Legal Aspects Team
Health Records Department
Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN

NHS
Greater Glasgow and Clyde

Private

MMA Legal Ltd
23 Goodlass road
Building B
Speke Liverpool
L24 9HJ

Date: 13th JULY 2026
Your Ref: 100299
Our Ref: SAR TEAM / TH
Telephone: 0141 211 0667
Email: Tracy.hunter3@nhs.scot

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: HENRY BURGESS D.O.B 22.08.1979

Thank you for your request received **24TH JUNE 2026** regarding the above patient.

We have now finished searching our files and systems for information on the patient.

Based on the details you supplied us we can confirm that we can't find any trace of the patient attending the hospital **NEW VICTORIA INFIRMARY HOSPITAL** in relation to request.
If you can supply me with more information, I would be happy to carry out a further Search.

Yours sincerely,

Tracey Hunter

SAR Team - SOUTH

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

NHS
Greater Glasgow and Clyde

MMA Legal Ltd
23 Goodlass road
Building B
Speke Liverpool
L24 9HJ

Date: **13TH JULY 2026**
Your Ref: **100299**
Our Ref: SAR/TEAM/TH
Enquiries to: Tracy Hunter
Direct Line: 0141 211 0667
Email: tracy.hunter3@nhs.scot

Dear Sir/Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: HENRY BURGESS **Date: 22.08.1979**

Thank you for your request received **24TH JUNE 2026** in which you seek a copy of your client's personal information.

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

QUEEN ELIZABETH UNIVERSITY HOSPITAL – GARTNAVEL GENERAL HOSPITAL RECORDS

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

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

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

- Patient health records, photographs or radiology images

- Video/telephone recordings, including CCTV images
- Witness statements
- Incident reports
- Complaints files
- Emails

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

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

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

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

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

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

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

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

Yours sincerely

SAR Team

ELECTRONIC PATIENT RECORDS

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

Including:

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

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Name: [redacted] .....
2208793218
Addre: BURGESS M .....
..... Henry 22/08/1979 .....
15/1 15 Scaraway Drive .....
DoB:.. Glasgow G22 7EX .....
CHI nu .....

Hospital: QEUH.	Ward: ARU2
Date of admission: 11/8/16	Time: 2215
Admitting Consultant:	Admitting Nurse: C. TURNER
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): Lauren McDermott
Age: 36	Relationship: Partner
Religion: —	NoK Address:
Telephone: 0141 258 4480.	
GP: Dr. WI Weir King Street Surgery	NoK Telephone:
GP address: The Surgery 15 King Street Paisley PA1 2PS	NoK Aware of admission: ☐ Yes ☐ No
	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
GP telephone: 0141 889 3144.	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

legal highs, valium OD.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☐

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
8	PUQR.	0	57	101/62	14	100	36.4
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
		—	4.2.	3	?	?	—

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

T1DM
known DVT. on dalteparin.

7. Risk Assessment

MUST

1. Is the patient's BMI:
   - > 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score 0
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 0
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 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

Name: .....
2208793218
Address:..... BURGESS M
..... Henry 22/08/1979
15/1 15 Scaraway Drive
DoB:..... Glasgow
G22 7EX
CHI numbe

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: ..... 4 ..... 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:

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):	C Turner	Signature:	C Turner
Designation:	SN	Date:	11/8/16

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: QEUH	Ward: ARV2
Date of Assessment: 11/5/16	Time: 2225.

Name: 2208793218
Addres: BURGESS Henry M
15/1 15 Scaraway Drive
DoB: 22/08/1979
Glasgow
CHI nu G22 7EX

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:

- [x] No symptoms
- [ ] Known cardiac or circulatory problems

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial: OT

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: OT

5. Hydration and Nutrition

Name: ...
Address:.. 2208793218
BURGESS M
Henry 22/08/1979
DoB: ..... 15/1 15 Scaraway Drive
Glasgow
CHI num G22 7EX

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

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

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address:.....
.....
DoB: .....
CHI numb

2208793218
BURGESS M
Henry 22/08/1979
15/1 15 Scaraway Drive
Glasgow
G22 7EX

Personal hygiene:

- [x] Self-caring and independent
- [ ] Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	[x] Yes	[ ] No
Does the the patient have a sore mouth	[ ] Yes	[x] No
Does the patient have a non healing mouth ulcer	[ ] Yes	[x] 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
- [x] 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 [ ] No [x] 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

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
- [x] No

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial

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:

- [x] Required
- [ ] Not required

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial

0. 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

Name: .....
Address:... 2208793218
BURGESS
..... Henry
DoB:..... 15/1 15 Scaraway Drive
Glasgow
CHI numb G22 7EX

M
22/08/1979

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

	Initial

1. 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

2. 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:

Name:	 2208793218
Address:....	BURGESS M
.....	Henry 22/08/1979
DoB:.....	15/1 15 Scaraway Drive
	Glasgow
CHI numbe	G22 7EX

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): C. TURNER
Signature: Corne
Designation: S/N Date: 11/8/16.

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
	Patient admitted via A+E in police custody with recreational drug use overdose. GCS is easily rousable. Admitted for observation. News score 3. On IVF and O_2. Awaiting bloods in.	C TURNER Corne S/N.
07[w]	Seen by midio & GCS 2° to alcohol and benzodiazepines, concurrent	

Clinical Notes continue on next page

Name: .. 2208793218 .....
Address:.. BURGESS M .....
..... Henry 22/08/1979 .....
15/1 15 Scaraway Drive
DoB: ..... Glasgow .....
G22 7EX
CHI num .....

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	LRTI unlikely given CRP < 1	
	and WCC (N). May have degree	
	of COPD already. Plan CXR,	
	(H) / back to custody	C Turner SN
12/08/16	Pt for home today. Venflon removed and pt mobilising with no issues during with no issues.	C. Bruce
		Home

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Nan
Add 2208793218
BURGESS M
..... Henry 22/08/197
15/1 15 Scaraway Drive
Dol Glasgow
Chi G22 7EX

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

****Please record insulin preparation and administration times in the main Medicine Prescription Form (Kardex) and write 'as per chart' across the administration boxes****

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)			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)					
12/8/16											Y / N
											Y / N
	Before Breakfast		9.2								Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										Y / N
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										Y / N
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										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)					
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										Y / N
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										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

W
N
Ac 2208793218
BURGESS M
Cl Henry 22/08/1979
Di 15/1 15 Scaraway Drive
Hi Glasgow
G22 7EX

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 phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula 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_____	14/1/16	20 mm	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	0	No phlebitis : Observe cannula
	One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
	Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis : Remove & resite cannula
	All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula 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 ☐	

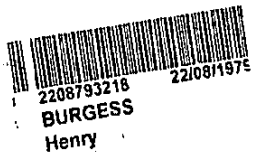
Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address



CHI No.
Do8

	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.

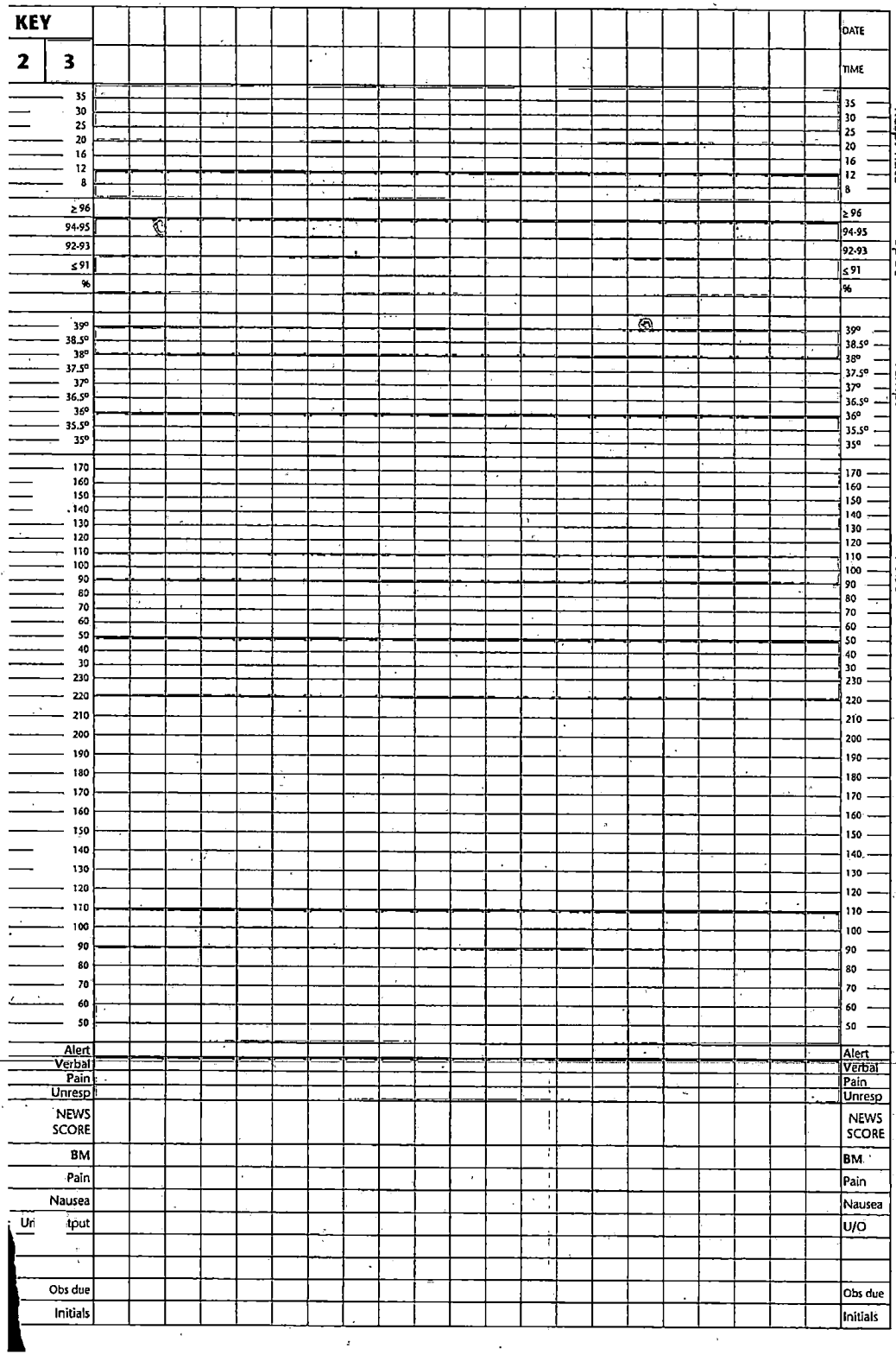
Henry Burgess

(24)

