MANUAL PATIENT RECORDS

ALL HOSPITAL RECORDS HELD NHSGGC	☐		
ACS	☐		
BEATSON HOSPITAL	☐		
CANNIESBURN HOSPITAL	☐		
DENTAL HOSPITAL	☐		
GARTNAVEL GENERAL HOSPITAL	☐		
GLASGOW ROYAL INFIRMARY	☐		
INVERCLYDE ROYAL HOSPITAL	☐	MATERNITY	☐
NEW VICTORIA ACH	☐		
PRINCESS ROYAL MATERNITY	☐		
QUEEN ELIZABETH UNIVERSITY HOSPITAL	☐	MATERNITY	☐
ROYAL ALEXANDRA HOSPITAL	☐	MATERNITY	☐
ROYAL HOSPITAL FOR CHILDREN	☐		
STOBHILL HOSPITAL (VOLUME 2)	☑		
VALE OF LEVEN	☐	MATERNITY	☐
WEST CARE AMBULATORY HOSPITAL	☐		
WESTERN INFIRMARY RECORDS	☐		

Including:

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

Acute Services Division

Surgery and Anaesthetics Directorate

New Stobhill Hospital
Balornock Road
3rd Floor, Management Offices
GLASGOW G21 3UW

NHS
Greater Glasgow and Clyde

Secretary Tel: 0141 355 1491

CHRONIC PAIN SERVICE

Ref No: ET/LA/10638479kK

Date: 28th January 2011

Dr C Rae
Consultant in Anaesthesia & Pain Management
Chronic Pain Service

Dear Colin

DEBORAH SULLIVAN, (DOB: 07/12/1972, CHI: 0712726128), 6 MUIRHEAD COURT, BAILLIESTON G69 7EP

I am writing to update you on the above named patient. Ms Sullivan last attended the psychology clinic on 21st August 2009. She had attended a total of 3 appointments. At that point she was due to go into hospital for an operation for a hernia and she agreed to contact the department once she felt ready to re-engage. As I have not heard from Ms Sullivan I can only assume she no longer wants to be seen by psychology and therefore she will now be discharged.

Yours sincerely

Dr E Toland
Clinical Psychologist

cc Dr J Langan
Baillieston Health Centre
20 Muirside Road
Baillieston G69 7AD

Clinic F
Second Floor
Stobhill ACH
Balornock Road
Glasgow G21 3UH
Reception 0141 355 1209/1831
Secretaries 0141 355 1210/1211/1829

SPECIALIST GYNAECOLOGY CLINICS

Dictated 07/01/2011
Typed 10/01/2011
Our Ref CK/JC

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan - 07/12/1972 - CHI: 0712726128 - CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Thank you for referring this 38 year old who has had a menstrual bleed following a period of amenorrhea. I gather her periods stopped two years ago when she was ill with gallstones. Trans-vaginal ultrasound examination on the 17th of December showed a normal sized anteverted uterus and normal ovaries which appeared active. A pipelle endometrial sample has been reported as showing weakly proliferative endometrium with no evidence of endometritis, hyperplasia or malignancy. It seems that ovarian activity has returned following a period of amenorrhea and I have suggested to the patient that she monitors the next few periods to see if any treatment is required or not. In the meantime I have not arranged any further follow-up here.

Yours sincerely

DR C KUMAR
Associate Specialist in Gynaecology

Clinic F
Second Floor
Stobhill ACH
Balornock Road
Glasgow G21 3UH
Reception 0141 355 1209/1831
Secretaries 0141 355 1210/1211/1829

SPECIALIST GYNAECOLOGY CLINICS

Dictated 07/01/2011
Typed 10/01/2011
Your Ref **CHI: 0712726128 - CRN: 10638479K**
Our Ref CK/JC

Ms Deborah Sullivan
6 Muirhead Court
Baillieston
G69 7EP

Dear Ms Sullivan

I am pleased to let you know that the biopsy I took from the lining of your womb did not show any abnormalities. As we discussed it seems that your periods have returned and if the next few periods continue to be heavy or irregular please consult your GP in the first instance for some treatment.

Yours sincerely

DR C KUMAR
Associate Specialist in Gynaecology

17/12/10

Patient Details

Surname	SULLIVAN
Forename	DEBORAH
CHI	0712726128
GP Details	LANGAN, JOHN 20 MUIRSIDE ROAD, BAILLIESTON, GLASGOW
Age	38
Hospital CRNs	10638479K

Referral Details

Date Received	03/12/2010 14:38:13
ReferralID	5689673
Priority	ROUTINE
New Priority	URGENT

Priority History

ROUTINE	06/12/2010 08:44:13
URGENT	10/12/2010 13:25:21

Redirection Information

Specialty	Hospital	Reason	Redirected Date	Redirected By
Gynaecology - Irregular Menstruation	Glasgow Royal Infirmary	Record Creation	06/12/2010 8:44	Mary Jane McAleavy

Tracking/Vetting Details

Cancer Code	
Date Vetted	10/12/2010 13:25:21
Vetting Status	Vetted
Outcome	Direct OP Appointment
Vetted By	Miriam Deeny

Tests

Clinics

One Stop Hysteroscopy

Consultant **Site** Stobhill Hospital

Instructions

HRCompleted False

WK

10638479K

Hospital use only	Clinic	Day Date	Time	Hospital No.

Transport required?

REFERRAL LETTER

MEDICAL IN CONFIDENCE

REFERRAL TO

Gynaecology - Irregular Menstruation
GGC Gynae Gen Ref

— **Consultant / receiving practitioner and/or specialty clinic**

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

— **Hospital and hospital address**

Hospital location code: G107H

Email address:

Urgency of referral ROUTINE
Date of referral 03-Dec-2010 **Date sent** 03-Dec-2010

PATIENT DETAILS

Surname	Sullivan
Forename(s)	Deborah
Title	Ms
Sex	Female
Date of birth	07-Dec-1972
CHI no.	0712726128

Patient's address

6 Muirhead Court
BAILLIESTON
GLASGOW
G69 7EP

Contact number(s)

Voice: 771 6310 07936225898

101001337438P Unique Care Pathway Number: 101001337438P

REGISTERED GP DETAILS

Name	Dr JJ Langan		
GMC code	1351886	GP code	G05193
Practice name	Baillieston Health Centre		
Practice code	46216		

Practice address

20 Muirside Road
Baillieston
Glasgow
G69 7AD

Contact number(s)

Voice: 0141-531-8050
Facsimile: 0141-531-8067

REFERRING GP DETAILS

Name	Dr. John Langan		
GMC code	1351886	GP code	05193
Practice name	BAILLIESTON HEALTH CENTRE (46216)		
Practice code	46216		

Practice address

20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

Contact number(s)

Voice: 01415318050

CLINICAL INFORMATION

History of presenting complaint
Presenting complaint

Description: Amenorrhoea

Comment: This lady has had amenorrhoea for the past two years. She has presented with a very heavy period which has lasted for more than five days.

I would be grateful if you would see her and for your opinion as to whether or not she warrants further investigation.

Yours sincerely

JOHN J LANGAN

Reason for referral

Care type requested: Out Patient

Expected outcome: Not Specified

Past medical history

Pre-existing conditions (High & medium priority - all)

Description	Comment	Modifier	Date recorded
Chronic pancreatitis	-	-	09-Mar-2009
GEMS- HOME VISIT	-	-	27-Feb-2007
Anxiety with depression	-	-	12-Oct-2006
GEMS - SEEN AT CENTRE	-	-	08-Apr-2006
GEMS - SEEN AT CENTRE	-	-	22-Oct-2005
GEMS - SEEN AT CENTRE	-	-	14-Aug-2005
GEMS- HOME VISIT	-	-	06-Aug-2005
GEMS- HOME VISIT	-	-	14-Jul-2005
Hiatus hernia NOS	moderately large	-	05-Nov-2004
Dislocation or subluxation of shoulder	Left shoulder	-	17-Mar-2004
Overdose of drug	Kapake and Tramadol with Diazepam	-	30-Aug-2002
[D]Abdominal pain	Vomiting	-	27-Aug-2002
Chronic pancreatitis	-	-	02-Jul-2002
Constipation	-	-	02-Jul-2002
Chronic pancreatitis	-	-	01-Oct-2001
Anxiety states	-	Chronic	01-Jul-2001
[X]Rape	-	-	01-Jul-2001
Sexual assault	-	-	01-Jul-2001
Reflux oesophagitis	-	-	23-Apr-1999
Diaphragmatic hernia	-	-	23-Apr-1999
[D]Abdominal pain	-	Recurrent	27-Mar-1999
Acute cholecystitis	-	-	23-Apr-1996
Cholelithiasis	-	-	23-Apr-1996
Urinary tract infection, site not specified	-	-	01-Jun-1995
[D]Nausea and vomiting	-	-	01-Feb-1995

Past procedures (High and medium priority - all)

Description	Comment	Date recorded
Laparotomy	and open fundoplication	14-Oct-2009
Laparotomy	and open revision of fundoplication	06-Oct-2009
Endoscopy / administration	-	05-Nov-2004

Nissen fundoplication using abdominal approach	-	26-Oct-2004
[SO]Sphincter of Oddi	Dysfuntion	14-Nov-1996
Endoscopic retrograde cholangiopancreatography	Major papilla was located in the second part of the duodenum	10-Oct-1996
Excision of gall bladder	-	23-Apr-1996
Other operations on appendix	-	16-Mar-1996

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

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Granisetron	34	TABS 1MG	1 tab	Twice daily	15-Jul-2010	02-Dec-2010
Gabapentin	168 caps	CAPS 300MG	2 caps	tid	15-Jul-2010	18-Nov-2010
Paracetamol	224	CAPS 500MG	2 Caps	qds	15-Jul-2010	18-Nov-2010
Esomeprazole	56	TABS 20MG	1 Tab	Twice daily	05-Jan-2009	18-Nov-2010

