT'S NAME

29/5/88 Emergency admission via GP

O/D co-dydramol

admitted 6am last night - irregular discharged
16 co-dydramol ~3am

further 10 co-dydramol ~6am
denies other tabs.
alcohol - cider 2 litres last night.

doesn't know why she took the tablets
? wanted to kill herself.

unemployed - previously working while on benefit.
struggling now

twin brother O/D - 4yrs ago - died
doesn't feel she is over it.

father - died 5yrs - HTD

Hx sexual abuse - pt. did not admit to this
- Hx from GP.

PMHx pneumonia - 2yrs ago

°MI °CVA °diabetes °asthma °epilepsy °TB °RF

DHx losec depoprovera
°known allergies.

SHx lives husband + 3 children 17, 13, 6yrs
smoker roll-ups 50g/wk
alcohol - binge drinker
passed 2 wks LL
previously problem

FORM2

DATE | URINE

Reaction | Albumin | Sugar | Ketones

Weight (In kilogrammes)

PHYSICAL EXAMINATION

FHx NIL.

Systemic.

Resp cough brown-green sputum. -2wks.

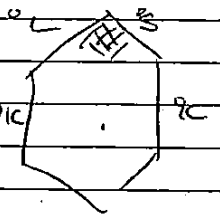
CVS NIL.

Abd awaiting upper GI endoscopy
epigastric pain + haematemesis -2wks ago.
diarrhoea -2wks -like water
? binge drinking °PR blood/mucus
-°melena now

°/e °SACCOL.

Resp chest

CVS. HS I + II + 0 °ankle oedema.

Abd 

so/t ~~non~~ tender - mild epigastrium
°masses
°organomegally
✓ BS.

INVESTIGATIONS Imp O/p ω-dydramol
level 0.2 between high risk + low risk
(≥ 12hrs) line ∴ Rx due to
binge drinking.

Plan. INR in am.

WC 11.95	GLu 5.6	PT 15
Hb 15.2	Para 0.2	APPT 28
MCV 88	Salicylate N/D.	TT 12
Plt 346.		Fib 188
		INR 1.20

STOBHILL NHS TRUST

CLINICAL NOTES

SURNAME CHRISTIAN/FORENAME	UNIT No
JENKINS Theresa	

DATE	CLINICAL NOTES	Initials
29/5/98	Thanks, as above	
	34 yr ♀.	
	Prev. well. Heavy drinking recently	
	Impulsive O/D of 26 codydramol between 0300 & 0600 onset ± alcohol intoxication, Visit x 1.	
	No persistent suicidal intent.	
	O/E NAD	
	Note: Urea sig. elevated.	
	In view of doubt about timing & alcohol dose.	
	— Rx = IV N-acetylcysteine	
	— check Coag ⁼ tomorrow.	
	Howard	
30.5.98	Well. If INR on Home Doesn't want to see psychiatrist	
	INR 1.16	

FORM 39

0181363

DATE	CLINICAL NOTES	Initials

RING SCORES IN TABLE. ADD TOTAL. SEVERAL SCORES PER CATEGORY CAN BE USED.

BUILD/WEIGHT FOR HEIGHT

Average	(0)
Above average	1
Obese	2
Below average	3

CONTINENCE

Complete/Catheterised	0
Occasion Incont.	1
Cath./Incontinent of Faeces	2
Doubly Incont.	3

SKIN TYPE VISUAL RISK AREAS

Healthy	(0)
Tissue paper	1
Dry	1
Oedematous	1
Clammy (Temp up)	1
Discoulered	2
Broken / Spot	3

If patient has discoloured or broken skin on pressure area, mark site + grade of sore in pressure sore 1 or 2 core care plan.

(4)

MOBILITY

Fully	(0)
Restless/Fidgety	1
Apathetic	2
Restricted	3
Inert/Traction	4
Chairbound	5

SEX/AGE

Male	1
Female	(2)
14–49	(1)
50-64	2
65-74	3
75-80	4
81+	5

APPETITE

Average	(0)
Poor	
NG Tube/fluids only	

SPECIAL RISKS

TISSUE MALNUTRITION

e.g. Terminal Cachexia	8
Cardiac Failure	5
Peripheral Vascular Disease	5
Anaemia	2
Smoking	(1)

NEUROLOGICAL DEFICIT

e.g. Diabetes M.S., CVA., Motor/Sensory Paraplegia	4-6

MAJOR SURGERY / TRAUMA

Orthopaedic - Below waist spinal	5
On table > 2 hours	5

MEDICATION

Steroids Cytotoxics	
High dose Anti-Inflammatory	4

313693
JENKINS THERESA F
38 BENCLOICH CRES M
LENNOXTOWN 13/08/1963
G65 7NB G.P.Prac.43261

Score 10 = At Risk 15 = High Risk 20 = Very High Risk

Date	Score	Mattress	Cushion	Date next due

(3) + (4)

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTIONS

PATIENT'S NAME Theresa Jenkins.

HOSPITAL ..... UNIT NUMBER .....

WARD 14A D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
Parvolex	15ml	500ml 5% dextrose	515ml		IV		

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Dose per Hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	29/5		over 8°				
Change 1							
Change 2							
Change 3							
Change 4							

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.	29/5/98	10pm				
Rpt. 1	30/5/98	8.10am	KRobertson			
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
29/5/98	10pm	500	0	62ml/hr	RLyle	Commenced
30/5/98	1AM	362	138	62/hr	E.Chapman	check
	3AM	241	259	62/hr	E.Chapman	check
	5.30am	89	411	62ml/hr	RLyle	check
	8.10a	0	500	62/hr.	KRobertson	Completed (3)
30/5/98	8.10am	500	0	62/hr	KRobertson	Commenced.

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments

5 DISCONTINUATION (Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS 1

PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP - GUIDELINES ON USE

ONLY APPROPRIATELY PREPARED REGISTERED NURSES MAY PARTICIPATE IN THE PREPARATION AND ADMINISTRATION OF MEDICINES GIVEN VIA A SYRINGE PUMP

THIS FORM IS NOT APPROPRIATE FOR USE IN CERTAIN HIGH DEPENDENCY AREAS:

The medicine should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use section". This sheet should be kept in close proximity to the device in use.

Each prescription sheet should be used to record the prescription, preparation and administration details of syringes or infusion bags which are prepared in accordance with the prescription in Section 1 of the form. **IF THE DETAILS IN SECTION 1 REQUIRE TO BE CHANGED A NEW PRESCRIPTION FORM MUST BE USED.**

Signatures must be written out in full in the appropriate spaces.

The form should be completed as follows:

SECTION 1 : PRESCRIPTION DETAILS:

(i) The prescription must be completed in full by a qualified medical practitioner.

(ii) "Total Amount of Drug(s)" refers to the total quantity of medicine in micrograms, milligrams or units, placed into the container.

(iii) If the medicine is further diluted, the diluent must be noted in the "Diluent" space and total **volume** recorded, ie, medicine + diluent.

(iv) The final concentration of drug in the syringe/bag should be recorded.

(v) The Route of Administration, Intravenous or Subcutaneous, must be recorded.

(vi) The type of infusion device, syringe driver or infusion pump, and the model when selected must be recorded by the doctor or nurse as appropriate.

(vii) The prescriber must sign the space provided.

SECTION 2: FLOW RATE DETAILS:

(i) The dose of drug (in microgram or mg/hour) and the resultant initial flow rate (in ml/hour or mm/hour depending on the device in use) must be prescribed by the Doctor on the "initial rate" line.

(ii) If the infusion rate is set and started by the prescriber, the "set by" section should also be signed. If this is done by two registered nurses/midwives, both "set by" and "checked by" sections should be signed.

(iii) Any subsequent alterations in dose and flow rate must be prescribed by the Doctor on the "Change" lines except for prescribed variable dose/sliding scale regimes (see (iv)).

(iv) When a **"VARIABLE DOSE REGIME"** (eg sliding scale insulin) has been prescribed, this should be recorded on the "initial rate" line and all changes recorded in the "Comments" section as appropriate.

SECTION 3: PREPARATION DETAILS:

If the final product (syringe or infusion attached to pump) is prepared by:

(i) a Qualified Medical Practitioner, then he/she must sign the "prepared by" space, or,

(ii) a Registered Nurse or Midwife, if calculation or dilution is involved, the preparation of the infusion should be witnessed by another Registered Nurse or Midwife. The "Prepared by/Checked by" and "Set by/Checked by" sections must be signed. Preparation of fresh infusions **of the same prescription** should be recorded on subsequent lines.

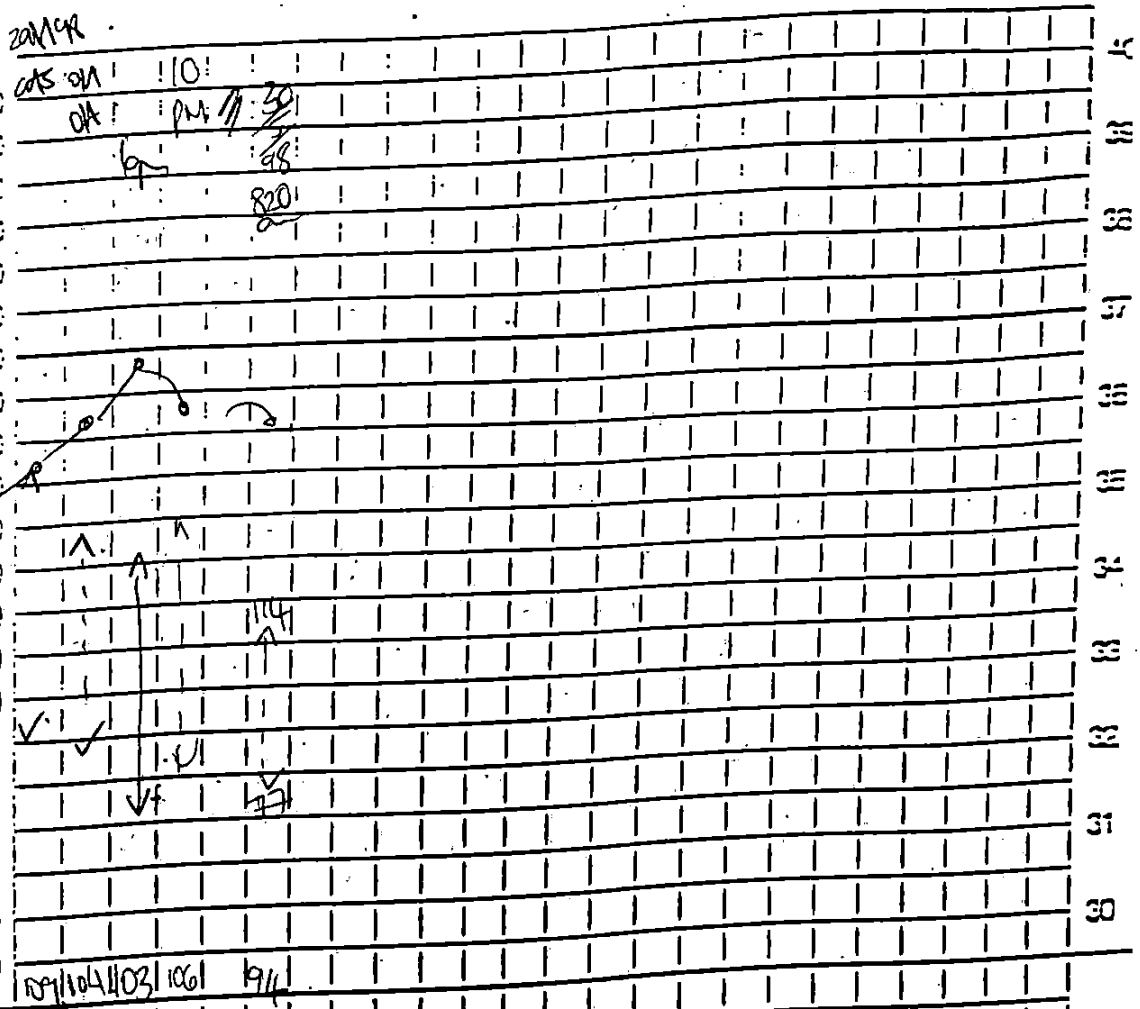
SECTION 4: ADMINISTRATION CHECK:

(i) The infusion must be checked at regular intervals, as indicated on the sheet, during the period that the pump is in use. Each section must be completed in full.

(ii) The "Comments" section should be used to record observations, including site checks. All unexpected events must be brought to the attention of the Nurse or Doctor in charge.

SECTION 5: DISCONTINUATION:

When the administration is to be discontinued, the prescriber should complete the appropriate sections on the sheet and on the main Kardex prescription sheet. A line should be drawn through each prescription to prevent continued use. Local guidelines for the "Duration of Use" should be followed prior to renewing the syringe/bag.



Pulse

Respiration Rate/min

Regular/irregular

0.2 Sat

BM Stix

Peak Flow

Weight

Bowel

Cumulative Totals

Urinalysis	Colour	S.G.	Reaction	Sugar	Blood	Protein	Ketach g/l	Bile	Others

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

STOBHILL NHS TRUST

313693

STOBHILL NHS TRUST
WARD 14A CARE PLAN

NAME: _____

UNIT NO _____

ADDR JENKINS THERESA F DATE OF ADMISSION 29/5/98

Signature of Registered Nurse: _____

Provisional Diagnosis: See Notes

Recording of Vital Signs

BP	Puise	Temp	Resp	Colour	Peakflow	CNS	CVP	Fluid Balance
☑ 6 hrly	☑ 6 hrly	☑ 6 hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly

Monitoring/Recording of Observations

IV Cannula	IV Infusion	Chest Drain	Urethral Catheter
☐ ___hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly

Telemetry	Cardiac Monitor	BM Stix	ECG During Pain
☐ ___hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly

Medications (Prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 Therapy
☐ ___hrly	☐ ___hrly	☐ ___hrly	☐ ___hrly
	☐ via syringe drive	☐ via O_2	☐ type of mas
	☐ via infusion pump	☐ nebuliser compressor pump	☐ flow rate

Nursing Care Plan Ward 14A Continued.

Name: _____ Unit No _____

Hygiene

Bed Bath (2 Nurses)	Assisted Wash (1 Nurse)	Shower/Bath (Independent)	Ambi/Shower (Supervised)	Basin (Independent but on bed rest)
☐	☐	☑	☐	☐

Mouth Care	Eye Care	Nasal Care	Catheter Care	Wound Care
☐	☐	☐	☐	☐
_____hrly	_____hrly	_____hrly	_____hrly	Specify on Information Sheet

Mobilisation

Bed Rest	Ambulant Independent	Supervised	Positional Change
☐	☑	☐	☐ _____hrly

Specialised Bed	Passive Limb Exercise	Number of Staff Required for M&H	Moving & Handling Aid
☐	☐ _____hrly	☐ _____specify	☐ _____hrly

Diet

Normal Diet	Special Diet	Nasogastric/Gastronomy Feeding. Use in conjunction with feeding instruction chart.
☑	☐ _____specify	☐

Requires help with feeding ☐

Fluids Only	Restricted Fluids	Fasting	Dietetic Advice
☐	☐	☐	☐

Nursing Care Plan Ward 14 A continued

Name: _____ Unit No: _____

Paramedic Services - To be involved

Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Liaison services - To be involved

Cardiac ☐ Respiratory ☐ Diabetic ☐ Stoma ☐ Social Work ☐

Bladder/Bowel Care

Offer Commode/ Urinal ☐ Wheel to Toilet ☐ Self Care ☑ Catheter Care ☐ Continence Aids ☐

Specimen Collection-

Tick Box if Specimen Required. Enter Date on Line when Obtained (*specify)

RSOU ☑	MSSU ☐	Sputum ☐	Wound Swab ☐	Blood Culture ☐
_____	_____	_____	_____	_____
Gases ☐	FOB ☐	AAFB ☐	Pathology ☐	* _____ ☐
* _____	* _____	* _____	* _____	* _____
☐	☐	☐	☐	☐
_____	_____	_____	_____	_____

Other Information

(2)

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTIONS

PATIENT'S NAME Theresa Jenkins

HOSPITAL ..... UNIT NUMBER .....

WARD ICU D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
Paracetamol.	15ml	500ml 5% dextrose	515ml		IV		

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Dose per Hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	29/5	18.30h	over 4P.	125ml/hr		olenick	
Change 1							
Change 2							
Change 3							
Change 4							

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.						
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
	17.30	500mls	—	125/hr	olenick	New bag charged.
	6.10	442mls.	79mls.	125/hr	MTM	Check.
29/5/19.	9.40	1	500	125ml/hr	Rhyu	check.
	10pm	Infusion	complete.			

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments

5 DISCONTINUATION (Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS 1

PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP - GUIDELINES ON USE

ONLY APPROPRIATELY PREPARED REGISTERED NURSES MAY PARTICIPATE IN THE PREPARATION AND ADMINISTRATION OF MEDICINES GIVEN VIA A SYRINGE PUMP

THIS FORM IS NOT APPROPRIATE FOR USE IN CERTAIN HIGH DEPENDENCY AREAS:

The medicine should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use section". This sheet should be kept in close proximity to the device in use.

Each prescription sheet should be used to record the prescription, preparation and administration details of syringes or infusion bags which are prepared in accordance with the prescription in Section 1 of the form. **IF THE DETAILS IN SECTION 1 REQUIRE TO BE CHANGED A NEW PRESCRIPTION FORM MUST BE USED.**

Signatures must be written out in full in the appropriate spaces.

The form should be completed as follows:

SECTION 1 : PRESCRIPTION DETAILS:

(i) The prescription must be completed in full by a qualified medical practitioner.

(ii) "Total Amount of Drug(s)" refers to the total quantity of medicine in micrograms, milligrams or units, placed into the container.

(iii) If the medicine is further diluted, the diluent must be noted in the "Diluent" space and total **volume** recorded, ie, medicine + diluent.

(iv) The final concentration of drug in the syringe/bag should be recorded.

(v) The Route of Administration, Intravenous or Subcutaneous, must be recorded.

(vi) The type of infusion device, syringe driver or infusion pump, and the model when selected must be recorded by the doctor or nurse as appropriate.

(vii) The prescriber must sign the space provided.

SECTION 2: FLOW RATE DETAILS:

(i) The dose of drug (in microgram or mg/hour) and the resultant initial flow rate (in ml/hour or mm/hour depending on the device in use) must be prescribed by the Doctor on the "initial rate" line.

(ii) If the infusion rate is set and started by the prescriber, the "set by" section should also be signed. If this is done by two registered nurses/midwives, both "set by" and "checked by" sections should be signed.

(iii) Any subsequent alterations in dose and flow rate must be prescribed by the Doctor on the "Change" lines except for prescribed variable dose/sliding scale regimes (see (iv)).

(iv) When a **"VARIABLE DOSE REGIME"** (eg sliding scale insulin) has been prescribed, this should be recorded on the "initial rate" line and all changes recorded in the "Comments" section as appropriate.

SECTION 3: PREPARATION DETAILS:

If the final product (syringe or infusion attached to pump) is prepared by:

(i) a Qualified Medical Practitioner, then he/she must sign the "prepared by" space, or,

(ii) a Registered Nurse or Midwife, if calculation or dilution is involved, the preparation of the infusion should be witnessed by another Registered Nurse or Midwife. The "Prepared by/Checked by" and "Set by/Checked by" sections must be signed. Preparation of fresh infusions **of the same prescription** should be recorded on subsequent lines.

SECTION 4: ADMINISTRATION CHECK:

(i) The infusion must be checked at regular intervals, as indicated on the sheet, during the period that the pump is in use. Each section must be completed in full.

(ii) The "Comments" section should be used to record observations, including site checks. All unexpected events must be brought to the attention of the Nurse or Doctor in charge.

SECTION 5: DISCONTINUATION:

When the administration is to be discontinued, the prescriber should complete the appropriate sections on the sheet and on the main Kardex prescription sheet. A line should be drawn through each prescription to prevent continued use. Local guidelines for the "Duration of Use" should be followed prior to renewing the syringe/bag.

(1)

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTIONS

PATIENT'S NAME Theresa Jenkins

HOSPITAL ..... UNIT NUMBER .....

WARD ..... D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
Parvolex	45ml	200mls Lactose	245ml		IV		

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Dose per Hour	Required Flow Rate Setting	Prescribed by	Set by	Checked by
Initial rate	29/5		245ml in 15 mins			olench	
Change 1							
Change 2							
Change 3							
Change 4							

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.						
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
29/5	17.15	240ml	[redacted]	999/h	olench	
	17.30	0	240ml		olench	completed.
29/5/24	9.35 pm					

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments

5 DISCONTINUATION (Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS 1

PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP - GUIDELINES ON USE

ONLY APPROPRIATELY PREPARED REGISTERED NURSES MAY PARTICIPATE IN THE PREPARATION AND ADMINISTRATION OF MEDICINES GIVEN VIA A SYRINGE PUMP

THIS FORM IS NOT APPROPRIATE FOR USE IN CERTAIN HIGH DEPENDENCY AREAS:

The medicine should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use section". This sheet should be kept in close proximity to the device in use.

Each prescription sheet should be used to record the prescription, preparation and administration details of syringes or infusion bags which are prepared in accordance with the prescription in Section 1 of the form. **IF THE DETAILS IN SECTION 1 REQUIRE TO BE CHANGED A NEW PRESCRIPTION FORM MUST BE USED.**

Signatures must be written out in full in the appropriate spaces.

The form should be completed as follows:

SECTION 1 : PRESCRIPTION DETAILS:

(i) The prescription must be completed in full by a qualified medical practitioner.

(ii) "Total Amount of Drug(s)" refers to the total quantity of medicine in micrograms, milligrams or units, placed into the container.

(iii) If the medicine is further diluted, the diluent must be noted in the "Diluent" space and total **volume** recorded, ie, medicine + diluent.

(iv) The final concentration of drug in the syringe/bag should be recorded.

(v) The Route of Administration, Intravenous or Subcutaneous, must be recorded.

(vi) The type of infusion device, syringe driver or infusion pump, and the model when selected must be recorded by the doctor or nurse as appropriate.

(vii) The prescriber must sign the space provided.

SECTION 2: FLOW RATE DETAILS:

(i) The dose of drug (in microgram or mg/hour) and the resultant initial flow rate (in ml/hour or mm/hour depending on the device in use) must be prescribed by the Doctor on the "initial rate" line.

(ii) If the infusion rate is set and started by the prescriber, the "set by" section should also be signed. If this is done by two registered nurses/midwives, both "set by" and "checked by" sections should be signed.

(iii) Any subsequent alterations in dose and flow rate must be prescribed by the Doctor on the "Change" lines except for prescribed variable dose/sliding scale regimes (see (iv)).

(iv) When a **"VARIABLE DOSE REGIME"** (eg sliding scale insulin) has been prescribed, this should be recorded on the "initial rate" line and all changes recorded in the "Comments" section as appropriate.

SECTION 3: PREPARATION DETAILS:

If the final product (syringe or infusion attached to pump) is prepared by:

(i) a Qualified Medical Practitioner, then he/she must sign the "prepared by" space, or,

(ii) a Registered Nurse or Midwife, if calculation or dilution is involved, the preparation of the infusion should be witnessed by another Registered Nurse or Midwife. The "Prepared by/Checked by" and "Set by/Checked by" sections must be signed. Preparation of fresh infusions **of the same prescription** should be recorded on subsequent lines.

SECTION 4: ADMINISTRATION CHECK:

(i) The infusion must be checked at regular intervals, as indicated on the sheet, during the period that the pump is in use. Each section must be completed in full.

(ii) The "Comments" section should be used to record observations, including site checks. All unexpected events must be brought to the attention of the Nurse or Doctor in charge.

SECTION 5: DISCONTINUATION:

When the administration is to be discontinued, the prescriber should complete the appropriate sections on the sheet and on the main Kardex prescription sheet. A line should be drawn through each prescription to prevent continued use. Local guidelines for the "Duration of Use" should be followed prior to renewing the syringe/bag.

STOBHILL

PATIENT PROGRESS / EVALUATION

WARD

313693
JENKINS THERESA F
38 BENCLOICH CRES M
LENNOXTOWN 13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

All entries must be signed.

Date	No.	Progress / Evaluation	
29/5/98		Medical Management	
	1)	Routine bloods	
	2)	CXR ECG.	
	3)	Paracetamol infusion	
	4)	Mobilise encouraging	
	5)	CBH review	
		Levels 0.2. Commenced on Parvolex	
30/5/98		Settled overnight	
31/5/98		Continues on IV Parvolex	
	1055 hrs	D/R Dr M°LAREN FINISH	
		PARVOLEX CHECK LFR/CODE	
		SATISFACTORY D/C HOME TODAY	
		LATER -	

JMcC/933360

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress / Evaluation	***All entries must be signed.***

STOBHILL **PATIENT PROFILE** WARD 14A.

Type / source of admission

Emergency via A&E

313693
JENKINS *THERESA F
38 BENCLOICH CRES M
LENNOXTOWN 13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

Religion

Allergies

No known

Next of kin informed

Husband - aware of patients admission.

Medical reasons for admission

O/D. co-codamol.

Patient's understanding of admission

Understands

Relative's understanding of admission

Understands

General condition on admission

Weepy - wanting help. admits ↑ binge drinking.

PATIENT PROFILE
(continued)

Social circumstances

Lives at home with husband + 3 children.

Occupation:

Hobbies / interests

Medical history

1/ Pneumonia.
1/ Previous OD
1/ Alcohol - binge drinking.
1/ Gastric Ulcer - awaiting Endoscopy.

Medication list

1/ Losec.

Valuables / belongings

Other information

Signature of Assessment Nurse _____ Date 29/9/11 Time 3.

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

NURSING ASSESSMENT

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

WARD

AFFIX DATA LABEL

Maintaining Safe Environment

No problems.

Communication

Hearing Aid Y/(N)

Spectacles (Y)/N

Reading.

No problems.

Breathing / Circulation

Resps

B.P. 130/88

Pulse 104. Regular

Smoker (Y)/N

No problems.

Eating / Drinking

Indigestion recently - commenced Loz.

- Nonelective

Dentures

Elimination

No problems.

Urinalysis

Awaited.

Personal Cleansing / Dressing

Independent.

JMcC/933380

CONTINUED OVER

NURSING ASSESSMENT

CONTINUED

Controlling Body Temperature

Temp

36.4°c.

Mobilisation

Weight

Waterlow - score

4

Ambulant

Expressing Sexuality

—

Sleeping

Poor

Pain

—

Socialization

—

Dying

—

Minister / priest

Signature of Assessment Nurse [signature] Date 29/8/19 Time 3

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL DISCHARGE PLAN

WARD

313693
JENKINS THERESA
38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AFFIX DATA LABEL

Proposed discharge date	
Discharge date	
Patient informed	Relative informed
Transport arrangements	Clothing requested for discharge
Medication / G.P.'s letter	
Out-patients appointment	Ambulance required

Social services:

Social worker

Home help

Meals on wheels

Other

District nurse

Aids and equipment

Other needs

Discharge summary / comments

Signature of Discharge Nurse _____ Date _____ Time _____

Signature of Named Nurse _____ Date _____ Time _____

JMcC/933380

STOBHILL

NAME
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

SPECIMEN / INVESTIGATIONS

WARD

DATE ORDERED	SPECIMEN	DATE OBTAINED

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL

JMcC/933380

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	29/5/08	ROSEC	20mg	O		✓										
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

DIET

313693
JENKINS THERESA
WARD 38 BENCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES 1.

STOBHILL NHS TRUST — **OUTPATIENT CHART**

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATE
JENKINS	THERESA	313693		M. S. W.

DATE OF BIRTH	AGE	SEX	WARD/DEPT.	RELIGION	MAIDEN NAME
13/8/63	34	F	OPD		

ADDRESS
38 BENCLOICH CRES
LENNOXTOWN
TEL: No.

G.P.'S NAME & ADDRESS
DR HENDERSON
MAIN ST
LENNOXTOWN
TEL. NO.

DATE | SPECIALTY MED | CONSULTANT'S NAME DR DAMOSH

17 JUL 1998

(34)

Haematemesis → vomited fresh blood.
No dizziness. Malena. x1

- Reflux symptoms +++
- Avoid spicy foods, onions.
- Regurgitation.
- Epigastric pain — settled on Lofec
  Cut out alcohol.

PMHx Chest Infects
Polycystic Ovaries.
Oesophagitis.

Drugs: On Nepaproxen → mod success.
Omeprazole

Allergies NIL

SHx Smokes roll ups → 10g/week

S/E Depressed.

O/E Normal.