DATE:	11/8					12/8	
TIME:	18 51			22 15	23 3	06 30	
Resp. Rate (35 / 30 / 25 / 20 / 16 / 12 / 8) Mark: •	14	15	15	14	14	•	
SpO_2 (≥96 / 94-95 / 92-93 / ≤91) (Enter Value)	92		100	100	100	94	
Any Sup'l O_2 % / Room air	AIR		RA	RA	AL	AL	
Temp. (39° – 35°) Mark: X	36.5			36.4	X	X	
Pulse (170 – 30) Mark: •	69		80	57	52	•	
Blood Pressure Mark: ◇ / NEWS SCORE using Systolic BP (230 – 50)	90/62		94/50	101/62	99/56	◇	
Conscious Level (Alert / Verbal / Pain / Unresp) Mark: •				A	A	•	
Total NEWS (with all obs)	5		(2)	3	4	3	
BM	7.9	5.1					
Pain							
Nausea							
Urine output							
Obs due	10						
Initials	MW		RJ		[illegible]	DP	

Right-hand key: DATE | TIME | 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

NEWS	
0	1


KEY
2
3
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
Urine Output
U/O
Obs due
Initials

Glasgow Coma Scale

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

Neurological Observations

Date:																						
Time:																						
COMA SCALE — E (Eyes open)	Spontaneously	4																				Eyes closed by swelling = C
	To speech	3																				
	To pain	2																				
	None	1																				
V (Best Verbal response)	Orientated	5																				Endotracheal tube or tracheostomy = 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																					
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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 BURGESS M Henry 22/08/1979 aph 15/1 15 Scaraway Drive Glasgow G22 7EX	Hospital: Ward:	**Points to consider:** • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
11/8/16	22:00	N	N	N	N	N	N	4-6 hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

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

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 11/8/16

Attach Addresso

2208793218
BURGESS M
Henry 22/08/1979
15/1 15 Scaraway Drive
Glasgow
G22 7EX

Ward:

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr (4hr) 6hr

1. Signed ..... Name ..... Designation .....
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

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

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	22[24]	09																	
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N																	
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	N																	
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		-	-																	
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I																	
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		-	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 or faeces		I	I																	
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N																	
		Encourage the patient to drink? Y / N / N/A		N	Y																	
		Food, snack or supplement taken? Y / N / N/A		N	-																	
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y																	
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		Y	Y																	
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		NA	NA																	
			Nurse Initials	LM	LM																	

Attach Addressograph label

Ward:

NHS Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet - Care Number

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

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902 GCC0098

Acute Services Division

Hospital / Department

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

2208793218

Patient name: .... BURGESS Henry M

Ward: ..... 15/1 15 Scaraway Drive Glasgow 22/08/1979

CHI number: .... G22 7EX ..... Unit/Hospital number .....

Contents

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

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

Acute 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: 1/1/8 Ward: A2 W2	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				1						
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 **	Medication for mental illness & drug / alcohol withdrawal 1	Blood pressure / water tablets 1	Sedatives / Analgesia / Night sedation 1	None of these 0		0010						
Medical history	Cardiovascular Disease / Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	01000						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chairbound / wheelchair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		3						
				TOTAL SCORE		8						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		Fel Aen						
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: 11/8 Ward: ACU	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.							

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.

Patient name TJ04577802
BURGESS M
Henry 22/08/1979
Patient CHI 0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

2208793218

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Presenting complaint - and relevant past medical history including allergies

Date and Time		Name/Signature
4/8/22 0810	IN PSYCH ROOM C POLICE BIBP: ?Ingested unknown drugs whilst in custody, Pt denies	

Nursing notes - on admission

Date and Time		Name/Signature
	same however police report empty ?drug packs wrapper found in cell. Pt alert & orientated, independent to toilet, NAD complaining, NEWS0 TOB 0 SN blanket given, awaits SW TO BUCHANAN	

Triage

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

Communication

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

Risk Assessments and Screening Tools

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

Signature:

Patient name

Patient CHI

TJ04577802
BURGESS M
Henry 22/08/1979
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

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

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

Patient name

TJ04577802
BURGESS M
Henry 22/08/1979
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

Patient CHI 2208793218

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**

NHS Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

Patient name

Patient CHI

TJ04577802
BURGESS M
Henry 22/08/1979
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

Nursing notes - discharge plannning

Date and Time		Name/Signature

Outcomes and outstanding issues

Date and Time		Name/Signature

Pause for Discharge or Transfer

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

Contact with relatives

Signature:

Patient name

Patient CHI

TJ04577802
BURGESS
Henry M
0/1 128 Neilston Road 22/08/1979
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

2207793218

4AT assessment - for delirium and cognitive impairment

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

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

TOTAL

Frailty Assessment Tool (Healthcare Improvement Scotland)

Step 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)? circle Y or N

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

If YES to any of the criteria in Step 1 move to Step 2
Step 2 Would this person be better managed by another speciality team at present? circle Y or N

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

Are any of the criteria met?
If YES to any criteria in Step 2: Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.
If YES to any criteria in Step 1 and NO to ALL criteria in STEP 2: Prioritise transfer of care to specialist geriatric assessment service.

Patient name

Patient CHI

TJ04577802
BURGESS M
Henry 22/08/1979
0/1 128 Neilston Road
Paisley, Renfrewshire
PA2 6EP

NHS
Greater Glasgow and Clyde

Nursing notes - ongoing care

Date and Time		Name/Signature

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

TJ04577802 M
BURGESS 22/08/1979
Henry
0/1 128 Neilston Road
Paisley, Renfrewshire PA2 6EP

220 879 3217

	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: ....

Pupil Reaction and size

S = sluggish
+ = reaction
- = no reaction
C = eyes closed

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

Glasgow Coma Scale

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.

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 tool.

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

TJ04577802 M
BURGESS 22/08/1979
Henry

MI • 316654 v5.1 • GGC0264

NEWS 2 Key	1	2	3

TJ04577802 BURGESS Henry M 22/08/1979

	Example		
Date	1/11	3/3	4/3
Time	11.00	22.35	03.00

A + B Respirations Breaths/min

Range	Score	Example		
≥25	3			
21-24	2			
12-20	0	•	•	•
9-11	1			
≤8	3			

A + B SpO2 Scale 1 Oxygen saturation (%)

Range	Score	Example		
≥96	0	97	99	98
94-95	1			
92-93	2			
≤91	3			

SpO2 Scale 2 Oxygen saturation (%) Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure

Only use scale 2 under direction of qualified clinician

Range	Score
≥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?

	Score	Example		
Air (A) or O2 device	0	A	A	A
O2 L/min 2	2			

C Blood Pressure mmHg (uses systolic BP)

Range	Score	Example		
≥220	3			
201-219	0			
181-200	0			
161-180	0			164
141-160	0		158	
121-140	0			
111-120	0			
101-110	1			
91-100	2			94
81-90	3		89	
71-80	3			
61-70	3			
51-60	3			
≤50	3			

C Pulse Beats / min

Range	Score	Example		
≥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 neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

	Score	Example		
A Alert	0	•	•	•
C New Confusion	3			
V Verbal	3			
P Pressure	3			
U Unresponsive	3			

Temperature

Range	Score	Example		
≥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			

	Example		
NEWS Total	0	0	0
Blood glucose	7.0	11.1	8.2
Pain / function score	0A	0/A	0/A
Time Pt last passed urine	10.20	X	CATT
Fluid balance chart indicated Y/N	N	N	N
GCS indicated Y/N	N	Y	Y
Time NEWS due	23.00	4	
Escalation of care Y/N	N	N	
Initials	AB	[illegible]	[illegible]

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)

TJ04577802 BURGESS Henry M 22/08/1979 2207793218

TJ04577802 BURGESS Henry M 22/08/1979 2207793218

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.

Y room

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: TJ04577802

Total Att: 0

12 Mth Att: 0

Title: MR

BURGESS

Henry

DOB 22/08/1979

Age: 42y

Sex: Male

0/1 128 Neilston Road

Paisley
Renfrewshire
PA2 6EP

Next of kin: GARRETT, Fiona
Relationship: Partner

GP: UNK-Foreign Visitors No GP
11111 111111

Attendance Date: 03/03/2022 Arrival Time: 21:32

Registration Time: 21:32 Date of Incident: 03/03/2022

Major Incident Desc:

Reason for Attendance: POLICE CUSTODY taken unknown substances

Nursing Assessment

Alerts: Not Recorded Allergies: Not Recorded Pain Score:

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

Presenting Complaint: Gastrointestinal Ingestion

Observation Date: 03/03/2022 22:35

Temp	36.2	C
HR	63,	bpm
BP	158/89	mmHg
MAP	112.00	mmHg
RR	16	bpm
SpO2	99	%
Oxygen	21	%

Nurse name: Nurse Susan Young

BM	11.1	mmol/L
PF		l/min
Expected PF		l/min
Weight		kg
Height		cm
Visual Acuity		
Left		
Right		
Corrected?		

GCS	
Eyes	4
Motor	6
Verbal	5
Total	15

Pupils-Right		Pupils-Left	
Size (mm)	3	Size (mm)	3
Reaction	Y	Reaction	Y

Nursing Notes: BIBP - Patient in police custody, empty drug wraps found in cell ?ingestion. Patient denies this. GCS 15/15, appears well.

Child Assessment Questionnair

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

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

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

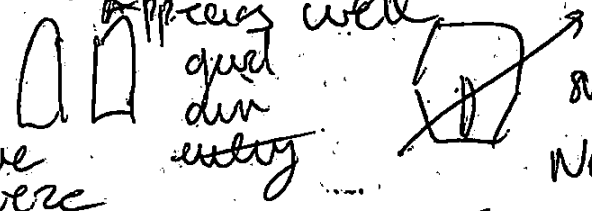
DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Hannah Bellerive Time seen 03:30

Hx Police report while in custody found with empty packets in cell
- Patient reports hasn't taken any medication or any of his regular medications
- no unprescribed medicines or illicit drugs today, last took something yesterday.
- no alcohol tonight either
- patient feels well
- has been in cell all day and reports no disorder
- unclear history from patient and police
- Patient well and wants to go back to police custody.

OE



HS 1+11+0 HR 65 regular
no murmurs. heard.
GCS 15/15 no meningism signs of head injury or other injury
awake alert & orientated.
CBS → Normal HR BP ± BM 11.1

PMH
- regular marijuana user
- methadone programme
- previous alcohol misuse & substance misuse.
- T1DM. - BM 11.1

Date	CLINICAL NOTES
	Cover DNO Dr Ameil. Plan — Discharge .. MD H. Dolleve FY2.