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Quantity	Formulation	Dosage	Frequency	Date started	Date last issued
Dihydrocodeine Tartrate	168	TABS 30MG	1 or 2 Tabs	3 times daily	02-Dec-2010	02-Dec-2010
Pyridoxine Hydrochloride	84	TABS 50MG	1 Tab	Daily	02-Dec-2010	02-Dec-2010
Tranexamic Acid	60	TABS 500MG	1 Tab	3 times daily	02-Dec-2010	02-Dec-2010
Lactulose	500ml	Oral SOLN 3.35G/5ML	10 ml	Twice daily	18-Nov-2010	18-Nov-2010
Cyclizine	84	TABS 50MG	1 Tab	3 times daily	18-Nov-2010	18-Nov-2010
Tramadol Hydrochloride	224	CAPS 50MG	1 or 2 Caps	up to qds prn	18-Nov-2010	18-Nov-2010
Fentanyl	10	75 Micrograms/Hour PATCH	apply 1 patch	every 72 hours	18-Nov-2010	18-Nov-2010
Imipramine Hydrochloride	168	TABS 25MG	3 Tabs	Twice daily	18-Nov-2010	18-Nov-2010
Diazepam	28	TABS 5MG	1 Tab	Daily	18-Nov-2010	18-Nov-2010
Temazepam	28 dispense fortnightly	TABS 10MG	1 Tab	At night	18-Nov-2010	18-Nov-2010
Dihydrocodeine Tartrate	168	TABS 30MG	1 or 2 Tabs	3 times daily	20-Oct-2010	20-Oct-2010
Temazepam	28 dispense fortnightly	TABS 10MG	1 Tab	At night	14-Oct-2010	14-Oct-2010
Diazepam	28	TABS 5MG	1 Tab	Daily	14-Oct-2010	14-Oct-2010
Imipramine Hydrochloride	168	TABS 25MG	3 Tabs	Twice daily	14-Oct-2010	14-Oct-2010
Fentanyl	10	75 Micrograms/Hour PATCH	apply 1 patch	every 72 hours	14-Oct-2010	14-Oct-2010
Tramadol Hydrochloride	224	CAPS 50MG	1 or 2 Caps	up to qds prn	14-Oct-2010	14-Oct-2010
Temazepam	28 dispense fortnightly	TABS 10MG	1 Tab	At night	20-Sep-2010	20-Sep-2010
Diazepam	28	TABS 5MG	1 Tab	Daily	20-Sep-2010	20-Sep-2010
Imipramine Hydrochloride	168	TABS 25MG	3 Tabs	Twice daily	20-Sep-2010	20-Sep-2010
Fentanyl	10	75 Micrograms/Hour PATCH	apply 1 patch	every 72 hours	20-Sep-2010	20-Sep-2010
Tramadol Hydrochloride	224	CAPS 50MG	1 or 2 Caps	up to qds prn	20-Sep-2010	20-Sep-2010

Dihydrocodeine Tartrate	168	TABS 30MG	1 or 2 Tabs	3 times daily	13-Sep-2010	13-Sep-2010
Temazepam	28 dispense fortnightly	TABS 10MG	1 Tab	At night	23-Aug-2010	23-Aug-2010
Diazepam	28	TABS 5MG	1 Tab	Daily	23-Aug-2010	23-Aug-2010
Imipramine Hydrochloride	168	TABS 25MG	3 Tabs	Twice daily	23-Aug-2010	23-Aug-2010
Fentanyl	10	75 Micrograms/Hour PATCH	apply 1 patch	every 72 hours	23-Aug-2010	23-Aug-2010
Tramadol Hydrochloride	224	CAPS 50MG	1 or 2 Caps	up to qds prn	23-Aug-2010	23-Aug-2010
Dihydrocodeine Tartrate	168	TABS 30MG	1 or 2 Tabs	3 times daily	11-Aug-2010	11-Aug-2010
Diazepam	28	TABS 5MG	1 Tab	Daily	27-Jul-2010	27-Jul-2010
Fentanyl	10	75 Micrograms/Hour PATCH	apply 1 patch	every 72 hours	27-Jul-2010	27-Jul-2010
Tramadol Hydrochloride	224	CAPS 50MG	1 or 2 Caps	up to qds prn	27-Jul-2010	27-Jul-2010
Imipramine Hydrochloride	168	TABS 25MG	3 Tabs	Twice daily	27-Jul-2010	27-Jul-2010
Temazepam	28 dispense fortnightly	TABS 10MG	1 Tab	At night	27-Jul-2010	27-Jul-2010
Diclofenac Sodium	56	SUPPS 50MG	1 to be inserted	Twice daily	15-Jul-2010	15-Jul-2010
Bisacodyl	60	TABS 5MG	1 or 2 Tabs	At night	15-Jul-2010	15-Jul-2010
Dihydrocodeine Tartrate	168	TABS 30MG	1 or 2 Tabs	3 times daily	15-Jul-2010	15-Jul-2010
Erythromycin	112	Ec CAPS 250MG	1 Cap	4 times daily	15-Jul-2010	15-Jul-2010
Metoclopramide Hydrochloride	84	TABS 10MG	1 tab tds	half hour before meal	15-Jul-2010	15-Jul-2010
Domperidone	84	TABS 10MG	1 Tab	3 times daily	24-Mar-2010	14-Jul-2010
Temazepam	28 dispense fortnightly	TABS 10MG	1 Tab	At night	30-Jun-2010	30-Jun-2010
Imipramine Hydrochloride	168	TABS 25MG	3 Tabs	Twice daily	30-Jun-2010	30-Jun-2010
Tramadol Hydrochloride	224	CAPS 50MG	1 or 2 Caps	up to qds prn	30-Jun-2010	30-Jun-2010
Diazepam	28	TABS 5MG	1 Tab	Daily	30-Jun-2010	30-Jun-2010
Fentanyl	10	75 Micrograms/Hour PATCH	apply 1 patch	every 72 hours	30-Jun-2010	30-Jun-2010
Varenicline Tartrate	1	Initiation Pack 11 X 0.5mg 14 X 1mg TABS	Take as directed	Dispense weekly	18-Jun-2010	18-Jun-2010
Dihydrocodeine Tartrate	168	TABS 30MG	1 or 2 Tabs	3 times daily	18-Jun-2010	18-Jun-2010

Lifestyle Risks and Alerts / Examinations and Investigations

Description/Question	Result/Comment	Date
Ex smoker:		14-Jan-2009
Current smoker:		23-Oct-2008
Current smoker:		09-May-2006
Never smoked tobacco:		18-Jan-2005

Investigations

Description/Question	Result/Comment	Date

Last smear result: negative -
Last smear date: 2009-06-15 -

Clinical warnings

Allergies

Description	Date recorded
Adverse reaction to penicillins	16-Feb-2009

Additional relevant information

Administrative information

OK to send correspondence to home address?:Yes
Patient will accept any site:Yes
Patient will accept cancellation or short notice appointment (within 1-6 days):Yes
Patient has disability or requires wheelchair access:No
Referred By:Referring GP
Electronic Attachment Present:No

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

STOBHILL HOSPITAL

OPERATION CHART

SURNAME	FORENAME	UNIT NUMBER
Sullivan DOB: 07/12/1972	Deborah WARD	10638479K

DATE OF OPERATION 07/08/2008

SURGEON'S NOTES

OPERATION PERFORMED

SURGEON MISS E CANNINGS
DR A RIDDELL

OPERATION: OGD under sedation.

PROCEDURE: Consented for procedure. 5mg I.V. Midazolam sedation given. Old scar used. OGD passed into stomach. OG junction at approximately 40cm.

FINDINGS: **Oesophagus –**

Normal.

Stomach –

Mild inflammation throughout stomach.

Duodenum –

D1 and D2 normal.

No real findings for patient's symptoms.

Two core biopsies taken and two biopsies taken for Pathology.

POST-OP.: Patient returned to ward.
Can drink as tolerated.

SPECIAL INSTRUCTIONS

EC/AS DICTATED & TYPED – 07 AUGUST 2008

DATE 2/7/8 SIGNATURE

00590

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 15/07/2010
Typed 16/07/2010
Our Ref JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw Deborah in clinic for review today. I know she has recently been in the Royal Infirmary and had another CT scan which did not show any evidence of obstruction. Deborah's problem appears to be that she has a pan GI motility disorder. Her barium shows no evidence of reflux but does, however, show un-co-ordinated contractions and I think this is why she is sick from time to time. As you know we tried to perform transit studies but Deborah could not attend to finish these and we will probably have to repeat them.

I really think we should start her back on Erythromycin, 250 mg qid, together with Metoclopramide, half an hour before meals, to see if we can stop her being sick. I have also suggested on my hand written note that we give her Volatarol by suppository because obviously with the Fentanyl patches and morphine which she can take this simply adds to more of her constipation and I would like to get her away from this if at all possible as it adds to the sluggishness of her bowel.

We will review her again in a fortnight and she will keep a chart of how many times she is sick and how much constipation she suffers and we will keep you informed of her progress.

Yours sincerely

Mr John S Smith
Consultant Surgeon

DNA
29/7/10

CONSULTANT
Dr Ruth F McKee

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
28/05/2010 Emergency	03/06/2010	65	07/12/1972	10638479

DISPOSAL
Home

FOLLOW UP
Stobhill

NAME AND ADDRESS
Deborah Sullivan
1 Camp Road

Glasgow G69 6QR

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Undiagnosed abdominal pain -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr MacKinnon
Baillieston Health Centre
20 Muirside Road
Glasgow G69 7AD

Mr J Smith
Consultant Surgeon
Stobhill Hospital
Glasgow
G21 2UW

OPERATION	CODE
1.	
2.	
3.	

17/06/2010

This girl was once more admitted as an emergency with upper abdominal pain and vomiting. She certainly did seem to vomit several times each day during her admission. She was treated conservatively and eventually felt well enough to be discharged home.

Yours sincerely

Dr Ruth F McKee
Consultant Colorectal Surgeon

Dr Ruth F McKee

05181

North Glasgow Hospitals

NHS
Greater Glasgow and Clyde

Patient Label

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Dear Dr Langlands

The patient attended SURGICAL Clinic at STOBHILL

Hospital on 15/7/2010. ½ hr before meal and I would advise a change to drug therapy from

METOCLOPRAMIDE AND ERYTHROMYCIN, 250mg. BD. Ogan

or ~~additional therapy~~ of HER BARIUM + transit Studies suggest

she has abnormal motility - Transit study was

incomplete but I think she has a

as detailed below. Full letter to follow.

Additional Comments: PAIN GI MOTILITY DISORDER

could we also give her BISACODYL for her bowel.

DRUG (print)	DOSE	FREQUENCY	~~DURATION / REVIEW DATE~~
and try paracetamol by suppository.			
DICLOFENAC	50mg	B.D.	I will see her in 8/52.

Yours Sincerely

Signature:

Name (print) Grade: Ext. No:

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

00545

CONSULTANT
Dr Ruth F McKee

GLASGOW ROYAL INFIRMARY
84 CASTLE STREET, GLASGOW G4 0SF

Telephone No. 0141-211-4000
Ext.

ADMITTED	DISCHARGED	WARD	AGE	HOSPITAL NUMBER
05/03/2010 Emergency	13/03/2010	65	07/12/1972	10638479

DISPOSAL
Home

FOLLOW UP
none

NAME AND ADDRESS
Deborah Sullivan
1 Camp Road

Glasgow G69 6QR

FINAL DIAGNOSIS AND ANY OTHER COMPLICATING ILLNESS	I.S.C. CODE
1. Undiagnosed abdominal pain -	
2.	
3.	
4.	
5.	
6.	

DISTRIBUTION OF LETTERS

Dr MacKinnon
Baillieston Health Centre
20 Muirside Road
Glasgow G69 7AD

Mr J Smith
Cons Surgeon
Stobhill Hospital
Balornock Road
Glasgow

OPERATION	CODE
1.	
2.	
3.	

09/04/2010

This young woman who is well known to the Royal Infirmary in that she has had previous pancreatitis and a previous fundoplication as well as a cholecystectomy was admitted as an emergency. She once again had the complaint of abdominal pain and vomiting. The vomiting seemed to settle very soon after admission and was not a significant problem although she did complain bitterly of symptoms of heartburn and on going abdominal pain. She eventually felt well enough to be discharged home on the 13/03/2010. She has an appointment for a gastrografin swallow at Stobill Hospital in a few days time and is already being seen for follow-up there.