Plan — Routine Endoscopy

Not been taking tabs. Lifestyle -

FORM 1 0181235

DATE	URINE			
	Reaction	Albumin	Sugar	Ketones
	WEIGHT (in Kilogrammes)			
	PHYSICAL EXAMINATION			

MEDICAL IN CONFIDENCE

NHS TRUST

ADMISSION FORM V3

CASE RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G207H	STOBHILL HOSPITAL	S/H-313693

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
26/08/98	08:11	10	1K	12 PR LR	DC		8	3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
DAY SURGERY UNI	11	GENERAL MEDICINE	DR B DANESH		

PATIENT

TITLE SURNAME: MRS JENKINS FORENAME (1): THERESA (2): AGE: 35 DATE OF BIRTH: 13/08/1963 SEX: F MARITAL STATUS: M

ADDRESS: 38 BENCLOICH CRES
LENNOXTOWN

ALT./PREV. SURNAME:

OCCUPATION:

C.H.I. NUMBER: 1308636407

POSTCODE: G65 7NB TELEPHONE No.: NONE

OCCUPATION (HUSBAND/FATHER):

HEALTH BOARD OF RESIDENCE: Greater Glasgow

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME: HENDERSON J
G.P. CODE: 2335801 PRACTICE: 43261|1
CONTRACT No.: SGC06 FH STATUS: N

ADDRESS: MAIN STREET
LENNOXTOWN
TEL No.: 01360 310357 POSTCODE: G65 7DD

REG. G.P.

NAME: HENDERSON J
G.P. CODE: 2335801 PRACTICE: 43261|1
CONTRACT No.: SGC06 FH STATUS: N

ADDRESS: MAIN STREET
LENNOXTOWN
TEL No.: 01360 310357 POSTCODE: G65 7DD

NEXT OF KIN

NAME:

RELATIONSHIP: HUSBAND

ADDRESS: SA

DAY PHONE No.: 313042 NIGHT PHONE No.:

MISC.

RELIGION:

VISIT REQ. BY CHAPLAIN YES/NO:

PENSION BOOK No.:

SMR1 COMPLETED

Admission

DIAGNOSIS		SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)		
OTHER CONDITIONS (D.G.3)		

SMR04

STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR
		SMR50

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

MAIN DIAGNOSIS	R101	SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)		
(D.G.3)		
(D.G.4)		
(D.G.5)		
(D.G.6)		

	CODE	DATE
MAIN OPERATION	G451	260898
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

LOCAL USE: ENN EADIE 26/08/98 08:12 NATIONAL USE:

THEATRE/RECOVERY CARE PLAN

313693
JENKINS THERESA F
38 BENCLOICH CRES M
LENNOXTOWN
13/08/1963
G65 7NB G.P.Prac.43261

CONSULTANT Dr. DANDOA
WARD D.S.U.
THEATRE ENDOSCOPY
DATE OF OPERATION 26.8.94
TIME:

A. WARD – PRE-OPERATIVE PREPARATION PREMEDICATION GIVEN WHEN BELOW CHECKED

	tick
1. LAST TIME PATIENT ATE OR DRANK 25.8. 12 midnight	✓
2. CONSENT SIGNED	
3. IDENTITY BAND	✓
4. CASE NOTES, X-RAYS, DRUG KARDEX	✓
5. OPERATION SITE PREPARED AND MARKED	—
6. TEETH – DENTURES REMOVED, CROWNS/CAPS/BRIDGE Fixed	✓
7. PROTHESIS REMOVED – CONTACT LENS, GLASSES	NO
8. REMOVED – MAKE-UP, NAIL VARNISH, UNDERWEAR, JEWELLERY (TAPED/REMOVED) ON	
9. ALLERGIES	NO
10. VOIDED URINE	✓
11. BASELINE OBSERVATIONS P: 91 BP: 133/91	

PROBLEMS/NEEDS **INTERVENTION** **OUTCOME**

Signature – WARD: D. Sid RECEPTION:

B. THEATRE

OPERATION PERFORMED Endoscopy + clo

DIATHERMY BIPOLAR/MONOPOLAR	☐		
HEEL RESTS	☐		
FLOWTRON BOOTS	☐		
SHEEPSKIN HEEL PADS/MATS	☐		
HEATED WATER BED	☐		
ARM BOARDS	☐		

PATIENT POSITION

LATERAL RIGHT	☐	TRENDELENBURG	☐
LATERAL LEFT	✓	REVERSE	☐
SUPINE	☐	LITHOTOMY	☐
PRONE	☐	LLOYD DAVIS	☐

TOURNIQUET TIME ON OFF

SPECIAL COMMENTS

SPECIMENS: PATH BACT OTHER
DRAINS
CATHETER

COUNTS CORRECT

SWABS – FIRST	☐
– FINAL	☐
INSTRUMENTS	☐
SHARPS – NEEDLES	☐
– BLADES	☐
THROAT PACK OUT	☐
PACK IN SITU	☐

INSTRUCTION FOR REMOVAL

Name of Scrub Nurse: I Dalli
Signature of Circulating Nurse: M Barlow

C. POST OPERATIVE RECOVERY ROOM INSTRUCTIONS

Theresa Jenkins

ROUTINE	– PULSE & B.P.					CONTINUE IV FLUIDS	RATE
	– OXYGEN/RECOVERY						
	– OXYGEN/WARD						
	– CANNULA/REMOVAL – RECOVERY		WARD				
SPECIAL							

INFORMATION/INSTRUCTIONS

Signature:

D. POST OPERATIVEOBSERVATIONS

TIME	9 09	9 15	9:30	9:45	10 00			12 00										
PULSE	78	80	74	72	90			98										
BLOOD PRESSURE	102/62	100/62	93/58	100/56	107/70	/	/	99/62	/	/	/	/	/	/	/	/	/	/
SATURATION (SaO^2)	95	94	94	94	94													
RESPIRATORY RATE	R	L	R	R	R													
AIRWAY	–	✓	✓	✓	✓													
OXYGEN	✓	✓	✓	✓	✓													
PAIN SCORE	0	0	0	0	0													
SEDATION SCORE	2	1	1	1	1/0													
TEMPERATURE		✓	✓	–	✓													
WOUND		✓	–	✓	✓													
Canula	(R)	✓	✓	✓	m													
	JP	✓	✓	✓	BL													

PAIN SCORE
0 = NO PAIN
1 = DISCOMFORT/ACHE AT REST
2 = PAIN ONLY ON MOVEMENT
3 = PAIN AT REST
4 = SEVERE PAIN AT REST

SEDATION SCORE
0 = ALERT
1 = RESPONDS TO VERBAL COMMAND
2 = RESPONDS TO PAINFUL STIMULI
3 = UNRESPONSIVE

DAY SURGERY - ENDOSCOPY

313693
JENKINS THERESA F
38 BENCLOICH CRES M
LENNOXTOWN 13/08/1963
G65 7NB G.P.Prac.43261

CONSULTANT: DR DANESH

DATE: 20.8.98.

1. Are you currently taking any medication? YES ☐ NO ☑

If yes what ? FINISHED ANTIBIOTICS FOR CHEST INF.

2. Have you ever had hepatitis or jaundice YES ☐ NO ☑

If yes what ?

3. Do you have any medical problems the doctor should know about ? YES ☐ NO ☑

If yes what ?

4. Do you have someone to collect you? YES ☑ NO ☐

If yes who ? PARTNER

5. Is someone staying with you overnight YES ☑ NO ☐

If yes who ? PARTNER

NURSES SIGNATURE: .....

1. NURSING NOTES:

26. 8. 98 A/G for endoscopy

Discharge info given

Discharged @ 12.2 pm

2. DISCHARGE OF DAY PATIENTS

Medication:

	YES	NO
1. Stable Vital Signs - Respiration. Pulse. B.P.	☑	☐
2. Venflon Removed	☑	☐
3. Alert and Orientated	☑	☐
4. Able to dress, sit and walk unaided	☑	☐
5. Tolerating food and fluids	☑	☐
6. Post sedation instructions given regarding:-		
• Driving and operating machinery	☑	☐
• Alcohol, sedatives and pain killers	☑	☐
• Responsible adult accompanying patient home as advised	☑	☐

7. Post surgical instructions

- Follow up appointment: NFU
- Special instructions: _____

NURSES SIGNATURE: ..... J Moore .....

FLUID BALANCE

TIME	INPUT	VOLUME	TIME	OUTPUT	VOLUME

E. **RECOVERY ROOM** **PROBLEM/NEEDS** **INTERVENTION** **OUTCOME**

Signature_____

CONSENT BY PATIENT/PARENT FOR OPERATION



31369 MTW
JENKINS THERESA
38 BINCLOICH CRES F
LENNOXTOWN M
13/08/1963
G65 7NB G.P.Prac.43261

_____ of _____

Self to the

Upper GI Endoscopy

the nature and effect of which have been explained to me by:

Dr/Mr Forrest

I also consent to such further or alternative operative measures as may be found to be necessary during the course of the operation and to the administration of a local or other anaesthetic for any of these purposes.

No assurance has been given to me that the operation will be performed by a particular surgeon.

Date 26.8.98 (Signed) X J Jenkins

•Relationship to Patient _____

I confirm that I have explained the nature and effect of this operation to the patient, parent, relative or guardian.

Date 26.8.98 Signed _____
(Doctor's Signature)

•Delete if not applicable

SPECIAL CONSENT FORM FOR STERILISATION AND JEHOVAH'S WITNESSES MUST BE USED.

OPIATE ANALGESIA – INTRAVENOUS (PCA)/EPIDURAL/SPINAL

Patients with spinal/epidural opiates must not receive opiates by other routes.

All patient to have supplemental Oxygen at night for duration of therapy.

Spinal/Epidural Opiate _____

PCA (Patient Controlled Analgesia)

Prepare: To a 50/60 ml syringe add _____

_____ Add sterile water to make 50/60ml volume

Settings: Concentration _____ Dose Duration _____

Loading Dose _____ Lockout Duration _____

Bolus Dose _____ Background Infusion _____

Monitor: Total dose of analgesia given

No. of good tries

Inform Anaesthetist if: Respiration 8/min or less

Patient unduly sedated – score 2/3

Patient in undue pain – score 3/4

Electronically printed by The Stationery Office 1/97

HOSPITAL
PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H																	
	J																	
	K																	
	L																	
	M																	
	N																	
	O																	
	P																	
	R																	
	S																	
	T																	
	V																	

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN
26.8.98	855	Midazolam	2 mgs	IV			

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS.

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

WARD	NAME OF PATIENT	AGE/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	Theresa Jenkins				313693	Dr Daresh

KNOWN MEDICINE 1.

STOBHILL
NHS TRUST

MEDICAL IN CONFIDENCE

CASE RECORD

ADMISSION FORM V3

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
25/12/98 00:45 3D 16 10 PRNAD IP	STOBHILL HOSPITAL	S/H 313693 8 3 NHS

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
WARD 14A	11	GENERAL		MEDICINE	DR J FORREST			

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
MRS JENKINS THERESA			35	13/08/1963	F M

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
38 BENCLOICH CRES LENNOXTOWN						

ADDRESS

ALT./PREV. SURNAME

1308636407

G65 7NB NONE Greater Glasgow

OCCUPATION

C.H.I. NUMBER

POSTCODE HENDERSON TELEPHONE No. J

OCCUPATION (HUSBAND/FATHER) MAIN STREET

HEALTH BOARD OF RESIDENCE 2335801 43261|1

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR? LENNOXTOWN

REF. G.P.

NAME SGC06 N

ADDRESS 01360 310357 G65 7DD

G.P. CODE PRACTICE HENDERSON J

CONTRACT No. 2335801 FH STATUS 43261|1

TEL No. MAIN STREET POSTCODE LENNOXTOWN

REG. G.P.

NAME SGC06 N

ADDRESS 01360 310357 G65 7DD

G.P. CODE PRACTICE

CONTRACT No. FH STATUS

TEL No. POSTCODE

SMR1 COMPLETED

NEXT OF KIN

NAME

RELATIONSHIP

ADDRESS

DAY PHONE No.

NIGHT PHONE No.

MISC.

RELIGION

VISIT REQ. BY CHAPLAIN YES/NO

PENSION BOOK No.

Admission

MAIN DIAGNOSIS

SPECIAL WARNINGS

OTHER CONDITIONS (D.G.2)

OTHER CONDITIONS (D.G.3)

SMR04

SMR50

STATUS	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
25/12/98	-	0	3	1	16	FORREST

DISCH./TRANSF. TO	READY FOR DISCH.	HOSPITAL: NAME	CODE	WARD	SPECIALTY	CONSULTANT CODE
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DIAGNOSES

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	Overdose	T600	
OTHER CONDITIONS (D.G.2)		X480	
(D.G.3)		T393	
(D.G.4)		T398	
(D.G.5)		X409	
(D.G.6)		F109	

OPERATIONS

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

JANE URQUHART 25/12/98 00:45

LOCAL NATIONAL

STOBHILL NHS TRUST, GLASGOW CASUALTY DEPARTMENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	A/E Number
JENKINS	TERESA	35	13/08/1963	24/12/98	23:09	048356

Address: 38 BENCLOICH CRES, LENNOXTOWN

Sex: FEMALE

Religion:

Date of Inc.: NOT KNOWN

Time:

Marital Status: UNKNOWN

Occupation/School:

Type of Inc.: O.D.

Mode of Arrival: WALK/OT

PC:

Tel:

Name: G65

Address:

Referred by:

Name:

Relat.: NOT STATED

Address: Ann Sinclair

Tel No.:

Complaint: OVERDOSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

VE NAMED PERSON ATTENDED THE ACCIDENT & EMERGENCY DEPARTMENT TODAY

GNOSIS INVESTIGATION SHOWS

ATMENT GIVEN

Brought in By police
Agitated and Aggressive Behaviour at home
C_2H_5OH ? Pt refused any information
According to Police took Antidepressants ? O/D
Ganinil ? Amitryptiline (from Husband) Time ? p.m.
Police Inquiries ? Methadone (Robbin 750ml)
PMH+ C_2H_5OH intox + Abuse Ibuprofen
O/D Behavioural disorder Cocodamol
O/E Clear Abdo soft NT DJ
BP 123/89 PEG T35.4 O/D 0.5gm 9%
FHC

D YOU PLEASE ARRANGE

ECG U+E + Gluc Paracetamol level

gations	X-Ray	Lab	ECG	Match	Bact

ient	Dressing	Suture	Tet Tox	Antibiotic	Analg

Pop | Resusc | Nurse's Signature

Admitted to ward | Consultant

Hospital Transferred: T600 XU80

Comments: Methadone Referral

Medical Officers Signature: T398 XL09

Medical Officers Name (BLOCK): PLANE

l Time	Home	Admit	A/E Clinic	Irreg Dis	Died	DOA	GP	Transfer	Other Clinic	DNW

STAFF GRADE: REG SHO JHO CA (PLEASE CIRCLE)

_____ days supply of _____ has been given

_____ days supply of _____ Written Advice Issued

_____ days supply of _____

Prophylaxis has / has not been administered. TT Course ☐ TT Booster ☐ HATI ☐ (Please Tick)

Patients Name

STOBHILL NHS TRUST, GLASGOW CASUALTY DEPARTMENT

urname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	TERESA	35	13/08/1963	24/12/98	22:00	[illegible]

ddress	Sex	Religion	Date of Inc.	Time
38 BENGLOICH CRES ENNOXTOWN	FEMALE		NOT KNOWN	

C	Tel	Marital Status	Occupation/School	Type of Inc.	Mode of Arrival
G65		UNKNOWN		O D.	WALK [illegible]

ame	Address	Referred by

ame	Address	Complaint
NOT STATED		OVERDOSE

elat.

al No.

TC COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

AE E NAMED PERSON ATTENDED THE ACCIDENT & EMERGENCY DEPARTMENT TODAY

iNOSIS_____ INVESTIGATION SHOWS_____

ATMENT GIVEN

BP 153/89

Brought in By police

Agitated and Aggressive Behaviour at home P148

C_2H_5OH ? Pt refused any information T35-9

According to police took Antidepressants O/D Sat: 97%

Gamnil? Amitryptiline (from husband) Time? p.m.?

Police Inquiries Methocarbamol (Robaxin 750mg)

PMH C_2H_5OH intox + abuse Ibuprofen

O/D Behavioural disorder Cocodamol

OIE clean ADD Soft NT DJ

O YOU PLEASE ARRANGE

E C G U/E + Gluc Paracetamol FBC

gations	X-Ray	Lab	ECG	Match	Bact

ient	Dressing	Suture	Tet Tox	Antibiotic	Analg

	Pop	Resusc	Nurse's Signature

Admitted to ward	Consultant

Hospital Transferred

Comments MEDICAL REFERRAL

Medical Officers Signature	Medical Officers Name (BLOCK)
	PATE

al Time	Home	Admit	A/E Clinic	Irreg Dis	Died	DOA	GP	Transfer	Other Clinic	DNW

STAFF GRADE
REG SHO JHO
CA
PLEASE CIRCLE

_____ days supply of _____ has been given

_____ days supply of _____ Written Advice Issued:

_____ days supply of _____

s Prophylaxis has / has not been administered. TT Course ☐ TT Booster ☐ HATI ☐ (Please Tick)

Patients Name

STOBHILL NHS TRUST, GLASGOW CASUALTY DEPARTMENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	TERESA	35	13/08/1963	24/12/98		

Address	Sex	Religion	Date of Inc.	Time
38 BENCLOICH CRES CAMBUSLANG	FEMALE		NOT KNOWN	

PC	Tel	Marital Status	Occupation/School	Type of Inc.	Mode of Arrival
		UNKNOWN		O.D.	

Name	Address	Referred by

Name	Address	Complaint
Relat. NOT STATED		OVERDOSE
Tel No.		

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

THE ABOVE NAMED PERSON ATTENDED THE ACCIDENT & EMERGENCY DEPARTMENT TODAY

DIAGNOSIS: _____ INVESTIGATION SHOWS _____

TREATMENT GIVEN

Brought in By police
Aggitated and Aggressive Behaviour at home
C/S OH ? Pt refused any information
According to Police took Antidepressants & O/D
Gabapentin ? Amitriptyline (from HUSBAND) Time ? p.m.?
Police Inquiries Methocarbamol (Robaxin 750mg)
PMH OH in ? Abuse Ibuprofen
O/D , Benzodiazepine Cocodamol
O/E Clear ADD Soft NT DJ

WOULD YOU PLEASE ARRANGE

ECG U+E + Gluc Panac Sal FBC

Investigations	X-Ray	Lab	ECG	Match	Bact

Treatment	Dressing	Suture	Tet Tox	Antibiotic	Analg

Pop	Resusc	Nurse's Signature

Admitted to ward | Consultant

Hospital Transferred

Comments: Medical Referral

Medical Officers Signature | Medical Officers Name (BLOCK): PLATE

Disposal Time	Home	Admit	A/E Clinic	Irreg Dis	Died	DOA	GP	Transfer	Other Clinic	DNW
							ECL			

STAFF GRADE: REG SHO JHO CA (PLEASE CIRCLE)

Drugs ____ days supply of _____ has been given

Drugs ____ days supply of _____

Drugs ____ days supply of _____

Written Advice Issued:

Tetanus Prophylaxis has / has not been administered. TT Course ☐ TT Booster ☐ HATI ☐ (Please Tick)

Patients Name

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYLAXIS)						
Date Given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given By

DATE	CLINICAL NOTES

STOBHILL NHS TRUST — INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STAUS
JENKINS.	TERESA			M S W

DATE OF BIRTH	AGE	SEX	WARD/DEPT	RELIGION	MAIDEN NAME
13/8/63	35	F	14A		

ADDRESS
38 BENCLOICH CRESC.
LENNOXTOWN
TEL. No.

G.P'S NAME & ADDRESS
TEL No.

DATE	SPECIALITY	CONSULTANT'S NAME
	MEDICINE	N. FORREST

28/12/98

A: ROBAXIN – METHOCARBAMOL – ANTI SPASMODIC
IBUPOFEN — UNSPECIFIED AMOUNTS
COCOMOL
ALCOHOL

S: 35 yo lady.
Arrested for breach of peace this evening from home address
Claims to have taken unspecified amount of above medications and alcohol.
Verified by husband
Apparently 2-3 previous overdoses

Feels stupid thing to do
Didn't want to kill herself.

PMH. claims unremarkable

Drugs. claims not regularly

O: Hyperacusal. Smelling strongly of alcohol.

Pulse 110 bpm reg BP 150/90 HS I + II + 0 ⇔ JVP. oedema

Clear — Soft.

A: OVERDOSE OF ABOVE

P: Admit
Ensure routine bloods unremarkable
Check Paracetamol + Salicylate levels — neither detected
CXR. ECG → unremarkable

J. DAVIDSON SHO

DATE	URINE			
	Reaction	Albumin	Sugar	Ketones
	Weight (In kilogrammes)			

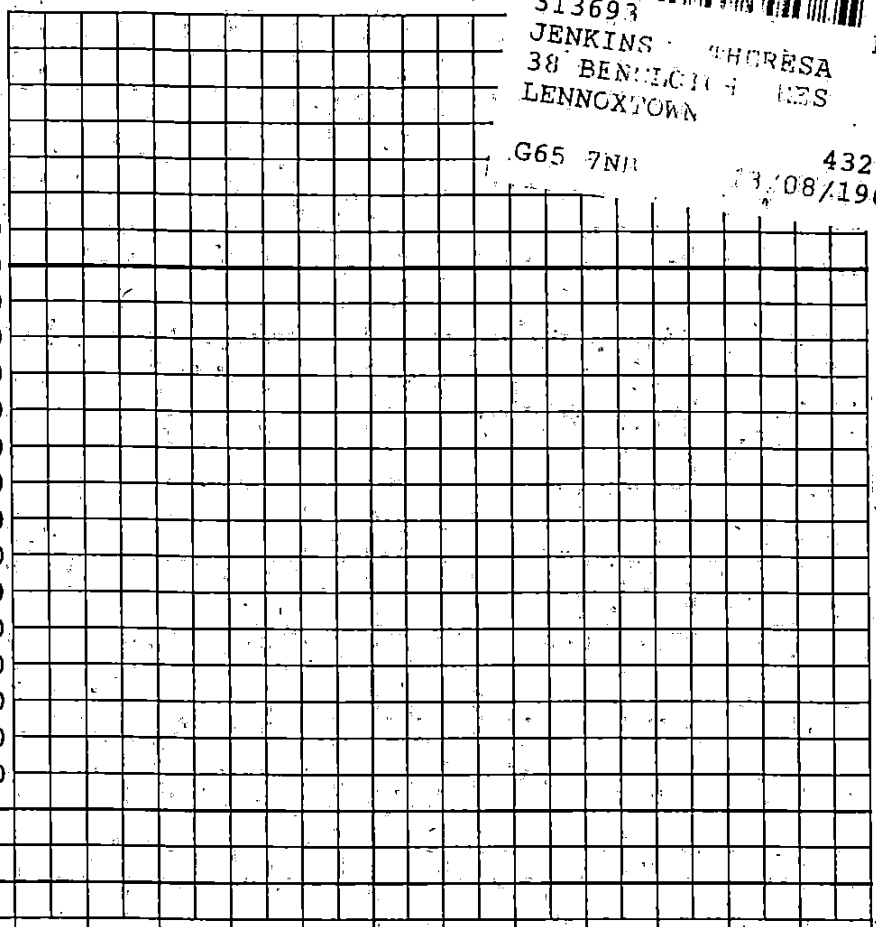
PHYSICAL EXAMINATION

25/12 02:30 Patient absconded from ward at 02:15 on 25/12/98 after reporting to sign inpatient discharge book.

INVESTIGATIONS

NAME

313693
JENKINS THERESA F/M
38 BEN[illegible] [illegible]ES
LENNOXTOWN
G65 7N[illegible] 43261
[illegible]/08/1963



Blood Pressure and Pulse rate

Temperature °C

Pulse

Respiration Rate/min

Regular/irregular

0.2 Sat

Size

BM Stix

Weight

Urinalysis	Colour	S.G.	Reaction	Sugar	Blood	Protein	Ketones	Bile	Others

Comments

BUILD/WEIGHT FOR HEIGHT

Average	0
Above average	1
Obese	2
Below average	3

CONTINENCE

Complete/Catheterised	0
Occasion Incont.	1
Cath./Incontinent of Faeces	2
Doubly Incont.	3

SKIN TYPE VISUAL RISK AREAS

Healthy	0
Tissue paper	1
Dry	1
Oedematous	1
Clammy (Temp up)	1
Discoulered	2
Broken / Spot	3

If patient has discoloured or broken skin on pressure area mark site + grade of sore in pressure sore 1 or 2 core care plan.

MOBILITY

Fully	0
Restless/Fidgety	1
Apathetic	2
Restricted	3
Inert/Traction	4
Chairbound	5

SEX/AGE

Male	1
Female	2
14–49	1
50-64	2
65-74	3
75-80	4
81+	5

APPETITE

Average	0
Poor	1
	2

SPECIAL RISKS

TISSUE MALNUTRITION
e.g. Terminal Cachexia
Cardiac Failure
Peripheral Vascular Disease
Anaemia
Smoking

NEUROLOGICAL DEFICIT
e.g. Diabetes M.S.. CVA..
Motor/Sensory Paraplegia

MAJOR SURGERY / TRAUMA
Orthopaedic - Below waist spinal

On table > 2 hours

MEDICATION
Steroids Cytotoxics
High dose Anti-Inflammatory

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

Date	Score	Mattress	Cushion	Date next

STOBHILL

PATIENT PROGRESS / EVALUATION

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

AFFIX DATA LABEL

All entries must be signed

Date	No.	Progress/ Evaluation	
25/12		Admitted following ? overdose of Robaxin, ibuprofen, co codamol & alcohol, brought in by the police.	
		Plan ECG	
		Paracetamol + salicylate levels non detected	
		full blood screen	
		refusing telemetry.	
		Nursing care as charted.	
		Weepy and noisy at times, Sister informed of admission.	SHO
		Absconded from the ward.	SHO
		Bawd St Police contacted - no follow up from them.	SHO

PATIENT PROGRESS / EVALUATION

(Continued)

Date No. Progress/ Evaluation ***All entries must be signed***

STOBHILL PATIENT PROFILE Ward

Type / source of admission

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963
AFFIX DATA LABEL

Religion

Alliergies

Next of kin informed
Husband SIA
Sister contacted

Medical reasons for admission
? o/d + alc shd.

Patient's understanding of admission
aware

Relative's understanding of admission
aware

General condition on admission
smelling of alc shd and inappropriate behaviour.

PATIENT PROFILE

(Continued)

Social circumstances Occupation Hobbies / interests
Medical history
Medication list
Valuables / belongings
Other information

Signature of Assessment Nurse _____ Date _____ Time _____

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

NURSING ASSESSMENT

WARD

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

AFFIX DATA LABEL

Maintaining Safe Environment

No problems

Communication

No problems

Hearing Aid Y/ N

Spectacles Y / N

Breathing / Circulation

No problems

Resps

B.P. 109/71

Pulse 95

Smoker Y/~~N~~

Eating / Drinking

No problems

Dentures

Elimination

No problems

Urinalysis

Personal Cleansing / Dressing

Self Care

CONTINUED OVER /

NURSING ASSESSMENT
(Continued)

Controlling Body Temperature Temp. 36.2
Mobilisation No problems Weight Waterlow - score
Expressing Sexuality
Sleeping
Pain
Socialization smelling of alcohol on admission
Dying Minister / priest

Signature of Assessment Nurse amason Date 25/12 Time 2am

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

SPECIMEN / INVESTIGATIONS

WARD

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

AFFIX DATA LABEL

DATE ORDERED	SPECIMEN	DATE OBTAINED

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL

STOBHILL DISCHARGE PLAN

WARD .....

NAME ADDRESS D.O.B. UNIT No.