Discharge Codes (Please CIRCLE)				Discharge date	4/3/22
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge time	04:00.

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged		Not arranged			To be arranged		
Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 2208793218

Total Att: 14

12 Mth Att: 5

Title: MR

BURGESS Henry

DOB: **22/08/1979** Age: **38y** Sex: **Male**

14 Thompson Brae

Paisley
Renfrewshire
PA1 1TP

Next of kin: **THOMSON, Lorna**
Relationship: **Sister**

GP: **S Goyal**
0141 889 3144

Attendance Date: **10/12/2017** Arrival Time: **14:56**

Registration Time: **14:56** Date of Incident: **10/12/2017**

Major Incident Desc:

Reason for Attendance: **unwell**

Nursing Assessment

Alerts: **Yes**

Allergies: **None Known** Pain Score:

Triage Category: **3**

Tetanus up to date/fully immunised:

Presenting Complaint: **General Generally Unwell**

Observation Date: **10/12/2017 15:24**

Nurse name: **Nurse Kimberley McLean**

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: **for police surgeon**

Child Assessment Questionnaire

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

attended ⓒ police supervision for entry search

performed in room by police supervisor.

Patient denied any hidden ~~TB~~

No further interaction with myself.

ⓒ.

Date	CLINICAL NOTES
	 2208793218 22/08/1979 BURGESS Henry

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow

Queen Elizabeth University Hospital

CHI: 2208793218

Total Att: 13

12 Mth Att: 4

Title: **MR**

BURGESS **Henry**

DOB: **22/08/1979** Age: **38y** Sex: **Male**

14 Thompson Brae

Paisley
Renfrewshire
PA1 1TP

Next of kin: **THOMSON, Lorna**
Relationship: **Sister**

GP: **S Goyal**
0141 889 3144

Attendance Date: **10/12/2017** Arrival Time: **11:49**

Registration Time: **11:49** Date of Incident: **10/12/2017**

Major Incident Desc:

Reason for Attendance: **leg ulcer unwell**

Nursing Assessment

Alerts: **Yes**

Triage Category: **5**

Allergies: **None Known** Pain Score:

Tetanus up to date/fully immunised:

Presenting Complaint:

Observation Date: **10/12/2017 12:09**

Temp	**36.1**	C
HR	**70**	bpm
BP	**164/109**	mmHg
MAP	**127.33**	mmHg
RR	**14**	bpm
SpO2	**97**	%
Oxygen	**21**	%

Nurse name: **Nurse Susanne Flanagan**

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: **Brought in by Police ? ingested drugs**

Child Assessment Questionnaire

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

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

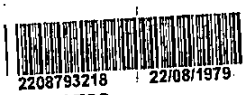
X-Ray and Other Reports to be filed on this side (if the patient is not being admitted)

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) VGORDON Time seen
10/12/17	out up by police nurse ? taken drugs
	patient denies this
	in custody for 48°
	had a cavity search O/A !
	∴ OBS as reqd
	patient well
	ⓘ

2208793218 22/08/1979
BURGESS
Henry

Date	CLINICAL NOTES
	 2208793218 22/08/1979 BURGESS Henry

Discharge Codes (Please CIRCLE)					Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)			
5. Died	6. Refer to OP Clinic (see below)		7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant if admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Name: 2208793218 .....
Addre: BURGESS M .....
Henry 22/08/1979 .....
15/1 15 Scaraway Drive .....
DoB:.. Glasgow G22 7EX .....
CHI nu .....

Hospital: GEUH.	Ward: ARU2
Date of admission: 11/8/16	Time: 22 15
Admitting Consultant:	Admitting Nurse: C. TURNER
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): Lauren McDermott
Age: 36	Relationship: Partner
Religion: /	NoK Address:
Telephone: 0141 258 4480.	
GP: Dr. WI Weir King Street Surgery	NoK Telephone:
GP address: The Surgery 15 King Street Paisley PA1 2PS	NoK Aware of admission: ☐ Yes ☐ No
	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
	Telephone - Day:
GP telephone: 0141 889 3144.	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

legal highs, valium OD.

Why does the patient think they are in hospital? *Use patients own words:*

3. Allergies (including food allergies)

No known allergies: ☐

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
8	PUDA.	0	57	101/62	14	100	36.4
Urinalysis:		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
		/	4.2.	3	?	?	—

5. Current Medication

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

TIAM
known DVT. on dalteparin.

7. Risk Assessment

MUST

1. Is the patient's BMI:
   - > 20 ..... Score 0
   - 18.5-20 ..... Score 1
   - <18.5 ..... Score 2

   Score 0

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 0

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 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

Name: .....
2208793218
Address:..... BURGESS M
..... Henry 22/08/1979
15/1 15 Scaraway Drive
DoB: ..... Glasgow
G22 7EX
CHI numbe

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: ..... 4 ..... 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:

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):	C Mullen	Signature:	Mum
Designation:	SN	Date:	11/8/16

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: QEUH	Ward: ARU2
Date of Assessment: 11/5/16	Time: 2225.

Name: .....
2208793218
Addres: BURGESS M
..... Henry 22/08/1979.....
15/1 15 Scaraway Drive
DoB:.. Glasgow .....
CHI nu G22 7EX .....

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:

- [x] No symptoms
- [ ] Known cardiac or circulatory problems

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial: OT

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: OT

5. Hydration and Nutrition

Name: ...  .....
Address:.. 2208793218 .....
BURGESS M
..... Henry 22/08/1979 .....
DoB:..... 15/1 15 Scaraway Drive .....
Glasgow
CHI num G22 7EX .....

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

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

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address:....
.....
DoB:.....
CHI numb

2208793218
BURGESS M
Henry 22/08/1979
15/1 15 Scaraway Drive
Glasgow
G22 7EX

Personal hygiene:

- [x] Self-caring and independent
- [ ] Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	[x] Yes	[ ] No
Does the the patient have a sore mouth	[ ] Yes	[x] No
Does the patient have a non healing mouth ulcer	[ ] Yes	[x] 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
- [x] 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 [ ] No [x] 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

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
- [x] No

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial

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:

- [x] Required
- [ ] Not required

Problem identified: [ ] Yes [x] No If 'Yes' please describe

Initial

0. 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

Name: [redacted]
Address: 2208793218
BURGESS M
Henry 22/08/1979
DoB: 15/1 15 Scaraway Drive
Glasgow
CHI numb G22 7EX

Problem identified: ☐ Yes ☑ No If 'Yes' please describe

Initial

OT

1. 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

OT

2. 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:

Name: .....
Address:.....
.....
DoB: .....
CHI numbe

2208793218
BURGESS M
Henry 22/08/1979
15/1 15 Scaraway Drive
Glasgow
G22 7EX

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:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
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): C. TURNER
Signature: Turner
Designation: S/N
Date: 11/8/16.

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
	Patient admitted via A+E in police custody with recreational drug use. Overdose. GCS 13 easily rousable. Admitted for observation. News score 3. On IVF and O_2. Awaiting clerk in.	C TURNER Turner S/N.
07:00	Seen by medic & GCS 2° to alcohol and benzodiazepines, concurrent	

Clinical Notes continue on next page

Name: 2208793218
Address: BURGESS M
Henry 22/08/1979
15/1 15 Scaraway Drive
DoB: ..... Glasgow
G22 7EX
CHI num

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	LRTI unlikely given CRP < 1	
	and WCC (N). May have degree	
	of COPD already. Plan CXR,	
	(H) / back to custody	C Turner SHO
12/08/16	Pt for home today. ventolin removed and pt mobilising waits no issues during waits no issues :	C. BRUCE
		Nurse

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Nan	2208793218
Add	BURGESS
	Henry M
	15/1 15 Scaraway Drive 22/08/197
DoI	Glasgow
Chi	G22 7EX

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

****Please record insulin preparation and administration times in the main Medicine Prescription Form (Kardex) and write 'as per chart' across the administration boxes****

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
12/8/16											Y / N
											Y / N
	Before Breakfast		9.2								Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										Y / N
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										Y / N
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										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)					
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										Y / N
											Y / N
											Y / N
	Before Breakfast										Y / N
											Y / N
	Before Lunch										Y / N
											Y / N
	Before Dinner										Y / N
											Y / N
	Before Bed										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

W
N.
Ac 2208793218
BURGESS M
Henry 22/08/1979
Cl 15/1 15 Scaraway Drive
Di Glasgow
Hr G22 7EX

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 phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs.: Observe cannula
Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis - Remove & resite cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula 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_____	14/1/16	① Arm.	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	0	No phlebitis : Observe cannula
	One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
	Two or more of the following are evident: pain,redness,swelling	2	Early stage of phlebitis : Remove & resite cannula
	All of the following are evident: pain,redness,hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula 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 ☐	

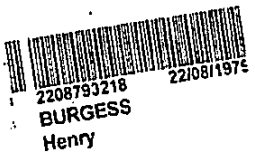
Date & time	PVC no.	Comments	Signature

Date removed_____ Reason for PVC removal_____ Reason PVC in greater than 72 hours_____