Yours sincerely,

Dr Ruth F McKee
Consultant Colorectal Surgeon

Dr Ruth F McKee

granisetron + domperidone

05181

Esophageal manometry report

SULLIVAN, DEBORAH

Gender:	Female	Investigation nr:	01
Date of birth:	07/12/1972	Hospital:	Royal Infirmary - Glasgow
Patient number:	0712726128	Investigator:	SN C MACKENZIE
Investigation date:	27/04/2010	Referred by:	MR SMITH

NHS Greater Glasgow

LES station results

LES upper border	41.0	cm
LES lower border	44.0	cm
LES length	3.0	cm

LES relaxation overview

	#	%	Normals
% Complete LES relaxations	10	100 %	90-100 %
% Partial LES relaxations	0	0 %	0-10 %
% Absent LES relaxations	0	0 %	0 %

LES resting pressures - Mean

#	P1	P2	P3	P4	P5	P6	P7	P8	Avg	Normals		Duration (s)
1	-	-	-	-	-	-	-	7	7	6-25	mmHg	44.3 s
2	-	-	-	-	-	-	3	-	3	6-25	mmHg	60.7 s
3	-	-	-	-	-	7	-	-	7	6-25	mmHg	52.0 s
4	-	-	-	-	8	-	-	-	8	6-25	mmHg	58.9 s
5	-	-	-	4	-	-	-	-	4	6-25	mmHg	73.1 s
6	-	-	7	-	-	-	-	-	7	6-25	mmHg	75.1 s
7	-	4	-	-	-	-	-	-	4	6-25	mmHg	75.5 s
8	10	-	-	-	-	-	-	-	10	6-25	mmHg	52.7 s
Avg	10	4	7	4	8	7	3	7	6	6-25	mmHg	
Max	10	4	7	4	8	7	3	7	6	6-25	mmHg	

Average of LES relaxations

	P1	Normals	
Percentage relaxation	100	90-100	%
Residual pressure	-1		mmHg
Duration	7.0	5-10	s

Esophageal motility results

Average calculations for 1 swallow(s) [Dry swallow]

	P8	P7	P6	P5	P4	Average	Normals	
Peak amplitude	49	63	116	149	84	93	30-160	mmHg
Contraction duration	1.8	3.0	3.6	4.7	3.2	3.3	2-6	s

Onset velocity(P8-P4)	2.80	cm/s
Peak velocity(P8-P4)	2.70	cm/s

Average calculations for 9 swallow(s) [Wet swallow 5 ml]

	P8	P7	P6	P5	P4	Average	Normals	
Peak amplitude	41	50	97	119	60	74	30-160	mmHg
Contraction duration	2.5	2.5	3.2	4.3	3.3	3.2	2-6	s

Onset velocity(P8-P4)	2.98	cm/s
Peak velocity(P8-P4)	3.00	cm/s

	#	%	Normals
% Peristaltic contractions	8	80 %	80-100 %
% Simultaneous contractions	0	0 %	0-20 %
% Retrograde contractions	0	0 %	0 %
% Non transmitted contractions	0	0 %	0-20 %
% Dropped contractions	0	0 %	
% Interrupted contractions	2	20 %	

SOPD 10/6/10

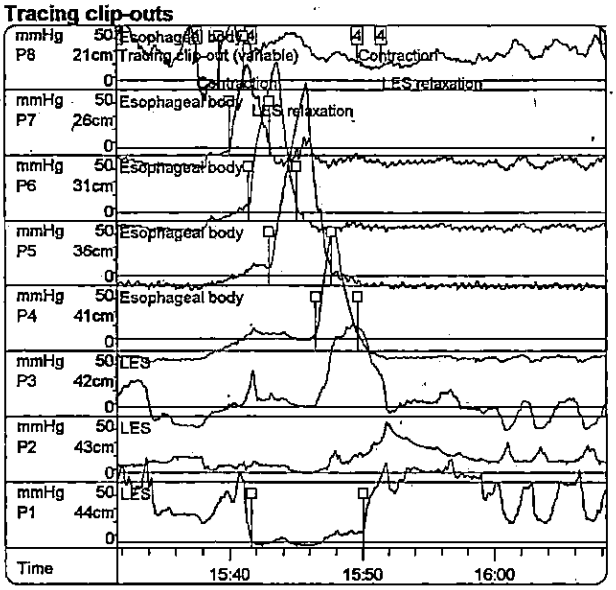
Esophageal manometry report

SULLIVAN, DEBORAH

Gender:	Female	Investigation nr:	01
Date of birth:	07/12/1972	Hospital:	Royal Infirmary - Glasgow
Patient number:	0712726128	Investigator:	SN C MACKENZIE
Investigation date:	27/04/2010	Referred by:	MR SMITH

NHS Greater Glasgow

Tracing clip-outs



Investigation conclusion

Clinical problem post fundoplication.
Intubation via **right** nare. Serial number of oesophageal manometry catheter.
Technical difficulties encountered during intubation- none.

Procedure: Manometric evaluation of oesophageal function

Description: Manometric procedure included Dent silicone 8 channel catheter. Distilled degassed water was perfused through each channel at a rate of 0.6 ml /min. A series of ten x 5ml water bolus induced swallows were evaluated.

Oesophageal peristalsis was **normal.**

The mean lower oesophageal sphincter pressure was 6 **mmhg**, referenced to stomach pressure.

The lower oesophageal relaxation reflex was **normal.**

The mean oesophageal contractions were **74 mmHg**.

Trace clipping shows peristaltic contraction.

Interpretation:
Oesophageal function was evaluated with perfused manometry. Peristaltic pressures and rates were **normal** for dry and water swallows. The lower oesophageal sphincter **did** relax on multiple swallows. Normal oesophageal study. Clinical correlation, follow-up by Mr J Smith.

Reported by:Sr S Thomson

Nurse Practitioner Clinical G I Physiology.

NHS Greater Glasgow and Clyde

Patient Name: **SULLIVAN, DEBORAH**

Patient ID: **0712726128**

Date of Test: **27/04/2010**

Date of Birth: **07/12/1972**

Time of Test:**16:04**

Physician: **WINTER, DR JACK**
Ref. Physician: **Smith, Mr J S**

Technician: **MacKENZIE, CAROLE**

1 Ch pH Study

Reason for Study:
PROBE AT 36CM.

User Comments

NORMAL OESOPHAGEAL ACID EXPOSURE OFF MEDICATION.

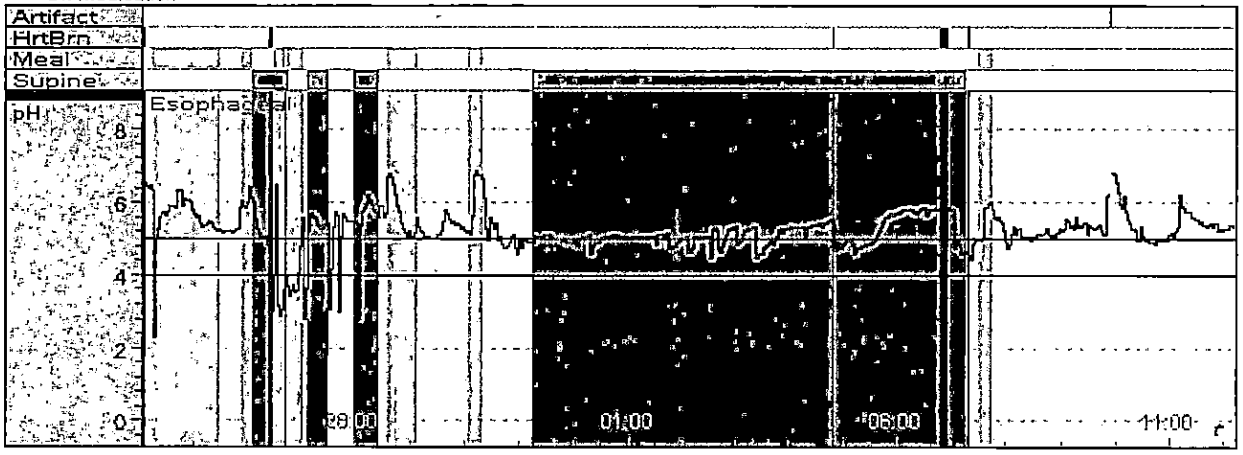
Indications for Test

- ☐ Heartburn
- ☐ Chest Pain
- ☐ Nausea
- ☐ Hoarseness
- ☐ Dysphagia
- ☑ Post-Fundoplication
- ☐ Sore Throat
- ☐ Wheezing
- ☐ Chronic Cough
- ☐ Throat Clearing
- ☐ Acid Regurg
- ☐ Post-Myotomy

- ☐ On Medication
- ☑ Off Medication

Last PPI Dose: NEXIUM 40MGS DAILY.

Dose:



Reflux Table - Oesophageal

	Total	Upright	Supine	Meal	PostPr	PrePra	HrtBrn
Duration of Period (d,hh:mm)	20:08	10:45	09:23	02:56	07:24	09:48	00:13
Number of Refluxes	36	30	6	25	11	0	2
Number of Long Refluxes>5 (min)	0	0	0	0	0	0	0
Duration of longest reflux (min)	2	2	1	2	1	0	0
Time pH <4 (min)	14	11	4	10	4	0	1
Fraction Time pH <4 (%)	1.2	1.7	0.6	5.8	0.9	0.0	4.8
Area (H+) (h*mmol/L)	0.21625	0.11886	0.09737	0.08616	0.06934	0.06074	0.00665
Normalized Area (H+) (h*mmol/L)	0.25776	0.26534	0.24906	0.70494	0.22488	0.14873	0.63885

NormalFraction Time pH < 4 at 95th Percentile. Total 4.5% Upright 8.4% Supine 3.5%
Jamieson JR, Stein HJ, DeMeester TR, et al: Ambulatory 24-HR Esophageal pH Monitoring: American Journal of Gastroenterology Vol 87

Patient Name: **SULLIVAN, DEBORAH** Patient ID: **0712726128** Date of Test: **27/04/2010**

DeMeester Table - Oesophageal

	Score
Duration (d,hh: mm: ss)	20:08
Number of Refluxes	2.9
Number of Long Refluxes	0.3
Longest Reflux	0.4
Fraction Time pH <4 (Total)	0.8
Fraction Time pH <4 (Upright)	0.8
Fraction Time pH <4 (Supine)	1.0
Total Score	6.1

Symptom Details Table - Oesophageal

Event	Start Time	End Time	Duration	Reflux Positive
HrtBrn	16:05	16:05	0	no
HrtBrn	18:25	18:28	3	yes
HrtBrn	04:50	04:50	0	no
HrtBrn	06:50	06:56	6	no
HrtBrn	07:19	07:19	0	no
Total HrtBrn: 5				1 of 5

DeMeester Score-Oesophageal

Total score = 6.1 , DeMeester normals less than 14.72 (95th percentile)

SAP Table - Oesophageal

	Total	Meal	Supine	Upright	PrePra	PostPr
HrtBrn	71.7	0.0	82.2	11.5	0.0	89.0
ChestP	0.0	0.0	0.0	0.0	0.0	0.0

SI Table - Oesophageal

	Total	Meal	Supine	Upright	PrePra	PostPr
HrtBrn	20.0	n/a	33.3	0.0	0.0	100.0
ChestP	n/a	n/a	n/a	n/a	n/a	n/a

SAP Details Table - Oesophageal

	Total		
	S+	S-	SAP
HrtBrn- R+	1.0	18.0	71.7
HrtBrn- R-	12.0	574.0	
ChestP- R+	0.0	19.0	0.0
ChestP- R-	0.0	586.0	

The symptom association probability is discussed in B.L.A.M Weusten, J.J.M. Roelofs et al. "The Symptom-Association Probability: An Improved Method for Symptom Analysis of 24 Hour Esophageal pH Data" (Gastroenterology 1994; 107:1741-1745):Referto the pH Reference Manual in the Help Menu.