AFFIX DATA LABEL

Proposed discharge date
Discharge date

Patient informed	Relative informed
Transport arrangements	Clothing requested for discharge

Medication / G.P.'s letter	
Out-patients appointment	Ambulance required
Social services: Social worker Home help Meals on wheels Other	
District nurse	
Aids and equipment	
Other needs	
Discharge summary / comments	

Signature of Discharge Nurse _____ Date _____ Time _____

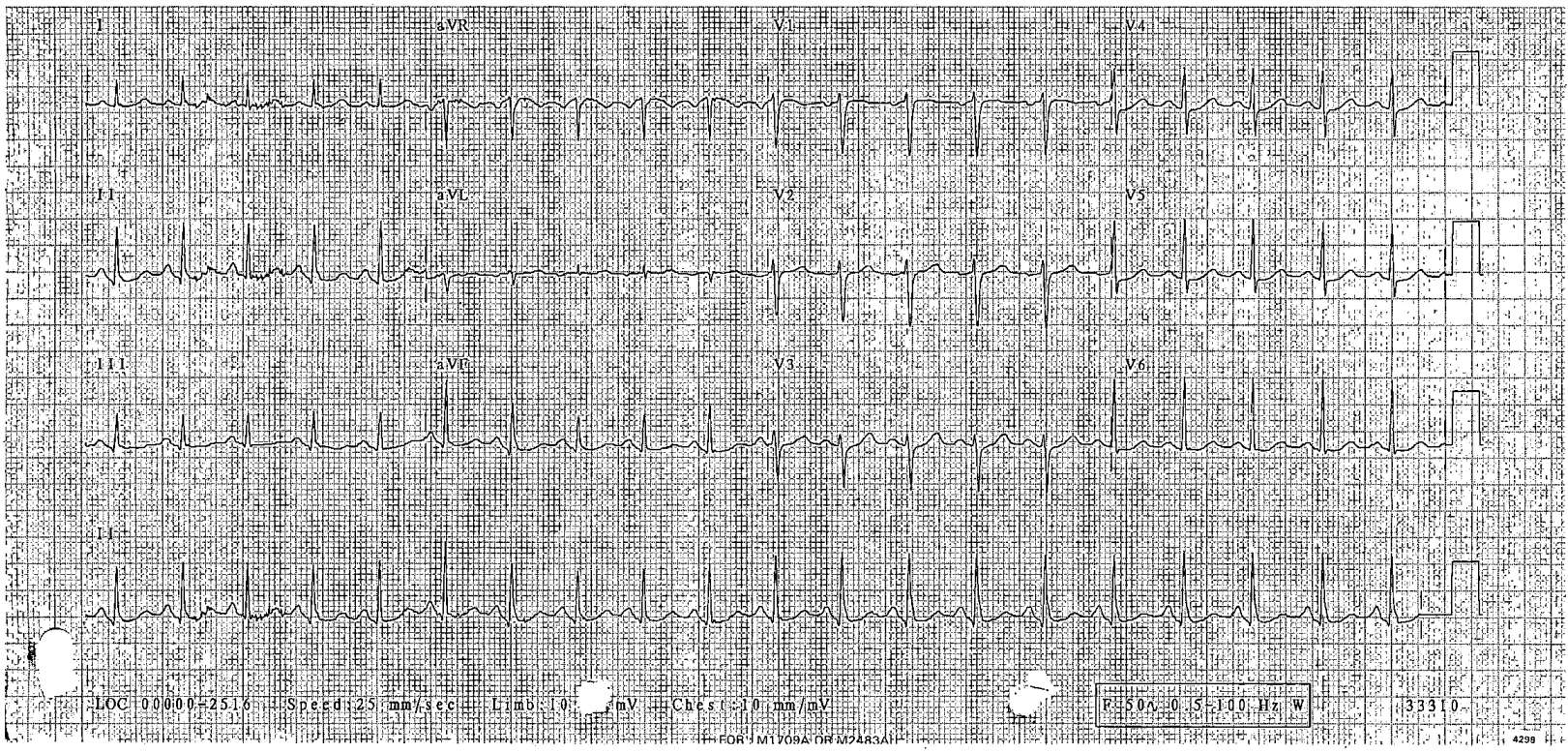
Signature of Named Nurse _____ Date _____ Time _____

Dept:

Teresa Jenkins 35yfs O.I. Oper:

c ? chest Pain.

Nil acute.



GREATER GLASGOW HEALTH BOARD - NORTHERN UNITS

OUTPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENTS OCCUPATION	MARITAL STATE
Jenkins	Theresa	313693		M. (yrs) S. W.

DATE OF BIRTH	AGE	SEX	~~WARD/DEPT~~	RELIGION	MAIDEN NAME
13/6/63	33	F	OPD		

ADDRESS 38 Benclosh Cres. Lennoxtown

G.P's NAME & ADDRESS Dr. Henderson Main St Lennoxtown

TEL No. 18 JUN 1996

TEL No.

DATE SPECIALITY-GYNAECOLOGY

CONSULTANT'S NAME Dr. Low

Complaint & Duration 2° amenorrhoea

Now menstruating every 3-4/12

Previous History

Previous Obstetric History (Summary of pregnancies and deliveries)

Discontinued COCP March 96

3+0. MCFDX1

SVDX2

Years Married

Gynaecological History Contraception F.M.P. L.M.P.

Cycle Loss Clots Regularity

Dysmenorrhoea Backache

Dyspareunia

Discharge Quantity Colour

Micturition-Dysuria

Frequency-Day Night

Stress incontinence Urgency

Bowels

History of Present condition On COCP 4yrs, although on COCP since ~17yrs and only off COCP to conceive.

No flushes. No pelvic pain.

Abdomen Breasts

Does not wish to conceive.

Pelvic Examination

Best action would be to go back on COCP - Trinordiol

Pap Smear ? 2yrs ago

Diagnosis

Suggested Treatment

Waiting List		Priority	

Seen by For Letter Yes/No

Return

JMcC/492368

MEDICAL IN CONFIDENCE

STOBHILL
NHS TRUST

CASE RECORD

ADMISSION FORM V3

HOSPITAL CODE	HOSPITAL NAME					CASE RECORD NUMBER
G216H	STOBHILL HOSPITAL					S/H-313693

TIME	TYPE OF ADMISSION	ADMIT TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
14/01/99 00:55	30 1K	10 PRNAD	IP		8	3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
WARD 14A	11	GENERAL MEDICINE	DR D GORDON		

PATIENT

TITLE SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MRS JENKINS	THERESA		35	13/08/1963	F	M

ADDRESS
38 BENCLOICH CRES
LENNOXTOWN

ALT./PREV. SURNAME

OCCUPATION

C.H.I. NUMBER
1308636407

POSTCODE G65 7NB TELEPHONE No. NONE

OCCUPATION (HUSBAND/FATHER)

HEALTH BOARD OF RESIDENCE Greater Glasgow

HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

REF. G.P.

NAME HENDERSON J
G.P. CODE 2335801 PRACTICE 43261|2
CONTRACT No. SGC06 FH STATUS N

ADDRESS
51 MAIN STREET
TORRANCE
TEL No. 0360 20516 POSTCODE G64

REG. G.P.

NAME HENDERSON J
G.P. CODE 2335801 PRACTICE 43261|1
CONTRACT No. SGC06 FH STATUS N

ADDRESS
MAIN STREET
LENNOXTOWN
TEL No. 01360 310357 POSTCODE G65 7DD

NEXT OF KIN

NAME
RELATIONSHIP
HUSBAND

ADDRESS SA

DAY PHONE No.

NIGHT PHONE No.

MISC.

RELIGION
Roman Catholic

VISIT REQ. BY CHAPLAIN YES/NO

PENSION BOOK No.

SMR1 COMPLETED

Admission

DIAGNOSIS		SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)		
OTHER CONDITIONS (D.G.3)		

SMR50

	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR
S		

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
14/1/99		1	3	1	16	GORDON
DISCH./TRANSF. TO	**READY FOR DISCH.**	**HOSPITAL: NAME**	**CODE**	**WARD**	**SPECIALTY**	**CONSULTANT CODE**
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

DIAGNOSES

		CODE	SPECIAL WARNINGS
MAIN DIAGNOSIS	MINOR LACERATIONS	K720	
OTHER CONDITIONS (D.G.2)	DIARRHOEA & VOMITING	KS29	
(D.G.3)		R11X	
(D.G.4)		F109	
(D.G.5)			
(D.G.6)			

OPERATIONS

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

STOBHILL NHS TRUST, GLASGOW CASUALTY DEPARTMENT

PATIENT

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	THERESA	35	13/08/1963	14/01/99	00:02	001797

Address	Sex	Religion	Date of Inc.	Time
38 BENCLOICH CRES LENNOXTOWN	FEMALE	CATHOLIC	NOT KNOWN	~

PC	Tel	Marital Status	Occupation/School	Type of Inc.	Mode of Arrival
G66 7NA	NA	MARRIED		EMERG.	AMBULANCE

GP

Name HENDERSON Address 51 MAIN STREET TORRANCE G64

Referred by: GP REF.-LETTER-G.MED

NEXT OF KIN

Name Relat. NOT STATED Tel No. HUSBAND SA Address

Complaint: PENDING

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

THE ABOVE NAMED PERSON ATTENDED THE ACCIDENT & EMERGENCY DEPARTMENT TODAY

DIAGNOSIS

INVESTIGATION SHOWS

TREATMENT GIVEN

14/1/99

WOULD YOU PLEASE ARRANGE

Investigations: X-Ray ✓ Lab ECG

Treatment: Dressing Suture Tet Tox Antibiotic Analg

Pop Resusc Nurse's Signature

Admitted to ward

Consultant

Hospital Transferred

Comments

Medical Officers Signature

Medical Officers Name (BLOCK)

Disposal Time	Home	Admit	A/E Clinic	Irreg Dis	Died	DOA	GP	Transfer	Other Clinic	DNW
01 34		14								

STAFF GRADE: REG SHO JHO CA (PLEASE CIRCLE)

_____ days supply of _____ has been given

_____ days supply of _____

_____ days supply of _____

Written Advice Issued:

Tetanus Prophylaxis has / has not been administered. TT Course ☐ TT Booster ☐ HATI ☐ (Please Tick)

Patients Name

CONFIDENTIAL

NUMBER 09697

IMMEDIATE DISCHARGE & MEDICINE PRESCRIPTION FORM

PATIENT AND GP LABELS MUST GO ON ALL FOUR COPIES

DR. J HENDERSON
MAIN STREET
LENNOXTOWN

G65 7DD
G.P. Prac. 43261

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN

43261
G65 7NB 13/08/1963

STOBHILL HOSPITAL
GLASGOW G21 3UW
TELEPHONE 0141 201 3000

DATE OF ADMISSION 13.1.99
DATE OF DISCHARGE 16.1.99
WARD N/A
CONSULTANT DR. GORDON

DIAGNOSIS
1. HAEMATEMESIS - ACUTE GASTRITIS
2.
3.
4.

OPERATION / PROCEDURES
1.
2.
3.

FOLLOW UP ARRANGEMENTS

OUTPATIENT/DAY HOSPITAL APPOINTMENTS

CONSULTANT	CLINIC	WHEN	DATE GIVEN	INITIALS

OUTPATIENT INVESTIGATIONS N.B. (request cards must be provided)

			DATE GIVEN	INITIALS

AMBULANCE REQUIRED YES / NO
WALKING
2 HANDED SEAT
STRETCHER
ESCORT
Tick as necessary

OTHER NEEDS (SPECIFY)

COMMUNITY CARE ARRANGEMENTS — ARRANGED BY

HOME HELP DAY CARE PHYSIO
MEALS ON WHEELS DN OR HV OT

SPECIAL DISPENSING INSTRUCTIONS
☐ LARGE PRINT ☐ NO C.R.C. ☐ OTHER

DISCHARGE MEDICATION

Medicine	Form	Dose	Times of Administration	Recommended Duration from discharge (Days)	No. of Days Supplied	Quantity, Name Strength & Manufacturer Supplied
OMEPRAZOLE	TAB	20mg	✓	INDEF	7	7 MAXA

PHARMACY USE ONLY

OTHER TREATMENT AND COMMENTS (including details of drug sensitivities, appliances etc.)

DISPENSED BY TB
CHECKED BY
DATE 14/1/99 CP CHECK

MEDICINES COLLECTED BY (MESSENGER)

WARD USE ONLY

RECEIVED ON WARD BY
ISSUED BY
DATE ISSUED
SIGNATURE OF RECIPIENT

DR.'s NAME IN BLOCK CAPITALS CAMPBELL **DATE** 14/1/99

SIGNATURE Campbell **PAGER No.** 4900

COPIES TO : WHITE - GP, PINK - MEDICAL RECORDS, BLUE - PHARMACY, YELLOW - LIAISON

STOBHILL NHS TRUST

CONTINUATION CHART

SURNAME / CHRISTIAN / FORENAME	UNIT NUMBER
JENKINS THERESA.	

14/1/99. GP REFERRAL
1AM/

PC/ Haematemesis.

Hx of PC/
Hx of alcohol XS.

1 previous admission with haematemesis
underwent endoscopy. Commenced on Omeprazole.
- Has stopped booze for ~3 days. Read something
about it causing liver damage & had stopped it
of her own accord.
- Since then has been feeling nauseous &
has vomited several times/day. (~3x).
- Today vomited 3x the first of which contained
a small amount fresh red blood.
Tonight vomited again → small amount blood.

- Abdo pain - epigastric. started today.
- Relieved by sitting forward.
- Comes & goes.

- Bowels - diarrhoea - not new.
- melena ? doesn't know.

- Has been taking co-dydramol for recent # wrist.

0176822

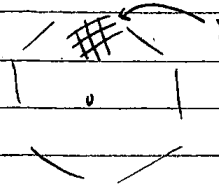
Past Med Hx/ Alcohol Xs
Wrist.

Social Hx/ Smokes ~ 20 cigs/day
Binge drinker
Has had ~ 8 units today.

Family Hx/ - Nil else.

Systemic Enq/
CVS - Some chest discomfort today.
Resp - Nil else
GNS - Nil else
GUS - Nil else.

On exam~
BP 125/76. Pulse 109.
Sats Temp. 35.7.

Abdo/  Slightly tender Left.
Liver edge ~ 1cm below costal margin.
BS ✓

CVS/ JVP ↳
HS 1+11+0
No oedema.

Resp/ Trachea ⊥
Exp L= R= N
Perc L= R= N
Vesic BS.
Nil added.

STOBHILL NHS TRUST — INPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STAUS
JENNING	THERESA	.		M S W

DATE OF BIRTH	AGE	SEX	WARD/DEPT	RELIGION	MAIDEN NAME

ADDRESS	G.P'S NAME & ADDRESS
TEL. No.	TEL No.

DATE	SPECIALITY	CONSULTANT'S NAME
	Imp - Small haematemesis 2y to alcohol xs.	
	- ? element of pancreatitis.	
	Plan → CXR & AXR	
	→ ECG	
	→ bloods incl LFTs & Amylase	
	Na+ 146 K - 4.6 U 106 HCO3 24	Sutherland (SHO)
	Urea 2.8 Creat 64	
	WCC 11.5 Hb 14.8 Plt 376	
	PT 14 APTT 29.	
0h30	Thank you Claire	
	Minor haematemesis this evening	
	- 3 episodes of vomit, the first had small amount of blood.	
	- No ~~mat~~ melaena	
	- Epigastric Pain - new onset.	
	Heavy drinker - was in pub when ambulance called to collect!!	
	- Admitted 26/12 w. similar story	
	- Endoscopy @ at that point	
	O/E Haemodynamically stable	
	Smelling of alcohol slightly	
	Minimal Soft Abdo	
	Tenderness No masses.	
	Mild Hepatomegaly.	

DATE | URINE

Reaction | Albumin | Sugar | Ketones

Weight (In kilogrammes)

Imp! PHYSICAL EXAMINATION

Abdo pain + minor ⊕ haematemesis in 45 yr old alcohol abuser w. recent normal endoscopy.

- Probably alcoholic gastritis - recently stopped taking Losec "bad for my liver"!

Plan 1/ Repeat FBC now
2/ FS, CRP - ?
3/ Probably does not require further endoscopy.

M Anderson
(Registrar (SHO)

14/11/99 35 yr old ♀ c dyspepsia history - diarrhoea from Fri for 3 days, then haematemesis small amounts of fresh blood NBT amount of melaena. Had stopped Losec 3 days ago Several vodkas yesterday History of alcohol excess

O/E Well.
Haemodynamically stable
Minimal epigastric tenderness

Imp Minor haematemesis ? new tear
? alcohol related

INVESTIGATIONS

Plan!- Repeat FBC If unchanged - home today

Dr
Senior

RING SCORES IN TABLE ADD TO...

BUILD/WEIGHT FOR HEIGHT

Average	(0)
Above average	1
Obese	2
Below average	3

CONTINENCE

Complete/Catheterised	(0)
Occasion Incont.	1
Cath./Incontinent of Faeces	2
Doubly Incont.	3

SKIN TYPE VISUAL RISK AREAS

Healthy	(0)
Tissue paper	1
Dry	1
Oedematous	1
Clammy (Temp up)	1
Discoulered	2
Broken / Spot	3

If patient has discoloured or broken skin on pressure area mark site + grade of sore in pressure sore 1 or 2 core care plan.

MOBILITY

Fully	(0)
Restless/Fidgety	1
Apathetic	2
Restricted	3
Inert/Traction	4
Chairbound	5

SEX/AGE

Male	1
Female	(2)
14–49	(1)
50-64	2
65-74	3
75-80	4
81+	5

APPETITE

Average 0

SPECIAL RISKS

TISSUE MALNUTRITION

e.g. Terminal Cachexia
Cardiac Failure
Peripheral Vascular Disease
Anaemia
Smoking

NEUROLOGICAL DEFICIT

e.g. Diabetes M.S.. CVA..
Motor/Sensory Paraplegia

MAJOR SURGERY / TRAUMA

Orthopaedic - Below waist spinal

On table > 2 hours

MEDICATION

Steroids Cytotoxics
High dose Anti-Inflammatory

313693
JENKINS THERESA F/M
38 BENCLOICH CRES
LENNOXTOWN

G65 7NB 43261
13/08/1963

Date	Score	Mattress	Cushion	Date next
14/1	3			

NAME

313693
JENKINS THERESA F/M
38 BENCLOICH CRES
LENNOXTOWN
G65 7NB 43261
13/08/1963

14/1

Blood Pressure and Pulse rate

240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

37 36 35 34 33 32 31 30

Temperature °C

Pulse	10 | 84 | 70
Respiration Rate/min	
Regular/irregular	
0.2 Sat	
BM Stix	
Weight	

Size

Urinalysis	Colour	S.G.	Reaction	Sugar	Blood	Protein	Ketones	Bile	Others

Comments

Drs. Rae and Henderson
Health Clinic
Main Street
Lennoxtown
Glasgow G65 7DD
Tel: 01360 310357
Fax: 01360 311740

13/1/99

Dear Dr

Teresa Jenkins
38 Berclouch Cr
Lennoxtown

This lady has had several
haematemeses today.
She has a history of dyspepsia
but endos. in Aug 98 was normal
She was on Omeprazole then
but has been off this recently.
She drinks heavily.
She is on no other medication.
(recent Co dyd for A wrist)
O/E Epigastric tender

P70

P 118/min
BP 120/76
Thanks for seeing her

GREATER GLASGOW HEALTH BOARD-NORTHERN DISTRICT

IRREGULAR DISCHARGE CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Jenkins	Teresa.	

I accept full responsibility for *my discharge

my.....

out of...STOBHILL... HOSPITALS against medical advice

Signed.....

Relationship to Patient.....

Date.25/12/98.....Witness.....

JMcC/5113 FORM 59

STOBHILL

PATIENT PROGRESS / EVALUATION

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

AFFIX DATA LABEL

All entries must be signed

Date	No.	Progress/ Evaluation	
14/1		Admitted following ? haematemesis	
		Plan Fast overnight ? scope	
		4hrly BP + P	
		C+R	
		ECG	
		full blood screen	FOB's.
		Nursing care as charted	Carlton
		Stopped Losec 3/7 ago, ↑alcohol consumption.	
5.50am		Settled & slept.	
		no further vomiting Hb 14.8.	L Rhys
		am Reviewed by Dr Gordon - ↓Hair readings not Hb ✓	
		- ↑ within normal parameters Then home	
		today - no meds.	
		Wdout ✓	
		Hb - 13.8.	
		allow home	L Sell
		No Varilon	

All entries must be signed

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress/ Evaluation	***All entries must be signed***

STOBHILL

NURSING ASSESSMENT

WARD

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

AFFIX DATA LABEL

Maintaining Safe Environment

No problems

Communication

No problems

Hearing Aid ~~Y~~/ N

Spectacles Y /~~N~~

Breathing / Circulation

No problems

Resps

B.P. 121/83

Pulse
84

Smoker Y/~~N~~
20 a day

Eating / Drinking

Nil by Mouth

Dentures

Elimination

Self Care

FOB's

Urinalysis

Personal Cleansing / Dressing

Self Care

CONTINUED OVER /

NURSING ASSESSMENT
(Continued)

Controlling Body Temperature Temp. 36.5
Mobilisation Weight Waterlow - score
Expressing Sexuality
Sleeping
Pain
Socialization
Dying Minister / priest

Signature of Assessment Nurse _____ Date _____ Time _____

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

SPECIMEN / INVESTIGATIONS

WARD

NAME
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

DATE ORDERED	SPECIMEN	DATE OBTAINED

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL

STOBHILL DISCHARGE PLAN

WARD .....

313693
JENKINS THERESA F/M
38 BENCLOICH CRES
LENNOXTOWN

G65 7NB 43261
13/08/1963

AFFIX DATA LABEL

Proposed discharge date	
Discharge date	14/1/99

Patient informed ✓	Relative informed
Transport arrangements own	Clothing requested for discharge

Medication / G.P.'s letter	given to PJ.
Out-patients appointment NMFH	Ambulance required
Social services: Social worker Home help Meals on wheels Other	
District nurse	
Aids and equipment	
Other needs	
Discharge summary / comments	P/C Haemotoma J McCabe c/o Loss Hb — Stable

Signature of Discharge Nurse L Smith Date 14/1/99 Time 1150

Signature of Named Nurse _____ Date _____ Time AM

STOBHILL PATIENT PROFILE Ward

Type / source of admission

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963
AFFIX DATA LABEL

Religion R.C.

Alliergies
N.C known

Next of kin informed
Chris Jenkins Husband 01360 312 571
S/A

Medical reasons for admission
haemolemsis

Patient's understanding of admission

Relative's understanding of admission

General condition on admission
#(L) hand in plaster - 1/7 ago.

PATIENT PROFILE
(Continued)

Social circumstances lives at home with husband + 3 children Occupation Hobbies / interests
Medical history
Medication list
Valuables / belongings
Other information

Signature of Assessment Nurse C Mason Date _____ Time _____

Signature of Named Nurse _____ Date _____ Time _____

HOSPITAL

PRESCRIPTION SHEET No.

REGULAR PRESCRIPTIONS – INJECTIONS

Pharmacy Use	Date Started	MEDICINE (Block Capitals)	DOSE	ROUTE	TIMES FOR ADMINISTRATION: am 6	am 8	am 10	md 12	pm 2	pm 4	pm 6	pm 10	pm 12	Other Times	Prescribers Signature (Full)	DISCONTINUED: Date	Signed
	A																
	B																
	C																
	D																
	E																
	F																
	G																

REGULAR PRESCRIPTIONS – OTHER MEDICINES INCLUDING OXYGEN THERAPY WHERE FLOW RATE, CONCENTRATION AND TYPE OF MASK MUST BE SPECIFIED

	H	14/1/99	OMEPRAZOLE	30mg	ORAL		✓										
	J																
	K																
	L																
	M																
	N																
	O																
	P																
	R																
	S																
	T																
	V																

ONCE ONLY PRESCRIPTIONS

DATE GIVEN	TIME OF ADMIN	MEDICINE (Block Letters)	DOSE	ROUTE	SIGNATURE	GIVEN BY	TIME GIVEN

DIET

PLEASE ✓ WHEN MEDICINES ARE PRESCRIBED ON OTHER PRESCRIPTION SHEETS

TOTAL PARENTERAL NUTRITION			
INSULIN		FLUID/ADDITIVE	
ORAL ANTICOAGULANT		ANAESTHETIC	
TOPICAL APPLICATION		VARIABLE DOSE	

IF MEDICINE DISCONTINUED BECAUSE OF SUSPECTED ADVERSE REACTION, ENTER BELOW.

MEDICINE	ADVERSE REACTION
1.	
2.	

KNOWN MEDICINE SENSITIVITIES 1.

WARD		E/DOB	HEIGHT	WEIGHT	UNIT NUMBER	CONSULTANT
	313693 TENKINS THERESA F/M					

HOSPITAL

MEDICINE RECORDING SHEET No.

REGULAR PRESCRIPTIONS

DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES	COMMENTS ON DISCREPANCIES
13/8/63	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	

PLEASE ENTER ALL PRESCRIBE CODE FROM PRESCRIPTION SHEET

NAME

UNIT NUMBER

WARD

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETT

13/08/1963

GB5 7NB

RI 10/90

HOSPITAL

MEDICINE RECORDING SHEET No.

PLEASE ENTER APPROPRIATE CODE FROM PRESCRIPTION SHEET

REGULAR PRESCRIPTIONS												COMMENTS ON DISCREPANCIES
DATE	6 a.m.	8 a.m.	10 a.m.	12 m.d.	2 p.m.	4 p.m.	6 p.m.	10 p.m.	12 m.n.	OTHER TIMES		
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial		

313693
JENKINS THERESA F/M

UNIT NUMBER

WARD

KEY: CODE LETTER CIRCLED E.G. (A) = MEDICINE REFUSED AND MEDICAL STAFF INFORMED

CODE LETTER SCORED E.G. X = PATIENT ABSENT

STOBI
NHS TRU

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
G65 7NB 43261 13/08/1963

WARD 1 'LAN

NAME : ..... UNIT NO. : .....
ADDRESS : ..... DATE OF ADMISSION : 14/1.....
.....
Signature of Registered Nurse : amos.....
Provisional Diagnosis : .....haematemesis.....

Recording of Vital Signs

BP	Pulse	Temp	Resp	Colour	Peak Flow	CNS	CVP	Fluid Balance
☑	☑	☑	☐	☐	☐	☐	☐	☐
4 hrly	4 hrly	4 hrly	..... hrly	..... hrly	..... hrly	..... hrly	..... hrly	..... hrly

Urine Volume ☐

Monitoring / Recording of Observations

IV Cannula	IV Infusion	Chest Drain
☑	☐	☐
.....hrly	.....hrly	.....hrly

Telemetry	Cardiac Monitor	BM Stix	ECG During Pain
☐	☐	☐	☐
.....hrly	.....hrly	.....hrly	.....hrly

Medications (Prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 Therapy
☐	☐	☐	☐
.....hrly	..... hrly	.....hrly	.....hrly
	via Syringe Drive ☐	via O_2 ☐	O_2 % ☐
	via Infusion pump ☐	nebuliser compressor pump ☐	flow rate ☐

Nursing Care Plan - Ward 14A (Cont'd.)

Name : ..... Unit No. : .....

Hygiene

Bed Bath (2 Nurses)	Assisted Wash (1 Nurse)	Shower Bath (Independent)	Ambu/Shower (Supervised)	Independe but on bed rest.
☐	☐	☑	☐	☐

Mouth Care	Eye Care	Nasal Care	Catheter Care	Wound C:
☐	☐	☐	☐	☐
.....hrly	.....hrly	.....hrly	.....hrly	.....hr

Mobilisation

Bed Rest	Ambulant		Positional Change
	Independent	Supervised	
☐	☑	☐	☐ .....hrly

Specialised Bed	Passive Limb Exercise	No. of Staff required for M & H	Moving & Handling Aid
☐	☐ .....hrly	☐ .....specify	☐ .....hrly

Diet

Normal Diet	Light Diet	Special Diet	Nasogastric / Gastronom Feeding. Use in conjunction with feeding Chart
☐	☐	☐ .....specify	☐

Requires help with feeding ☐

Fluids Only	Restricted Fluids	Fasting	Dietetic Advice
☐	☐	☑	☐

ice to suck ☐

Nursing Care Plan - Ward 14A (Cont'd.)

Name : ..... Unit No. : .....