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address



CHI No.
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

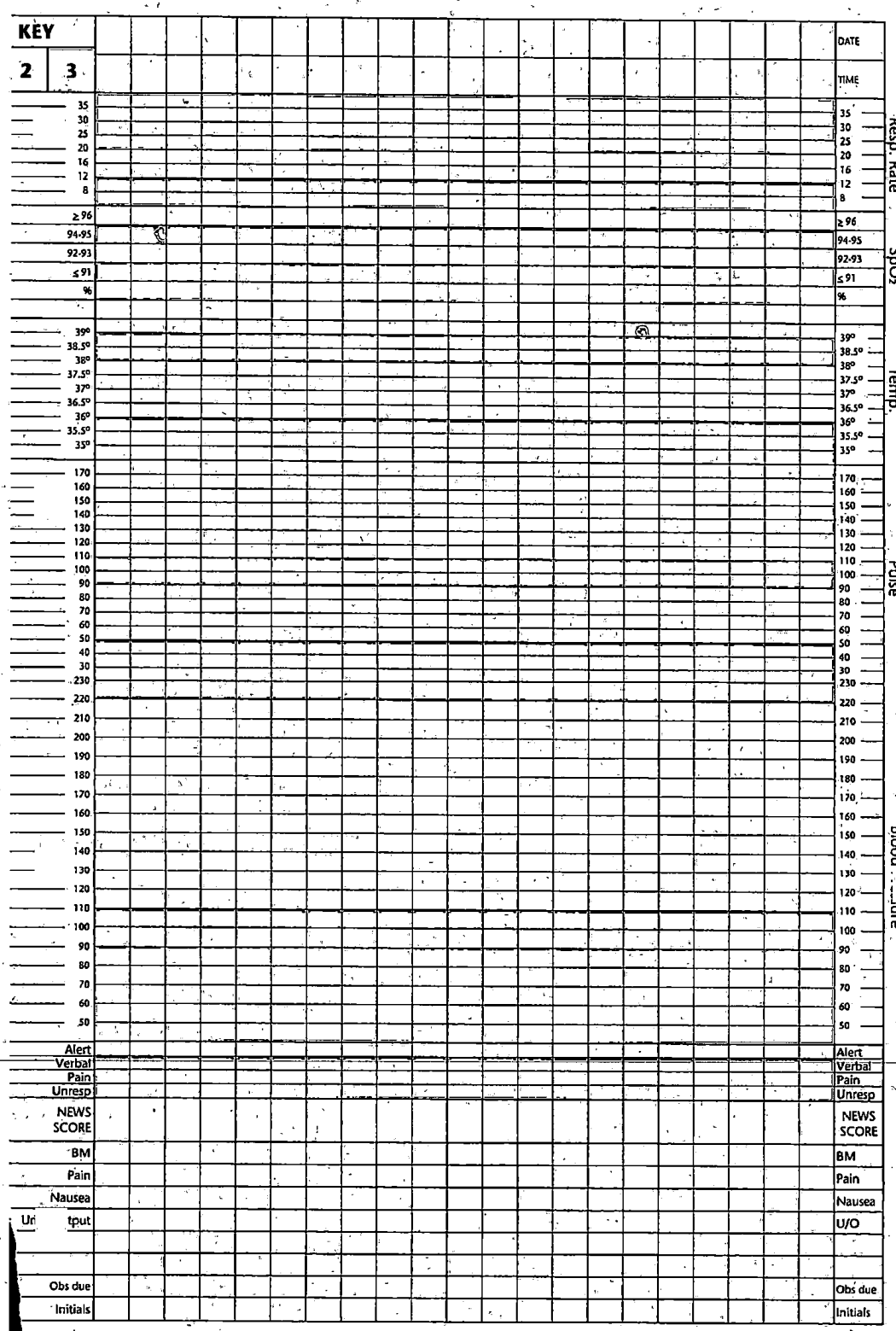
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need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

Henry Burgess

(21)

	DATE:	11/8					12/8	
	TIME:	19 51			22:15	23:3	08:30	
Resp. Rate Mark: •	35 / 30 / 25 / 20 / 16 / 12 / 8	14	15	15	14	14	•	
SpO$_2$ (Enter Value)	≥96 / 94-95 / 92-93 / ≤91	92		100	100	100	90	
Any Sup'l O$_2$	%				1L A	AL	AL	
Room air		AIR		RA				
Temp. Mark: X	39° / 38.5° / 38° / 37.5° / 37° / 36.5° / 36° / 35.5° / 35°	36.5			36.4	>	X	
Pulse Mark: •	170 / 160 / 150 / 140 / 130 / 120 / 110 / 100 / 90 / 80 / 70 / 60 / 50 / 40 / 30	69		80	57	52	•	
Blood Pressure Mark: ◇ / NEWS SCORE using Systolic BP	230 … 50	90/62		94/50	101/62	99/56	^ / V	
Conscious Level Mark: •	Alert / Verbal / Pain / Unresp				A	A	•	
Total NEWS (with all obs)		5		(2)	3	4	3	
	BM	7.9	5.1					
	Pain							
	Nausea							
	Urine output							
	Obs due	1°						
	Initials	[illegible]		RJ.	[illegible]	[illegible]	DP.	

NEWS	0	1
DATE		
TIME		
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		


KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood ...ure
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
Uri tput
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

1 2 3 4 5 6 7 8

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = 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																									
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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

2208793218 BURGESS M Henry 22/08/1979 *aph* 15/1 15 Scaraway Drive Glasgow G22 7EX	Hospital: Ward:	**Points to consider:** • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
11/8/16	22:40	N	N	N	N	N	N	4-6 hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

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

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 11/8/16

Attach Addresso
2208793218
BURGESS M
Henry 22/08/1979
15/1 15 Scaraway Drive
Glasgow
G22 7EX

Ward:

I have evaluated and deemed that the frequency of care delivery over the next work shift based on the patient's most critical need should be every (Please circle): 1hr 2hr 3hr (4hr) 6hr

1. Signed ..... Name ..... Designation .....
2. Signed ..... Name ..... Designation .....
3. Signed ..... Name ..... Designation .....

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

USE FOLLOWING CODE:
O = Off the ward V = Variant S = Sleeping I = Independent NT = No Thanks

			Times	22[24]	04 00	12[24] 8																	
	1.	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N																		
S	2.	SKIN INSPECTION Pressure areas checked: Y / N / I (Independent)		I	N																		
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		-	-																		
K	3.	KEEP MOVING: Have you moved or walked Y / N / I (independent)		I	I																		
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		-	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 or faeces		I	I																		
N	5.	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N																		
		Encourage the patient to drink? Y / N / N/A		N	Y																		
		Food, snack or supplement taken? Y / N / N/A		N	-																		
	6.	ENVIRONMENT: Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y																		
	7.	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S		Y	Y																		
	8.	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		NA	na																		
			Nurse Initials																				

Attach Addressograph label

Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet - Care Number

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

Date	Time	Number	Variation	Signed

CEDAR CODE 102083

MIS 258902 GGC0098

Acute Services Division

Hospital / Department

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

2208793218

Patient name: .... BURGESS Henry M

Ward: ..... 15/1 15 Scaraway Drive Glasgow 22/08/1979

CHI number: .... G22 7EX ..... Unit/Hospital number .....

Contents

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

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

Acute 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: 11/8 Ward: A12	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				1						
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 **	Medication for mental illness & drug / alcohol withdrawal 1	Blood pressure / water tablets 1	Sedatives / Analgesia / Night sedation 1	None of these 0		0010						
Medical history	Cardiovascular Disease / Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	01000						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chairbound / wheelchair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		3						
				TOTAL SCORE		8						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		Sec den						
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: 11/8 Ward: Rm	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.							

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 Oxcycontin.

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.

24

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Queen Elizabeth University Hospital

CHI: 2208793218

Total Att: 8

12 Mth Att: 5

Title: MR

BURGESS Henry

DOB: 22/08/1979 Age: 36y Sex: Male

15/1 15 Scaraway Drive

Glasgow
G22 7EX
0141 258 4480

Next of kin: MCDERMITT, LAUREN
Relationship: Partner

GP: WI Weir
0141 889 3144

Attendance Date: 11/08/2016 Arrival Time: 18:51

Registration Time: 18:51 Date of Incident: 11/08/2016

Major Incident Desc:

Reason for Attendance: bibp - high on substances, has dvt

Nursing Assessment

Alerts: Yes Allergies: None Known Pain Score:

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

Presenting Complaint:

Observation Date: 11/08/2016 19:10 Nurse name: Nurse Karen Bowden

Temp	36.5	C
HR	69	bpm
BP	90/62	mmHg
MAP	71.33	mmHg
RR	14	bpm
SpO2	92	%
Oxygen		%

BM	7.9	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: in police custody. under influence drugs. iddm. states has taken x2 valium. very drowsy

Nursing Notes:

Child Assessment Questionnaire

Create

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

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

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

DO NOT WRITE HERE PLEASE

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

Date	CLINICAL NOTES
	Seen by (Dr) Time seen

Pt is 36 yo male. brought in by police from custody. @ Arrested at 16:00 today. ~~after a fight.~~ Admittes to taking valium 2pcs and having a beer, has previously described having taken smoked drugs today. Was found sleeping and difficult to rouse in cell, therefore brought to ED. ~~Arrested~~ due to charges in fight in april, no known recent trauma.

History: type 1 DM according to police dr. nurse
IV. drug abuse + alcoholism.
DVT on dalteparin,

Exam. GCS 13. Follows commands.
symm. reactive pupils, no sign of trauma on face, head, thorax, abdomen.
heart S1 + S2
Lungs: no crackles but prolonged expirations w. phlegmatic upper airway sound.
Abdomen soft, generelly slightly tender, no rebound tenderness.
limbs. left leg ok. right leg w. redness, sore, swollen. painful calv right.

Date	CLINICAL NOTES

Labs: pO_2 arterial 8,8. ↓ pCO_2 7,2 ↑
FBC, LFT, CK, CRP, U & E not back.
glucose 7,9 and 5,1!

Dx: Recreational drug use overdose.

GCS 13. Saturation 89-95, w 1-2 $L O_2$ is 92-97. Easily roused with touch.

Adm. for observation.

- Respiration and saturation
- kidney function and CK in Labs.
- Obs glucose.
- Chest X-ray for coughing.

Already recieving NaCl

Cre_GB. A&E

Discharge Codes (Please CIRCLE)				Discharge date	
1. Admission	2. Discharge	3. Refer to GP	4. Transfer to other (see below)		
5. Died	6. Refer to OP Clinic (see below)	7. Irregular Discharge	8. D.O.A.	Discharge time	

Ward number (if admitted):	Transfer to hospital:	Consultant If admitted):

Follow up	Arranged	Not arranged	To be arranged

Clinic referred to	A&E	Hand injury	Fracture	Pop Check	Medical	Surgical	ENT	Others (specify):

Discharge Prescription Packs

Date Given	DRUG (BLOCK CAPITALS)	Dose	Method of Administration	Frequency	Signature	Given By

Glasgow City CHP
Police Custody Healthcare Services
923 Helen St
Glasgow
G52 1EE

NHS
Greater Glasgow and Clyde

Date 11/08/2016
Your Ref
Our Ref
Direct Line 0141 5325026
Fax
E-mail

Re : Name : Henry Burgess
DOB: 22/08/1979

lease see the above gentleman

Clinical Presentation

Type I diabetic who was a hand in today to Govan Police Office.
He appeared under influence of substance/substances unknown, states took legal highs this afternoon, unsure of what they were but they were smoked.
He currently has right DVT and is on Dalteparin for same, unsure how his compliance is, his leg is hot to touch, swollen and painful, obviously I have no markers on how this was previously.
Observations – T 37.6, P – 85, BP – 124/74, SpO2 – 91%, BM – 12.9mls.
He usually takes Novorapid 30 – 22iu BD.

I have discussed this case with DR Moughal FP, he suggests that he is taken to ED for further assessment.