Signature:_____

Patient Diary

NHS Greater Glasgow and Clyde

Name :

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date: 27/4/10

Hospital Numbe

Comments:

Intubation *(please* 2) left nare ☐ 3) the mouth ☐

Technical difficulties encountered during intubation:

Please record the START and FINISH time for the following events.

1. **When eating and drinking** - it is helpful if you record which food you have eaten.
2. **When lying down or asleep** - the recording device can be placed under your pillow.
3. **Episodes of heartburn or chest pain** - you need only record the onset of these.

16.04

Start Time	Event:	Finish Time
16.15	WATER	16.47
16.50	TEA	17.29
17.53	Golden Balls cereal + milk	17.51
18.01	Woken	18.01
		18.41
18.07	Lying down.	18.44
18.27	Heartburn	
18.30	Drink milk	18.31
18.45	Yougart	19.02
19.08	Lying down	19.29
20.00	Lying down.	20.25
20.36	Red Biscuits	21.08
22.09	Few Crisps	22.17
22.27	WATER	22.27
23.15	WENT TO BED	07.15
4.50	HEARTBURN	07.30
7.30	HEARTBURN SUGARPUFFS →	07.42

It would be beneficial if you could complete these three questions on completion of this study.

1. Have your activities been limited today due to having this study? Yes ☑ No ☐
2. Have you had your normal dietary intake during this study? Yes ☐ No ☑
3. In relation to the amount of heartburn/chestpain you would normally have over a day, how would you compare this to the amount you have experienced during this study?

1] same ☐ 2] more ☐ 3] less ☑

9.20 Lying down 9.45

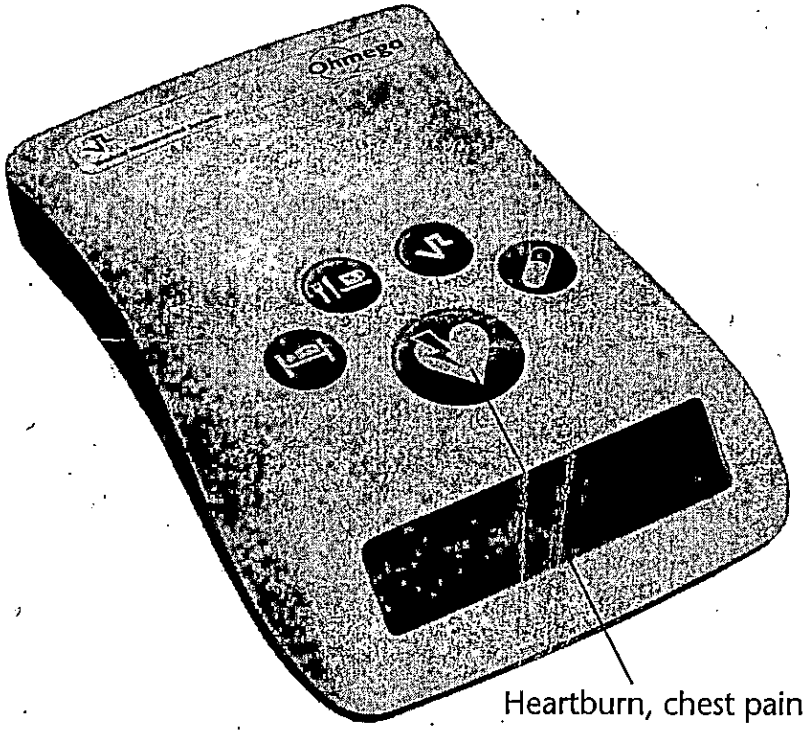
Care of Ambulatory PH Recording Device:

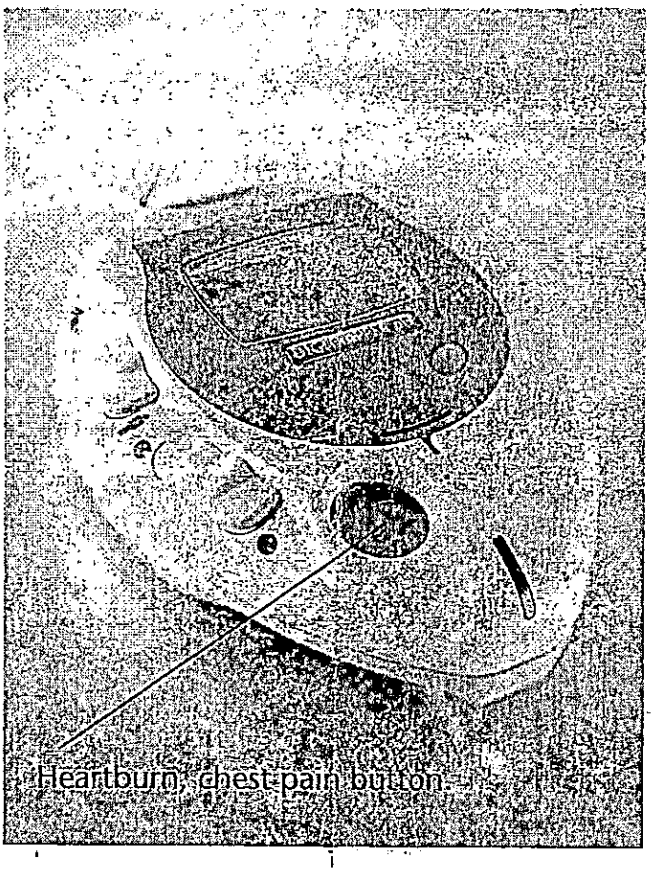
1. Do not allow this unit to come in contact with water or household agents.
2. If the catheter (TUBE) is coughed into the mouth it should be removed by pulling it from the nose. DO NOT re-pass the tube. Make a note of the time that the tube was removed.
3. The hours of this unit are 8am-5pm. If you need advice outside these hours contact your G.P. or local casualty unit.

Compiled by Shona Thomson – Motility Nurse

Designed & Produced by Medical Illustration GRI Job No. 98560

9.30 TEA + BISCUITS 10.12


Omnego
Heartburn, chest pain button.


Heartburn, chest pain button.

North Glasgow Hospitals

NHS
Greater Glasgow and Clyde

Patient Label

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

0

The patient attended SURGICAL Clinic at STOBHILL

Hospital on 10th June 2010, and I would advise a change to drug therapy from

She has had The BARIUM with ct stent

~~or additional therapy~~ of DYSMOTILITY of HER OESOPHAGUS

AND STOMACH - This is probably To

as detailed below. Full letter to follow. Caused by symptoms.

~~Additional Comments~~: Could you try her on ERYTHROMYCIN

250mg T.D.

SMITH

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE
? MORPHINE		BY SUPPOSITORY for pain.	

Yours Sincerely will talk to pain specialist re pts

Signature: TRANSFER STUDY.

Name (print) Grade: Ext. No:

Consult

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

00545

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 10/06/2010
Typed 11/06/2010
Our Ref. JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw Deborah in clinic today. As you know she was recently in the Royal Infirmary with another episode of dehydration after her vomiting. Her recent barium shows that she does have a dysmotility of her oesophagus and stomach and it may be that this has been behind her abdominal pain and weight loss. I thought we should get her some transit studies to see if we could confirm that this is the case for the rest of her small bowel. In the meantime could you try her on some Erythromycin for the prokinetic effect as this might help her gut to contract better. I appreciate that you already have her on Metoclopramide and Motilium but it may be that this will work better.

We will review her in clinic once she has had her transit studies performed and keep you informed of her progress.

Yours sincerely

Mr John S Smith
Consultant Surgeon

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 25/02/2010
Typed 01/03/2010
Our Ref JSS/EM

Sister Shona Thomson
Motility Nurse Specialist
Ward 32
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SD

Copy to:

Dr John Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Dear Shona

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I wonder if you could see this young woman for me. She has had several Nissen's fundoplications in order to try and stop her getting reflux. The last procedure we performed was an anterior wrap and she has now come back saying she is no better. I am not sure whether this is functional or true bile and acid reflux and would be grateful if you could perform pH and motility studies to see what they show. I will review her in my clinic with the results following completion of your tests.

With many thanks,

Yours sincerely

Mr John S Smith
Consultant Surgeon

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 25/02/2010
Typed 01/03/2010
Our Ref JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw this lady in clinic today. She is really no better since we performed the anterior wrap and she is still refluxing and vomiting. It is difficult to know whether this is functional or truly a result of dysfunction in her upper GI tract. For this reason I am going to get her a barium swallow and a barium meal and I am also going to repeat her pH and motility studies to see what they show.

Yours sincerely

Mr John S Smith
Consultant Surgeon

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 10/12/2009
Typed 15/12/2009
Our Ref JSS/WK

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I understand this lady was admitted as an emergency to the Royal Infirmary and had an MRI scan. I am happy to report her MRI really shows no abnormality apart from a bit of inflammatory change amongst the fat behind the wound which is not unexpected following her surgery.

As you know her sickness has now stopped but she is still troubled by heartburn. This is quite interesting because she is on high doses of Nexium and Metoclopramide and that really should be enough to prevent her having her heartburn, having had this tightening of her wrap.

I am going to repeat her pH and motility studies in the New Year and also get her a barium swallow. I have reassured her that things are ok at the moment. We are just waiting to see how the effects of her inflammation from her operation settle and then we can investigate her further in the New Year.

She has not lost any weight and I think I am happy at present with her. I have reassured her we are progressing along in a reasonable fashion and discharged her to be seen in 2 months time.

Yours sincerely

Mr John S Smith
Consultant Surgeon

FINAL DISCHARGE LETTER

NHS Greater Glasgow

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone : 0141 - 201 - 3000

First Issued: 18/11/2009 16:13
Printed: 18/11/2009 16:13

Admitted: 06/10/2009 **Discharged:** 13/10/2009
Discharged to: Home
Ward: 5
Consultant: MS C CRAIG, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES **ICD10** **PROCEDURES** **OPCS4**

No diagnoses have been made for this patient

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8	12	14	18	22	PRN/Comment	Course Length	Quantity Dispensed
Gabapentin	Cap	Oral	600mg	X		X		X		Indefinite	21x600mg
Granisetron	Tab	Oral	1mg	X				X		Indefinite	14x1mg
Fentanyl patch		Topical	75micrograms							72 hours	see handwritten
Paracetamol	Tab	Oral	1g						4-6hrly for pain	Indefinite	30x500mg
Tramadol	Tablet	Oral	100mg	X	X		X	X		Indefinite	50x50mg
Imipramine	Tablet	Oral	150mg					X		Indefinite	42x25mg
Temazepam	Tab	Oral	10mg					X		Indefinite	7x10mg
Ciprofloxacin	Tab	Oral	500mg	X				X	For UTI - had one day	2 days	4x500mg
Diazepam	Tab	Oral	5mg	X				X		Indefinite	14x5mg

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	MS C CRAIG	6-8 weeks

Outpatient Investigations **Date**
No arrangements made

Community Care **Date** **Reason**
No arrangements made

GENERAL COMMENTS

Dear Doctor

This lady was admitted to Stobhill hospital for laparotomy and open revision of fundoplication. The procedure was succesful and she taken to HDU afterwards. With her background of chronic pain issues, there was some difficulty in managing her pain post-operatively. She was reviewed by anaesthetists and the pain sister who made suggestions to make her more comfortable.