Paramedic Services - To be involved

Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Liaison Services - To be involved

Cardiac ☐ Respiratory ☐ Diabetic ☐ Stoma ☐ Social Work ☐

Bladder / Bowel Care

Offer Commode / Urinal ☐ Wheel to toilet ☐ Self Care ☐ Catheter Care ☐ Continence Aids ☐

Sputum Specimen for :

- CS ☐
- AAFB ☐
- Pathology ☐

Urine Specimen for :

- RSOU ☐
- MSSU ☐
- EMU ☐

Wound Swab ☐

Specify

Stool Specimen for :

- CS ☐
- FOB ☐

Other Information :

MEDICAL IN CONFIDENCE

STOBHILL
NHS TRUST

ADMISSION FORM V3

CASE RECORD

HOSPITAL CODE	HOSPITAL NAME	CASE RECORD NUMBER
G207H	STOBHILL HOSPITAL	S/H-313693

DATE	TIME	TYPE	REASON	ADM./TRANS. FROM	INPAT./DAYCASE	DATE ON W.L.	W.L. TYPE	PATIENT CATEGORY
16/06/99	03:58	31	1C	12 PR LR	IP		18	3 NHS

WARD	S. FACILITY	SPECIALTY	CONSULTANT	FROM LOCATION	W.G.E.
WARD 14A	11	GENERAL MEDICINE	DR L ERWIN		

TITLE	SURNAME	FORENAME (1)	(2)	AGE	DATE OF BIRTH	SEX	MARITAL STATUS
MRS	WILKINS	THERESA		35	13/08/1963	F	M

ADDRESS: 3 RESNCLOICH CRES
LENNOXTOWN
POSTCODE: G65 7NB
TELEPHONE No.: NONE
HEALTH BOARD OF RESIDENCE: Greater Glasgow

ALT./PREV. SURNAME:
OCCUPATION:
CHI NUMBER: 1308636407
OCCUPATION (HUSBAND/FATHER):
HAVE YOU LIVED IN THIS COUNTRY FOR PAST YEAR?

G.P.
NAME: HENDERSON J
G.P. CODE: 2335801
PRACTICE: 43261|1
CONTRACT No.: SGC06
FH STATUS: N

ADDRESS: MAIN STREET
LENNOXTOWN
TEL No.: 01360 310357
POSTCODE: G65 7DD

G.P.
NAME: HENDERSON J
G.P. CODE: 2335801
PRACTICE: 43261|1
CONTRACT No.: SGC06
FH STATUS: N

ADDRESS: MAIN STREET
LENNOXTOWN
TEL No.: 01360 310357
POSTCODE: G65 7DD

NEXT OF KIN
NAME:
RELATIONSHIP:
ADDRESS:
DAY PHONE No.:
NIGHT PHONE No.:

RELIGION:
VISIT REQ. BY CHAPLAIN YES/NO:
PENSION BOOK No.:

Admission

DIAGNOSIS							SPECIAL WARNINGS
OTHER CONDITIONS (D.G.2)							
OTHER CONDITIONS (D.G.3)							

SMR1 COMPLETED

R04

SMR50

ST	PREVIOUS PSYCH. CARE	CONTRIBUTORY SOCIAL FACTOR

DISCHARGE SUMMARY

DATE	TIME	DISCH. TYPE	PATIENT CATEGORY	MANAGEMENT OF PATIENT	SPECIALTY	CONSULTANT CODE
16-5-99		6	3	1	16	Erwin
DISCH./TRANSF. TO	**READY FOR DISCH.**	**HOSPITAL: NAME**	**CODE**	**WARD**	**SPECIALTY**	**CONSULTANT CODE**
SMR04	TYPE OF CARE PROVIDED		ECT - 1st TREATMENT DATE		ECT - NUMBER OF TREATMENTS	

MAIN DIAGNOSIS							SPECIAL WARNINGS
	T	42	4				
OTHER CONDITIONS (D.G.2)	X	41	9				
(D.G.3)	F	10	9				
(D.G.4)							
(D.G.5)							
(D.G.6)							

	CODE	DATE
MAIN OPERATION		
OTHER OPERATION (O.P.2)		
(O.P.3)		
(O.P.4)		

JAQUELINE REYNOLDS 16/06/99 03:59

STOBHILL HOSPITAL, GLASGOW CASUALTY DEPARTMENT

(3)

Surname	Forename	Age	Date of Birth	Arr Date	Time	AE Number
JENKINS	THERESA	35	13/08/1963	16/06/99	02:08	022674

Address	Sex	Religion	Date of Inc.	Time
38 BENCLOICH CRES LENNOXTOWN	FEMALE		NOT KNOWN	~

PC	Tel	Marital Status	Occupation/School	Type of Inc.	Mode of Arrival
		MARRIED		EMERG	AMBULANCE

Name 365 HENDERSON Address MAIN STREET +LENNOXTOWN

Referred by

Name

Relat. NOT STATED

Tel No. HUSBAND

Complaint OVERDOSE

TO BE COMPLETED BY MEDICAL OFFICER AFTER SEEING PATIENT

THE ABOVE NAMED PERSON ATTENDED THE ACCIDENT & EMERGENCY DEPARTMENT TODAY

DIAGNOSIS OD

INVESTIGATION SHOWS

TREATMENT GIVEN

O/D → ? vomit ± diazepam

? doctor much ? when?

PE drifting in and out of consciousness

O/E → GCS = 9-10/15 (M = 5/6, V = 2/5, E = 2/4)

? PMN

? Drugs

? Allergies

Pupils dilated but reactive

? tachy

HS 1 + II + 0 murmur

Chest clear

Abdo: NAD

PR 2 1 16 Erwin

+ glands as ↓BP

O2

Bloods, Meds

BP 91/56

P 108

T 36.7

O2 94%

BM 8.1

FV Klot

Hb 13.3

WBC 11.

Plt 351

WOULD YOU PLEASE ARRANGE

Investigations	X-Ray	Lab	ECG	Match	Bact
			✓		

Treatment	Dressing	Suture	Tet Tox	Antibiotic	Analg

Pap | Resusc | Nurse's Signature

Admitted to ward | Consultant

Hospital Transferred F109

Comments

Medical Officers Signature

Medical Officers Name (BLOCK)

Disposal Time	Home	Admit	A/E Clinic	Irreg Dis	Died	DOA	GP	Transfer	Other Clinic	DNW
04.10		14A								

STAFF GRADE REG SHO JHO CA (PLEASE CIRCLE)

Drugs ____ days supply of ____ has been given

Drugs ____ days supply of ____

Drugs ____ days supply of ____

Written Advice Issued:

Tetanus Prophylaxis has / has not been administered. TT Course [ ] TT Booster [ ] HATI [ ] (Please Tick)

Patients Name

STOBHILL HOSPITAL

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
JENKINS	THERESA	

DATE	CLINICAL NOTES	INITIALS
16/6/94 03:45	PC Diazepam 10	
	HPC Drank a large amount of alcohol 10⁺ 5mg Diazepam - Very drowsy, no recal. History.	
	OE P. 100 BP 91/46 T 36.7°C BM 8.1 SaO2 91/7 GCS E2 V2 M5 9/15 No focal deficit Pupils equal + reactive CVS JVP ↑ RS Expansion L=R=@ HS S1 S2 NAD NV resonant No crips/ oedema Vesicular B.S. No added	
	GIS Not examined.	
	Impr Alcohol / Diazepam induced ↓ reduction of consciousness level. - SaO2 maintained	
	Plan Monitor SaO2 Flumazenil if desaturates Observe overnight.	
16/6/94	Awoke Fully known.	A Gribbon Paramedic (SAV)

FORM 39

DATE	CLINICAL NOTES	INITIALS
6/5/99	Dazepam o/D. with Alcohol hosp Hx of Alcohol abuse Nuerosis per o/D's Remembers little about circumstances Uncertain why she took it + remembers nothing about coming into hospital No suicidal intent Discharge Will make a referral to alcohol service BCO 8pm	

STOBHILL

NHS TRUST

WARD 14A

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN

NAME : .....
ADDRESS : G65 7NB

43261
13/08/1963

NO. : .....
ADMISSION : 16.6.99

.....

Signature of Registered Nurse : E Kane

Provisional Diagnosis : See notes

Recording of Vital Signs

BP	Pulse	Temp	Resp	Colour	Peak Flow	CNS	CVP	Fluid Balance
☑ 4	☑ 4	☑ 4	☑ 4	☑ 4	☐	☐	☐	☐
hrly	hrly	hrly	hrly	hrly	hrly	hrly	hrly	hrly

Urine Volume ☐

Monitoring / Recording of Observations

IV Cannula	IV Infusion	Chest Drain		
☑ Cont.	☐	☐		
.....hrly	.....hrly	.....hrly		
Telemetry	**Cardiac Monitor**	**BM Stix**	**ECG During Pain**	
☐	☐	☐	☐	
.....hrly	.....hrly	.....hrly	.....hrly	

Medications (Prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 Therapy
☐	☐	☐	☐
.....hrly	..... hrly	.....hrly	.....hrly
	via Syringe Drive ☐	via O_2 ☐	O_2 % ☐
	via Infusion pump ☐	nebuliser compressor pump ☐	flow rate ☐

Nursing Care Plan - Ward 14A (Cont'd.)

Name : ..... Unit No. : .....

Hygiene

Bed Bath (2 Nurses)	Assisted Wash (1 Nurse)	Shower Bath (Independent)	Ambu/Shower (Supervised)	Independent but on bed rest.
☐	☑	☐	☐	☐

Mouth Care	Eye Care	Nasal Care	Catheter Care	Wound Care
☐ .....hrly	☐ .....hrly	☐ .....hrly	☐ .....hrly	☐ .....hrly

Mobilisation

B Rest	Ambulant: Independent	Ambulant: Supervised	Positional Change
☑	☐	☐	☐ .....hrly

Specialised Bed	Passive Limb Exercise	No. of Staff required for M & H	Moving & Handling Aid
☐	☐ .....hrly	☐ .....specify	☐ .....hrly

Diet

Normal Diet	Light Diet	Special Diet	Nasogastric / Gastronomy Feeding. Use in conjunction with feeding Chart
☑	☐	☐ .....specify	☐

Requires help with feeding ☐

Fluids Only	Restricted Fluids	Fasting	Dietetic Advice
☐	☐	☐	☐

ice to suck ☐

Nursing Care Plan - Ward 14A (Cont'd.)

Name : ..... Unit No. : .....

Paramedic Services - To be involved

Physiotherapy ☐ Occupational Therapy ☐ Speech Therapy ☐

Liaison Services - To be involved

Cardiac ☐ Respiratory ☐ Diabetic ☐ Stoma ☐ Social Work ☐

Bladder / Bowel Care

Offer Commode / Urinal ☑ Wheel to toilet ☐ Self Care ☐ Catheter Care ☐ Continence Aids ☐

Sputum Specimen for :

CS ☐

AAFB ☐

Pathology ☐

Urine Specimen for :

RSOU ☑

MSSU ☐

EMU ☐

Wound Swab ☐

Specify

Stool Specimen for :

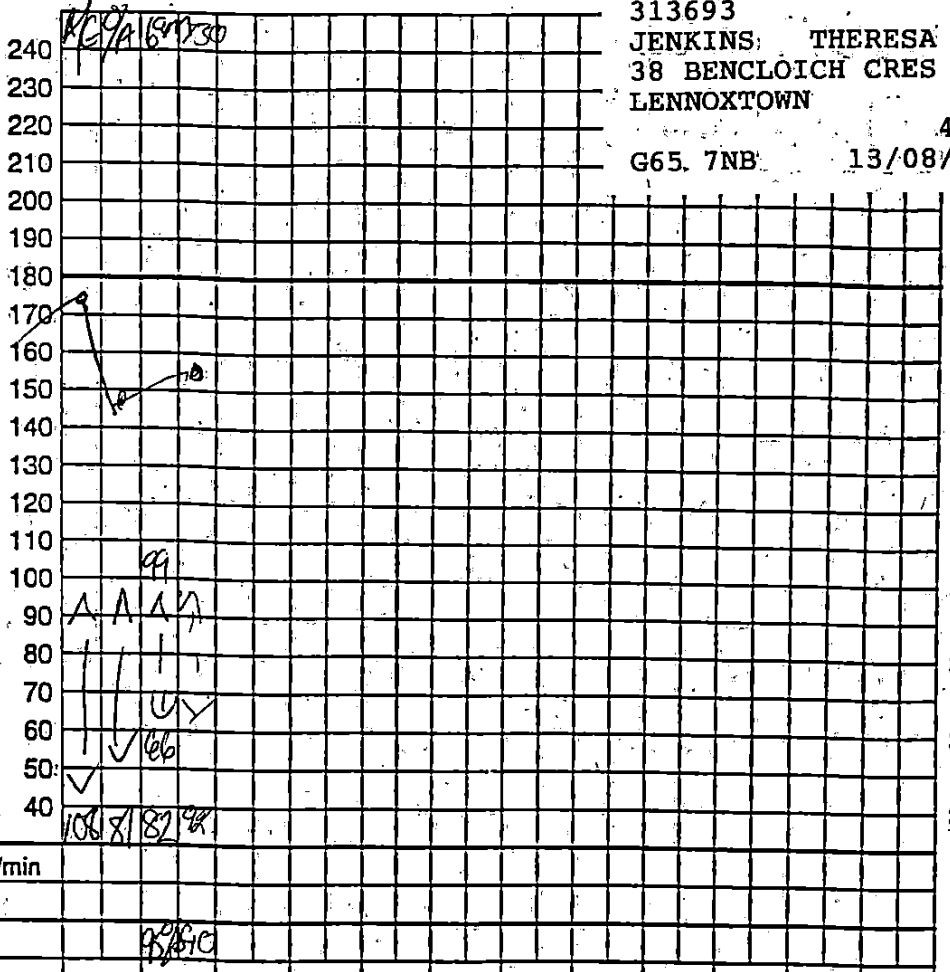
CS ☐

FOB ☐

Other Information :

16-6-99

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963



Blood Pressure and Pulse rate

Tempera °C

Pulse

Respiration Rate/min

Regular/irregular

0.2 Sat

Size

BM Stix

Weight

Urinalysis	Colour	S.G.	Reaction	Sugar	Blood	Protein	Ketones	Bile	Others

Comments

RING SCORES IN TABLE. ADD TOTAL. SEVERAL SCORES PER CATEGORY

CHILD/WEIGHT FOR HEIGHT

verage	0
bove average	1
base	2
elow average	3

CONTINENCE

Complete/Catheterised	0
Occasion Incont.	1
Catheterised/Incontinent of Faeces	2
Doubly Incont.	3

SKIN TYPE VISUAL RISK AREAS

Healthy	0
Tissue paper	1
Dry	1
Oedematous	1
Clammy (Temp up)	1
Discoulered	2
Broken / Spot	3

If patient has discoloured or broken skin on pressure area mark site + grade of sore in pressure sore 1 or 2 core care plan.

MOBILITY

Fully	0
Restless/Fidgety	1
Apathetic	2
Restricted	3
Inert/Traction	4
Chairbound	5

SEWAGE

Male	1
Female	2
14–49	1
50-64	2
65-74	3
75-80	4
81+	5

APPETITE

SPECIAL RISKS

TISSUE MALNUTRITION

e.g. Terminal Cachexia
Cardiac Failure
Peripheral Vascular Disease
Anaemia
Smoking

NEUROLOGICAL DEFICIT

e.g. Diabetes M.S.. CVA..
Motor/Sensory Paraplegia

MAJOR SURGERY / TRAUMA

Orthopaedic - Below waist spinal

On table > 2 hours

MEDICATION

Steroids Cytotoxics
High dose Anti-Inflammatory

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
G65 7NB 13/08/1963 43261

Date	Score	Mattress	Cushion	Date next di

STOBHILL

PATIENT PROGRESS / EVALUATION

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

Date	No.	Progress/ Evaluation	All entries must be signed
16-6-99		E/A via A+E presenting with O/D	
		Diazepam ? amount & Alcohol	
		? 10 x 5mg Diazepam tablets	
		Imp: As above	
		Plan: Routine Bloods/CXR/ECG	RSD
		IV ACCESS	4 hrly PR
		Paracetamol/Salicylate levels	(J)
		Monitor O2 Saturations	
		IV Annexate if required	
		Observe overnight	F Kane
	5 5am	O2 Sats on air 95%.	
	am	DR Gwin	
		- allow to awake	
		- medically fit.	
		- refer psych.	
		- indent awaited	
		Psychiatric review - fit for discharge	
		Will make referral to alcohol services	
		Not formally discharged	H Fisher

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress/ Evaluation	***All entries must be signed***

STOBHILL PATIENT PROFILE Ward 1LA

Type / source of admission

EA via

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
43261
G65 7NB 13/08/1963

AFFIX DATA LABEL

no Hx from Patient on admission

Religion

Alliergies

Next of kin informed Husband: no one available at time of patient admission

Medical reasons for admission Overdose of alcohol ↑c diazepam.

Patient's understanding of admission Rousable but not able to comprehend.

Relative's understanding of admission none with patient

General condition on admission drowsy but rousable.

PATIENT PROFILE
(Continued)

Social circumstances Occupation Hobbies / interests
Medical history
Medication list
Valuables / belongings
Other information

Signature of Assessment Nurse H Broadbent Date 16/6/99 Time 5am

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

NURSING ASSESSMENT

WARD 12A

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN
G65 7NB 43261
13/08/1963
AFFIX DATA LABEL

Maintaining Safe Environment
cotsides on bed for patient safety.

Communication
unable to assess.

Hearing Aid Y/ N

Spectacles Y / N

Breathing / Circulation
not breathless on admission

Resps

B.P. 96/56

Pulse 81

Smoker Y/ N ?

S0294

Eating / Drinking
?

Dentures ?

Elimination
?

Urinalysis

Personal Cleansing / Dressing
Basin / Assisted wash during period of bedrest.

CONTINUED OVER /

NURSING ASSESSMENT
(Continued)

Controlling Body Temperature	Temp. 35.2
Mobilisation ~~Bedrest~~ on admission	Weight Waterlow - score
Expressing Sexuality not discussed	
Sleeping	
Pain	
Socialization ? Alcohol intake	
Dying	Minister / priest

Signature of Assessment Nurse H Brown Date 16/6/99 Time 5am

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

SPECIMEN / INVESTIGATIONS

WARD

313693 F/M
JENKINS THERESA
D 38 BENCLOICH CRES
U LENNOXTOWN 43261
G65 7NB 13/08/1963
AF. IX DATA LABEL

DATE ORDERED	SPECIMEN	DATE OBTAINED

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL

STOBHILL DISCHARGE PLAN

WARD .....

Proposed discharge date
Discharge date

NAME
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

Patient informed	Relative informed
Transport arrangements	Clothing requested for discharge

Medication / G.P.'s letter	
Out-patients appointment	Ambulance required
Social services: Social worker Home help Meals on wheels Other	
District nurse	
Aids and equipment	
Other needs	
Discharge summary / comments psychiatric review – will be referred to alcohol assessment service Not formally discharged	

Signature of Discharge Nurse M Fisher Date 16/6/99 Time 11·30 am

Signature of Named Nurse _____ Date _____ Time _____

CONFIDENTIAL NUMBER 5172

IMMEDIATE DISCHARGE & MEDICINE PRESCRIPTION FORM

PATIENT AND GP LABELS MUST GO ON ALL FOUR COPIES

DR. J HENDERSON
MAIN STREET
LENNOXTOWN

G65 7DD
G.P. Prac: 43261

313693 F/M
JENKINS THERESA
38 BENCLOICH CRES
LENNOXTOWN

43261
G65 7NB 13/08/1963

STOBHILL HOSPITAL
GLASGOW G21 3UW
TELEPHONE 0141 201 3000

DATE OF ADMISSION 15.6.9(
DATE OF DISCHARGE
WARD
CONSULTANT DR Erwin

DIAGNOSIS
1. Delirium OD - drug reaction
2.
3. Reviewed by psych
4. on ward

OPERATION / PROCEDURES
1.
2.
3.

FOLLOW UP ARRANGEMENTS

OUTPATIENT/DAY HOSPITAL APPOINTMENTS

CONSULTANT	CLINIC	WHEN	DATE GIVEN	INITIALS

OUTPATIENT INVESTIGATIONS N.B. (request cards must be provided)

			DATE GIVEN	INITIALS

AMBULANCE REQUIRED YES / NO
WALKING
2 HANDED SEAT
STRETCHER
ESCORT.
Tick as necessary

OTHER NEEDS (SPECIFY)

COMMUNITY CARE ARRANGEMENTS ARRANGED BY

HOME HELP ____ DAY CARE ____ PHYSIO ____
MEALS ON WHEELS ____ DN OR HV ____ OT ____

SPECIAL DISPENSING INSTRUCTIONS
☐ LARGE PRINT ☐ NO C.R.C. ☐ OTHER

DISCHARGE MEDICATION

Medicine	Form	Dose	Times of Administration	Recommended Duration from discharge (Days)	No.of Days Supplied	Quantity, Name Strength & Manufacturer Supplied

PHARMACY USE ONLY

OTHER TREATMENT AND COMMENTS (including details of drug sensitivities, appliances etc.)

Irregular Discharge

DISPENSED BY
CHECKED BY
DATE CP CHECK

MEDICINES COLLECTED BY (MESSENGER)

WARD USE ONLY

RECEIVED ON WARD BY
ISSUED BY
DATE ISSUED
SIGNATURE OF RECIPIENT

DR.'s NAME IN BLOCK CAPITALS Iqbal DATE 16/6/99
SIGNATURE Iqbal PAGER No. 4195

COPIES TO : WHITE - GP, PINK - MEDICAL RECORDS, BLUE - PHARMACY, YELLOW - LIASON

STOBHILL HOSPITAL

OUTPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STAUS
				W

313693 F/M

JENKINS THERESA

38 BENCLOICH CRES

LENNOXTOWN

43261

G65 7NB 13/08/1963

TEL. No.

DR. J HENDERSON
MAIN STREET
LENNOXTOWN

G65 7DD
G.P. Prac. 43261

TEL No.

DATE | SPECIALITY MEDICAL | CONSULTANT'S NAME DR. DANESH

9 SEP 1999 Wgt 57 Kgs

20 APR 2000

D.N.A.

FORM 1

DATE	URINE			
	Reaction	Albumin	Sugar	Ketones
	Weight (In kilogrammes)			
	PHYSICAL EXAMINATION			

Accident and Emergency Department
Stobhill Hospital

RMS

23004807E

A&E No. 07004632

Surname	SINCLAIR	**Forename**	TERESA	**Title:** MS
Address:	38 Bencloich Crescent Lennoxtown GLASGOW	**Postcode**	G66 7NB	**CHI No:**1308636407
		Telephone:		
Date of Birth:	13.08.63	**Sex:**	F	**Age:** 43 yrs

GP Name:	HENDERSON JAMES			
Address:	LENNOXTOWN CLINIC 103 MAIN STREET LENNOXTOWN	**Postcode**	G66 7DA	14A
		Telephone:	01360310357	

Next of Kin	
Relationship:	
Address:	**Postcode**
	Telephone:
Primary Carer:	

Date of Attendance: 02.07.07 01:08
Date of Incident:
Presenting Complaint: OVERDOSE

Triage	**Tetanus Cover:**
	Allergies:
P= **BP=** / **RR=**	**Sat=** **BM=**
PF= **GCS=E:** **M:** **V:** **Total:**	

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

© 1998 - 2007 HAS Solutions Pty. Limited

via ambulance.

23004807E
SINCLAIR
TERESA
CHI-130863640

General Notes

c/o ingestion of 16 ~~Fresh~~ + Ciders
tablets of paracetamol. + Irish meadows.
at ~12:30 AM
wanted to ~~KB~~ sleep forever. own tablets;
still wants to kill herself,
does not regret it.
denies previous mental health problems | DSH | Lives.
Alcohol abuse +, denies any suggested overdose | any other above probs.
B.P- 107/83, HR-98/min Sats -96% Temp-36.
Chest- Clear B/L equal air entry. nil adventitious.
VS- S_1+, S_2+ nil added.
Abd soft, BS+nt no guarding, no rigidity. BS+nt

- Levels at 4hrs ✓ PCM+ salicylate.
- CPN R/V.
- U+E, LFT, F-BC.

PCM-129.

Have you considered Child Protection? (Please Circle)

ser

N/A No Yes (Refer to Child Protection flow chart)

DISCHARGE CODES: (*Please circle*)

1. Admission 2. Refer to G.P. 3. Discharge 4. Died 5. DOA 6. Refer to O.P. (see below)

7. Transfer to other hospital (see below) 8. Irregular Discharge

ADMISSION:

Ward No. (*if admitted*)	Transfer to Hospital

FOLLOW-UP:

None:	Arranged:	We will arrange:

SERVICE/CLINICAL REFERRAL:

AE	Dressing	Hand	Fracture	Ortho	Medical	Surgical	Skin	ENT	Gyn	OHPAT	IRIS	Other (specify)

Doctor/ENP name (*PRINT*)

NAVNEET DUA

CON AS SpR SG SHO3 SHO FY1 FY2 CA ENP (*please circle*)

Signature of Doctor/ENP

CODE:

© 1998 - 2007 HAS Solutions Pty. Limited

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

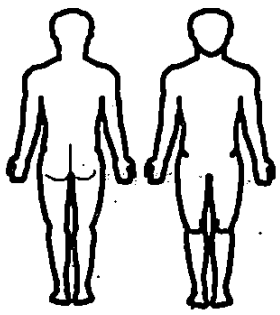
CCS INCIDENT No. Z16936O

Last Name: Sinclair
First Name: Theresa
Location: 9 MAINSTLENNOX TOWN
Age: 43
Sex: F
D of B: 13/08/63

Date: 02/07/07
Time of Call: 0020
Time at Patient: 0036
Time Left: 0045
AMPDS Code: 23C08I
AMPDS Revised:

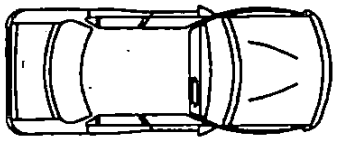
Airway Clear: Y | Suction: | N/OPA: | ET: | LMA: | Successful ?: | C-spine Injury:
Breathing: Y | Rate: N | BVM: | Ventilation: | Successful ?: | Paralysis: | Fitting:
Pulse: Y | Rate: F | CPR: | IV/IO: | Fluids: | Successful ?: | ECG:
Disease above unable to
Clear Airway: | Detect breathing: | Detect pulse: | A

Injury Site	#	Pain	Splint	Dressed
Head				
Neck				
Ch				
Abdomen				
Back				
R/Arm				
R/Leg				
L/Arm				
L/Leg				



RTA:
Trapped:
Ejected:
M / cyclist:
Cyclist:
Pedestrian:
>20 min. Extricate:

Temp. °C
PEFR %
B. Sugar mmol



Allergies: NKA
Medication: nill
Assisted by and Name -
Doctor: Nurse: Other:

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
0037	115	18	152	085	FCN 98	456		9 R

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result Rhythm

Condition at STOB hospital | Pulse: Y | Breathing: Y | Conscious: Y | Time at Hospital: 0108

History and Additional Information: 999 - 43yr old (F) who claims to have taken 16 paracetamol, & has been drinking all day. Has overdosed previously. Police in attendance.

H/x: alcohol abuse, depression Med: omeprazole.

Working assessment: | Diagnosis Code:

Crew Name 1: LBAIRD | Grade: A
Crew Name 2: DMILLER | Grade: A

Greater Glasgow Primary Care NHS Trust

NHS
Greater Glasgow and Clyde

Out of Hours Psychiatric Nursing Service
Siemens Business Park
Boydstone Road
G58 1SB

NAME : TERESA SINCLAIR DOB : 13/8/63
ADDRESS : 38, BENCLOICH CRES
LENNOXTOWN, G66 7NB.

Dear Colleague,

The above named person was assessed in your Accident and Emergency Department on 2/7/07

Appropriate Referral: Yes ☑
No ☐ (If no give reason)

SUMMARY 43 YR OLD FEMALE C LONG HX ALCOHOL DEPENDENCE (BINGE DRINKING) EVERY 1-2/52 FOR PERIODS OF UP TO 10 X 2/52. DRINKING ON THIS OCCASION SINCE THURSDAY LAST, UNSURE ABOUT EXACT AMOUNTS BUT KNOWS IT WAS BOTTLES OF CIDER, IRISH MEADOW/VODKA. STATES OD C PARACETAMOL WAS IMPULSIVE AND PROMPTED BY ARGUMENT/PHYSICAL CONFRONTATION C PARTNER. BELIEVES WANTED TO DIE AT TIME, BUT NOW CERTAIN SHE DOES NOT. NO ONGOING SUICIDAL PLAN/INTENT. ALLUDED TO BEHAVIOURAL PROBS AGE 13YRS, WAS REFERRED TO CARADOS AT THAT TIME.

Imp:- IMPULSIVE OD PROMPTED BY ARGUMENT C PARTNER WHILST INTOXICATED.

Signature .....

PLAN:- DISCHARGE HOME IF MEDICALLY FIT, FOLLOW UP VIA GP ? REFERRAL TO CAT. NO CLEAR EVIDENCE OF AGGRESSIVE SX.