Yours sincerely

Anne Keys
Police Custody Healthcare Nurse

NHS GGC Hospitals, Emergency Department

NHS Greater Glasgow and Clyde

Affix Label

Hospital (*circle*)	IRH	RAH	RHSC	GRI	WIG	VI	VIMIU	Stob	VOL	SGH

Title:	Sex: M ☐ F ☐
SURNAME:	Forename:
CHI:	Dob:: Age:
Local address:	Next of kin:
	Relationship:
	Tel:
	GP:
Postcode:	
Tel:	Tel:

Attendance date:	Arrival time:	Date of incident:
Registration time:	Major incident description:	
Reason for attendance:		

Affix Label

Nursing Assessment	Alerts:
Presenting complaint:	

Triage category:	Pain score:	Tetanus up-to-date / fully immunised?
Allergies:		

Observations date:			Time:			Nurse's name:			
Temperature		°C	BM		mmol/L	GCS			
HR		bpm	PF		l/min	Eyes			
BP		mmHg	Expected PF		l/min	Motor			
MAP		mmHg	Weight		kg	Verbal			
RR		bpm	Height		cm	Total			
SpO_2		%	Visual Acuity			Pupils – Right		Pupils – Left	
Oxygen		%	Left	6/		Size		Size	
			Right	6/		Reaction		Reaction	
			With correction?						

Nursing Notes:

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

Date	Emergency Department Notes	
	Seen by (Doctor)	Time seen

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

Done/ completed	Imedlate Managment Plan

Signature:	Designation:	Page No:

Acute Medical or Surgical Admission Unit Notes

2208793218
BURGESS M
Henry 22/08/1979

Ple e

Initial Assessment

Seen by (print): RALSTON

Time seen: 0600 12/8/16

Presenting Complaint

↓ responsiveness

History of Presenting Complaint

36♂ in police custody. Arrested yesterday re: fight in April. Found difficult to rouse in his cell. Noted to be under the influence of ?snorted legal highs on arrest.

Vague on events pre-arrest. Drank a bottle of wine and took 2 street valium. Denies other drug use. Denies ongoing symptoms, though has a chronic cough productive of brown phlegm.

Past Medical History

T1DM
DVT

Systemic Enquiry

CVS
N.1

RESP
As above. No dyspnoea/haemoptysis

GI
N.1

CNS/PNS
N.1

GU
N.1

Musculoskeletal
N.1

Clinical Data

Last Emergency Care Summary received 09 August 2016

Allergy

Description	Date Recorded	Comments

Acute Medication (including those greater than 30 days)

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date

Repeat Medication

Originator	Drug ID	Formulation	Dose	Frequency	Medication Start Date	Prescription Date	Dispensed Date	Cancel Date
In Practice	Pregabalin	150 mg Capsules	N/A	TAKE TWO IN THE MORNING AND TWO AT NIGHT	14-Jan-2013	09-Aug-2016	X	
In Practice	Mirtazapine	30 mg Tablets	N/A	ONE TO BE TAKEN AT NIGHT	19-Dec-2012	29-Jul-2016	X	
In Practice	Novorapid Flexpen	100 units/ml, 3 ml pre-filled pen Solution for Injection	N/A	TO BE USED AS DIRECTED	19-Dec-2012	29-Jul-2016	X	
In Practice	Glucose	40 % Oral gel	N/A	TO BE USED AS DIRECTED	19-Dec-2012	29-Jul-2016		
In Practice	Onetouch Ultra	Test strips	N/A	AS DIRECTED	06-Feb-2013	29-Jul-2016		
In Practice	Omeprazole	20 mg Capsules (Gastro-Resistant)	N/A	ONE TO BE TAKEN EACH DAY	28-Apr-2015	29-Jul-2016	X	
In Practice	Omnican Fine	8 mm/31 gauge Needles for insulin pens	N/A	USE AS DIRECTED	28-Apr-2015	29-Jul-2016		
In Practice	Novomix 30 Flexpen	100 units/ml, 3 ml pre-filled pen Suspension For Injection	N/A	TO BE USED AS DIRECTED	19-Dec-2012	29-Jul-2016	X	
In Practice	Dalteparin Sodium	12,500 units/0.5 ml pre-filled syringe Injection	N/A	TO BE INJECTED DAILY UNTIL 11.10.2016	12-Jul-2016	22-Jul-2016	X	

MEDICINES RECONCILIATION (ECS can be stapled here and annotated with plan for medicines. Please sign medicines plan.)

Source of medication history: Patient ☐ Relative/ carer ☐ GP Surgery ☐ ECS ☐
PODs ☐ Com. Pharmacist ☐ GP letter ☐ Rpt Presc ☐

Admissions medicines				Plan for medicines			
Name	Dose	Frequency	Continue	Stop	Amend	Hold	Comments/ reason

Allergies	Medication needs
None known ☑	Further clarification? Yes ☒ No ☑
Completed by: RACston	Designation: FY2 Date: 12/8/16

Drugs prescribed on admission checked and correct

Compliance aid? Yes ☐ No ☐

Comments:
Not completed - pt discharged back to police custody before seen.

Community Pharmacist

Reviewed by: MRichards Designation: Pharmacist Date: 12/8/16

2208793218
BURGESS M
Henry 22/08/1979

Social History

Smoking History: Heavy smoker

Alcohol History:

Other drug use?:

Home circumstances

General Examination

Temp: 36.2	RR: 14
Pulse 52	BG:
SpO2: 100% on 4l	Weight:
BP: 99/58	Urinalysis:

Cardiovascular Examination

WNSPP, CRT <2s

0 oedema

HS 1+11+0

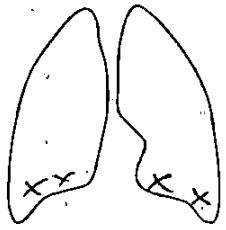
General Observations

Comfortable at rest

Sleeping but alert + oriented once woken

Respiratory Examination

Coarse bibasal crepes L>R

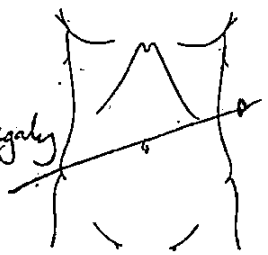


Abdominal Examination

SNT

0 masses / organomegaly

BS✓



Neurological and Other Examination (e.g. locomotor)

Cranial Nerves

PEARL

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

AMT 4

Fundoscopy:

Upper limb neurological examination

Grossly intact

Lower limb neurological examination

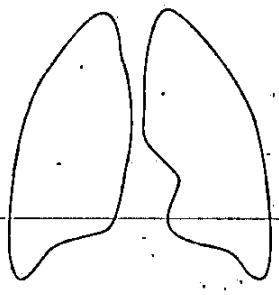
Grossly intact

No clonus

Other

Key Results:

CXR: Awaited (!)



Urinalysis:

ECG: NSR @ 66 bpm

Differential Diagnosis/Problem List

↓GCS 2° to alcohol + benzodiazepines

Concurrent LRTI unlikely given CRP <1 and WCC (N). May have degree of COPD already.

SEWS ☐ 0-7

RED FLAG ☐ (Tick)

SIRS ☐

CURB 65 ☐

Immediate Management Plan	Done/ Ordered	Checklist
1. CXR		Medicines plan documented ☑
2. (H)/ back to custody		Blood results received ☑
		Kardex ☑
		Antimicrobials as per Policy
		Yes ☐ No ☑ N/A
		If 'No' state reason:
		DVT prophylaxis indicated
		Yes ☐ No ☑ ~~Rx~~ ON Rx DOSE
		DVT prophylaxis prescribed
		Yes ☐ N/A ☑

Doctor Completing Initial Assessment

Name (print): RALSTON Signature: Designation: FY2

Page No. 85621

Please affix patient ID label here

Secondary or Senior Focused Review

Seen by (print):

Time seen:

Done/ completed	Continuing Managment Plan

Doctor Completing Initial Assessment

Signature: Designation: Page No.:

Senior Doctor Review

Seen by (print): Hopkinson

Time seen: ARU-2 12/8/16 10.30

36 ♂

Intoxicated ↑ alcohol

30 mg diazepam

Gabapentin

Now awake, drinking water, stable on feet

→ fit to be discharged to police custody now

Needs usual daltepam dose 12500 units

DVT Prophylaxis indicated Yes ☐ No ☐	Antimicrobials choice compliant Yes ☐ No ☐
DVT Prphylaxis prescribed Yes ☐ N/A ☐	If 'No' state reason
Medicines Reconciliation completed Yes ☐ No ☐	

Done/ completed	Continuing Managment Plan

Signature: [signature] Designation: CONS Page No: 07855 108341

Please affix patient ID label here

Continuation Sheet

Date: Time	
12/8/16 11AM	Acute Addiction Liaison (6/0204) Patient discharged NO assessment done PAM CHANDLER P.C. Senior Addict Nurse

Continuation Sheet	
Date: Time	

Please affix patient ID label here

Continuation Sheet	
Date: Time	

Continuation Sheet	
Date: Time	

PLEASE DO NOT WRITE HERE

Attach GP Letter, Results or Emergency Care Summary

Serial Blood Results								
	Date:	17/8						
	Time:	20:35						
	Signature:	[illegible]						
Sodium	135 - 146	142						
Potassium	3.5 - 5.3	4.2						
Chloride	95 - 108	105						
Urea	2.6 - 7.8	(1.8)						
Creatinine	40 - 130	66						
Estimated GFR		>60						
Bicarbonate	22 - 29							
Glucose	3.5 - 6.0							
CRP	0 - 10	<1						
Magnesium	0.7 - 1.0							
Calcium	2.2 - 2.6							
Calcium Adj	2.2 - 2.6							
Phosphate	0.8 - 1.5							
Cardiac Enzymes & Liver Function Tests	Normal Values							
Troponin	<0.04							
CK	<150	63						
Amylase	0 - 100							
ALT / AST	0 - 50	77/93						
Gamma-GT	0 - 70							
Alk Phos	30 - 130	119						
Total Bilirubin	0 - 20	7						
Albumin	35 - 50	37						
Haematology & Clotting Screen	Normal Values							
White Blood Count	4.0 - 11.0	6.5						
Haemoglobin	115 - 165	139						
Haematocrit	0.370 - 0.470	0.451						
MCV	80 - 100	95.6						
Platelet Count	150 - 410	215						
Neutrophils	1.8 - 7.7	3.1						
Lymphocytes	1 - 4.8	2.5						
Prothrombin Time	9 - 13							
PCT Ratio								
APTT	27 - 38							
APTT ratio	0.8 - 1.2							
Thrombin Time	10 - 16							
TCT Ratio								
Arterial Blood Gas	Normal Values							
H+	36 - 43							
PCO_2	4.5 - 6							
PO_2	10.5 - 13.5							
Base excess	+/- 2.5							
Bicarbonate	20 - 28							
FiO_2 (Inspired Oxygen)								
Other								
ETHANOL		33						

Emergency Department Nursing Documentation

Done/ Time	

Once only prescriptions (inlcuding tetanus prophylaxis)

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

Discharge prescription packs

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

DISCHARGE CODES: Please Circle

1. Admission 2. Discharge 3. Refer to G.P. 4. Transfer to other hospital (see below)
5. Died 6. Refer to O.P. Clinic (see below) 7. Irregular Discharge 8. D.O.A.