After four days in HDU her pain was controllable and she was transferred to the general ward where she settled. She did complain of flank pain and dysuria and a urinalysis revealed haematuria. As she was symptomatic she was commenced on a 3 day course of Ciprofloxacin.

She was fit for discharge home on the 14th Ocober. No changes were made to her regular medications. She will be reviewed at Miss Craig's outpatient clinic in 6-8 weeks.

FINAL COMMENT DICTATED: 15.11.09 PG/EM

NHS Greater Glasgow

Patient: DEBORAH SULLIVAN D.O.B: 07/12/1972 Hosp. No: 10638479K
Admitted: 06/10/2009 Discharged: 13/10/2009 Printed: 18/11/2009 16:13

GENERAL COMMENTS (continued)

Mrs Sullivan underwent revisional anti-reflux surgery. She was changed from a Nissen's fundoplication to a Watson's fundoplication. She will be reviewed in Mr Smith's clinic in due course.

Yours sincerely

Mr Paul Glen
Specialist Registrar

Signed: _____ Designation: _____

STOBHILL HOSPITAL

OPERATION CHART

SURNAME	FORENAME	UNIT NUMBER
Sullivan	Deborah	10638479K
DOB: 07/12/1972	WARD 6	

DATE OF OPERATION 06/10/2009

SURGEON'S NOTES

OPERATION PERFORMED

SURGEON MR J S SMITH

OPERATION: Re-do Nissen's fundoplication.

PROCEDURE: The abdomen was opened through the previous incision excising the stretched scar. On entering the abdominal cavity we were able to dissect the adhesions from the back wall of the wound. This allowed us to free up the colon and also to identify the liver and stomach. The adhesions to the stomach and liver were freed to allow us to gain access to the hiatus. It was quite obvious that there was a failure of the wrap with the wrap having slipped back through the posterior part of the stomach at the posterior window. We therefore elevated the oesophagus, freed this up in order to put in two sutures to close the crura behind the oesophagus. This tightened up the hiatus and should stop her developing further para oesophageal hernia. Secondly as the adhesions were such to the posterior part of the stomach it was felt impossible to perform a posterior wrap and therefore an anterior wrap was created suturing the redundant floppy stomach onto the right crus giving a 120° wrap anteriorly. Hopefully this will stop the patient's symptoms.

SPECIAL INSTRUCTIONS

JSS/AS DICTATED & TYPED – 07 OCTOBER 2009

DATE _____ SIGNATURE _____

00590

IMMEDIATE DISCHARGE LETTER

NHS Greater Glasgow

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone : 0141 - 201 - 3000

GP COPY

First Issued: 14/10/2009 10:42
Printed: 14/10/2009 10:43

Admitted: 06/10/2009 **Discharged:** 13/10/2009
Discharged to: Home
Ward: 5
Consultant: MS C CRAIG, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES **ICD10** **PROCEDURES** **OPCS4**

No diagnoses have been made for this patient

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8	12	14	18	22	PRN/Comment	Course Length	Quantity Dispensed
Diazepam	Tab	Oral	5mg	X				X		Indefinite	14x5mg
Gabapentin	Cap	Oral	600mg	X		X		X		Indefinite	21x600mg
Granisetron	Tab	Oral	1mg	X				X		Indefinite	14x1mg
Fentanyl patch		Topical	75micrograms							72 hours	see handwritten
Paracetamol	Tab	Oral	1g						4-6hrly for pain	Indefinite	30x500mg
Tramadol	Tablet	Oral	100mg	X	X			X X		Indefinite	50x50mg
Imipramine	Tablet	Oral	150mg					X		Indefinite	42x25mg
Temazepam	Tab	Oral	10mg					X		Indefinite	7x10mg
Ciprofloxacin	Tab	Oral	500mg	X				X	For UTI - had one day	2 days	4x500mg

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	MS C CRAIG	6-8 weeks

Outpatient Investigations **Date**

No arrangements made

Community Care **Date** **Reason**

No arrangements made

GENERAL COMMENTS

Final discharge letter to follow

Dear Doctor

This lady was admitted to Stobhill hospital for laparotomy and open revision of fundoplication. The procedure was succesful and she taken to HDU afterwards. With her background of chronic pain issues, there was some difficulty in managing her pain post-operatively. She was reviewed by anaesthetists and the pain sister who made suggestions to make her more comfortable.

After four days in HDU her pain was controllable and she was transferred to the general ward where she settled. She did complain of flank pain and dysuria and a urinalysis revealed haematuria. As she was symptomatic she was commenced on a 3 day course of Ciprofloxacin.

She was fit for discharge home on the 14th Ocober. No changes were made to her regular medications. She will be reviewed at Miss Craig's outpatient clinic in 6-8 weeks.

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 13/08/2009
Typed 14/08/2009
Our Ref JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw Deborah in clinic today. Unfortunately Deborah, as you know, has really had a recurrence of vomiting and she tells me that she has been in hospital with two episodes of chest infections. I was somewhat reluctant to perform any more surgery on her but she has no quality of life at the moment, vomiting eight times a day, and I am, therefore, going to bring her in and perform a laparotomy, tighten her oesophagus and see if we can help stop her sickness.

In the meantime, perhaps you could give her some Metoclopramide liquid as when she takes the tablets she tends to vomit them up before they have any effect. I would like her to take this four times a day. The other thing which might be helpful is to give her Bucastem which she could actually tuck under her upper lip and this might also help her to stop vomiting.

I will keep you informed of her progress in due course.

Yours sincerely

Mr John S Smith
Consultant Surgeon

North Glasgow Hospitals

NHS
Greater Glasgow and Clyde

Patient Label

The patient attended SURGICAL Clinic at STOBHILL

Hospital on 13/8/09 and I would advise a change to drug therapy from

METOCLOPRAMIDE LIQUID. - 10mgs Q.I.D

~~or additional therapy of~~ to help stomach settle

until we can do operation to fix

as detailed below. Full letter to follow. her paraesophageal hernia

Additional Comments:

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE

Yours Sincerely

Signature:

Name (print) [illegible] Grade: [illegible] Ext. No:

White copy to - *G.P.* Pink copy - *File this copy in Case Records*

00545

North Glasgow Hospitals

Department of Pathology
Pathology Report

Enquiries: 0141 211 2473

Lab No.:P,09.0008644 CHI No. 0712726128

Name:SULLIVAN DEBORAH DOB/Age:07.12.72
Post code:G69 7EP

Hosp.No(orPath.Comp.Ref.ZP): 10638479K

Consultant:MR.J.SMITH STOBHILL Location:STOBHILL DAY SURGERY UNIT

GASTRIC BIOPSIES.

Clinical history

Gastritis and bowel reflux.
Staining of stomach.

Gross

Two endoscopic biopsies.

Microscopy

Sections show antral type mucosa with changes in keeping with reactive gastritis. No Helicobacter are seen.

Sk R Reid

Date collected 30.04.09
Date received 01.05.09
Date reported 05.05.09

Acute Services Division

Surgery and Anaesthetics Directorate

New Stobhill Hospital
Balornock Road
3rd Floor, Management Offices
GLASGOW G21 3UW

NHS
Greater Glasgow and Clyde

CHRONIC PAIN SERVICE

Dictated: 01/07/2009
Typed: 13/07/2009

Our Ref: ET/LA/10638479K

Dr C Rae
Consultant in Anaesthesia & Pain Management
Stobhill Hospital

15/7/09
File please
Chae

Dear Colin

Deborah Sullivan, (DOB: 07/12/1972, CHI: 0712726128),
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

Thank you for referring the above named lady who's referral status was changed from a routine to an urgent case at the end of May following a discussion. I managed to meet with Ms Sullivan on 1st July 2009 for an assessment. Ms Sullivan was very open to discussing her difficulties and engaged well in the session. She was distressed throughout and her main complaints were around low mood, marked anxiety and marked levels of inactivity.

In telling her pain story Ms Sullivan reported that the pain started in the right of her abdomen in 1992. Owing to causing vomiting it was questioned as irritable bowel syndrome. Unfortunately at one point she perceived that she was told by the doctor at GRI that the pain was in her head. She went on to explain that in 1996 she was rushed into hospital and had her appendix removed but was only described as mildly inflamed afterwards. Days later she reported that her gallstones had to be removed and the pain had resided with her since.

Ms Sullivan linked the pain with difficult periods in her life. For example she explained that the pain increased 3½ years ago following the break-up from a difficult boyfriend.

Ms Sullivan described a difficult day as getting up in the morning for her daughter to get ready for school. However once her daughter leaves at 8.30am she described lying on the sofa all day watching television until she returns. She explained that she hardly gets dressed most of the time. In terms of housework she explained that she neglects it and that her family have to come over and do it for her which is vastly different from the values she practiced in the past.

Ms Sullivan described marked anxiety around leaving the house. She reported anxiety related symptoms of a tight chest when she tries to leave. The anxiety related thoughts around leaving were that something dangerous might happen and she feels more safe in the house. Ms Sullivan explained that she was violently raped in 2001 and despite attending counselling and responding well to eye movement desensitisation therapy, she has had an increase in symptoms in the past year. However, Ms Sullivan went through a very difficult break-up from a violent boyfriend 3½ years ago and it seems all of her anxiety related thoughts are attributed to this situation rather than the rape.

Acute Services Division

Surgery and Anaesthetics Directorate

New Stobhill Hospital
Balornock Road
3rd Floor, Management Offices
GLASGOW G21 3UW

NHS
Greater Glasgow and Clyde

CHRONIC PAIN SERVICE

Cont/...Deborah Sullivan/...10638479K

Ms Sullivan reports low mood. She explained that she cries a lot and has suicidal thoughts such as "my daughter would be better off without me". However she did say that she would never act on these thoughts despite taking an overdose in the past following sexual assault. Ms Sullivan has a close supportive family including 2 sisters and her mum and dad.

I have arranged to meet with Ms Sullivan again to continue with the assessment. I feel that it may be necessary to do some cognitive behavioural therapy around anxiety and agoraphobia. This will hopefully encourage her to increase her activity. In the meantime I think it may be important to help her increase her activity in the house to gain the benefits in her mood and pain.

Of course I will keep you updated on this case but if you would like to discuss it in the meantime please do not hesitate to do so.