STOBHILL PATIENT PROFILE Ward IGA

Type / source of admission

Bych referal to AIC

23004807E
SINCLAIR F
TERESA 13/08/1963
38 Bencloich Crescent
Lennoxtown
GLASGOW G66 7NB
CHI-1308636407

AFFIX DATA LABEL

Religion Catholic

Alliergies NKDA

Next of kin informed ~~Date~~
Partner Eddie Devlin : In Prison.
Sister Jan Sinclair : 312229.
01360

Medical reasons for admission Overdose of Paracetamol x16 tablets with alcohol

Patient's understanding of admission Aware

Relative's understanding of admission Aware . Informed by Staff.

General condition on admission Pale , drowsy

00599/1

PATIENT PROFILE

(Continued)

Social circumstances Livesalone.

Occupation Unemployed

Hobbies / interests

Medical history Depression
Alcohol Abuse.

Medication list ~~Act~~ error
Omeprazole.

Valuables / belongings Inlocker.

Other information

Dr. J HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN

G66 7DA

Signature of Assessment Nurse [signature] Date 02/07/07 Time 08[illegible]

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

NURSING ASSESSMENT

WARD 14A

NAME MS T SINCLAIR
ADDRESS 38 Bencloich Crescent
Lennoxtown
GLASGOW
G66 7NB

D.O.B. 13/08/63
UNIT No. 230048076

AFFIX DATA LABEL

Maintaining Safe Environment Independent lady who is on bed rest

Communication Speech Clear

Hearing Aid Y/(N)

Spectacles (Y)/N

Breathing / Circulation No problems

Resps 16 B.P. 141/79

Pulse 93 Smoker (Y)/N 20 per day

Saturations 98% on air

Eating / Drinking No special diet. poor appetite

Dentures N/A

Drinks approx 20 units per day.

Elimination No problems

Urinalysis

Personal Cleansing / Dressing Self caring

CONTINUED OVER /

NURSING ASSESSMENT

(Continued)

Controlling Body Temperature	Temp. 36.5°C
Mobilisation Independent	Weight 54kg Waterlow - score
Expressing Sexuality Not discussed	
Sleeping Sleeping poorly	
Pain No pain	
Socialization family	
Dying Not discussed	Minister / priest

Signature of Assessment Nurse [signature] Date 02/07/07 Time 0840

Signature of Named Nurse _____ Date _____ Time _____

STOBHILL

PATIENT PROGRESS / EVALUATION

23004807E
SINCLAIR F
TERESA 13/08/1963
38 Bencloich Crescent
Lennoxtown
GLASGOW G66 7NB
CHI-1308636407

AFFIX DATA LABEL

All entries must be signed

Date	No.	Progress/ Evaluation	
04/07/07	0845	Patient admitted via A+E after taking Paracetamol 500mg x16 tablets and alcohol. Plan: Routine bloods ECG Parvolex - 1st bag given in A+E Coag / LFTs. Nasheen seen by CPN - F/U w/c G.P. CAT.	
		Paracetamol 129, Salicylate - <40. 2nd bag IV Parvolex commenced @ 12mls/hr.	
		S/w Dr Cleland, continue parvolex. Rpt LFTs, coag in am. ?home tomorrow. Medical	
		Patient was seen by CPN in A+E - impulsive overdose prompted by argument w/ partner whilst intoxicated. Discharge home if medically fit. Follow up via G.P. Agreed to CAT. No clear evidence of depression	
	1110	Obs Stable as charted Parvolex continues. No complaints offered Pt self discharge	
		Written Discharge Book S. appt	

PATIENT PROGRESS / EVALUATION

(Continued)

Date	No.	Progress/ Evaluation	***All entries must be signed***

STOBHILL

SPECIMEN / INVESTIGATIONS

WARD 16A

MS T SINCLAIR

NAME
ADDRES 38 Bencloich Crescent
Lennoxtown
GLASGOW
G66 7NB

D.O.B. 13/08/63
UNIT No. 230048076

AFFIX DATA LABEL

DATE ORDERED	SPECIMEN	DATE OBTAINED
02/07/07	MSU	02/07/07

INVESTIGATION	DATE	AMBULANCE	ESCORT	HOSPITAL

00599/4

STOBHILL DISCHARGE PLAN

WARD .....

Proposed discharge date
Discharge date

NAME
ADDRESS

D.O.B.
UNIT No.

AFFIX DATA LABEL

Patient informed	Relative informed
Transport arrangements	Clothing requested for discharge

Medication / G.P.'s letter	
Out-patients appointment	Ambulance required
Social services: Social worker Home help Meals on wheels Other	
District nurse	
Aids and equipment	
Other needs	
Discharge summary / comments	

Signature of Discharge Nurse _____ Date _____ Time _____

Signature of Named Nurse _____ Date _____ Time _____

Patient's name Theresa Sinclair Age _____ Date of Birth 13·08·63

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 02/08/07 Time 0110 Triage Nurse PMASSON PC OTD

Paracetamol x 16 approx 30 mins ago
c Alcohol +++

Triage category 1 2 (3) 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) 01.15
HR: 98
BP: 107/83
RR: 18
SaO_2: 96%
Temp: 36°
G.C.S:
Signed

55kg

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS

TIME	hrs	
EYES OPEN	spontaneously 4	1 eye closed by swelling =C
	to speech 3	
	to pain 2	
	none 1	
BEST VERBAL RESPONSE	orientated 5	Endotracheal tube or Tracheostomy = E Dysphaisa=D
	confused 4	
	inappropriate words 3	
	incomprehensible sounds 2	
	none 1	
BEST MOTOR RESPONSE	obey commands 6	Record the best arm response Paralysed =P
	localises pain 5	
	normal flexion to pain 4	
	abnormal flexion to pain 3	
	extention to pain 2	
	none 1	
COMA SCORE 15		

PUPILS	RIGHT	size (mm) / Reaction	2 += Reacts - =No Recaction C= Eye closed SL= sluggish pupil
	LEFT	size (mm) / Reaction	

LIMB MOVEMENT

ARMS	Normal power	3 Record right (R) and left (L) seperatly if there is a difference between the two sides Fractured limb = #
	Mild weakness	
	Severe weakness	
	Extention	
	No response	
LEGS	Normal power	
	Mild weakness	
	Severe weakness	
	Extention	
	No response	

PUPIL SCALE (mm): 1 2 3 4 5 6 7

BLOOD PRESSURE mm Hg: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90

PULSE RATE: 80 70 60 50 40 30

4: 40 39 38 37 Temp C° 36 35 34 33 32 31 30

5 RESPIRATORY RATE

SaO_2

NURSE INITIALS 6

BLOOD GLUCOSE / BM STIX	Time	01.15
	BM	7.3
PEAK FLOW	Time	
	PF	
VISUAL ACUITY	R. eye aided/unaided	
	L. eye aided/unaided	
	pH L. eye	R. eye

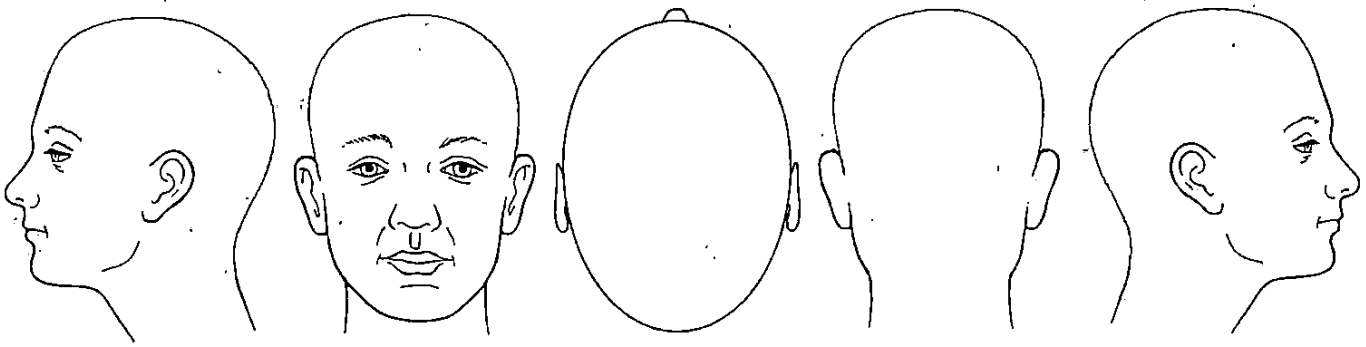
Signed:

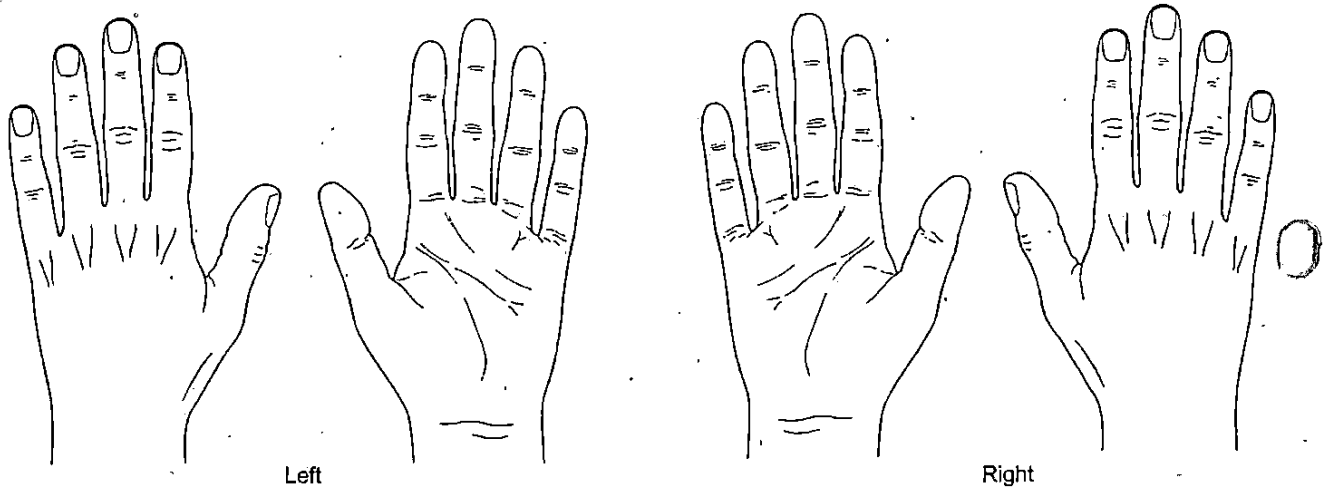
URINALYSIS

Urobilinogen µmol/L	Normal 3 16	33	66	131			
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

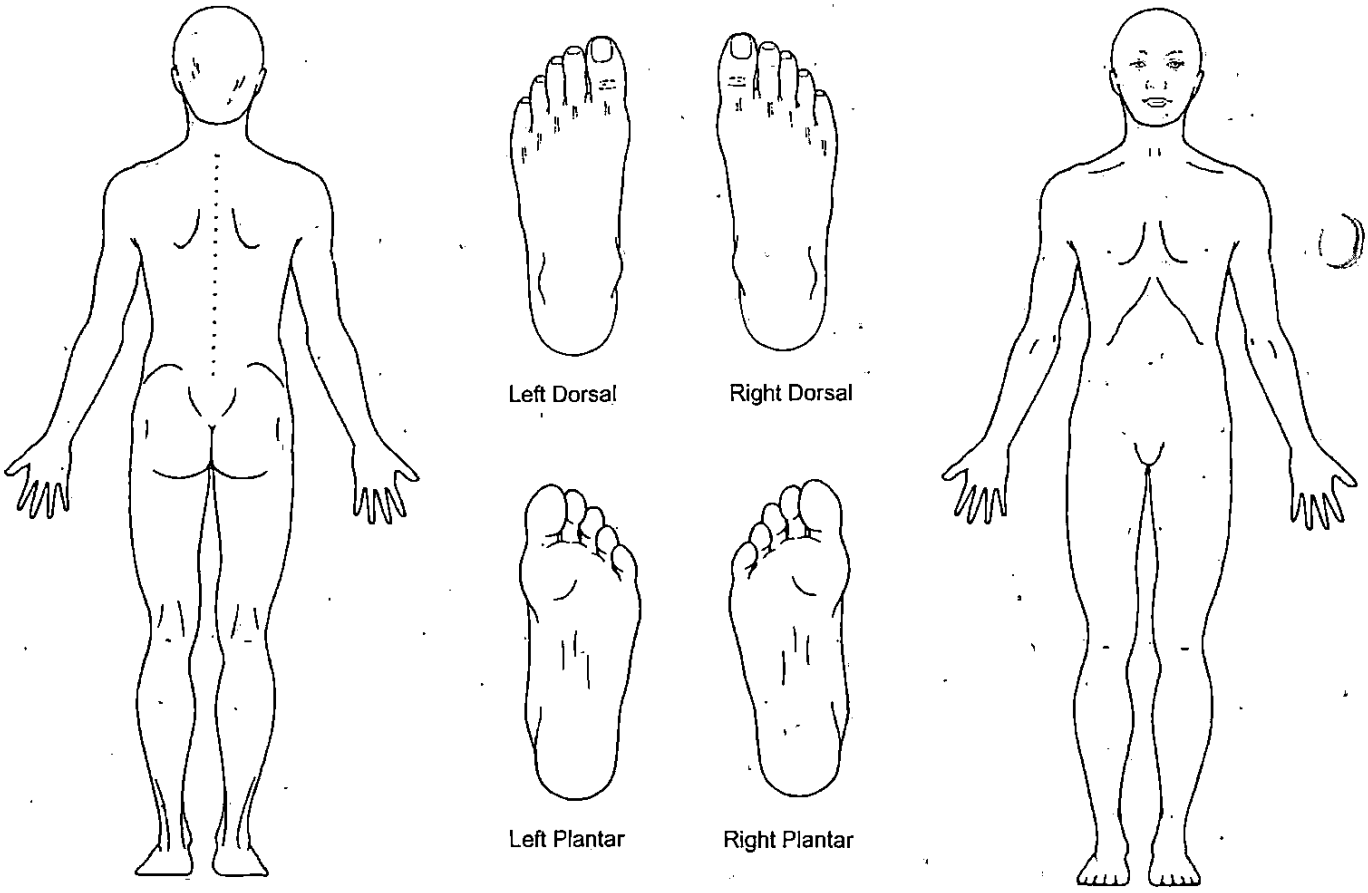
Signed: _____

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds





Dorsal Left Palmar Palmar Right Dorsal



Left Dorsal Right Dorsal

Left Plantar Right Plantar

Signed _____

NURSING NOTES

Signature: [illegible] Time: 01.15

Initial Management

02 Y/N Litres Per Min

ECG Y/N X-ray Y/N

Urinalysis:

History Says she took 16 paracetamol 2 days ago. History of depression + alcohol abuse.

PMH Depression, Alcohol abuse

DH ~~None~~ Omeprazole.

Allergies No/Yes

None.

βHCG +ve -ve

Cannula Y/N

Bloods Y/N

U & Es ☐

FBC ☐

GL ☐

Amyl ☐

Coag ☐

Group ☐

D. Dimers ☐

Other:

Social History	NOK	Not / present
		Keys / valuables
	Social Services	Not / contacted

MEDICAL NOTES - HISTORY and EXAMINATION

Consultant Dr. Cleland. Seen by Saunders

Grade: SpR SHO SHO3 JHO Clin Assist ENP SG AS *(Please circle)* At (time) 0700.

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

Date	
2/7/17	A & E ref Fa
	(43) Prev. DSH.
	+ Alc. XS.
	Presented with OD. — Paracetamol 500mg x 16.
	— Has been drinking for 3/7.
	Impulsive OD.
	Has mentioned to CPN that 'she wanted to die at the time'. Now denies.
	No further suicidal ideation.
	Wanted to jump into water - but didn't - because she doesn't know swimming!
	Feels thirsty
	Nausea° | Vomiting° | aldupan°
	NWSA
	Fruchen

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

AF: 11-32/min.
BP- 107/83

I+11+0
Chest - Clear

PARACETAMOL

NAC level - 129 mg/L (Above high risk & line)
LFT
U&E

Plan: (1) Admit

(2) Planjv fep

(3) Has not had her coags checked — Please check

(4) Has been F/U CPN — Flu & GP

(5) CAT.

Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

	Name	D.o.B.	Sex	Loc.
3004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL CASUA

Specimen N,07.0157352.D Type Specimen
Collected 02.07.07 04:30 A.Diag OVERDOSE

U&E		LFTs		Glucose		CRP	
Sodium	143	AST	30				
Potassium	3.9	ALT	30			CRP	5
Chloride	+ 110	G-GT	33				
Urea	2.6	A Phos	99				
Creat	77	Protein	70				
eGFR	>60	Alb	39				
		Globulin	31				
Bili	6			Glucose	5.2		

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatment levels - 200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high risk patient
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700mg/L, >280mg/L if under 5 years.

...hill Hospital Haematology ** LIVE **
...ient enquiry ---- Express results Result mode : absolute

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL CASUAL

Specimen R,07.0618315.F Type BLOOD
Collected 02.07.07 04:45 A.Diag OVERDOSE

.....FBC.....	
WBC	10.46
RBC	4.41
Hgb	136
HCT	0.396
MCV	90
MCH	30.8
PLT	443
NEUT	3.63
LYMPH	6.33
MONO	0.39
EOSIN	0.03
...ASO	0.08

.....FILM.....
outstanding

...Glasgow Biochemistry & Immunology ** LIVE **
...ent enquiry ---- Express results

	Name	D.o.B.	Sex	Loc.
...004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL CASUAL

...pecimen N,07.0157352.D Type Specimen
...ollected 02.07.07 04:30 A.Diag OVERDOSE

.....Bone.....	
A Phos	99
Protein	70
Alb	39
Globulin	31
Calcium	2.16
Ad Cal	2.23
Phosphate	1.21

.....Osmolal.....
Osmol + 341
.....Parac'mol.....
Pmol mg/L 129
.....Salicylate.....
Salic mg/L <40

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatment levels - 200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h. Less if high risk patient
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700mg/L, >280mg/L if under 5 years.

2/7/7 (43) F c emptying OD of paracetamol + alcohol
If already vomited → discharged.

On paracetamol
finish this, LFT (can have → home

Medical.

S Clelland
LIFEAND
CNS

Stobhill Hospital Haematology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL WARD 1

Specimen R,07.0618344.L Type BLOOD
Collected 02.07.07 08:00 A.Diag OVERDOSE

.....COAG.....

PT	12
APTT	33
TT	13
FIB	231

Stobhill Hospital Haematology ** LIVE **
Patient enquiry ---- Express results Result mode : absolute

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL CASUAL

Specimen R,07.0618315.F Type BLOOD
Collected 02.07.07 04:45 A.Diag OVERDOSE

.....FBC.....

WBC	10.46
RBC	4.41
Hgb	136
HCT	0.396
MCV	90
MCH	30.8
PLT	443
NEUT	3.63
LYMPH	6.33
NO	0.39
SIN	0.03
BASO	0.08

.....FILM.....
unauthorised

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL CASUAL

Specimen N,07.0157352.D Type Specimen
Collected 02.07.07 04:30 A.Diag OVERDOSE

.....Bone.....

A Phos	99
Protein	70
Alb	39
Globulin	31
Calcium	2.16
Ad Cal	2.23
Phosphate	1.21

.....Osmolal.....
Osmol + 341

.....Parac'mol.....
Pmol mg/L 129

.....Salicylate.....
Salic mg/L <40

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatment levels - 200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high risk patient
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700mg/L, >280mg/L if under 5 years.

North Glasgow Biochemistry & Immunology ** LIVE **
Patient enquiry ---- Express results

Reg	Name	D.o.B.	Sex	Loc.
23004807E	SINCLAIR THERESA	13.08.63	F	STOBHILL CASUAL

Specimen N,07.0157352.D Type Specimen
Collected 02.07.07 04:30 A.Diag OVERDOSE

.....U&E.....

Sodium	143
Potassium	3.9
Chloride	+ 110
Urea	2.6
Creat	77
eGFR	>60

.....LFTs.....

Bili	6
AST	30
ALT	30
G-GT	33
A Phos	99
Protein	70
Alb	39
Globulin	31

.....Glucose.....
Glucose 5.2

.....CRP.....
CRP 5

Parac'mol Refer to BNF diagram for paracetamol overdose. Treatment levels - 200mg/L @ 4h, 100mg/L @ 8h, 50mg/L @ 12h.Less if high risk patient
Salicylate Salicylate intoxication >350mg/L, severe toxicity >700mg/L, >280mg/L if under 5 years.

RESULTS PAGE

Please record all results of investigations, time, date and sign. Append all referral letters / SAS report forms, etc to this page.

Date

2/7/7 St03;

Wishes to self dlch
Agrees against med advice
Note c/u by Y – not depressed
dlch from thup.
∴ not determinable

She is competent to make decision + I have explained risks

∴ dlch against med advice

MCL
St03

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug *(BLOCK CAPITALS)*	Dose	Method of Administration	Time of Administration	Signature	Given by

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
2/7	5% Dextrose	250ml	15 min	1L	Pamidex	41ml			07.25	RS	P.M.	06F169 06/2008

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* THERESA SINCLAIR Signature T Sinclair

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date 2/7/07 Signature C. MCINNES

(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

Note: THIS MEDICINE MUST ALSO BE PRESCRIBED ON PATIENT'S MAIN PRESCRIPTION SHEET/CHARDEX

3+ (4)

PRESCRIPTION SHEET NUMBER ..... THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTIONS

PATIENT'S NAME SINCLAIR TERESA 23004907E

HOSPITAL STOBHILL UNIT NUMBER .....

WARD 14A D.O.B. .....

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
PAROLEX	14 mls	5% DEXTROSE 500mls			IV.		

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Conc'n(s) (mg/ml)	Required Flow Rate Setting	Drug Dose per Hour	Prescribed by	Set by	Checked by
Initial rate	24/07	15:00	-	63mls	2.25 mg	[signature]	[signature]	[signature]
Change 1								
Change 2								
Change 3								
Change 4								

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.	24/07	13:20	[signature]	[signature]	[signature]	[signature]
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
24/07	0335	500	0ml	63ml/hr	[signature]	Commenced							
	1435	279ml	220ml	63ml/hr	[signature]	Check							

5 DISCONTINUATION

(Sign): ..... DATE: ..... TIME: .....

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE 'COMMENTS' SECTION.

REF: PAS 1/REV 3/03

PRESCRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE PUMP/ INFUSION PUMP - GUIDELINES ON USE

ONLY APPROPRIATELY PREPARED REGISTERED NURSES MAY PARTICIPATE IN THE PREPARATION AND ADMINISTRATION OF MEDICINES GIVEN VIA A SYRINGE PUMP

THIS FORM IS NOT APPROPRIATE FOR USE IN CERTAIN HIGH DEPENDENCY AREAS:

The medicine should be prescribed in the patient's main prescription sheet, cross referenced by annotating the "other prescription sheets in use section". This sheet should be kept in close proximity to the device in use.

Each prescription sheet should be used to record the prescription, preparation and administration details of syringes or infusion bags which are prepared in accordance with the prescription in Section 1 of the form. **IF THE DETAILS IN SECTION 1 REQUIRE TO BE CHANGED A NEW PRESCRIPTION FORM MUST BE USED.**

Signatures must be written out in full in the appropriate spaces.

The form should be completed as follows:

SECTION 1 : PRESCRIPTION DETAILS:

(i) The prescription must be completed in full by a qualified medical practitioner.

(ii) "Total Amount of Drug(s)" refers to the total quantity of medicine in micrograms, milligrams or units, placed into the container.

(iii) If the medicine is further diluted, the diluent must be noted in the "Diluent" space and total **volume** recorded, ie, medicine + diluent.

(iv) The final concentration of drug in the syringe/bag should be recorded.

(v) The Route of Administration, Intravenous or Subcutaneous, must be recorded.

(vi) The type of infusion device, syringe driver or infusion pump, and the model when selected must be recorded by the doctor or nurse as appropriate.

(vii) The prescriber must sign the space provided.

SECTION 2: FLOW RATE DETAILS:

(i) The dose of drug (in microgram or mg/hour) and the resultant initial flow rate (in ml/hour or mm/hour depending on the device in use) must be prescribed by the Doctor on the "initial rate" line.

(ii) If the infusion rate is set and started by the prescriber, the "set by" section should also be signed. If this is done by two registered nurses/midwives, both "set by" and "checked by" sections should be signed.

(iii) Any subsequent alterations in dose and flow rate must be prescribed by the Doctor on the "Change" lines except for prescribed variable dose/sliding scale regimes (see (iv)).

(iv) When a **"VARIABLE DOSE REGIME"** (eg sliding scale insulin) has been prescribed, this should be recorded on the "initial rate" line and all changes recorded in the "Comments" section as appropriate.

SECTION 3: PREPARATION DETAILS:

If the final product (syringe or infusion attached to pump) is prepared by:

(i) a Qualified Medical Practitioner, then he/she must sign the "prepared by" space, or,

(ii) a Registered Nurse or Midwife, if calculation or dilution is involved, the preparation of the infusion should be witnessed by another Registered Nurse or Midwife. The "Prepared by/Checked by" and "Set by/Checked by" sections must be signed. Preparation of fresh infusions **of the same prescription** should be recorded on subsequent lines.

SECTION 4: ADMINISTRATION CHECK:

(i) The infusion must be checked at regular intervals, as indicated on the sheet, during the period that the pump is in use. Each section must be completed in full.

(ii) The "Comments" section should be used to record observations, including site checks. All unexpected events must be brought to the attention of the Nurse or Doctor in charge.

SECTION 5: DISCONTINUATION:

When the administration is to be discontinued, the prescriber should complete the appropriate sections on the sheet and on the main Kardex prescription sheet. A line should be drawn through each prescription to prevent continued use. Local guidelines for the "Duration of Use" should be followed prior to renewing the syringe/bag.

STOBHILL HOSPITAL
24 HOUR FLUID CHART

NHS Greater Glasgow

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sinclair	Teresa	

DATE 02/07/07

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			12 mid.					
			1 a.m.					
			2 a.m.					
			3 a.m.					
			4 a.m.					
			5 a.m.					
			6 a.m.					
Admitted			7 a.m.					
			8 a.m.					
			9 a.m.					
			10 a.m.					
			11 a.m.					
			12 noon					
			1 p.m.					
			2 p.m.					
			3 p.m.					
			4 p.m.					
			5 p.m.					
			6 p.m.					
			7 p.m.					
			8 p.m.					
			9 p.m.					
			10 p.m.					
			11 p.m.					
TOTALS								
TOTAL INTAKE							TOTAL OUTPUT	

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results		Time	
Serum:	Urea		
	Sodium		
	Potassium		
	Chloride		
	Bicarbonate		
	Creatinine		
Urine:	Urea		

No. 00260

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name
A23004807E 13/08/1963
TERESA SINCLAIR
38 Bencloich Crescent
Lennoxtown
GLASGOW
Hospital No.
G66 7NB CHI-1308636407
D08

Admitted Date 02/07/07 Ward 16A
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

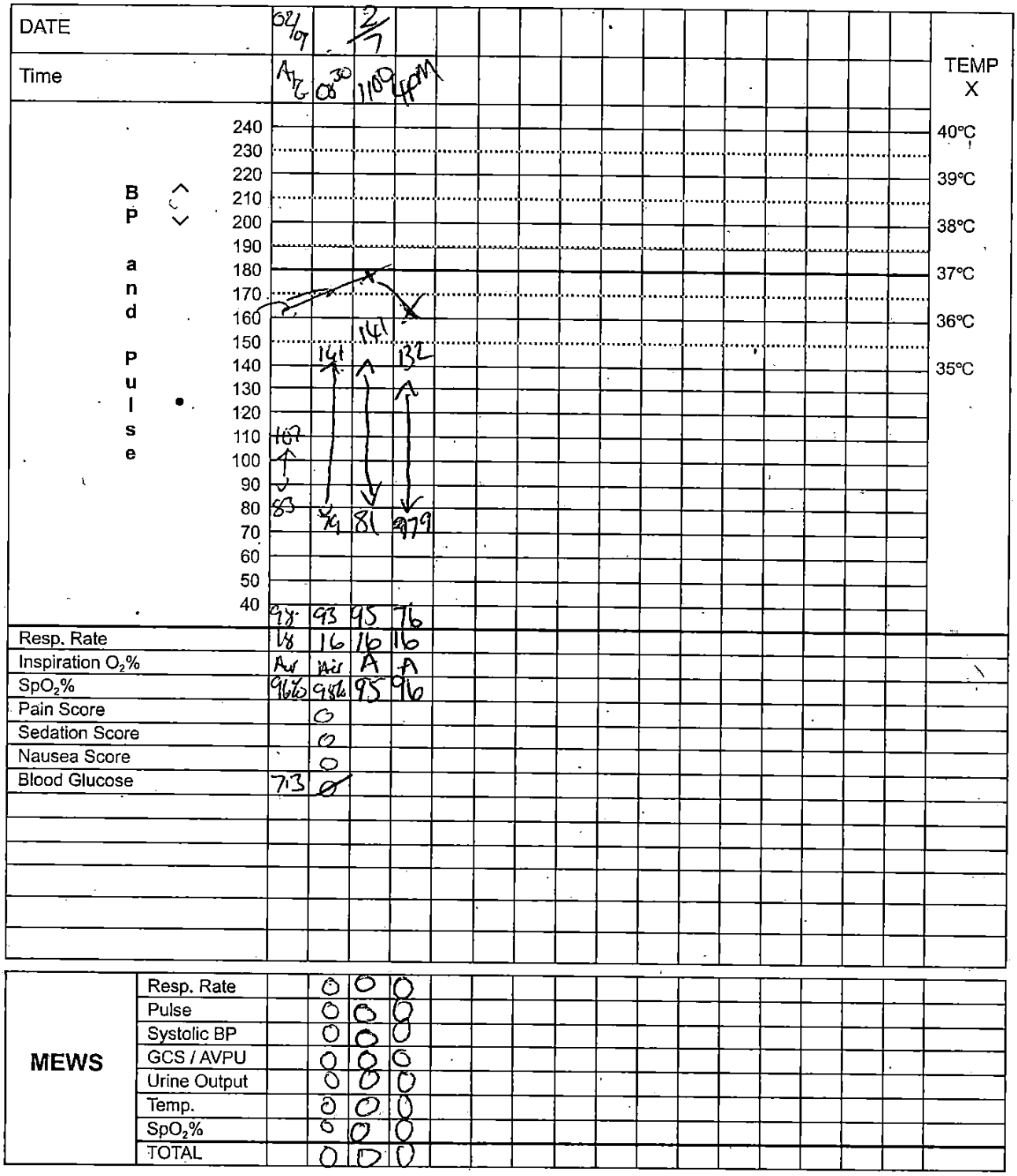
Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.



Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO2%	≤87	88-91	92-94	95-100			

DATE																		TEMP X
Time																		
BP ^ v and Pulse •	240																	40°C
	230																	
	220																	39°C
	210																	
	200																	38°C
	190																	
	180																	37°C
	170																	
	160																	36°C
	150																	
	140																	35°C
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
	50																	
	40																	
Resp. Rate																		
Inspiration O_2%																		
SpO_2%																		
Pain Score																		
Sedation Score																		
Nausea Score																		
Blood Glucose																		
MEWS	Resp. Rate																	
	Pulse																	
	Systolic BP																	
	GCS / AVPU																	
	Urine Output																	
	Temp.																	
	SpO_2%																	
	TOTAL																	

Calling Criteria

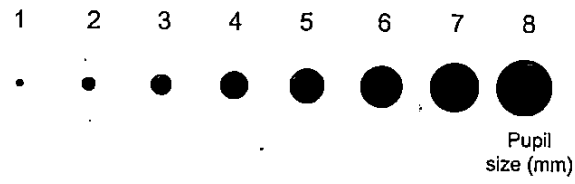
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

DATE																				
Time																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropropriate 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																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Glasgow Coma Scale



DATE																				
Time																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		Inappropropriate 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																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

CARE PLAN WARD 14A

NHS Greater Glasgow and Clyde

23004807E
SINCLAIR :
TERESA
CHI-1308636407

UNIT NO:

DATE OF ADMISSION : 02/07/07

SIGNATURE OF REGISTERED NURSE :

PROVISIONAL DIAGNOSIS :

Recording of Vital Signs

BP	Pulse	Temp.	Resp.	Colour	Peak Flow	CNS	CVP	Fluid Balance	Urine Volume
☑	☑	☑	☑	☑	☐	☐	☐	☑	☑
6 hrly	6 hrly	6 hrly	6 hrly	6 hrly	— hrly	— hrly	— hrly	6 hrly	

Monitoring / Recording of Observations

IV Cannula	IV Infusion	Chest Drain	Telemetry	Cardiac Monitoring	BM Stix	ECG during Pain
☑	☑	☐	☐	☐	☐	☐
6 hrly	1 hrly	— hrly	— hrly	— hrly		

Medications (Prescribed)

Analgesia	Drug Infusion	Nebulised Therapy	O_2 therapy
☐	☑	☐	☐
— hrly	1 hrly	— hrly	— hrly

via syringe Drive	via O_2	O_2 %	via Infusion Pump	Nebuliser Compressor Pump	Flow Rate
☐	☐	☐	☑	☐	☐

Hygeine

Bed bath (2 Nurses)	Assisted wash (1 Nurse)	Shower bath (Independent)	Ambu / Shower (Supervised)	Independent but on bed rest
☐	☐	☐	☐	☑

Mouth Care	Eye Care	Nasal Care	Catheter Care	Wound Care
☐	☐	☐	☐	☐
— hrly	— hrly	— hrly	— hrly	— hrly

Bladder and Bowel Care

Offer Commode / Urinal	Wheel to toilet	Self Care	Catheter Care	Continence Aids
☑	☐	☐	☐	☐

Stool Specimen for : CS ☐ FOB ☐

Mobilisation

Ambulant ☐

Bed Rest ☑ | Independent ☐ | Supervised ☐ | Positional Change ☐ — hrly | Specialised Bed ☐

Passive Limb Exercise ☐ — hrly

No. of Staff required for M & H ☐ — specify

Moving & Handling Aid ☐ — hrly

DIET

Normal diet ☑ | Light diet ☐ | Special Diet ☐ ——— specify | Nasagastric / Gastronomy feeding. Use in conjunction with feeding chart. ☐

Requires help with feeding ☐ | Restricted Fluids ☐ | Fasting ☐ | Dietetic Advice ☐ | Ice to suck ☐ | Fluids only ☐

Paramedic Services to be Involved

Physiotherapy ☐ | Occupational Therapy ☐ | Speech Therapy ☐

Liaison Services to be Involved

Cardiac ☐ | Respiratory ☐ | Diabetic ☐ | Stoma ☐ | Social Work ☐

Sputum Specimen for :

CS ☐

AAFB ☐

Pathology ☐

Urine Specimen for :

RSOU ☑ | Wound Swab ☐

MSSU ☐ | Specify

EMU ☐

Urinalysis	Colour	A.G.	Reaction

Weight: 54kg

Sugar	Blood	Protein	Ketones	Bile	Others

Bayer HealthCare LLC
Clinitek Status®

Patient: _____

Multistix® 10 SG
Test date 02-07-2007
Time 08:06
Operator
Test number 0594
Color Not Entered
Clarity Not Entered

GLU Negative
BIL Negative
*KET 2+ *
SG 1.015
BLD Negative
pH 5.0
PRO Negative
UBG 3.2 umol/L
NIT Negative
LEU Negative

FALLS RISK ASSESSMENT A.M.R.U.
WARD 14 A

SEX	MALE 1	FEMALE (2)				2
AGE	0-70 (1)	71-80 2	81+ 3			1
GAIT	Steady (1)	Hesitant 1	Poor Transfers 3	Unsteady 3		1
SENSORY DEFICIT	Sight 2	Hearing 1	Balance 2			0
FALSS HISTORY	None (0)	At Home 2	In Ward 1	Both 3		0
MEDICINE	Hypnotics 1	Seditives 1	Hypotensives 1			0
MEDICAL HISTORY	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Unable to 1	0
MOBILITY	Fully Mobile 1	Uses Aid 2	Restricted 3	Bed Bound (1)		1
TOTAL						5

Score 3-8 LOW RISK Score 9-12 MEDIUM RISK Score 13+ HIGH RISK

PATIENT MANAGEMENT

LOW RISK

1. Explain to patient the importance of asking for help when walking.
2. Ensure nurse call buzzer is at hand.
3. Ensure patient's footwear has been assessed as being appropriate.
4. Ensure variable height bed is left in a low position and the brakes are on.
5. Orientate to environment and ensure the area is hazard free.
6. If walking aid is used, ensure it is within easy reach of the patient.
7. If patient has had previous falls, speak to patient and family and offer advice to avoid reoccurence.
8. Initiate Multi-disciplinary falls assessment.

MEDIUM RISK

9. If possible ensure bed is in an area of close supervision.
10. Ensure patient, staff and relatives are aware of the risk of falling and precautions being taken.
11. Refer to Physiotherapist, Occupational Therapist and Podiatry.
12. Highlight risk in nursing notes.

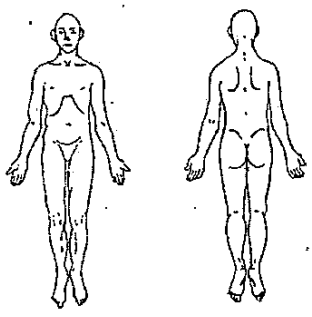
HIGH RISK

As for low and medium risk

13. Ensure maximum supervision at all times.
14. One to one supervision if required.

Signature: ..... Designation: Staff Nurse Date: 02/07/07

Waterflow Risk Assessment														
	Initials:	[illegible]												
	Date:	04/07												
	No.	1	2	3	4	5	6	7	8	9	10	11	12	13
Body weight for height:														
Average	0	0												
Above average	1													
Obese	2													
BelowAverage	3													
Continence:														
Completely catheterised	0	0												
Occasionally incontinent	1													
Cath. Incontinence of faeces	2													
Doubly Incontinent	3													
Skin Type-Visual Risk Areas:														
Healthy	0	0												
Tissue paper/Dry	1													
Oedematous/Clammy (Temp.)	1													
Discoloured	2													
Broken spot	3													
Mobility:														
Fully	0													
Restless/Fiidgety	1													
Apathetic	2													
Restricted	3													
Inert/Traction	4													
Chairbound	5	5												
Age/Sex:														
MaleFemale	1/2	2												
14-49	1	1												
50-64	2													
65-74	3													
75-80	4													
80+	5													
Appetite:														
Average	0													
Poor	1	1												
N.G. Tubes/Fluids only	2													
nbm - anorexic	3													
Special Risks - Tissue Malnutrition:														
e.g. Terminal Cachexia	8													
Cardiac Failure	5													
Peripheral Vascular Disease	5													
Anaemia	2													
Smoking	1	1												
Neurological Deficit:														
e.g. Diabetes, MS., CVA														
Motor-sensory Paraplegia	4-6	0												
Major Surgery/Trauma:														
Orthopaedic														
Below waist; Spinal	5	0												
On table > 2 hours	5													
Medication:														
Cytotoxics, Highdose steroids	4	0												
Anti-inflammatory														
TOTAL SCORE		10												
SCORE: <10 = low risk; 10-14 = at risk; 15-19 = high risk; 20+ - very high risk.												4		



MIS 115449

23004807E
SINCLAIR
TERESA
CHI-1308636407

THIS MEDICINE MUST ALSO BE PRESCRIBED ON PATIENTS MAIN PRESCRIPTION SHEET/KARDEX

PRESCRIPTION SHEET NUMBER ..... (2) THIS DOCUMENT MUST BE RETAINED REFER OVERLEAF FOR INSTRUCTIONS

PATIENT'S NAME .....

HOSPITAL Stoke ..... UNIT NUMBER .....

WARD 14A ..... D.O.B. 13/03/67

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
Ranitidine	14ml	5% Dextrose	500ml	—	IV		

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Conc'n(s) (mg/ml)	Required Flow Rate Setting	Drug Dose per Hour	Prescribed by	Set by	Checked by
Initial rate	2/7	0935	—	125ml/hr	4.5ml/hr		KWBaylis	JWilkins
Change 1								
Change 2								
Change 3								
Change 4								

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.	02/07	0830	KWBaylis	JWilkins	KWBaylis	JWilkins
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
02/07	0835	500	0	125ml/hr	KWBaylis	Commenced							
	1050	210	290ml	125ml/hr	KWBaylis	Check							
	1320	Complete											

Note [redacted]E MUST ALSO BE PRESCRIBED ON PATIENT'S [redacted] IN PRESCRIPTION SHEET/KARDEX

23004807E
SINCLAIR F
PRESCRIPTION SHEET TERESA 13/08/1963
38 Bencloich Crescent
Lennoxtown
PATIENT'S NAME GLASGOW G66 7NB
HOSPITAL CHI-1308636407 UNIT NUMBER
WARD D.O.B.

THIS DOCUMENT MUST BE RETAINED

REFER OVERLEAF FOR INSTRUCTIONS

Prescriptions and Administration sheet for medicines given by Syringe / Infusion Pump
Each prescription must be completed fully and unambiguously. FULL SIGNATURE TO BE USED

1 PRESCRIPTION DETAILS (to be completed by DOCTOR before start of therapy)

MEDICINE(S)	TOTAL AMOUNT OF DRUG(S) in syringe / bag	DILUENT	TOTAL VOLUME in syringe / bag	DRUG CONC'N(S) (mg/ml)	ROUTE	TYPE SYRINGE PUMP OR INFUSION PUMP MODEL:	PRESCRIBERS SIGNATURE
Ranitidine	41ml	5% Dextrose	250ml	—	IV		

2 FLOW RATE DETAILS (to be completed by DOCTOR and NURSING STAFF)

	Date	Start Time	Drug Conc'n(s) (mg/ml)	Required Flow Rate Setting	Drug Dose per Hour	Prescribed by	Set by	Checked by
Initial rate	2/7	0700	—	500ml/hr	162 ml		RG.	P.H
Change 1								
Change 2								
Change 3								
Change 4								

3 PREPARATION DETAILS (to be completed by DOCTOR or NURSING STAFF)

	Date	Time	Prepared by	Checked by	Set by	Checked by
Initial Prep.						
Rpt. 1						
Rpt. 2						
Rpt. 3						
Rpt. 4						

4 ADMINISTRATION CHECK (to be completed HOURLY by NURSING STAFF)

Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments	Date	Time	Volume Remaining	Total Volume Infused	Rate Setting	Checked by	Comments
		Given in ATC											

5 DISCONTINUATION

(Sign): DATE: TIME:

NOTE: IF THE 'BOOST' FACILITY OF A SYRINGE DRIVER IS USED, RECORD THIS IN THE [illegible]

PRESCRIPTION FORM

Hospital Name: .....

PATIENT DETAILS

Name: 23004807E SINCLAIR F TERESA 13/08/1963

Hospital Number: 38 Bencloich Crescent Lennoxtown GLASGOW G66 7NB

DOB: CHI-1308636407

Height:

Weight:

Surface area:

Date of writing discharge prescription: __/__/__

Date of Admission: __/__/__

Consultant Name:

Ward:

Date and time this form prepared: __/__/__ Time:

Sheet No .....

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

NKDA

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin ☐

PCA and other infusions ☐

Anticoagulants: Heparin ☐ Oral ☐

Topical: ☐

TPN: ☐

Enteral Nutrition: ☐

Oxygen Therapy: ☐

Other:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE →

MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

A DRUG: PAKVOLEX

DOSE: as charted | ROUTE: IV | DATE: 2.17 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF DOCTOR: WJ

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR DOCTORS USE ONLY

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Nurse/Midwife Administration by Protocol - 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.

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:

   Milligram = **mg** Gram = **g**
   Millilitre = **ml** Microgram: **to be written in full.**
   Units: **to be written in full.**

   Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.
5. Method of administration should be abbreviated as follows:

   Intravenous = **IV** Oral = **O**
   Subcutaneous = **SC** Per rectum = **PR**
   Inhalations = **INH** Topical = **TOP**
   Sublingual = **SL** Nasogastric = **NG**
   Intramuscular = **IM** Vaginal = **PV**
   Intradermal = **ID**

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

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

Ver 7, 07/2005

Gynaecology

STOBHILL HOSPITAL

OUTPATIENT CHART

SURNAME	23004807E SINCLAIR F TERESA 13/08/1963 90A MAIN STREET LENNOXTOWN GLASGOW G66 7DA CHI-1308636407	UNIT NUMBER	PATIEN	Dr. J HENDERSON LENNOXTOWN CLINIC 103 MAIN STREET LENNOXTOWN G66 7DA	L STATUS S W
DATE OF BI		WARD/DEPT	RELIG		
ADDRESS			G.P'S		
TEL. No.			TEL No.		
DATE	SPECIALITY- GYNAECOLOGY		CONSULTANTS NAME	Dr MATHEWS	

COMPLAINT & DURATION

PREVIOUS HISTORY

PREVIOUS OBSTETRIC HISTORY (Summary of pregnancies and deliveries)

Years Married

Gynaecological History	Contraception	F.P.M.	L.P.M.
Cycle	Loss	Clots	Regularly
Dysmenorrhoea		Backache	
Dyspareunia			
Discharge	Quantity		Colour
Micturition-Dysuria			
	Frequency-Day	Night	
Stress Incontinence		Urgency	
Bowels			

History of Present Condition

Abdomen — Breasts

Pelvic Examination — Pap Smear

Diagnosis

Suggested Treatment

Waiting List		Priority	

Seen by — For letter YES/NO

Return

STOBHILL HOSPITAL — OUTPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATUS
				S W
DATE OF BIRTH	23004807E SINCLAIR TERESA 13/08/1963 F 90A MAIN STREET LENNOXTOWN GLASGOW G66 7DA CHI-1308636407	WARD/DEPT	RELIGION	Dr. J HENDERSON LENNOXTOWN CLINIC 103 MAIN STREET LENNOXTOWN G66 7DA
ADDRESS			G.P.'S NAME &	
TEL. NO.			TEL. NO.	

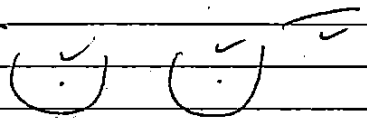
DATE	SPECIALITY Surgical	CONSULTANT Mr. Hunsall.
09 MAR 2018		
27 MAY 2018	Rev'd	

Had Lmp (R) breast

Had Mirena IUS → has had this removed

Pain ↓ and less obvious lmp

O/E



nil palpable with breast area pointed to feels like usual BT same as (L) side

No discrete areas or areas of concern

Discharged

Happy

Mammo see GP if any issues

M. Rowe (Nurse)

DATE	URINE			
	Reaction	Albumin	Sugar	Ketones
	Weight (in kilogrammes)			
	PHYSICAL EXAMINATION			

Results

REMOVE ONE STRIP AT A TIME TO AFFIX REPORT, STARTING FROM BOTTOM LINE

NHS Greater Glasgow and Clyde

Stobhill Hospital

SINCLAIR, Teresa
90A Main Street, Lennoxtown, Glasgow, Stirlingshire, G66 7DA
Referrer: DR DT HANSELL - STOB WARD 5 OUTPATIENT

Diagnostic Imaging Report

DoB: **13/08/1963**
Chi No: **1308636407**
CRIS No: **5135906**
Hosp No: **23004807E**

VERIFIED Verified By: LINDSEY LEEN (Radiog) 11/03/10 1624 and: DR NF DAWSON.

Clinical History : Patient complaining of right breast lump. On examination today at approximately 12 o'clock within the right breast there is a 1 x 1 cm lobular breast tissue. This is graded P2. It is within an area of P2 fibrocystic change.

XR Mammogram Both :
There is a moderately dense breast parenchyma. No significant abnormality demonstrated in either breast. R1.

US Breast Rt :
NAD - U1.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UW
Exams: XR Mammogram Both,US Breast Rt
Exam Date: 09/03/10 Event: E-12272963

08965

North Glasgow Hospitals

Kalamazoo S-10579851-12x8.25 © Copyright 01/2002 Tel: 0121 258 2000

RADIOLOGY MANAGEMENT SYSTEM 10
Patient Enquiry - Report Text Screen

1. Patient Number : MN0075770 JENKINS, Theresa
2. Attendance No. : 96052654H Female 13 Aug 63 A & E 26
Radiologist : BRYDEN F

Report Text: Clinical Information Pleuritic Chest Pain Decreased air en
lung bases.

CHEST
The heart is not enlarged. There is loss of translucency throughout both lung fields. Although this is partly due t underexposure of the film there is also thought to be addi intrapulmonary abnormality. The combination of ground glas shadowing and interstitial shadowing is suspected. Is ther history to suggest atypical infection? Acute alveolitis wo also have to be considered in the differential diagnosis.

<NA>Next Attendance <PA>Previous Attendance
<R>eport <Q>uit

RADIOLOGY MANAGEMENT SYSTEM 10
Patient Enquiry - Report Text Screen

1. Patient Number : MN0075770 JENKINS, Theresa
2. Attendance No. : 96054878H Female 13 Aug 63 Main 05
Radiologist : BRYDEN F

Report Text: Clinical Information Resolving pneumonia.

CHEST
The heart is not enlarged. There has been clearing of the previously noted intrapulmonary shadowing. The lung fields now within normal limits.

<PA>Previous Attendance
<R>eport <Q>uit

UPPER GI ENDOSCOPY

NAME: - THERESA JENKINS WARD - DSSU OP/IP DATE: - 26 08 98 SMOKER: YES/NO

UNIT NO: - 313693 D.O.B: - 13 08 63 REQUESTED BY:

HISTORY - Minor haematemesis secondary to oesophagitis, depression, polycystic ovaries

Current Therapy:

Barium Meal: Date:
Report:

INDICATION: (circle appropriate number)

(a) Diagnostic:
1. Oesophageal dis.
2. Peptic ulcer dis.
3. Malignancy
4. Anaemia
5. Bleeding
6. Duod. biopsy
7. Duod. aspiration
8. Other

(b) Therapeutic
1. Oesophageal dilatation
2. Sclerotherapy
3. Polypectomy
4. Feeding Tube (PEG)
5. Other

ENDOSCOPY REPORT: Sedation: **Midazolam 7 mgs IV**

Oesophagus: This was normal without any evidence of reflux oesophagitis. There was no hiatus hernia present.

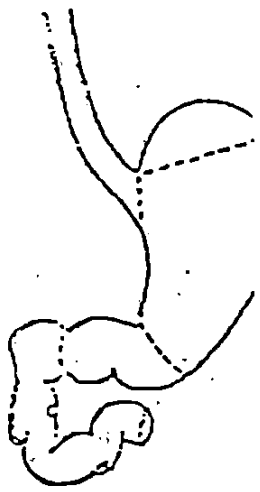
Stomach: This was entirely normal.

Duodenum: This showed no abnormality in either the bulb or post-bulbar region.

INSTRUMENT

DU GU CA
Biopsy Sites
No.
1.
2.
3.
4.
5.
6.

Photographs
Film No.:-
Frames:-



Conclusion and recommendations: Normal upper GI endoscopy however she continued to take Proton Pump Inhibitor up until the day before this endoscopy and therefore her reflux disease may well have healed. There is certainly no source of haematemesis noted. Follow-up has not been arranged. A maintenance dose of Omeprazole 10 mgs per day may be appropriate to control her symptoms.

E FORREST
Specialist Registrar

use Only | Clinic | Day Date 7-2-91 | Time 8.45 | Hospital No. 313693 GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category
Routine ☐ Soon ☐ Urgent ☐

Hospital Stobhill Date 23/1/91

Please arrange for this patient to attend the Ante Natal clinic of Dr/~~Mr~~ STILL / SINCLAIR

PARTICULARS OF PATIENT - IN BLOCK LETTERS PLEASE

Patient's Surname JENKINS
First Names THERESA
Address 38 BENCLOICH CRES
LENNOXTOWN
Postal Code
Contact telephone number

Maiden Surname
Single/Married/Widowed/Other
Date of Birth 13/8/63
Patient's Occupation

Has the patient attended hospital before YES/NO if "YES" please state:
Name of Hospital Stobhill
Year of Attendance 1985 Hospital No 313693
If the patient's name and/or address has/have changed since then please give details:
63 Benclouch Cres.
3 Benclouch Cres.

Can patient attend at short notice? YES/NO

If YES, minimum notice required.....days

Name, Address and Telephone Number of MEDICAL/DENTAL PRACTITIONER

DR. A. J. RAE
DR. J. R. HENDERSON
HEALTH CLINIC
MAIN STREET
LENNOXTOWN G65
(LENNOXTOWN 310357)

Please use rubber stamp

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Thank you for seeing this lady, para 2+0, pregnant (pos. urine test) for the third time. Her previous pregnancies were fairly uneventful (1981, 1985). She had a urinary infection during the second, and I note she was a poor attender at the AN clinic. She is currently well, although prone to anxiety and a smoker.

LMP was 2/11/90, and I note recent casualty and GP treatment for apparent Pelvic inflammato

I would be grateful if you would share ante natal care

Diagnosis/provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

HMSO Dd8177736MD 11/89 M10.5 CCN13161

RMS/AD/CLIN. 7/2/91
15th February 1991

Dr. J.R. Henderson,
Health Clinic,
Main Street,
Lennoxtown G65

Dear Dr. Henderson,

Theresa Jenkins, d.o.b. 13.8.63, Unit No. 313693
38 Bencloich Crescent, Lennoxtown G65

Thank you for your letter about this patient whom I saw at my Antenatal Clinic on 7th February.

She has at present a 14 week gestation, making the expected date the 9th of August. I have booked her for delivery in Stobhill. I note she smokes 40 cigarettes per day and she has been strongly advised to cut down. She declined to have cervical smear carried out today and does not wish blood withdrawn for alpha foeto protein. The blood pressure is 110/60 and she was unable to provide a specimen of urine. We will, however, arrange to send a mid-stream specimen of urine for culture and we have done routine bloods.

I have arranged to see her again in 14 weeks if you would be kind enough to see her in the interim.

Kind regards,

Yours sincerely,

R. M. Still

Consultant Obstetrician and Gynaecologist

GREATER GLASGOW HEALTH BOARD

SGH Stobhill General Hospital
Glasgow G21 3UW

Telephone: 041-558 0111

DIVISION OF OBSTETRICS AND GYNAECOLOGY
Dr. D. McKAY HART (Chairman) Dr. J.A. DAVIS (Secretary)
Dr. R.M. STILL Dr. C.A. FORREST
Dr. R.A.L. LOW

Dear Doctor,

Name: THERESA JENKIN Unit No. 313693

Address: 38 BENGLOICH CRES CENNOXTOWN

This patient was admitted for ~~induction~~/in labour/~~with A/N~~ complication on 20/8/91

She had an SVD/~~Forceps/LUSCS~~ delivery of a live/~~stillborn~~ female/~~male~~ child on 20/8/91

The child weighed 3·39 kg. at birth and was ~~breast~~/bottle fed. Episiotomy ~~was~~/was not performed.

The puerperium was uneventful and she was discharged home well on 21/8/91 with/~~without baby~~. Bacteriological culture of the urine was sterile/~~infected~~. The organism is sensitive to ..... Her postnatal haemoglobin was.....and her blood group is O Rhesus +ve Anti-D ~~was~~/was not required and ~~was~~/was not given. The patient's Rubella status is Immune/~~Not Immune~~. Vaccine ~~was~~/was not given and contraceptive advice ~~was~~/was not given. The patient has been asked to return to the ~~hospital~~/to you for her postnatal check.

A more detailed report ~~will~~/will not require to follow.

Yours sincerely,

House Officer.

MEDICAL UNIT A

DR B J DANESH - GASTROENTEROLOGY
(IN ADMINISTRATIVE CHARGE)
DR A P RAE - CARDIOLOGY
DR R MILROY - RESPIRATORY
DR K J HOGG - CARDIOLOGY

Fax no. 041-557-0468

IMCL/PCS.

Dict. 20.1.93.

Typed.27.1.93.

Dr. Henderson.
Main Street.
Lennoxtown.
Glasgow. G65.

Dear. Dr. Henderson.

Theresa Jenkins. d.o.b. 13.8.63. Unit no. 313693.
38 Bencloich Crescent. Lennoxtown. Glasgow.

Admitted. 27.12.92. Discharged.(self discharge. 27.12.92.

Diagnosis. Paracetamol - self poisoning. Consultant. Dr. R. Milroy.

The above twenty-nine year old married non-smoker presented to our Casualty Department two hours following a self-poisoning. Apparently her father had died a week earlier and she took an uncertain quantity of Paracetamol after drinking as she was feeling down.

There was a history of self-poisoning in childhood but her health was otherwise good and she was on no regular treatment.

At admission she was nauseated and smelling of alcohol but further examination was unremarkable.

Ipicac was given in Accident and Emergency with moderate return. Paracetamol levels four hours post-ingestion were 0.8mmol/1. Thus she was started on an intravenous infusion of N Acetylcysteine as in "a grey area". Other bloods including full blood count, U`s and E`s glucose, clotting and salicylate levels were normal. After her third bag of N Acetylcysteine and against our advice she took her own discharge. We have not arranged for routine review.

She was on no drugs at discharge.