Time Ready to Depart	
Discharge Time	

Ward No. (If admitted)	Transfer to Hospital	Consultant (if admitted)

Outpatient clinic specialty	Admission or specialty clinic consultant

Clinic Referred to	AE	OP DVT	DME Falls	TIA	Medical	Surgical	First Seizure	Others Specify

Acute Services Division

All Directorates

Department of

Specialty:Infectious Diseases

OutPatient Continuation Sheet eForm - Version 0.23

Hospital: Gartnavel General Hosptial

Patient Details		GP Details	
Name:	Burgess, Henry	**Name:**	CALVO RODRIGUEZ, JUAN
Address:	76 STOCK STREET Paisley Renfrewshire	**Address:**	Lonend Paisley
Postcode:	PA2 6NH	**Telephone:**	
Correspondence Address 1:			
Correspondence Address 2:			
Correspondence Postcode:			
Telephone:			
Patient Contact Number:		**Consent:**	Yes
CHI Number:	2208793218	**Sensitivity:**	Highly Sensitive
CRN:	DYK2208793218, 23096267R, ZNC09292533, Z02378970,		
D.O.B:	22/08/1979		
Sex	Male		

Typed Notes

HMP Low Moss NLC

...ished treatment 2 weeks ago. Fully compliant, never missed a dose.

EOT bloods obtained today. Very difficult to venepuncture therefore only able to obtain small amount for HCV PCR.

RV in 2/52.

Date:	10/12/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

HMP Low Moss NLC

Informed of decision at MDT noted below.
Informed to stop PPI for length of treatment

Awaiting treatment arriving from pharmacy - start date no later than 19/09/2019.

RV at EOT.

Date:	17/09/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

MDT
GT3
Previous treatment in 2013 - ?where done, ?what with
For Epclusa 8 weeks as reinfection
Stop PPI

Date:	11/09/2019	Seen By:	David Bell	Designation:	Consultant

HMP Low Moss NLC

Called worker at RDS. They state that they have been trying to get Henry to engage in treatment but does not show to appointments. Encouraged treatment start in prison as he is chaotic in the community.
Is fully committed at the moment and started this last month. Could have another 10 weeks left. Is expecting a sentance.

Previously treated for HCV in 2013 with interferon.
Re-infected in 2016.

. ..oscan done today. Liver stiffness 5.7 kPa.
HCV GT 3
HIV and HBV negative.

Currently prescribed Pregabalin 300mg BD, Mirtazapine 30mg OD, Omeprazole 20mg OD.

Discuss at MDT.

Date:	10/09/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

HMP Low Moss NLC

All blood results returned bar HCV GT. Have retaken this today and sent to lab.
Listed for next weeks Fibroscan clinic.

RV 1/52

Date:	03/09/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

P Low Moss NLC

Returned DBS result of HCV detected 6 weeks ago. States he already knows about this diagnosis.
Last BBV test done in 2017 shows HCV GT 3 and HIV neg.

? Was due to start treatment with RDS but was incarcerated. Have attempted to call today to confirm this but cannot get worker.

Retaken HCV PCR and HIV bloods today.

Plan: Await phone call from RDS.
RV in 2/52 with results.

Date:	13/08/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

- End of Report -

Emergency Attendance Letter

NHS
Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2930/2931
Fax: 0141 201 2804
Email:

Date Completed: 10/12/2017

Consultant: Dr Jonny Gordon

S Goyal
King Street Surgery
The Surgery
15 King Street
Paisley
Paisley
PA1 2PS

Dear S Goyal,

Re: **Burgess Henry** DOB: **22/08/1979** CHI: **2208793218**
14 Thompson Brae
Paisley PA1 1TP

Attended on: **10/12/2017 at 11:49 hrs.** Departed on: **10/12/2017 at 12:26 hrs.**
Discharge Type: **01a - Discharge with no follow up** Destination: **Private residence**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
leg ulcer unwell

Nursing Assessment:
Brought in by Police ? ingested drugs

Investigations in ED: **None**

Diagnosis:

Diagnosis	Side	Site
No Injury or Abnormality Detected		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:
in police custody. Denies taking drugs. discharged

Followup :
Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Jonny Gordon
Consultant

Copies to:
1. S Goyal (GP)

School Address:

Emergency Attendance Letter

NHS Greater Glasgow and Clyde

Emergency Department
Queen Elizabeth University Hospital
1345 Govan Road
Glasgow
Lanarkshire
G51 4TF

Dept. Contact Details:
Tel: 0141 452 2810/2811
Fax:
Email:

Date Completed: 12/08/2016

Consultant: Dr Jonny Gordon

WI Weir
King Street Surgery
The Surgery
15 King Street
Paisley
Paisley
PA1 2PS

Dear WI Weir

Re: **Burgess Henry** DOB: **22/08/1979** CHI: **2208793218**
15/1 15 Scaraway Drive
Glasgow G22 7EX

Attended on: **11/08/2016 at 18:51 hrs.** Departed on: **11/08/2016 at 22:00 hrs.**
Discharge Type: **02 - Admitted** Destination: **Admission to this Hospital**
Previous ED Attendance in last 12 months: **5**

Presenting complaint
bibp - high on substances, has dvt

Nursing Assessment:
in police custody. under influence drugs. iddm. states has taken x2 valium. very drowsy

Investigations in ED:

1. CRP	**2. Urea and Electrolytes**	**3. LFT**
4. Full Blood Count	**5. Ethanol**	**6. CK**

Diagnosis:

Diagnosis	Side	Site
Acute Hypnotic Intoxication		

Procedures: **None**

Immunisations: **None**

Dispensed Medication: **None**

Clinician Notes:

Brought in by police. Found near unconscious in his cell. Admits to recreational drug use. GCS 13, saturation 89-91. Given oxygen and bloods drawn. Reacts well to O2 nasally. Admitted for observation.

Followup :

Highly sensitive: N Consent for sharing withheld: N

Yours sincerely,
Gudrun Bjornsdottir
Doctor

Copies to:

1. WI Weir (GP)

School Address:

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. GC Perrett
The Consulting Rooms
21 Neilston Rd
Paisley
PA2 6LW

Main Switchboard:	
Department:	podiatry Gartnavel royal wards
Contact Tel:	
Enquiries to:	david.bisset
Letter Date:	15/08/2024
Reference:	
Dictated Date:	15/08/2024
Transcribed Date:	15/08/2024

Dear Dr. GC Perrett,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
0/1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR17-GGH POD WARD ATTENDER THURSDAY
Date and Time of Appointment - 15/08/2024 09:00

Follow Up: ward staff to monitor heel skin condition aware file was given to patient for own use

Clinical Comments:
S patient seen in Kershaw unit in treatment room said both his big nails are sore ingrowing and picked a bit on left heel staff dressed

O both 1st nails long involuted due to length and nail spike in sulci both medial borders left heel intact call right heel small intact fissure area.

A birth 1st nails cut back cleared sulci advice on cutting with nippers and keeping shorter both heels reduced callus with scalpel and file advised to use moisturiser and not to wear slides closed in laced trainer

P discharged to self and ward staff care patient given file to use on heels staff aware

david Bisset

Podiatry team lead

Electronically Signed: ,

cc. ward staff

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. MJ McGovern
The Charleston Surgery
5 South Campbell St
Paisley
PA2 6LR

Main Switchboard:	
Department:	podiatry gartnavel Royal wards
Contact Tel:	07909873588
Enquiries to:	david.bisset
Letter Date:	14/12/2022
Reference:	
Dictated Date:	14/12/2022
Transcribed Date:	14/12/2022

Dear Dr. MJ McGovern,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
FLAT 0-1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR15-GGH POD WARD ATTENDER WEDNESDAY
Date and Time of Appointment - 14/12/2022 09:00

Follow Up: staff on ward advised to organise emollient for dry skin e45

Clinical Comments:
S patient seen on Kershaw ward both 1st nails sore and ingrowing digging in

O both 1st nails spikes of nail medially no infection skin very dry and can be itchy no signs of inflammation

A all nails cut filed and cleared spikes and callus debris patient advised to trim nails and cut the last bit away from the sides as leaving spikes so open area or sepsis

P discharged episode of care complete

David Bisset

podiatry team lead

Electronically Signed: ,

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. LE Cormack
The Consulting Rooms
21 Neilston Rd
Paisley
PA2 6LW

Main Switchboard:	
Department:	podiatry Gartnavel royal wards
Contact Tel:	
Enquiries to:	david.bisset
Letter Date:	12/08/2021
Reference:	
Dictated Date:	12/08/2021
Transcribed Date:	12/08/2021

Dear Dr. LE Cormack,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
FLAT 0/1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR17-GGH POD WARD ATTENDER THURSDAY
Date and Time of Appointment - 12/08/2021 09:00

Follow Up: n/a

Clinical Comments:
S patient seen on Kershaw ward treatment room painful big nails

O both 1st nails involution callus and corn in sulci

A all nails cut filed both 1st cleared corns enucleated both 365 dressings as small haems patient to file corners of nails

P discharged to personal care

David Bisset

podiatry team lead

Electronically Signed: ,

cc.

Acute Services Division
Diagnostics Directorate

Department Of Clinical Genetics
Laboratory Medicine Building
Southern General Hospital
1345 Govan Road, Glasgow
G51 4TF

Dr Rosemarie Davidson
Consultant Clinical Geneticist/ Lead clinician

Secretary: Julia King
Telephone Number: 0141 354 9227

NHS
Greater Glasgow and Clyde

Our ref. RD/JK/62705/CHI: 2208793218
23 September 2014 (dictated 16/09/14)

Dr L Smith
Consultant Gastroenterologist
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER

Dear Dr Smith

Re: Henry Burgess ~ DOB: 22/08/79 ~ Ped No: 62705
The Health Centre, PO Box 2893, Glasgow, G64 9BU

Thank you for your letter about this gentleman who is 35 and has a sister with bowel cancer at 32. It doesn't sound as if there is any further family history and we would then call this moderate risk and suggest colonoscopy for Mr Burgess, which currently would be suggested be done at the age of 50 or 55. If it was normal at that stage it wouldn't need to be repeated. The evidence based guidelines do not suggest colonoscopy before that age, although commonly if there were any symptoms at all, one would be done in the thirties age group in view of the very young age of his sister.