Yours sincerely

Dr E Toland
Clinical Psychologist

cc Dr J Langan
Baillieston Health Centre
20 Muirside Road
Baillieston G69 7AD

New Stobhill Hospital
Balornock Road
3rd Floor, Management Offices
GLASGOW G21 3UW

CHRONIC PAIN SERVICE

Secretary Tel: 0141 355 1491

Ref No: CR/LA/10638479K

Clinic: 13/05/2009
Typed: 21/05/2009

Dr J Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
G69 7AD

Dear Dr Langan

DEBORAH SULLIVAN, (DOB: 07/12/1972, CHI: 0712726128)
6 MUIRHEAD COURT, BAILLIESTON G69 7EP

Problems: **Chronic upper abdominal pain**
Gastro-oesophageal reflux
Persistent nausea and vomiting
Depression

Deborah attended the Pain Management Clinic today. Unfortunately, her Stobhill case sheet was unavailable today but I understand from our discussion that she has recently had an upper GI endoscopy and is now awaiting surgery under the care of Mr Smith regarding a small Para oesophageal hernia.

Deborah is having problems with sweating and her current main analgesic, Fentanyl patch is not sticking well.

One option would be to prescribe the Fentanyl durogesic patch rather than the generic form she is currently prescribed, as it is a smaller area and is reported to stick better. She also continues to take Gabapentin 600mgs 3 times daily and Tramadol 100mgs 4 times daily.

I had a long chat today with Deborah about her mood. She is feeling very low at present. She is currently on the waiting list to see the Pain Management Clinic Clinical Psychologist and I will find out whether this appointment can be moved forward.

I also discussed with Deborah today, commencing a trial of Imipramine, starting with 10mgs at night and increasing at weekly intervals as per the attached protocol. Once this has been started, her current antidepressant Fluoxetine could be reduced and stopped.

Cont/...

New Stobhill Hospital
Balornock Road
3rd Floor, Management Offices
GLASGOW G21 3UW

CHRONIC PAIN SERVICE

Secretary Tel: 0141 355 1491

Cont/...Deborah Sullivan/...10638479K

I will review Deborah in due course but please contact me if I can be of help before then.

Yours sincerely

Dr C Rae
Consultant in Anaesthesia & Pain Management

Enc

cc Dr E Toland
Clinical Psychologist
Chronic Pain Service

46216 - 3 APR 2009 1063847QK

DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLEOD
DR ELAINE E POLLOCK
DR GERARD A MCKAIG
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKER
DR JOHN MENZIES
DR LIANA MCMILLAN

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Shettleston
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 6212

SW/RC

27 March 2009

Dr Colin Rae
Consultant in Anaesthesia & Pain Management
Chronic Pain Service
Department of Anaesthetics
Stobhill NHS Trust
Balornock Road
Glasgow G21 3UW

has appt 13/5/09 @ 3.30pm ✓ pharmacy LW Thanks.

Dear Dr Rae

DEBORAH SULLIVAN D.O.B. 07.12.72
6 MUIRHEAD COURT, BAILLIESTON, GLASGOW G69 7EP

I would be grateful if Deborah could be reviewed at the clinic sooner than her October appointment. I have seen her recently and she was complaining of possible perimenopausal symptoms and, in particular, hot flushes and sweats. These are making the Fentanyl patches unsuitable.

As usual she was complaining bitterly of chronic epigastric and abdominal pains and was specifically requesting going on OxyNorm. She continues to take her Tramadol and Gabapentin.

I know you were trying to wean her off opiates when last seen at the clinic but in the meantime I have given her 30 mgs of Dihydrocodeine to use up to four times a day.

We are currently awaiting the results of her blood tests to ascertain the cause of the sweats but would appreciate your input regarding her analgesia medications.

Yours sincerely

JDoW

SCOTT WILSON
GP SPECIALIST TRAINEE 3

NHS Greater Glasgow And Clyde

Day Surgery Unit, Stobhill Hospital

GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN, 07/12/1972 (F)**	Address:	6 Muirhead Court Baillieston Glasgow Lanarkshire G697EP
CHI No:	**0712726128**		
Case note no.:	**10638479K**		

GP: Dr John Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G697AD

Procedure date
30th April 2009

Status: Day patient/NHS
Hospital: Stobhill Hospital
Ward: STO - DSU
Referring Cons: Mr J Smith (General Surgery)

Indications
Nausea and/or vomiting and reflux.

Report

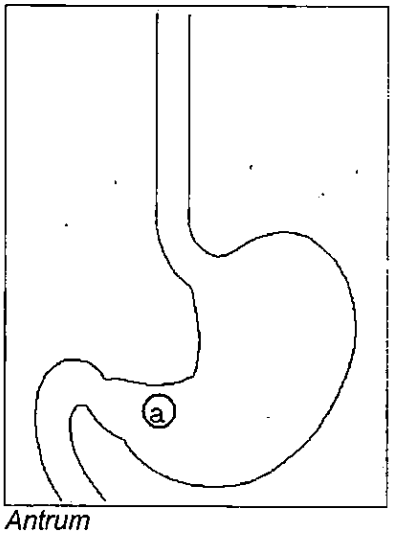
Consultant/Endoscopist
Mr John Smith
Nurses: SN Margaret Barlow
SN Catriona Bradley

Instrument
STP PURPLE STR EG2770K A120370

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Gastritis and grosss bile reflux staining whole of stomach.
DUODENUM. Normal.

Premedication
Midazolam (IV) 10 mg

Medication
This lady should have high doses of Altacite plus and metoclopramide or motillium for her bile reflux she will also need a revision of her Nissen which appears too lax.



a: *Antrum*

Follow up
Awaiting pathology results. Review will be in the Surgical Clinic.

Mr John Smith
Consultant Upper GI Surgeon

Specimens taken
Biopsy (x2)

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 16/04/2009
Typed 17/04/2009
Our Ref. JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw Deborah in clinic today. Her pH studies do show some reflux and her barium shows a little bit of a para-oesophageal hernia and I think we might have to contemplate an operation to tighten up her hiatus. However, prior to this I think we should repeat her endoscopy. I would also like Deborah to cut down on her smoking as this could certainly cause reflux.

I wonder if it would be possible for you to prescribe some Opsite dressings for this lady to hold her patches on as, with her menopause, she becomes very sweaty and the patches fall off.

Yours sincerely

Mr John S Smith
Consultant Surgeon

GREATER GLASGOW AND CLYDE
Acute Services Division

Gastroenterology Investigation Unit, GRI

OESOPHAGEAL MANOMETRY REPORT

Date: 17.03.2009

106384789K
DEBORAH
SULLIVAN 07.12.1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP

CHIE: 0712726128

Pre-op **Post-op** **Diagnostic**

Clinical Problem: .....Query GORD..... **Polygram for Windows (2.04 software)**
Consultant: Mr Smith
..... **Source: SOPD, Stobhill Hospital**

Clinical Manometrist: S Thomson \ C Buchanan \ **C Mackenzie**

Intubation (*please indicate*): **1)** right nare **2)** left nare **3)** the mouth
Technical difficulties encountered during intubation:

None

Lower Oesophageal Sphincter			
Amplitude as an average of all pressures (N = 10-25mmHg)	-	25	**mmHg**
Position of high pressure zone	-	45-42	**cms**
Relaxation: Complete (< 5mmHg) Incomplete / Absent	-	100	**%**
Oesophageal Body			
Peristaltic contractions - Monophasic	-	100	**%**
- Multipeaked	-		**%**
Low-pressure waves (< 30mmHg)			
Simultaneous contraction (< 1 sec)	-		**%**
Incomplete propagation	-		**%**
Spontaneous/tertiary contractions	-		**None**
Propagation Velocity	-	1.04	**cm/sec**
Distal contraction amplitude (N = 20-190mmHg)	-	94	**mmHg**
Distal wave duration prolonged (N < 7 sec)	-	3.5	**cm/sec**

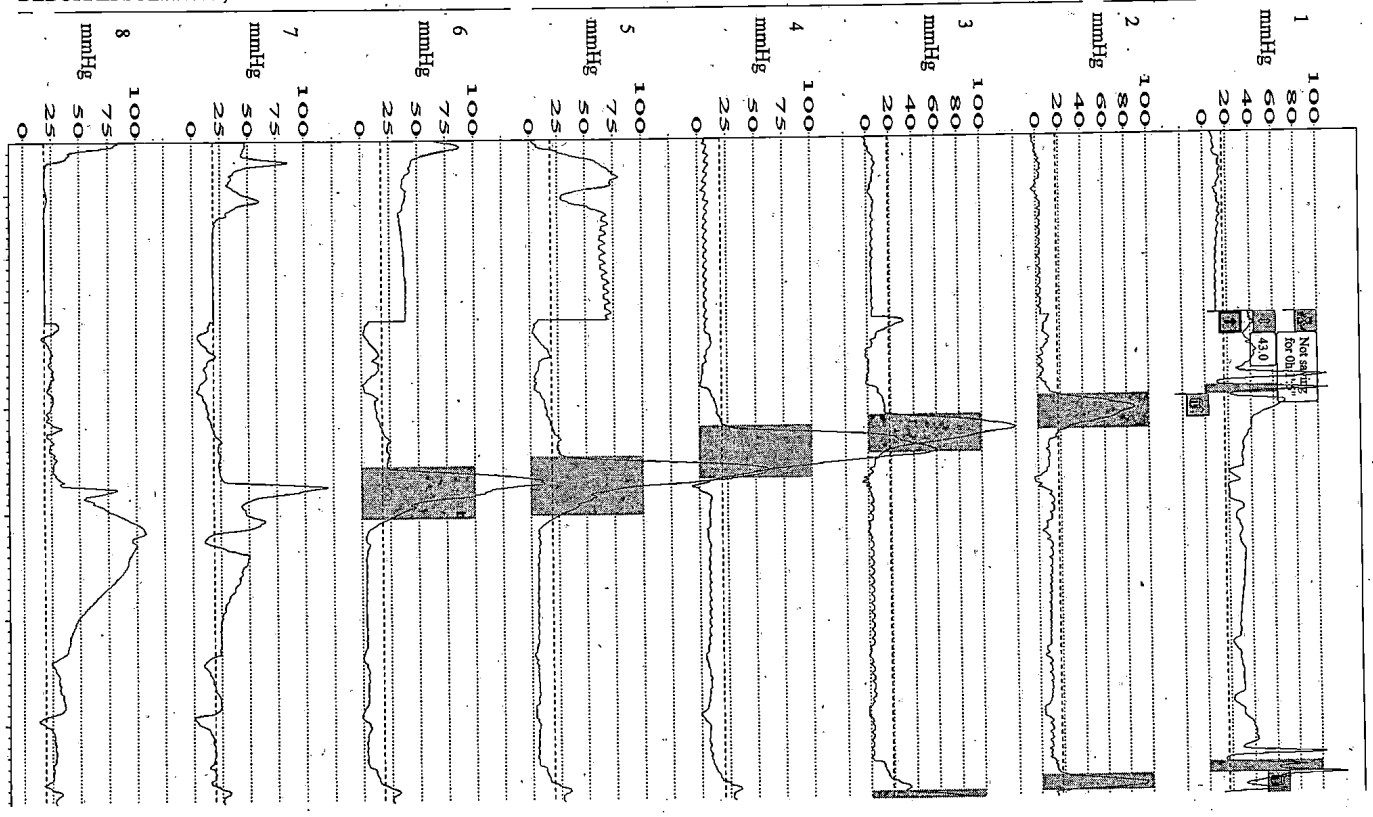
Type of catheter: LOS Silicone / EMC8-S / Dent sleeve / Disposable
Serial Number:

Comment:

Normal oesophageal manometric values.