Yours sincerely.

I. McLaughlin.
S.H.O.

SURGICAL DIVISION
GENERAL SURGERY - UNIT 6

Mr R Dalling
Mr J S Smith
Mr D T Hansell

Ext. 3180
Fax No: 041 557 0468

Dr J R Henderson
Health Services Clinic
Main Street
Lennoxtown
G65 7DD

Dear Dr Henderson

THERESA JENKINS DOB 13.08.63 UNIT NO 313693
38 BENCLOICH CRESCENT LENNOXTOWN G65 7NB

Admitted:	07.10.93
Discharged:	10.10.93
Ward:	6
Diagnosis:	Acute abdominal pain
Treatment/ Procedure:	Conservative measures
Follow Up:	SOPD 2 weeks

This young lady was admitted with acute abdominal pain of sudden onset. This settled fairly rapidly and abdominal and pelvic ultrasound revealed no abnormality. Urine microscopy revealed polymorphs and bacteria and it is likely that the problem was a urinary tract infection, although culture was negative.

She will be reviewed as shown above.

Yours sincerely

Douglas T Hansell MD (Hons) FRCS
Consultant Surgeon

SURGICAL DIVISION
GENERAL SURGERY
WARD 6

MR. R. DALLING
MR. J. S. SMITH
MR. D. T. HANSELL
Tel.No: 0141-201-3785

xxxxxxxxxx0141-201-3000

Fax. 041 557 0468

AB/MMcD. Dict: 4.1.95

8th January, 1995.

Dr. J.R. Henderson,
Health Clinic,
Main Street,
Lennoxtown,
G65 7DD.

Dear Dr. Henderson,

Theresa Jenkins, dob. 13.08.63, Unit No. 313693
38 Bencloich Crescent, Lennoxtown, G65 7NB

Admitted: 20.12.94
Discharged: 22.12.94
Diagnosis: Non specific abdominal pain
Procedure: Conservative
Follow-up: SOPD - 3 months

Your patient was admitted with a rather unsual history of right sided abdominal pain associated with some vomiting. There was no other real specific history from this lady and she did not appear to have any significant past history.

On examination she had a tender abdomen with slight distension, tender predominantly in the right hypochondrium and the right iliac fossa. However, on admission her bloods were all normal with the exception of an elevated white count of 18.3000. This obviously raised the concern of either perhaps cholecystitis or appendicitis given the lady's distribution of pain. She was, therefore, placed on conservative therapy. Ultrasound examination revealed a normal gallbladder and biliary system and a little fluid in the right iliac fossa. However, with continuing intravenous therapy of fluids and antibiotics, the lady's condition gradually improved and by 22nd December she was pain free.

Mrs. Jenkins was, therefore, allowed home in view of her pain settling and also her white count reaching normal levels and we shall her back at the Clinic as above to see how she is progressing at that stage.

Yours sincerely,

Dr. A. Brown
S.H.O. - Mr. Hansell

SURGICAL DIVISION - GENERAL SURGERY

Ward 6
Mr R Dalling
Mr J S Smith
Mr D T Hansell

Direct Line: 0141 201 3785
Fax No: 0141 557 0468

DTH/LJA/Cli: 04 04 95

12 April 1995

Dr J R Henderson
Health Clinic
Main Street
LENNOXTOWN
Glasgow
G65 7DD

Dear Dr Henderson

Theresa Jenkins DOB 13 08 63 Unit No 313693
38 Bencloich Crescent Lennoxtown G65 7NB

This lady has failed to attend my clinic on two consecutive occasions and no further appointment will be sent.

Yours sincerely

Douglas T Hansell M.D. (HONS), F.R.C.S.
Consultant Surgeon

MEDICAL DIRECTORATE

MEDICAL UNIT B Secretary: 0141 201 3324
Fax: 0141 201 3324

Dr Derek Gordon, Consultant Physician

MEDICAL CLINIC

FG/MAM/5
Dictated: 10.9.96
Typed: 11.9.96

Dr Henderson
Main Street
LENNOXTOWN
G65 7DD

Dear Dr Henderson

THERESA JENKINS DOB - 13.8.63 UNIT No: 313693
38 BENCLOICH CRESCENT LENNOXTOWN G65]

I reviewed this patient in Dr Gordon's medical clinic today. This is her first visit to this clinic since her discharge from hospital two weeks ago. Her respiratory symptoms have now completely settled and she is feeling generally well. A chest x-ray carried out a few days ago was reported as normal. Therefore her pneumonia is now considered to be completely resolved. However today she mentioned to me that she has had no periods since March this year. She had a pregnancy test carried out on 27 August which was negative. She is not lactating and she is not on any medication. I was originally planning to discharge her from this clinic but in view of the secondary amenorrhoea, I took some blood samples to do a number of investigations including a serum prolactin, thyroid function tests, biochemical screen and FBC and will review her in this clinic in two months time.

Yours sincerely

FATHI GORMAN
Senior House Officer 3



GENERAL OUT PATIENT DEPT.

Stobhill NHS Trust
Balornock Road, Glasgow G21 3UW
Telephone: 0141-201 3000

EXTN . 3511 & 3512

HOSPITAL NO 313693

FREEPHONE: 0800 132157

Theresa Jenkins
38 Benenden Cres
Lennoxtown

Dear Sir/Madam,

I am writing to inform you that due to unforseen circumstances your

appointment time for DR/MR Gordon CLINIC ON

DAY 12/11/98

has had to be changed. I am enclosing an alternative time for 3.25

.....and I hope that this will not cause you any inconvenience.

If this new time is unsuitable, please telephone the freephone no. above and another appointment will be arranged.

PLEASE ALTER YOUR APPOINTMENT CARD AND BRING WITH YOU TO YOUR NEW APPOINTMENT.

Yours sincerely,

Brian Campbell

Brian Campbell
Outpatient Reception Manager

Dr Derek Gordon
MEDICAL DIRECTORATE
MEDICAL CLINIC

Consultant Physician

Tel: 0141 201 3324
Fax: 0141 201 3888

DG/MAM/
Dictated: 12.11.96
Typed: 15.11.96

Dr Henderson
19 Springfield Road
BISHOPBRIGGS G64

Dear Dr Henderson

THERESA JENKINS dob - 13.8.63 UNIT NO 313693
38 BENCLOICH CRESCENT LENNOXTOWN G65

Diagnosis: Previous hospital admission with pneumonia.
Recent secondary amenorrhoea

Your patient was reviewed at the medical clinic. She had one light period in September and no bleeding since that time. Investigations undertaken by Dr Gorman at the last attendance are as follows, TFTs normal. Prolactin 95, LH 17.3, FSH 5.2, Testosterone 3.2. These results are generally satisfactory and do not suggest ~~and do not suggest~~ any significant underlying endocrine pathology. The LFTs however were mildly abnormal with a raised Gamma GT at 53, AST at 51 and ALT at 57 and she did admit to fairly heavy drinking just prior to her last clinic visit.

I have reassured Mrs Jenkins that there is unlikely to be any significant underlying problem. She is currently taking no contraceptive precautions and I have advise her that she could become pregnant although her periods are irregular. I have rechecked her thyroid function tests and will inform you for the results.

I have not arranged for any further clinic follow-up. However if her amenorrhoea persists and you feel she requires further investigation I would be happy to reassess her at a future date.

Yours sincerely

Derek Gordon

DR DEREK GORDON
Consultant Physician

The results are in keeping with polycystic ovarian syndrome.

Hospital use Only | Clinic | Day Date 18/6/97 | Time 3.45 | Hospital No. 3/3693 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

Hospital STOBHILL NHS TRUST Date 25.3.97 | CHI No. 1308 6364 07

Please arrange for this patient to attend the GYNAECOLOGY clinic of Dr/Mr XX LOW

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname JENKINS Maiden Surname

First Names THERESA Single/Married/Widowed/Other

Address 38 BENCLOICH CRESCENT Date of Birth 13.8.63

LENNOXTOWN Patient's Occupation

Postal Code G65 7NS Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital STOBHILL

Year of attendance 1996 Hospital No. 313693

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR. A. J. RAE
DR J R. HENDERSON
HEALTH CLINIC
MAIN STREET
LENNOXTOWN G65 7DD
(LENNOXTOWN 310357)

Please use rubber stamp

43261

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

This lady was recently in Stobhill with pneumonia and complained of secondary amenorrhoea.

Various tests were performed and I am sure you will have a copy of Dr. Gordon's letter.

LFT's were mildly abnormal (alcohol). Dr. Gordon felt the hormone levels were generally satisfactory but appended a note that they were in keeping with polycystic ovarian syndrome.

Mrs. Jenkins came off the pill last March and has had a "period" last April and in November. She is not fat or hairy. A recent pregnancy test is negative.

My feeling is that she has on-going post pill amenorrhoea. Should she have a scan to look at her ovaries? I would value your advice.

Yours sincerely

Dr. J.R. Henderson JRH/AF

DATE RECEIVED	26 MAR 1997
URGENT	
SOON	
ROUTINE	✓
REMARKS	
SIGNATURE DATE	

Diagnosis / ~~provisional diagnosis~~:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Printed for HMSO Scotland, Dd8456915, 08/96, R.P.(53791)

DIVISION OF GYNAECOLOGY

Dr. C.A. Forrest (Clinical Director)
Dr. J.A. Davis
Dr. D. McKay Hart
Dr. R.A.L. Low
Dr. M. Deeny

Direct Line. 201 3440
Fax No: 0141 201 3889

KDR/MB/OPC. 18.06.97.
Typed. 24th June, 1997.

Dr. J.R. Henderson,
The Health Clinic,
Main Street,
Lennoxtown,
GLASGOW, G65 7DD.

Dear Dr. Henderson,

Mrs. Theresa Jenkins, DOB. 13.08.63, Unit No. 313693.
38 B encloich Crescent, Lennoxtown, Glasgow, G64 7NB.

Thank you for referring Theresa to Dr. Low's Gynaecology Clinic where I saw her on 18th June, 1997 with her complaint of secondary amenorrhoea following discontinuation of the combined oral contraceptive pill. She now has oligomenorrhoea having a menstrual cycle every 3 to 4 months. The hormonal profile obtained when Theresa was recently admitted under the care of the Physicians with a chest infection was suggestive of polycystic ovarian syndrome and this would be in keeping with the clinical picture. Theresa has no flushes or sweats and no pelvic pain and more importantly, no desire to conceive.

The best treatment for Theresa would be to restart the combined pill which she was on before - Trinordiol. She was apparently told to come off the pill by the Physicians because of her chest infection but I find this rather unusual. There is no indication for an ultrasound scan as the appearance of polycystic ovaries will not change her management unless she develops pelvic pain related to abnormally enlarged cysts.

We have not arrange to review her routinely at the clinic.

Yours sincerely,

Kay Donaldson,
Registrar to Dr. R.A.L. Low.

DIRECTORATE OF MEDICINE

GENERAL MEDICINE UNIT A

Dr E H McLaren, Lead Consultant.
Dr P E McGill Dr Gavin Boyd
Dr B J Danesh Dr F G Dunn

Direct Line: 0141 201 3309 (Dr McLaren's Secretary)

Fax No 0141 201 3888

EHMcL/EP

Dictated: 1.6.98
Typed: 3.6.98

Dr J R Henderson
The Health Clinic
Main Street
Lennoxtown
GLASGOW
G65 7DD

Dear Dr Henderson,

THERESA JENKINS, DOB: 13.8.63 UNIT NO: 313693
38 BENCLOICH CRESCENT, LENNOXTOWN, G65 7NB

Admitted: 29.5.98
Discharged: 31.5.98

Diagnosis: Co-dydramol overdose.

This was patient admitted as an emergency, having taken an overdose of about twenty-six Co-dyramol tablets about twelve hours before admission, along with some alcohol. She had vomited following this. On admission, Paracetamol levels were at the lower range were treatment was required, but in view of the associated alcohol intake she was treated with Parvolex.

Her INR was, however, normal on admission and remained normal over the next 24 hours, so after the infusion was completed she was discharged home. She declined psychiatric follow-up.

Yours sincerely,

E H McLAREN
CONSULTANT PHYSICIAN

MEDICAL UNIT A
DR B DANESH - GASTROENTEROLOGIST

Fax No: 0141-201-3389
Direct Line: 0141- 201-3305

EF/AK

DICTATED & TYPED: 26 08 98

DR HENDERSON
MAIN STREET
LENNOXTOWN
G65 7DD

Practice No: 43261/1

Dear Dr Henderson

THERESA JENKINS ODB - 13 08 63 . UNIT NO - 313693
38 BENCLOICH CRESCENT LENNOXTOWN G65 7NB

ADMITTED: DAY CASE 26 08 98
WARD: DAY SURGICAL UNIT

Your patient attended for an upper GI endoscopy. This was carried out with out any complication. This showed no significant abnormality. It have been noted however that up until the day prior to the test she was taking Omeprazole and therefore any reflux oesophagitis may have been healed. I would suggest that symptomatic treatment with Omeprazole 10 mgs a day as a maintenance dose may be appropriate, although ideally she should be able to stop her Proton Pump Inhibitor all together at this stage. No routine follow-up has been arranged although we would be happy to see her again should you feel this is appropriate.

Yours sincerely

E FORREST
Specialist Registrar

Hospital use Only | Clinic | Day Date 17 7 98 | Time 2.30 | Hospital No. 313693 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Hospital STOBHILL NHS TRUST Date 21.5.98

CHI No. 1 3 0 8 6 3 6 4 0 7

Please arrange for this patient to attend the MEDICAL/GI clinic of Dr/Mr DANESH

Patient's Surname JENKINS Maiden Surname

First Names THERESA Single/Married/Widowed/Other

Address 38 BENCLOICH CRESCENT Date of Birth 13.8.63

LENNOXTOWN Patient's Occupation

Postal Code G65 Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital STOBHILL

Year of attendance 1997 Hospital No. 313693

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR. J.R.HENDERSON
HEALTH CLINIC
MAIN STREET
LENNOXTOWN
G65 7DD
TEL. 01360 310357
FAX. 01360 311740

Please use rubber stamp

43261

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

Thanks for seeing this 34 year-old lady who suffers from recurrent upper abdominal pain.

She now complains that she has had several small haematemesis. Ultrasound of gallbladder was normal prior to her recent complaint.

She drinks heavily and I suspect she is having recurrent gastritis, but I feel we should exclude peptic ulcer. Could you see with view to endoscopy?

Yours sincerely

Dr. J.R. Henderson

JRH/AH

DATE RECEIVED	26 MAY 1998
URGENT	
SOON	
ROUTINE	✓
REMARKS	
SIGNATURE DATE	

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Printed for The Stationery Office Dd8457201 5/97 (71412)

DIRECTORATE OF MEDICINE
MEDICAL UNIT `B`

GASTROENTEROLOGY

DR J A H FORREST
SECRETARY 0141-201-3338

FAX NO 0141-201-3888

SD/AMMCK/DICT. 11.01.99
TYPD. 11.01.99

Dr Henderson
Lennoxtown Health Centre
Main Street
Lennoxtown
GLASGOW

Dear Dr Henderson

Theresa Jenkins d.o.b. 13.08.63, Unit No 313693
38 Bencloich Crescent, Lennoxtown, Glasgow

Admitted 24.12.98 Discharged 25.12.98

Consultant Dr J A H Forrest

Diagnosis: 1 Robaxin - Anti Spasmodic
2 Ibuprofen
3 Co-Codamol
4 Alcohol excess

Presenting history

This 35 year old lady who had been brought in by the Police for breach of the peace and subsequently found to have taken an unspecified amount of the above medications and alcohol. This was verified by her husband and had apparently had 2-3 previous overdoses. She feels this was a fool hardy thing to do and she had no suicidal intent.

Examination

On examination she was apyrexial, smelt strongly of alcohol. Her cardiovascular system was stable as was her respiratory and abdominal systems.

Investigations

Her ECG was unremarkable.

Her Paracetamol levels were 0.2 with her urea and electrolytes being otherwise unremarkable.

DIRECTORATE OF MEDICINE
MEDICAL UNIT `B`

GASTROENTEROLOGY

DR J A H FORREST
SECRETARY 0141-201-3338

FAX NO 0141-201-3888

Progress on ward

She subsequently took her own discharge against medical advice.

Follow up: Nil arranged.

Yours sincerely

S Davidson
SHO

Dr John A H Forrest
Consultant Physician and Gastroenterologist

MEDICAL DIRECTORATE
MEDICAL UNIT B
Dr Derek Gordon - Consultant Physician
☎ **Dr Gordon 0141 201 3323**
☎ **Secretary 0141 201 3324**
Fax: 0141 201 3888

DG/MAM/11
21 January 1999

Dr J Henderson
Health Clinic
Main Street
Lennoxtown
G65 7DD

Dr Henderson

Theresa Jenkins, DOB 13/08/63, Unit No. 313693
38 Bencloich Cres, Lennoxtown, G65 7NB

Date of admission: 14.1.99
Date of discharge: 14.1.99
Diagnosis: Minor haematemesis

This 35 year old patient with a dyspeptic history had developed diarrhoea and vomiting for three days prior to admission. On the day of admission she had vomited up small amounts of fresh blood. There was no history of melaena. She had stopped taking her Losec tablets three days prior to admission. She admitting to drinking several Vodka's on the day of admission.

On examination pulse initially 109/minute. B P 125/76. Heart sounds pure. Chest clear to auscultation. Abdominal examination revealed slight epigastric tenderness.

Investigations:

Hb 14.8g/dl
White count 11.5
Platelets 376
Clotting screen normal.
Urea and electrolytes normal.
Amylase normal.
Liver function tests showed a Gamma GT of 60. Other liver function tests not undertaken because of haemolysis of the sample.
Glucose 5.6mmols/l.

Progress:

The patient remained haemodynamically stable. In view of the fact that she had had a recent endoscopy it was decided not to repeat this. Omeprazole was restarted.

Drugs on discharge:

Omeprazole - 20mg daily

Discharge arrangements: Patient discharged to own home. No medical follow-up arranged.

Yours sincerely

Dr Derek Gordon
Consultant in Diabetes and Endocrinology

DIRECTORATE OF MEDICINE

DIVISION OF GENERAL MEDICINE UNIT 'A'
GASTROENTEROLOGY

DR B J DANESH

Direct Line: 0141 201 3305 (Dr Danesh's Secretary)
Fax No: 0141 201 3888

FMcG/EA
Clinic &
Dictated: 17 July, 1998
Typed: 22 July, 1998

Dr J Henderson
Health Clinic
Main Street
Lennoxtown
G65 7DD

Dear Dr Henderson

Theresa Jenkins, DOB 13/08/63, Unit No. 313693
38 Bencloich Cres, Lennoxtown, G65 7NB

Diagnoses:
1. Minor haematemesis secondary to presumed oesophagitis
2. Polycystic ovaries
3. Depression

Thank you for referring this 34 year old lady to Dr Danesh's Clinic. She complains bitterly of reflux symptoms and is avoiding spicy foods, onions etc. She complains of acid regurgitation and epigastric pain. She has had previous problems with alcohol excess, but has cut this out completely. She is completely asymptomatic on the Omeprazole which you have started.

She has a past medical history of chest infection, polycystic ovaries and a Co-proximal overdose. She is currently on Depo-Provera and blames this for her recent mood swing. She is a smoker. Examination was unremarkable.

Impression
I think this lady has symptoms of reflux oesophagitis which are controlled by a Proton Pump inhibitor. She is not keen on taking tablets life-long and would be prepared to consider fundoplication if this was required. Given that she has had a haematemesis, I will arrange routine endoscopy although this may well be normal as she is on Omeprazole. These results will be passed on and I have not routinely re-appointed her.

Yours sincerely

FIONA McGARRY
Senior House Officer

DIRECTORATE OF MEDICINE
MEDICAL UNIT `B`

GASTROENTEROLOGY

DR J A H FORREST
SECRETARY 0141-201-3338

FAX NO 0141-201-3888

SD/AMMCK/DICT. 11.01.99
TYPD. 11.01.99

Dr Henderson
Lennoxtown Health Centre
Main Street
Lennoxtown
GLASGOW

Dear Dr Henderson

Theresa Jenkins d.o.b. 13.08.63, Unit No 313693
38 Bencloich Crescent, Lennoxtown, Glasgow

Admitted 24.12.98 Discharged 25.12.98

Consultant Dr J A H Forrest

Diagnosis: 1 Overdose of tablets including Ibuprofen and Co-Codamol
2 Alcohol excess

Presenting history

This 35 year old lady who had been brought in by the Police for breach of the peace and subsequently found to have taken an unspecified amount of the above medications and alcohol. This was verified by her husband and had apparently had 2-3 previous overdoses. The patient advised us that the overdose was not taken in a suicidal intent.

Examination

On examination she was apyrexial, smelt strongly of alcohol. Her cardiovascular system was stable as was her respiratory and abdominal systems.

Investigations

Her ECG was unremarkable.

Her Paracetamol levels were 0.2 with her urea and electrolytes being otherwise unremarkable.

Progress on ward

DIRECTORATE OF MEDICINE
MEDICAL UNIT `B`

GASTROENTEROLOGY

DR J A H FORREST
SECRETARY 0141-201-3338

FAX NO 0141-201-3888

She subsequently took her own discharge against medical advice.

Follow up: Nil arranged.

Yours sincerely

S Davidson
SHO

Dr John A H Forrest
Consultant Physician and Gastroenterologist

STOBHILL
NHS TRUST
Stobhill Hospital NHS Trust
Balornock Road, Glasgow, G21 3UW
Telephone : 0141 201 3000

IMMEDIATE DISCHARGE LETTER

PATIENT COPY

Issued: 18/06/99 09:43

Admitted: 16/06/1999 Discharged:
Discharged to: Home
Ward: 14a Stay No: 9
Consultant: Dr L ERWIN, General Medicine
Hospital No: SH313693 Date of birth: 13/08/1963

REGISTERED GP
Dr J HENDERSON
HEALTH CLINIC
MAIN STREET
LENNOXTOWN
G65 7DD

PATIENT
THERESA JENKINS
38 BENCLOICH CRES
LENNOXTOWN
G65 7NB

DIAGNOSES	ICD10	PROCEDURES	OPCS4
1. Self-poisoning with benzodiazepine	T424	*No procedures have been performed for this patient*	
2. Alcohol abuse (chronic)	F102		

MEDICATION

No medication has been prescribed for this patient

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
No arrangements made		

Outpatient Investigations	Date	Community Care
No arrangements made		*No arrangements made*

GENERAL COMMENTS Diagnosis discussed with: G.P.: No Patient: No Next of Kin: No

No final discharge letter to follow

Admitted with overdose of diazepam and alcohol. Seen by psychiatric services who will refer her on for alcohol counselling.

Signed: _____ Designation: _____

Contact: Dr L Erwin Pager Number: ----

Hospital use Only | Clinic | Day Date 9 9 99 | Time 2 20 | Hospital No. 313693 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category
Routine ☐ Soon ☐ Urgent ☐

Hospital STOBHILL NHS TRUST Date 17.5.99

CHI No. 1 3 0 8 6 3 6 4 0 7

Please arrange for this patient to attend the MEDICAL/GI clinic of Dr/Mr DANESH

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Patient's Surname JENKINS Maiden Surname

First Names THERESA Single/Married/Widowed/Other

Address 38 BENCLOICH CRESCENT Date of Birth 13.8.63

LENNOXTOWN Patient's Occupation

Postal Code G66 7NB Contact telephone number

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital STOBHILL

Year of attendance 1999 Hospital No. 313693

If the patient's name and/or address has/have changed since then please give details:

Can patient attend at short notice? YES / NO

If YES, minimum notice required ..... days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR. J.R. HENDERSON
HEALTH CLINIC
MAIN STREET
LENNOXTOWN
G66 7DD
TEL: 01360 310357
FAX: 01360 311740

Please use rubber stamp

43261

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

This 35 year-old lady complains of persistent loose stools, sometimes, she says, accompanied by fresh blood loss.

The duration of this is hard to ascertain, probably several months. Mrs. Jenkins has an alcohol problem and a clear history is hard to get..

She had upper endoscopy last year, which was normal. She takes Omeprazole for reflux symptoms.

Stool culture has recently been negative. A nephew has coeliac disease and I have sent blood for anti-endomysial Abs.

Could you advise on sigmoidoscopy.

Yours sincerely

Dr. J.R. Henderson

JRH/AH

DATE RECEIVED 19 MAY 1999
URGENT
SOON
ROUTINE ✓
REMARKS
SIGNATURE
DATE

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

Printed for The Stationery Office , Dd8457208,08/97, R.P.(53791)

DEPT. OF GASTROENTEROLOGY

DR. B.J. DANESH

☎ *0141 201 3305 (Secretary)*

☎ *0141 201 3888 (Fax. No.)*

JE/MMcK
Dict: 9.9.99
Typed: 16.9.99

Dr. J.R. Henderson,
Health Clinic,
Main Street,
Lennoxtown, G65.

Dear Dr. Henderson,

Theresa Jenkins, d.o.b. 13.8.63, Unit No. 313693
38 Bencloich Crescent, Lennoxtown, G65.

Thank you very much for referring this 35 year old lady who complains of diarrhoea over the last year. She opens her bowels up to five times a day with no blood or mucus. There is no abdominal pain and her weight remains stable. She mentioned about a history of salmonella infection about two months ago, but that she thinks, is over.

She occasionally complains of abdominal bloating especially in the mornings. She is on Seroxat for depression and she was started on Omeprazole about a year ago which was changes to Lansoprazole about 2-3 months ago. She is a smoker of 40 cigarettes a day, heavy alcohol drinker until about 6 weeks ago. She has a family history of coeliac disease.

Clinically she looks well, undistressed, with unremarkable examination of chest, heart and abdomen. On further questioning she mentioned about a history of intermittent sweating and an intolerance to heat. This lady's complaints could be secondary to her proton pump inhibitors as they can cause diarrhoea on occasions, but we also need to exclude the two possibilities of coeliac disease or thyrotoxicosis, although she has no signs of an active thyroid gland. I have taken bloods today for routine examination, thyroid function tests, ESR and anti-endomysial antibody.

/.....

DEPT. OF GASTROENTEROLOGY

DR. B.J. DANESH

☎ *0141 201 3305 (Secretary)*

☎ *0141 201 3888 (Fax. No.)*

Theresa Jenkins cont'd.

She had an endoscopy about two years ago and that was normal, but at the time no distal duodenal biopsies were taken.

I have asked her to stop taking her proton pump inhibitors as she has no upper GI complaints, and see if her symptoms improve, and if not we will review the results of her bloods and consider an endoscopy and distal duodenal biopsies when she comes back to the clinic next time. She will be reviewed in about three months' time.

Yours sincerely,

JAMAL ELTOHLI
Registrar

DEPT. OF GASTROENTEROLOGY

[redacted]

DR. B.J. DANESH

☎ *0141 201 3305 (Secretary)*

☎ *0141 201 3888 (Fax. No.)*

JE/MMcK
Dict: 26.10.99
Typed: 28.10.99

Dr. J.R. Henderson,
Health Clinic,
Main Street,
Lennoxtown, G65.

Dear Dr. Henderson,

Theresa Jenkins, d.o.b. 13.8.63, Unit No. 313693
38 Bencloich Crescent, Lennoxtown, G65.

This lady's anti-endomysial antibody was negative.

She will be reviewed in the outpatient clinic as was previously arranged.

Yours sincerely,

JAMAL ELTOHLI
Registrar

DEPT. OF GASTROENTEROLOGY

DR. B.J. DANESH

☎ *0141 201 3305 (Secretary)*

☎ *0141 201 3888 (Fax. No.)*

BJD/MMcK
Dict: 20.4.00
Typed: 9.5.00

Dr. J.R. Henderson,
Health Clinic,
Main Street,
Lennoxtown, G65

Dear Dr. Henderson,

Theresa Jenkins, d.o.b. 13.8.63, Unit No. 313693
38 Bencloich Crescent, Lennoxtown, G65

Your patient was sent an appointment to attend my clinic today but failed to do so.

Please let us know if you wish us to send her another appointment.