In order to try to investigate things further, we would need to see the sister rather than Mr Burgess, to see whether we could access her tumour for markers of genetic predisposition and particularly given Mr Burgess's situation it might make more sense to see the sister. I have written to Mr Burgess asking if he could fill in a family history questionnaire and possibly give me his sister's contact details. However, if he wishes to be seen now rather than awaiting further family investigation, we are happy to do so.

Kind regards

Yours sincerely

Dr Rosemarie Davidson
Consultant Clinical Geneticist

c.c.
Dr W I Weir
The Surgery
15 King Street
Paisley
PA1 2PS

Acute Services Division

All Directorates

Department of

Specialty:Infectious Diseases

OutPatient Continuation Sheet eForm - Version 0.23

Hospital:	Gartnavel General Hosptial

Patient Details		GP Details	
Name:	Burgess, Henry	**Name:**	CALVO RODRIGUEZ, JUAN
Address:	76 STOCK STREET Paisley Renfrewshire	**Address:**	Lonend Paisley
Postcode:	PA2 6NH	**Telephone:**	
Correspondence Address 1:			
Correspondence Address 2:			
Correspondence Postcode:			
Telephone:			
Patient Contact Number:		**Consent:**	Yes
CHI Number:	2208793218	**Sensitivity:**	Highly Sensitive
CRN:	DYK2208793218, 23096267R, ZNC09292533, Z02378970,		
D.O.B:	22/08/1979		
Sex	Male		

Typed Notes:

HMP Low Moss NLC

...ished treatment 2 weeks ago. Fully compliant, never missed a dose.

EOT bloods obtained today. Very difficult to venepuncture therefore only able to obtain small amount for HCV PCR.

RV in 2/52.

Date:	10/12/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

HMP Low Moss NLC

Informed of decision at MDT noted below.
Informed to stop PPI for length of treatment

Awaiting treatment arriving from pharmacy - start date no later than 19/09/2019.

RV at EOT.

Date:	17/09/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

MDT
GT3
Previous treatment in 2013 - ?where done, ?what with
For Epclusa 8 weeks as reinfection
Stop PPI

Date:	11/09/2019	Seen By:	David Bell	Designation:	Consultant

HMP Low Moss NLC

Called worker at RDS. They state that they have been trying to get Henry to engage in treatment but does not show to appointments. Encouraged treatment start in prison as he is chaotic in the community.
Is fully committed at the moment and started this last month. Could have another 10 weeks left. Is expecting a sentance.

Previously treated for HCV in 2013 with interferon.
Re-infected in 2016.

›roscan done today. Liver stiffness 5.7 kPa.
:V GT 3
HIV and HBV negative.

Currently prescribed Pregabalin 300mg BD, Mirtazapine 30mg OD, Omeprazole 20mg OD.

Discuss at MDT.

Date:	10/09/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

HMP Low Moss NLC

All blood results returned bar HCV GT. Have retaken this today and sent to lab.
Listed for next weeks Fibroscan clinic.

RV 1/52

Date:	03/09/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

HMP Low Moss NLC

›turned DBS result of HCV detected 6 weeks ago. States he already knows about this diagnosis.
Last BBV test done in 2017 shows HCV GT 3 and HIV neg.

? Was due to start treatment with RDS but was incarcerated. Have attempted to call today to confirm this but cannot get worker.

Retaken HCV PCR and HIV bloods today.

Plan: Await phone call from RDS.
RV in 2/52 with results.

Date:	13/08/2019	Seen By:	Poppy Lyons	Designation:	Specialist Nurse/Practitioner

- End of Report -

RP09 — 1D

Request for Fibroscan

Send to:
Gartnavel Hepatitis Centre
Ward 7B
Gartnavel General Hospital

Patient details
Henry Burgess
CHI 2208793218

Consultant: Dr Peters
Location: HMP Low Moss
Requesting Doctor: Dr Peters
Date: 28/2/17

Indications:		
	HCV	☑
	HCV/HIV co-infection	☐
	HCV post transplant	☐
	HBV	☐
	Cholestatic liver disease	☐
	Alcohol	☐
	Other:	

Performed by:

Liver Stiffness: 6.3 kPa

IQR: 0.5

Number of valid scans 15 / 10 / 15 100%

Date: 28/2/17 Signed: Paton

Interpretation

	F0 – F1	F1-F2	F2	F3	F3-F4	F4
HCV	0-7.1	7.1-8.7	8.7-9.5	9.5-12.5	12.5-14.5	>14.5
HCV-HIV	0-7.2	7.2-11.9	-	-	11.9-14.6	>14.6
HCV post transplant	0-6.3	6.3-7.9	7.9-8.5	8.5-11.9	11.9-14.5	>14.5
HBV	0-7.2	7.2-8.1	8.1-10.5	10.5-11.0	11.0-18.2	>18.2
Cholestatic liver disease	0-7.1	7.1-11.1	11.1-14.7	14.7-15.6	15.6-17.5	>17.3
Alcohol	0-7.9	7.8-11	11.1 -	-11.8	11.8-19.5	>19.5

Correlation between liver stiffness (kPa) and METAVIR score

For further help with interpretation speak to a hepatologist

Colonic Biopsy

Performed	08-Feb-2023 12:43	Received	08-Feb-2023 16:51
Reported	26-Mar-2023 19:37	Order Number	D,23,0009573.L
Status	Final	Source System	Telepath

Pathology Final

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

Date collected: 08.02.2023
Date received : 08.02.2023 Date reported: 26.03.2023

Reporting Pathologist : Victoria Phillips PATH
Consultant Pathologist: Victoria Phillips PATH

CLINICAL DETAILS;
The examination to the limit of insertion was normal.

MACRO;
Caecal biopsies; 4 fragments of tissue the largest 3 mm.

MICROSCOPY;
Microscopy shows focally congested large intestinal mucosa without significant pathological abnormality. There is no crypt activity, granulomatous inflammation, dysplasia or malignancy.

Reported by;
Dr Victoria Phillips (Consultant)
Authorised: 26/03/23 by Dr V Phillips

Spleen (B)

Performed	25-Nov-2020 12:20	Received	25-Nov-2020 15:23
Reported	02-Dec-2020 17:27	Order Number	D,20.0054453.V
Status	Final	Source System	Telepath

Pathology Final

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

Date collected: 25.11.2020
Date received : 25.11.2020 Date reported: 02.12.2020

Reporting Pathologist : Imran Ahmed PATH
Consultant Pathologist: Khun La Win Myint

SPLEEN

CLINICAL HISTORY:
Infarcted infected spleen.

MACRO:
Disrupted spleen measuring 130 x 90 x 50 mm and weighing 320g. On sectioning, some areas appear haemorrhagic and necrotic.

MICROSCOPY:
Representative sections of the spleen show large areas of infarct and suppurative necrosis with bacterial colonies. Where the spleen is better preserved, there is normal architecture. There is a mild increase in histiocytes in splenic cords, in keeping with reactive changes. There is no evidence of metastasis or lymphoproliferative disorders. Special stains for mycobacteria and fungus are negative. The findings are consistent with the history. Please correlate with microbiology for organisms.

Dr I Ahmed (ST3)
Dr Khun Myint (Consultant)
Dictated: 27.11.20 Typed: 30.11.20 mh
Authorised: 02/12/20 by Dr Khun La Win Myint

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. GC Perrett
The Consulting Rooms
21 Neilston Rd
Paisley
PA2 6LW

Main Switchboard:	
Department:	podiatry Gartnavel royal wards
Contact Tel:	
Enquiries to:	david.bisset
Letter Date:	15/08/2024
Reference:	
Dictated Date:	15/08/2024
Transcribed Date:	15/08/2024

Dear Dr. GC Perrett,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
0/1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR17-GGH POD WARD ATTENDER THURSDAY
Date and Time of Appointment - 15/08/2024 09:00

Follow Up: ward staff to monitor heel skin condition aware file was given to patient for own use

Clinical Comments:
S patient seen in Kershaw unit in treatment room said both his big nails are sore ingrowing and picked a bit on left heel staff dressed

O both 1st nails long involuted due to length and nail spike in sulci both medial borders left heel intact call right heel small intact fissure area.

A birth 1st nails cut back cleared sulci advice on cutting with nippers and keeping shorter both heels reduced callus with scalpel and file advised to use moisturiser and not to wear slides closed in laced trainer

P discharged to self and ward staff care patient given file to use on heels staff aware

david Bisset

Podiatry team lead

Electronically Signed: ,

cc. ward staff

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. GC Perrett
The Consulting Rooms
21 Neilston Rd
Paisley
PA2 6LW

Main Switchboard:	
Department:	podiatry Gartnavel royal wards
Contact Tel:	
Enquiries to:	david.bisset
Letter Date:	15/08/2024
Reference:	
Dictated Date:	15/08/2024
Transcribed Date:	15/08/2024

Dear Dr. GC Perrett,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
0/1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR17-GGH POD WARD ATTENDER THURSDAY
Date and Time of Appointment - 15/08/2024 09:00

Follow Up: ward staff to monitor heel skin condition aware file was given to patient for own use

Clinical Comments:
S patient seen in Kershaw unit in treatment room said both his big nails are sore ingrowing and picked a bit on left heel staff dressed

O both 1st nails long involuted due to length and nail spike in sulci both medial borders left heel intact call right heel small intact fissure area.

A birth 1st nails cut back cleared sulci advice on cutting with nippers and keeping shorter both heels reduced callus with scalpel and file advised to use moisturiser and not to wear slides closed in laced trainer

P discharged to self and ward staff care patient given file to use on heels staff aware

david Bisset

Podiatry team lead

Electronically Signed:

cc. ward staff

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. MJ McGovern
The Charleston Surgery
5 South Campbell St
Paisley
PA2 6LR

Main Switchboard:	
Department:	podiatry gartnavel Royal wards
Contact Tel:	07909873588
Enquiries to:	david.bisset
Letter Date:	14/12/2022
Reference:	
Dictated Date:	14/12/2022
Transcribed Date:	14/12/2022

Dear Dr. MJ McGovern,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
FLAT 0-1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR15-GGH POD WARD ATTENDER WEDNESDAY
Date and Time of Appointment - 14/12/2022 09:00

Follow Up: staff on ward advised to organise emollient for dry skin e45

Clinical Comments:
S patient seen on Kershaw ward both 1st nails sore and ingrowing digging in

O both 1st nails spikes of nail medially no infection skin very dry and can be itchy no signs of inflammation

A all nails cut filed and cleared spikes and callus debris patient advised to trim nails and cut the last bit away from the sides as leaving spikes so open area or sepsis

P discharged episode of care complete

David Bisset

podiatry team lead

Electronically Signed: ,

cc.