Normal Study

Reported by: Sr S Thomson
Nurse Practioner G I Physiology



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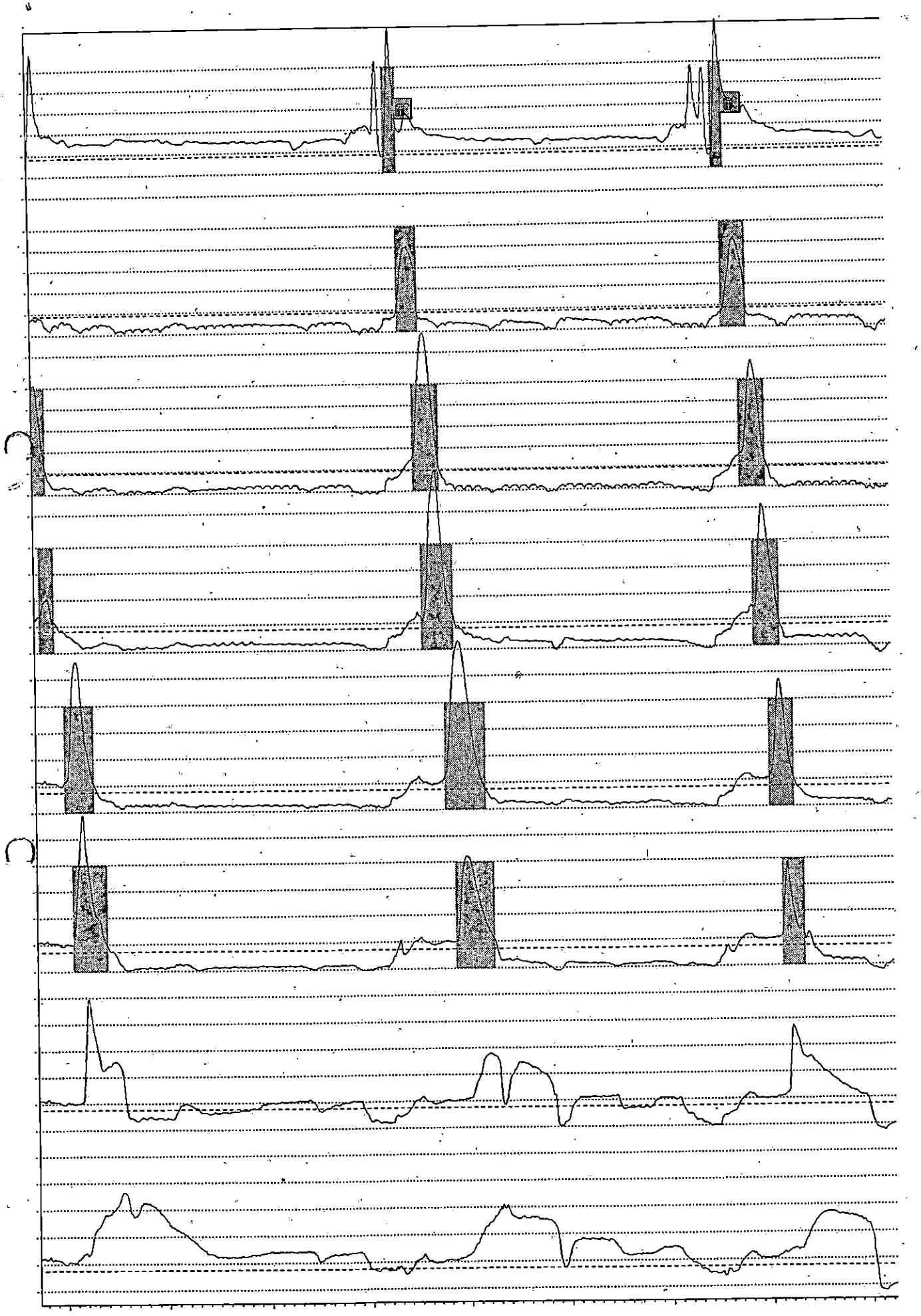
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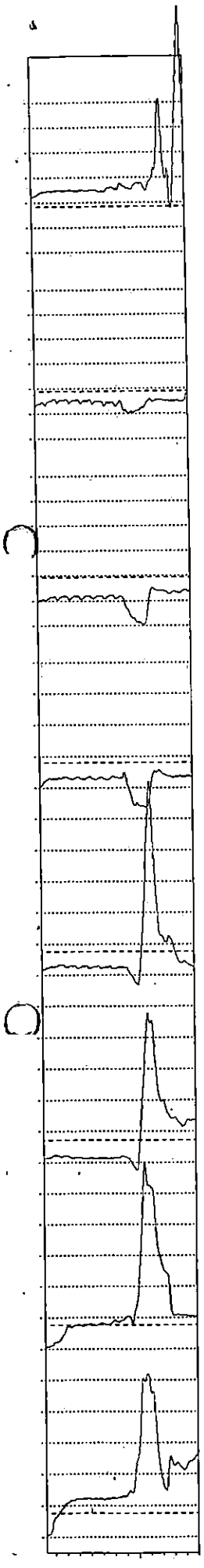


09:14:59

DEMONSTRATION USE ONLY

pH Report, Oesophageal Function Unit

Glasgow Royal Infirmary, Greater Glasgow and Clyde Health Board

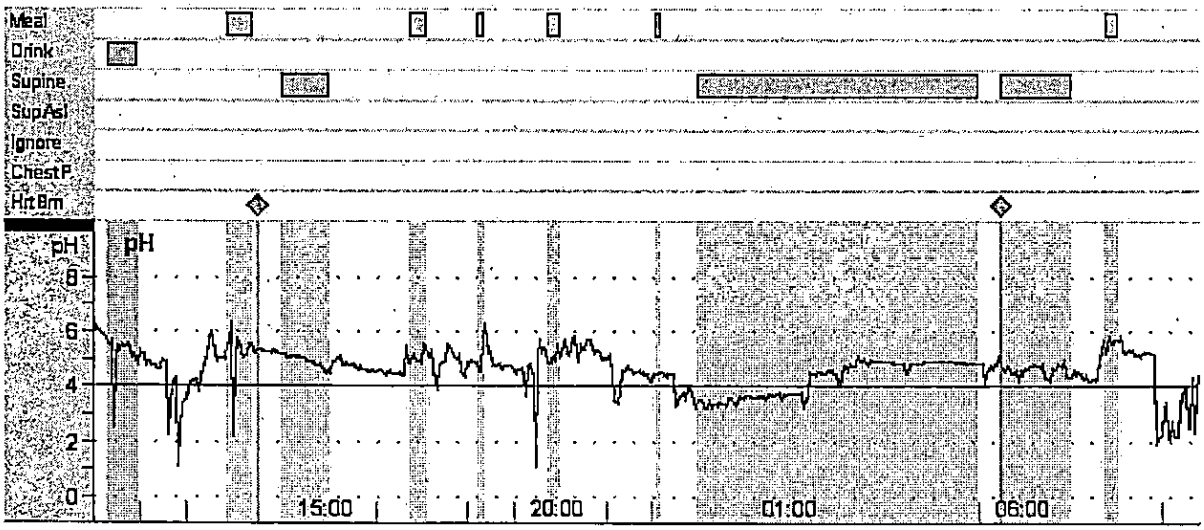
Patient Name:	**SULLIVAN, DEBORAH**
Patient ID:	**0712726128**
Date of Birth:	**07/12/1972**
Ref. Physician:	**Smith, Mr John S**
Physician:	**Gillespie, Dr Ruth**
Technician:	**MacKenzie, Carole**

Date of Test: **17/03/2009, 10:02**
Reason for Study: **POST OPERATIVE STUDY. OFF MEDICATION STUDY, OMEPRAZOLE 40MGS DAILY.**

Comments and Interpretation

PROBE AT 37CM. GORD EVIDENT ABNORMAL OESOPHAGEAL ACID EXPOSURE WHEN SUPINE.

Study Summary



Analysis Results - pH

Acid Period Table

	Total	Uprigt	Supine	SupAsl	Meal	Postpr	HrtBrn
Duration of Period	23:52	15:22	08:30	00:00	01:33	10:26	00:04
Number of refluxes	108	93	16	0	2	60	0
Number of long refluxes	4	3	2	0	0	3	0
Duration of longest reflux (min)	120	120	120	-	1	120	0
Time pH < 4 (min)	218	81	138	0	1	135	0
Fraction time pH < 4 (%)	15.2	8.7	27.0	-	0.6	21.5	0.0

	ChestP	Drink
Duration of Period	00:00	00:37
Number of refluxes	0	1
Number of long refluxes	0	0
Duration of longest reflux (min)	-	1
Time pH < 4 (min)	0	1

Fraction time pH < 4 (%)	-	2.3

Acid SAP Table

	Total	Uprigt	Supine	SupAsl	Meal	Postpr	Drink
Heartburn	34.8	26.6	0.0	-	0.0	26.3	-0.0
Chest Pain	0.0	-0.0	0.0	-	0.0	-0.0	-0.0

Acid SI Table

	Total	Uprigt	Supine	SupAsl	Meal	Postpr	Drink
Heartburn	0.0	0.0	-	-	-	0.0	-
Chest Pain	-	-	-	-	-	-	-

DeMeester Score (Total): 69.4 DeMeester normals: < 14.72 (95th percentile)

Signature: SR Shane Thomas

Patient Diary

NHS Greater Glasgow and Clyde

Name :	Date: 17/3/09
Hospital Numb	
Comments:	

10638479K F
SULLIVAN
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Intubation *(please tick)*: 1) right nare ☑ 2) left nare ☐ 3) the mouth ☐

Technical difficulties encountered during intubation:

Please record the START and FINISH time for the following events.

1. **When eating and drinking** - it is helpful if you record which food you have eaten.
2. **When lying down or asleep** - the recording device can be placed under your pillow.
3. **Episodes of heartburn or chest pain** - you need only record the onset of these.

Start Time	Event:	Finish Time
10·20	DRINK DIET COKE	10·23
10·45	TOAST + BANANA	10·57
12·50	PANCAKE CUP OF TEA	13·20
13·30/14·00	HEARTBURN ASLEEP	15·00
16·45	CHEESE & HAM TOASTIE	17·05
18·12	FRUIT PASTLES	18·20
19·45	PORTION McDONALDS CHIPS + MILKSHAKE	
10·05	FRUIT PASTEL	10·08
11·00	ASLEEP	5·00
5·30	WOKE UP WITH HEARTBURN TABLETS WENT BACK TO BED	5·30
07·45	HOT OATS + CUP COFFEE	0·800
9·15	JUICE	9·20

It would be beneficial if you could complete these three questions on completion of this study.

1. Have your activities been limited today due to having this study? Yes ☑ No ☐
2. Have you had your normal dietary intake during this study? Yes ☐ No ☑
3. In relation to the amount of heartburn/chestpain you would normally have over a day, how would you compare this to the amount you have experienced during this study?