Yours sincerely,

B.J. DANESH, Ph.D., FRCP.
Consultant Physician & Gastroenterologist

Hospital use Only | Clinic | Day Date 24 401 | Time 9.25 | Hospital No. 313693 | GP112

REQUEST FOR OUT-PATIENT CONSULTATION
THE INFORMATION IN THIS SECTION MUST BE COMPLETED

Appointment Category: Routine ☐ Soon ☐ Urgent ☐

PARTICULARS OF PATIENT IN BLOCK LETTERS PLEASE

Hospital STOBHILL NHS TRUST Date 30.1.01 | CHI No. 1308636407

Please arrange for this patient to attend the GYNAECOLOGY clinic of Dr/Mr MacKENZIE

Patient's Surname JENKINS Maiden Surname

First Names THERESA Single/Married/Widowed/Other

Address 90A MAIN STREET Date of Birth 13.8.63

LENNOXTOWN Patient's Occupation

Postal Code G66 Contact telephone number 827479 (01236)

Has the patient attended hospital before? YES / NO If "YES" please state:

Name of Hospital STOBHILL

Year of attendance 2000 Hospital No. 313693

If the patient's name and/or address has/have changed since then please give details:

38 BENCLOICH CRESC

LENNOXTOWN

Can patient attend at short notice? YES / NO

If YES, minimum notice required ..... days

Name, Address and Telephone number of MEDICAL / DENTAL PRACTITIONER

DR. J.R. HENDERSON
HEALTH CLINIC
MAIN STREET
LENNOXTOWN
G66 7DD
TEL: 01360 310357
FAX: 01360 311740

Please use rubber stamp

43261

I would be grateful for your opinion and advice on the above named patient. A brief outline of history, symptoms and signs is given below:

This 37 year-old lady, para 4 + 0, requests sterilisation. She had her last baby in July 2000.

She smokes, and until recently was on Ovranette. She recently reported headaches with paraesthesia in her face, and I have changed her to a POP. I think that she would benefit from a more permanent contraceptive solution and would appreciate your seeing her.

She has a history of Depression and of alcohol abuse.

Yours sincerely

Dr. J.R. Henderson

JRH/AH

DATE RECEIVED	31 JAN 2001
URGENT	
SOON	
ROUTINE	✓
REMARKS	
SIGNATURE	
DATE	01/02/01

Diagnosis / provisional diagnosis:

Present drug treatment and potential special hazards:

X-ray (women of childbearing age). Date of first day of L.M.P.

Relevant X-rays available from: No. (if known)

Signature

355-2104

STOBHILL
HOSPITAL

DEPARTMENT OF GYNAECOLOGY

Balornock Road, Glasgow G21 3UW

Fax No: 0141 201 3889
Direct Line: 0141 201 3432

Dr C A Forrest (Clinical Director)
Dr J A Davis
Dr M Deeny
Dr F Mackenzie
Dr P Owen
Dr N Siddiqui
Dr D M Hart (Menopause Clinic)

AEN/MC/ 4
Dict: 24 April 2001
Typed: 25/04/01

Dr J R Henderson
Health Clinic
Main Street
LENNOXTOWN
G65 7DD

Dear Dr Henderson

Theresa Jenkins, dob 13 8 63, Unit No 313693
90A Main Street, Lennoxtown, G66

Thank you for referring this 37 year old Para 4+0 woman whom I saw on behalf of Dr Mackenzie today. As you know, Ms Jenkins requests sterilisation. She tells me that she is certain that her family is complete. She is currently using the progesterone-only pill for contraception but wishes something more permanent. She is not keen to consider the Mirena IUS or Implanon. Her partner does not wish to consider vasectomy. I note her history of depression and alcohol abuse. Mrs Jenkins tells me that she is well at present.

I have discussed the procedure of laparoscopic sterilisation with Mrs Jenkins and in particular I discussed its failure rate, that it must be regarded as irreversible, an that there are subsequent risks of ectopic pregnancy.

I have arranged for her to be admitted as a day case on 18 June 2001.

Yours sincerely

Dr Antony E Nicoll
Registrar to Dr Fiona Mackenzie

DEPARTMENT OF GYNAECOLOGY

DR C A FORREST
DR J A DAVIS
DR M DEENY
DR F MACKENZIE
DR P OWEN
DR N SIDDIQUI

Direct Line: 0141 201 3432
Fax No: 0141 201 3889

FM/AK

DICTATED & TYPED: 03 09 01

Practice No: 432611

DR J HENDERSON
LENNOXTOWN CLINIC
103 MAIN STREET
LENNOXTOWN
G65 7DD

Dear Dr Henderson

THERESA JENKINS DOB 13 08 63 UNIT NO. 313693
90 MAIN STREET, LENNOXTOWN, G66 7DA

ADMITTED: DAY CASE - 03 09 01
WARD: DAY SURGERY UNIT

This 37 year old had laparoscopic sterilisation performed today. The findings were of a normal pelvis. One Filshie clip was applied to each tube. The patient was discharged home later the same day and no follow-up arranged.

Yours sincerely

DR F MACKENZIE
CONSULTANT

CONFIDENTIAL

IMMEDIATE DISCHARGE & MEDICINE PRESCRIPTION FORM

PATIENT AND GP LABELS MUST GO ON ALL FOUR COPIES

DEAR DOCTOR
NAME Dr S Henderson.
ADDRESS 103 Main Street
Lenzie
G66 7QA

YOUR PATIENT
NAME MELISSA SINCLAIR.
ADDRESS 204 MAIN STREET
LENZIE G66 5QA
Date of Birth 13/8/65 Unit No. Z300L80TE

STOBHILL HOSPITAL
GLASGOW G21 3UW
TELEPHONE 0141 201 3000

DATE OF ADMISSION 2/7/99
DATE OF DISCHARGE 7/7/99 KR
WARD 11A
CONSULTANT R Weland.

DIAGNOSIS
1. Vomiting following paracetamol + ASA ingestion.
2.
3.
4.

OPERATION / PROCEDURES
1.
2.
3.

FOLLOW UP ARRANGEMENTS

OUTPATIENT/DAY HOSPITAL APPOINTMENTS

CONSULTANT	CLINIC	WHEN	DATE GIVEN	INITIALS

OUTPATIENT INVESTIGATIONS N.B. (request cards must be provided)

		DATE GIVEN	INITIALS

AMBULANCE REQUIRED YES / NO
WALKING
2 HANDED SEAT
STRETCHER
ESCORT
Tick as necessary
OTHER NEEDS (SPECIFY)

COMMUNITY CARE ARRANGEMENTS — ARRANGED BY

HOME HELP _____ DAY CARE _____ PHYSIO _____
MEALS ON WHEELS _____ DN OR HV _____ OT _____

SPECIAL DISPENSING INSTRUCTIONS
☐ LARGE PRINT ☐ NO C.R.C. ☐ OTHER

DISCHARGE MEDICATION

Medicine	Form	Dose	Times of Administration	Recommended Duration from discharge (Days)	No of Days Supplied	Quantity, Name Strength & Manufacturer Supplied

Regular Diet

PHARMACY USE ONLY
DISPENSED BY
CHECKED BY
DATE CP CHECK
MEDICINES COLLECTED BY (MESSENGER)

WARD USE ONLY
RECEIVED ON WARD BY
ISSUED BY
DATE ISSUED
SIGNATURE OF RECIPIENT

OTHER TREATMENT AND COMMENTS (including details of drug sensitivities, appliances etc.)

43 year old lady presented acutely c/o self poisoning 16 x 500mg Paracetamol and ASA intake past 3/7 - Commenced on IV Parvolex which was prematurely disc due to patient taking irregular doses against medical advice - LFT's / FBC / UE all within (N) parameters.

DR.'s NAME IN BLOCK CAPITALS _____ **DATE** _____

SIGNATURE _____ **PAGER No.** _____

COPIES TO : WHITE - GP, PINK - MEDICAL RECORDS, BLUE - PHARMACY, YELLOW - LIASON

Maroon - Mylene OD - to further Suicidal tendencies.

PJSTOBH72/0799

Consultants:

Dr Steve Cleland, Consultant Physician
Dr Derek Gordon, Consultant Physician

Department of General Medicine

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW

Enquiries to: Carol Walker (Secretary)
☎ Direct Line: 0141 201 3309
🖷 Fax No: 0141 201 3888
✉ Email: Carol.Walker@NorthGlasgow.Scot.NHS.UK

Dr J Henderson
Lennoxtown Health Centre
Main Street
Lennoxtown
G66 7DD

Date dictated: 02/08/07
Date typed: 02/08/07
Ref: SC/CTW/23004807E

Dear Dr Henderson,

TERESA SINCLAIR, DOB 13/08/63 (CHI 6407), 38 BENCLOICH CRES, LENNOXTOWN, G66 7NB

Admitted:	02/07/07
Discharged:	02/07/07
Diagnosis:	Overdose.

This 43 year old lady took an impulsive overdose of Paracetamol along with alcohol. Her Paracetamol levels were above the treatment line and she was given Parvolex. Unfortunately she took her own discharge against medical advice before we had time to reassess her liver function tests and coagulation status. There was no psychiatric reason to detain her.

Yours sincerely,

S Cleland
Consultant Physician &
Honorary Senior Lecturer

Hospital use only	Clinic	Day Date	Time	Hospital No 23004807

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

30/1

1.45

REFERRAL TO

Gynaecology F2
G General Referral DR DEERY

— **Consultant / receiving practitioner and/or specialty clinic**

Stobhill Hospital

— **Hospital and hospital address**

Hospital location code.
G207H

Email address

Urgency of referral ROUTINE
Date of referral 10-Dec-2008 **Date sent** 12-Dec-2008

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s)

-

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)

Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		
Practice code	43261		

Practice address

103 MAIN STREET
LENNOXTOWN

Contact number(s)

Voice: 01360310357

hop ± M1 → 25A

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: heavy periods

Comment: This 45 year old lady has been troubled by heavy periods for several months. Clinical exam and smear are normal. FBC ..... Hb 116g/dl.
She has tried Tranexamic Acid without marked success. Could you see her and perhaps discuss Mirena IUS?

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
teetotal:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Modifier	Extension	Date of onset
Overdose of drug	-	DIAZEPAM AND ALCOHOL	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	-	LIBRIUM AND ALCOHOL	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	-	OVERDOSE	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	Mild	-	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Modifier	Date performed
Female sterilisation op.NOS	-	03-Sep-2001
CLO test negative	-	26-Aug-1998

Family conditions (All priorities)

Description	Modifier	Extension	Date Recorded
FH: Ischaemic heart dis. <60	-	-	02-Apr-2008
No family history diabetes	-	-	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration
Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003	-	1915 Days

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration
Chlordiazepoxide	21	CAPS 5MG	1 Cap	3 times daily	05-Dec-2008	-	0 Days
Tranexamic Acid	60	TABS 500MG	2 Tabs	3 times daily	20-Nov-2008	-	0 Days
Buscopan	56	TABS 10MG	1 or 2 Tabs	3 times daily	15-Oct-2008	-	0 Days
Buscopan	56	TABS 10MG	1 or 2 Tabs	3 times daily	28-Jul-2008	-	0 Days
Vapour-Permeable Adhesive Film Dressing With Absorbent Pad	20	Mepore Ultra 6cmx7cm	-	-	24-Jul-2008	-	0 Days
Buscopan	56	TABS 10MG	1 or 2 Tabs	3 times daily	27-Jun-2008	-	0 Days

Clinical warnings

Additional relevant information

Administrative information

Previous Surname:Jenkins

OK to send correspondence to home address?:Yes

Patient will accept any site:Yes

Patient will accept cancellation or short notice appointment (within 1-21 days):Yes

Patient has disability or requires wheelchair access:No

Referred By:Referring GP

Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT

29 Dec 2008 ALMCC

TERESA SINCLAIR
90A MAIN STREET
LENNOXTOWN
GLASGOW

G66 7DA

Dear MS SINCLAIR

HOSPITAL NUMBER: 23004807E
CHI NUMBER: 1308636407

As you are aware you have been asked to come along to the Hysteroscopy clinic by Dr Miriam Deeny for examination (information leaflet enclosed). This clinic is held in the Day Surgery Unit at Stobhill Hospital

Please report to the Day Surgery Unit, Reception Desk on:
30 Jan 2009
13:45

If you are unable to attend please contact Dr Deeny's secretary on 0141 201 3451 as soon as possible to enable us to send for another patient in your place.

Please bring any medications, in their original containers, prescribed by your GP.

Should you neglect to inform us that this appointment is unsuitable and you fail to attend this appointment, you may be removed from the waiting list and referred back to the care of your General Practitioner – referrer who will require to re-refer you in order for you to obtain another appointment.

Yours sincerely

Alison McCormick
Secretary to Dr M Deeny

Acute Services Division

Women and Children's Directorate

NHS
Greater Glasgow and Clyde

Department of Gynaecology

Dr M Deeny
Dr M Rankin

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Dictated & Typed 06/03/2009
Our Ref MR/JC
Enquiries to: Alison McCormick
Direct Line: 0141-201-3451

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Admitted: DAY CASE - 06.03.09
Ward: DAY SURGERY UNIT

You referred this lady in early December with a history of heavy periods to hysteroscopy clinic. Unfortunately she has failed to attend appointments offered to her in January and again today. I trust this means that her symptoms are improved and I have sent no further appointment.

Yours sincerely

DR MARION RANKIN
Clinical Assistant

Hospital use only	Clinic	Day Date	Time	Hospital No.
		6/7/09		2300480TE.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology F2
G General Referral DR MATHEW — **Consultant / receiving practitioner** and/or **specialty clinic**

Stobhill Hospital — **Hospital and hospital address**

Hospital location code: G207H

Email address: -

Urgency of referral ROUTINE
Date of referral 09-Jun-2009 **Date sent** 10-Jun-2009

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s): -

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)

Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		
Practice code	43261		

Practice address

103 MAIN STREET
LENNOXTOWN
DATE 12 JUN 2009

Contact number(s)

Voice: 01360310357

CLINICAL INFORMATION

History of presenting complaint / examination findings / investigation results

Presenting complaint

Description: heavy periods

ıment: This 45 year old lady has been troubled by heavy periods for several months. Clinical exam and smear are normal. FBC.....Hb 116 g/dl
She has tried Tranexamic Acid without marked success. Could you see her and perhaps discuss Mirena IUS?
She missed a previous appointment but is keen to have your advice.

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
teetotal:		02-Apr-2008
teetotal:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Routine
15/6/19

Reason for referral

Care type requested: Out Patient
Expected outcome: Not Specified

Past medical history

Pr··existing conditions (High & medium priority - all)

ɔcription	Modifier	Extension	Date of onset
Overdose of drug	-	DIAZEPAM AND ALCOHOL	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	-	LIBRIUM AND ALCOHOL	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	-	OVERDOSE	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	Mild	-	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Modifier	Date performed
Female sterilisation op.NOS	-	03-Sep-2001
CLO test negative	-	26-Aug-1998

F··· ···y conditions (All priorities)

ɔcription	Modifier	Extension	Date Recorded
FH: Ischaemic heart dis. <60	-	-	02-Apr-2008
No family history diabetes	-	-	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued	Duration

Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003 -	2054 Days.

Recent medication (Any medication issued within last 90 days not shown above)
No recent medications recorded

Clinical warnings

Additional relevant information
Administrative information
Previous Surname:Jenkins
Send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-21 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

NHS
Greater Glasgow and Clyde

DEPARTMENT OF GYNAECOLOGY

Dr S Mathew

GLASOW ROYAL INFIRMARY
CASTLE STREET
GLASGOW, G4 OSF

TEL NO: 211 4000

Dr J H Kennedy Dr H Lyall
Dr A M Mathers Dr R Jamieson
Dr R W S Yates Dr P Owen
Dr M. Perera Dr. M. Rodger
Dr J E Norman Dr. M. Deeny

Enquires: Catherine Donaghy (Secretary)
Direct: 0141 211 4755
Fax: 0141 800 1973
E-Mail: Catherine.Donaghy@northglasgow.scot.nhs.uk

Clinic &
Dictated: 06/07/2009
Typed 08/07/2009
Our Ref SM/CK

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair - 13/08/1963 - CHI: 1308636407 - CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

This lady has failed to attend our clinic and another appointment has been sent.

Yours sincerely

Dr Sarju Mathew
Consultant Gynaecologist & Obstetrician

23004807

Hospital use only	Clinic	Day Date	Time	Hospital No.
		9/3/10	9am	

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO HANSELL

General Surgery - Breast
GGC General Referral

— **Consultant / receiving practitioner and/or specialty clinic**

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UW

— **Hospital and hospital address**

Hospital location code: G207H

Email address:

Urgency of referral ROUTINE
Date of referral 01-Feb-2010 **Date sent** 02-Feb-2010

PATIENT DETAILS

Surname	Sinclair
Forename(s)	Theresa
Title	Ms
Sex	Female
Date of birth	13-Aug-1963
CHI no.	1308636407
Previous surname	Jenkins

Patient's address

90a Main St
Lennoxtown
GLASGOW
G66 7DA

Contact number(s): -

101000159785I Unique Care Pathway Number: 101000159785I

REGISTERED GP DETAILS

Name	Dr JR Henderson		
GMC code	2335801	GP code	G01236
Practice name	LENNOXTOWN SURGERY		
Practice code	43261		

Practice address

MAIN STREET
LENNOXTOWN
G66 7DD

Contact number(s)

Voice: 01360 310357
Facsimile: 01360 311740

REFERRING GP DETAILS

Name	Dr. James Henderson		
GMC code	2335801	GP code	01236
Practice name	LENNOXTOWN CLINIC (43261)		
Practice code	43261		

Practice address

103 MAIN STREET
LENNOXTOWN

Contact number(s)

Voice: 01360310357

S 9/3

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Breast Clinic

Comment: This lady, 46, has a small mobile lump above her (R) nipple. It has been present for approximately 6/12.

O/E - No skin tethering or nipple changes. No axillary lymphadenopathy. Small firm lump approximately 1 x 1 cm.

Thanks for seeing her.

Dr Jill Carmichael

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date of onset
[X]Intentional self-harm	overdose of drug	-	06-Jul-2009
Overdose of drug	DIAZEPAM AND ALCOHOL	-	21-Jun-2008
Overdose of drug	-	-	02-Jul-2007
Overdose of drug	LIBRIUM AND ALCOHOL	-	27-Oct-2003
Spontaneous vaginal delivery	-	-	16-Dec-2001
Suicide and selfinflicted injury	OVERDOSE	-	20-Feb-2000
Single major depressive episode	-	-	20-Dec-1999
Alcohol dependence syndrome	-	-	18-Jun-1999
Suicide and selfinflicted injury	-	-	15-Jun-1999
Haematemesis	-	Mild	14-Jan-1999
Dislocations and subluxations	-	-	11-Jan-1999
Pain in limb	-	-	22-Sep-1998
Suicide and selfinflicted injury	-	-	10-Aug-1998
Suicide and selfinflicted injury	-	-	29-May-1998
Suicide and selfinflicted injury	-	-	01-Jan-1993
Single major depressive episode	-	-	20-Oct-1990

Past procedures (High and medium priority - all)

Description	Date performed
Introduction of Mirena coil	30-Aug-2009
Female sterilisation op.NOS	03-Sep-2001
CLO test negative	26-Aug-1998

Family conditions (All priorities)

Description	Date of Onset
FH: Ischaemic heart dis. <60	02-Apr-2008
No family history diabetes	02-Apr-2008

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Omeprazole	56	CAPS 20MG	1 Cap	In the morning	12-Sep-2003	2292 Days

Recent medication (Any medication issued within last 90 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Duration
Ferrous Sulphate	60	TABS 200MG	Half Tab	Twice daily	29-Dec-2009	0 Days
Citalopram	28	TABS 20MG	1 Tab	In the morning	21-Dec-2009	0 Days
Citalopram	28	TABS 20MG	1 Tab	In the morning	05-Nov-2009	0 Days

Citalopram	28	TABS 20MG	1 Tab	In the morning	06-Oct-2009	0 Days
Chlordiazepoxide	15	CAPS 5MG	1 Cap 3 times daily	dispense daily	25-Sep-2009	0 Days
Chlordiazepoxide	15	CAPS 5MG	1 Cap 3 times daily	dispense daily	15-Sep-2009	0 Days
Chlordiazepoxide	15	CAPS 5MG	1 Cap	3 times daily	10-Sep-2009	0 Days
Temazepam	5	TABS 20MG	1 Tab nocte	dispense daily	31-Aug-2009	0 Days
Temazepam	10	TABS 20MG	1 Tab nocte	dispense daily	20-Aug-2009	0 Days

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Current smoker:		27-Jul-2009
Current smoker:		02-Apr-2008
Current smoker:		28-Mar-2008
Current smoker:		11-Jul-2005
Alcohol intake above recommended sensible limits:		27-Jul-2009
unknown:		02-Apr-2008
Current non drinker:		11-Jul-2005
Enjoys light exercise:		02-Apr-2008
Enjoys light exercise:		11-Jul-2005

Clinical warnings

Additional relevant information
Administrative information

Previous Surname:Jenkins
OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

Signature of referring doctor (or other professional) **Date**

BREAST CLINIC

DIRECT REPORT - PROVISIONAL

DATE: 9/3/10

NAME: TERESA SINCLAIR

CRIS 5135906.

( ) MAMMOGRAPHY: Moderately dense breasts

UXD – R,

L Leen

( ) ULTRASOUND: RIGHT

nil to see U,

PLEASE RETURN FILMS TO X-RAY FOR FORMAL REPORTING

Acute Services Division

Surgery and Anaesthetics Directorate

NHS
Greater Glasgow and Clyde

Department of General Surgery

Digestive Diseases Directorate
Surgical Division
Stobhill Hospital
133 Balornock Road
GLASGOW G21 3UW

Mr D Hansell
General Surgical Clinic
Symptomatic One Stop Breast Clinic
Combined Surgery/Oncology Breast Clinic
Breast Family History Clinic

Clinic	09/03/2010
Dictated	09/03/2010
Typed	10/03/2010
Our Ref	SB/MJS
Clinic Co-ordinator	0141 201 3000 Page 4232
Secretary	0141 355 1506

Dr James Henderson
Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

Thank you for referring this lady to the Breast Clinic.

She is 46 and has had a lump in her right breast for many months. Initially, it was sore and it is now not so painful. She has a Mirena coil in-situ and is pre-menopausal. She has no family history of breast cancer.

On examination she does have bilateral fibrocystic change locally at 12 o'clock in both breasts. In the right breast there is a small, 1cm lump within this area of fibrocystic change. Mammogram showed moderately dense breasts and the right breast ultrasound showed no real abnormality in this area. I do not think there is anything to be concerned about and I suspect that things could change in this area of fibrocystic change and the lump may become less prominent. I therefore think we should see her in the clinic in 2 months time and only perform a biopsy if the lump is still palpable.

I have reassured her thoroughly and we will see her in the clinic in due course.

Yours sincerely

Miss Sylvia Brown
ST4

Acute Services Division

Surgery and Anaesthetics Directorate

NHS
Greater Glasgow and Clyde

Department of General Surgery

Digestive Diseases Directorate
Surgical Division
Stobhill Hospital
133 Balornock Road
GLASGOW G21 3UW

Mr D Hansell
General Surgical Clinic
Symptomatic One Stop Breast Clinic
Combined Surgery/Oncology Breast Clinic
Breast Family History Clinic

Clinic	27/05/2010
Dictated	28/05/2010
Typed	
Our Ref	MR/LM
Clinic Co-ordinator Secretary	0141 201 3000 Page 4232 0141 355 1506

Dr James Henderson
Campsie Surgery, Lennoxtown Clinic
103 Main Street
G66 7DA

Dear Dr Henderson

Teresa Sinclair ~ 13/08/1963 ~ CHI: 1308636407 ~ CRN: 23004807E
90a Main Street, Lennoxtown, Glasgow, G66 7DA

I reviewed this lady today at Mr Hansell's Clinic.

As you know she has been seen by Miss Sylvia Brown in March 2010. She had had a lump in her right breast. She had a Mirena IUS in situ and has since had that removed. She feels the pain has gone and she feels the lump is much less obvious.

On examination today there was nothing palpable in either breast. The area that the patient pointed to was at around 10-12 o'clock in the right breast. There was in fact some difficulty in finding this area again. This all felt like normal breast tissue. It was symmetrical and felt exactly the same as the left side. I could find no discrete areas of concern today. No axillary lymph nodes and no lymphadenopathy. I discussed this fully with her at the clinic. As you know she had a normal mammogram and ultrasound in March. There was nothing that could be biopsied and certainly I was not concerned about anything today. I have discussed this fully with her at the clinic. She was reassured by this. I understand that she has a court case pending and has recently had two grandchildren, one of whom has spina bifida and one has downs syndrome. She was obviously very anxious today but atytributed it to returning to the clinic and these three family concerns.

I have obviously asked her to keep an eye on things and to see her GP should there be any further concerns. She was quite happy to do this. I am happy to discharge her today.

Thank you for your help.

Yours sincerely

DR MARY ROUSE
Specialty Doctor

Mental Health Service

NHS
Greater Glasgow and Clyde

Receiving Consultant Physician
Ward 14A
Stobhill Hospital

Glasgow Liaison Psychiatry Service
c/o East Dunbartonshire CHP Offices
1st Floor
Stobhill Hospital
300 Balgrayhill Road
GLASGOW
G21 3UR

Date Rec'd: 16th September 2010
Date Typed: 17th September 2010

Our Ref: CMcL/ms/1305755
Your Ref:

Direct Line: 0141 531-3255
Fax: 0141 531-3222
E-mail: Marion.Sinclair@ggc.scot.nhs.uk

Dear Doctor

Teresa Sinclair – DOB 13.08.63 – CHI: 1308636407
90A Main Street, Lennoxtown, Glasgow G66 7DA

Thank you for the referral of the above named woman whom I assessed in Ward 14A of Stobhill hospital on 16th September 2010. Ms Sinclair was admitted on 16th September 2010 at 1.58 a.m. having taken an impulsive overdose of approximately 12 Citalopram tablets following the consumption of a large quantity of alcohol.

Ms Sinclair was due to "hand herself in" to the police station yesterday due to a warrant being issued for her arrest. She stated she intended to go to the police station but decided to get drunk first. She had consumed Pils lager, vodka and normal lager, and was extremely intoxicated as she had not had any alcohol for 7 days prior to this. She stated that whilst drinking the police were apparently called to her friend's house due to the noise and attempted to arrest her due to the outstanding warrant. She then informed them that she had taken the overdose of Citalopram. She denied any suicidal intent when she took the overdose and only had vague memories of actually taking it. She stated she did not want to die. She did state that the last year had not been particularly good for her. Her boyfriend was killed in a road traffic accident last year which she witnessed, and both her daughters have had children, one being diagnosed with Spina Bifida and the other Down's syndrome. She is finding this difficult to deal with.

Ms Sinclair is currently involved with the Community Addiction Team. She stated she has been drinking to excess and has a long history of alcohol excess, but has been trying to cut down so that she can take her anti-depressants. She has had one charge in the past for breach of the peace and is currently under arrest for a domestic breach after apparently "shouting at her husband".

Ms Sinclair currently lives in her own accommodation. She separated from her husband 12 years ago stating he was extremely abusive both physically and verbally towards her,

NHS
Greater Glasgow and Clyde

which makes her more upset that she has now been charged with "shouting at him". She has a 10 year old daughter from a previous relationship who currently resides with a paternal aunt. She has 3 grown up daughters from her first marriage and 5 grandchildren. Her own mother died 4 years ago and her father died 17 years ago. Her twin brother died 17 years ago at age 30. She still has 3 remaining sisters and she is the second youngest child. She has contact with all her siblings. She stated her mother was schizophrenic and one of her sisters has been diagnosed with a bipolar illness.

Ms Sinclair was born and brought up in Lennoxtown. She described her childhood as being difficult due to her mother's illness, and worse when her father died. Her mother put her into care when she was age 13 and she remained there until the age of 16. She stated her mother could not cope due to her mental health problems. She truanted from school and left at age 16. She has had various jobs over the years. She has lived in her present accommodation for 5 years and there appears to be no problems with this. She stated that during the day she tries to get out and about and see friends and family but finds night time particularly lonely.

At interview today Ms Sinclair presented dressed in hospital night attire. She was a woman with dyed blonde hair and appeared somewhat older than her years. She maintained good eye contact and her conversation was spontaneous and appropriate. Her mood was stable and reactive. Her speech was of normal rate and tone and there was no evidence of any psychotic phenomena and no evidence of any formal thought disorder. She continued to state there was little or no suicidal ideation at the time of taking the tablets. She was so intoxicated that she was unsure what her intention was at the time. She was fully orientated in all spheres and appeared cognitively intact.

This appears to have been an impulsive overdose in a woman who was intoxicated and attempting to avoid arrest by the police. There was no evidence of any psychiatric symtomatology at interview and I therefore recommended discharge into police custody when medically fit.

Yours sincerely

pp

Carolann McLaughlin
Psychiatric Liaison Nurse

Cc Dr J Henderson, Campsie Surgery, 103 Main Street Lennoxtown G66 7DA