Clinic Letter

NHS
Greater Glasgow and Clyde

Gartnavel General Hospital
1053 Great Western Road
Glasgow
G12 0YN
0141 211 3000

Dr. LE Cormack
The Consulting Rooms
21 Neilston Rd
Paisley
PA2 6LW

Main Switchboard:	
Department:	podiatry Gartnavel royal wards
Contact Tel:	
Enquiries to:	david.bisset
Letter Date:	12/08/2021
Reference:	
Dictated Date:	12/08/2021
Transcribed Date:	12/08/2021

Dear Dr. LE Cormack,

Henry Burgess; D.O.B: 22 Aug 1979; CHI: 2208793218
FLAT 0/1, 128 NEILSTON ROAD, Paisley, Renfrewshire, PA2 6EP

Attendance: Specialty - Podiatry; Clinic - GGWAPR17-GGH POD WARD ATTENDER THURSDAY
Date and Time of Appointment - 12/08/2021 09:00

Follow Up: n/a

Clinical Comments:
S patient seen on Kershaw ward treatment room painful big nails

O both 1st nails involution callus and corn in sulci

A all nails cut filed both 1st cleared corns enucleated both 365 dressings as small haems patient to file corners of nails

P discharged to personal care

David Bisset

podiatry team lead

Electronically Signed: ,

cc.

BURGESS, HENRY ID: 8793218 11-Aug-2016 19:25:03 UTH GLASGOW UNIVERSITY HOSPITAL

22-Aug-1979
Male

Vent. rate 66 bpm
PR interval 142 ms
QRS duration 100 ms
QT/QTc 392/410 ms
P-R-T axes 12 67 44

[redacted] Normal sinus rhythm
[redacted] Normal ECG

Loc: 1301

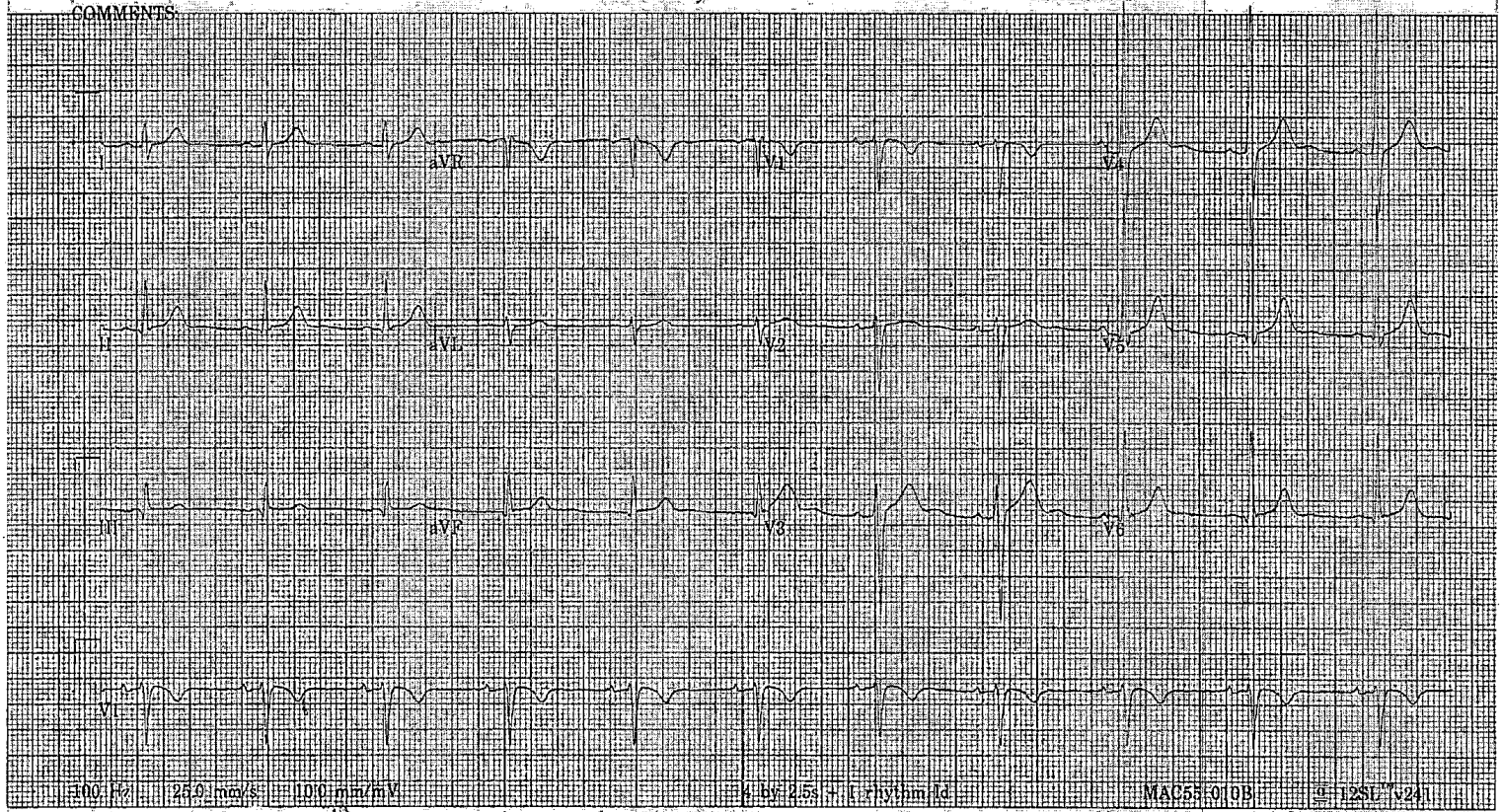
[redacted]

Technician:
Test ind:

Referred by:

Unconfirmed

COMMENTS:



RP09 — 1D

Request for Fibroscan

Send to:
Gartnavel Hepatitis Centre
Ward 7B
Gartnavel General Hospital

Patient details
Henry Burgess
CHI 2208793218

Consultant: Dr Peters
Location: HMP Low Moss
Requesting Doctor: Dr Peters
Date: 28/2/17

Indication:		
	HCV	☑
	HCV/HIV co-infection	☐
	HCV post transplant	☐
	HBV	☐
	Cholestatic liver disease	☐
	Alcohol	☐
	Other:	

Performed by:

Liver Stiffness: 6.3 kPa

IQR: 0.5

Number of valid scans 15 / 10 100%

Date: 28/2/17 Signed: JPaton

Interpretation

	F0 – F1	F1-F2	F2	F3	F3-F4	F4
HCV	0-7.1	7.1-8.7	8.7-9.5	9.5-12.5	12.5-14.5	>14.5
HCV-HIV	0-7.2	7.2-11.9	-	-	11.9-14.6	>14.6
HCV post transplant	0-6.3	6.3-7.9	7.9-8.5	8.5-11.9	11.9-14.5	>14.5
HBV	0-7.2	7.2-8.1	8.1-10.5	10.5-11.0	11.0-18.2	>18.2
Cholestatic liver disease	0-7.1	7.1-11.1	11.1-14.7	14.7-15.6	15.6-17.3	>17.3
Alcohol	0-7.9	7.8-11	11.1	-11.8	11.8-19.5	>19.5

Correlation between liver stiffness (kPa) and METAVIR score

For further help with interpretation speak to a hepatologist

CT Head

Performed	26-Apr-2022 21:04	Received	27-Apr-2022 10:33
Reported	27-Apr-2022 10:31	Order Number	G405H38375742
Status	Final	Source System	MiSys

CT Head Final
Henry Burgess
Clinical History :

42 yo ex IVDU presented last night with confusion following 2 seizures. Had fallen down 6 stairs after 2nd seizure. self dc before assessment. re-presented today after a further seizure, confusion significant. Unable to answer questions, vacant. partner states extremely out of character. febrile temp 38.7,WCC 21. ?intracranial bleed ?CNS infection

CT Head :
Unenhanced CT head. No previous available for comparison.
No acute intra or extra-axial bleed, space occupying lesion or infarct. Normal appearance of the brain parenchyma. Normal appearance of the ventricles and basal cisterns. Normal appearance of the midline structures, posterior fossa and cranial cervical junction. There mucosal thickening and dependent fluid within the right maxillary sinus, sinuses are otherwise clear. Mastoid air cells are clear. Normal orbits. No destructive bony lesion.

Conclusion: No acute intracranial abnormality, please note CT may be normal in encephalitis, given clinical history consider LP and MRI brain.

Discussed with clinical team at time of reporting. Sticky note on PACS.

Consultant review: Agree with above report

Reported by: Dr Gillian Halafihi (SpR) and Dr Caroline Cameron
Verified by: Dr Caroline Cameron

CT Head

Performed	26-Apr-2022 21:04	Received	27-Apr-2022 10:33
Reported	27-Apr-2022 10:31	Order Number	G405H38375742
Status	Final	Source System	MiSys

CT Head Final
Henry Burgess
Clinical History :

42 yo ex IVDU presented last night with confusion following 2 seizures. Had fallen down 6 stairs after 2nd seizure. self dc before assessment. re-presented today after a further seizure, confusion significant. Unable to answer questions, vacant. partner states extremely out of character. febrile temp 38.7,WCC 21. ?intracranial bleed ?CNS infection

CT Head :
Unenhanced CT head. No previous available for comparison.
No acute intra or extra-axial bleed, space occupying lesion or infarct. Normal appearance of the brain parenchyma. Normal appearance of the ventricles and basal cisterns. Normal appearance of the midline structures, posterior fossa and cranial cervical junction. There mucosal thickening and dependent fluid within the right maxillary sinus, sinuses are otherwise clear. Mastoid air cells are clear. Normal orbits. No destructive bony lesion.

Conclusion: No acute intracranial abnormality, please note CT may be normal in encephalitis, given clinical history consider LP and MRI brain.

Discussed with clinical team at time of reporting. Sticky note on PACS.

Consultant review: Agree with above report

Reported by: Dr Gillian Halafihi (SpR) and Dr Caroline Cameron
Verified by: Dr Caroline Cameron