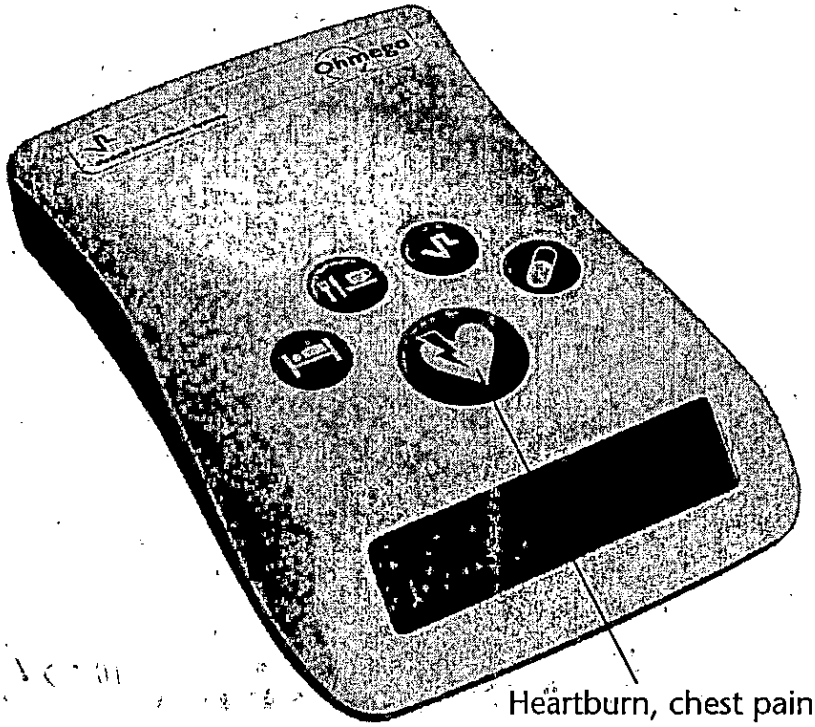
   1] same ☐ 2] more ☐ 3] less ☑

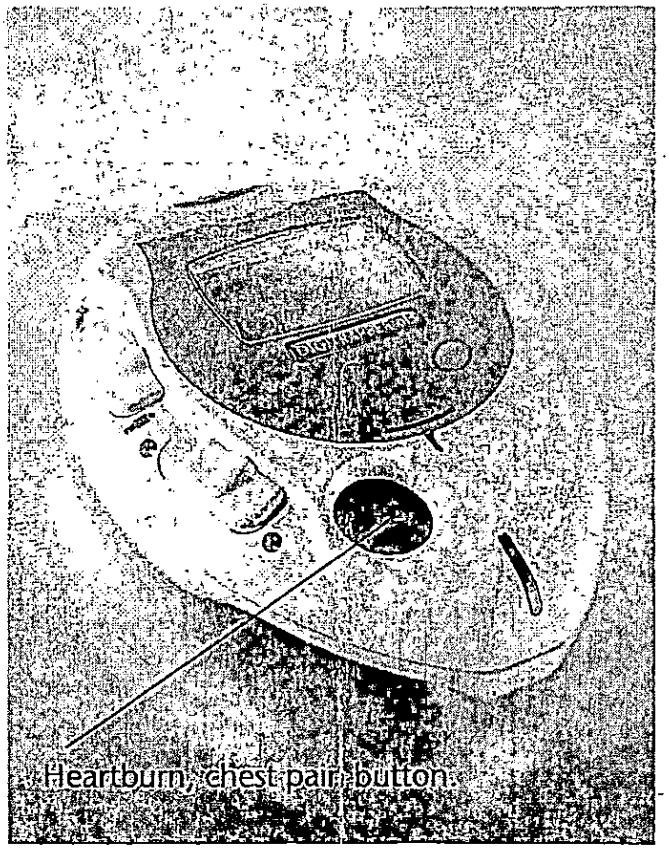
Care of Ambulatory PH Recording Device:

1. Do not allow this unit to come in contact with water or household agents.
2. If the catheter (TUBE) is coughed into the mouth it should be removed by pulling it from the nose. DO NOT re-pass the tube. Make a note of the time that the tube was removed.
3. The hours of this unit are 8am-5pm. If you need advice outside these hours contact your G.P. or local casualty unit.

Compiled by Shona Thomson – Motility Nurse

Designed & Produced by Medical Illustration GRI Job No. 98560


Heartburn, chest pain button.


Heartburn, chest pain button.

24 DEC 2008

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 18/12/2008
Typed 19/12/2008
Our Ref SK/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I reviewed this lady in Mr Smith's clinic today. She has on going epigastric discomfort and vomiting. She is jointly under our care and that of Dr Rae in view of her chronic pain issues in the past.

We arranged for her to have a barium meal to try and further assess her stomach. This would suggest that her fundoplication is sub-diaphragmatic. The radiologists have noted, however, that when she lies flat there is a small amount of reflux. They have also commented that there is a slightly atypical appearance of the gastric fundus and they have queried a small para-oesophageal hernia. She is still awaiting her pH studies and manometry and I will try to expedite these for her. We will see her for review once these studies have been completed.

I did not double check with Deborah today which PPIs, if any, she is on and would be grateful if you could look into this and ensure, if possible, that we try her on high dose Esomeprazole, 20 mg bd, to see if this improves her symptomatology.

Yours sincerely,

Mr Segun Komolafe
Specialist Registrar

File please
8/1/09
Rae

Copy to:

Dr Colin Rae
Consultant Pain Specialist
Stobhill Hospital

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
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NHS
Greater Glasgow and Clyde

Clinic 18/12/2008
Typed 19/12/2008
Our Ref SK/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

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Yours sincerely,

Mr Segun Komolafe
Specialist Registrar

Copy to:

Dr Colin Rae
Consultant Pain Specialist
Stobhill Hospital

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 18/12/2008
Typed 19/12/2008
Our Ref SK/EM

Sister Shona Thomson
Endoscopy Nurse Specialist
Ward 32
Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SD

Dear Shona

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

This young woman is presently waiting for manometry and pH studies but does not appear to have received an appointment. I am not sure if Mr Smith's initial referral has reached you but would be grateful if you could arrange for these investigations to be carried out in the near future.

Kind regards.

Yours sincerely,

Mr Segun Komolafe
Specialist Registrar

Department of Anaesthetics
Stobhill Hospital
Balornock Road
GLASGOW G21 3UW

CHRONIC PAIN SERVICE

Secretary Tel: 0141 201 3005
Fax: 0141 201 4167

Ref No: CR/CMcD/10638479K

Clinic: 03/12/2008
Typed: 09/12/2008

Dr John Langan
Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan, (DOB: 07/12/1972, CHI: 0712726128), 6 Muirhead Court, Baillieston, G69 7EP

Problems:
- Chronic epigastric pain
- Previous chronic pancreatitis
- Previous colosesectomy (1996)
- Recurrent hospital admissions with abdominal pain
- Inappropriate analgesic intake
- Marked anxiety and depression

I was pleased that Deborah attended the Chronic Pain Management Clinic today. She has not attended since 2006. She has ongoing problems with chronic epigastric pain and she also has difficult social circumstances and marked anxiety and depression. She scores very highly on a visual analogue pain scale and also has marked disability as a result of her pain. Her current medications are Omeprazole, Fluoxetine, Gabapentin 600mgs TDS, Fentanyl patch 75Micrograms every 72 hours, Dihydrocodeine 60mgs 4 times daily, Graniestron, Maxolon and Temazepam. There were recent problems with her analgesia, in particular she was receiving pethidine which I do not think would be helpful for her. She has also in the past had trials of Oramorph and Tramadol. She is intolerant of non-steroidals. She has also had trials of homeopathic treatments, acupuncture, a TENS machine and has attended healers unfortunately without success. She scores highly on the hospital anxiety and depression questionnaire for both anxiety and depression and she describes being virtually a recluse at home mainly because of depression.

I have had a long chat with Deborah today about her situation. I have discussed the stressors she has in her life and relationship this has to her chronic pain and its management. I have talked about the following options with her:

1. Referral to Pain Clinic Clinical Psychologist regarding her depression and her difficulty in managing her pain.

Cont/...

Consultant Anaesthetists: Dr C P Rae, Dr L Manchanda.
Pain Sisters: Sr S Calwell, Sr K Scullion. **Clinical Psychologist:** Dr E Toland.
Physiotherapists: C Farish, J Ford, A Williams. **Secretaries:** Miss L Armstrong. Miss C McDade

Department of Anaesthetics
Stobhill Hospital
Balornock Road
GLASGOW G21 3UW

CHRONIC PAIN SERVICE

Secretary Tel: 0141 201 3005
Fax: 0141 201 4167

2. Regular follow up in the Chronic Pain Clinic with a view to monitoring opioid analgesia with the long term aim of reducing opioid intake.

3. Discontinuing Dihydrocodeine and replacing with Tramadol, initially 100mgs 4 times daily with the aim of reducing the strength of this over the next few weeks.

4. I have said to Deborah that I do not think she should be prescribed pethidine.

5. I have invited Deborah to attend our Pain Management Advice Classes and have given her a Patient Information sheet on this.

I will see Deborah again in due course but please contact me if there are problems before then.

Yours sincerely

Dr Colin Rae
Consultant in Anaesthesia & Pain Management

cc Miss Carol Craig
Consultant General Surgeon
Stobhill Hospital

cc Dr Emma Toland
Clinical Psychologist
Chronic Pain Service
Stobhill Hospital

Consultant Anaesthetists: Dr C P Rae, Dr L Manchanda.
Pain Sisters: Sr S Calwell, Sr K Scullion. **Clinical Psychologist:** Dr E Toland.
Physiotherapists: C Farish, J Ford, A Williams. **Secretaries:** Miss L Armstrong. Miss C McDade

IMMEDIATE DISCHARGE LETTER

NHS Greater Glasgow

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone : 0141 - 201 - 3000

GP COPY

First Issued: 18/11/2008 15:00
Printed: 18/11/2008 15:00

Admitted: 17/11/2008 **Discharged:** 18/11/2008
Discharged to: Home
Ward: 7a
Consultant: MS C CRAIG, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES **ICD10** **PROCEDURES** **OPCS4**

No diagnoses have been made for this patient

MEDICATION

No medication has been prescribed for this patient

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Chronic Pain	DR CR RAE	03/12/2008 00:00

Outpatient Investigations **Date**
No arrangements made

Community Care **Date** **Reason**
No arrangements made

18.11.08

GENERAL COMMENTS

Final discharge letter to follow

Dear Doctor,

Ms Sullivan was admitted via A&E with a 3 days history of epigastric pain and vomiting. Examination on arrival revealed a tender epigastric region but observations were all stable. Blood results were unremarkable. As you know, Ms Sullivan has a past history of chronic pancreatitis and suffers from chronic abdominal pain. She is taking strong analgesica including fantenyl patches, pethidine, gabapentin and dihydrocodeine and she is under review by chronic pain team as OP. During her stay, Ms Sullivan was also reviewed by one of the hospital chronic pain team nurse. However, she noticed that Ms Sullivan has missed or cancelled multiple pain clinic appointments in the past. She is therefore very worry about her opioid usage without regular review. After discussed with Dr Langan at Ballieston Health Centre, it is decided to stop her pethidine but to keep her on fentanyl patches and dihydrocodeine as breakthrough at the moment until she is reviewed by Dr Rae at her next pain clinic appointment on 03/12/2008.

At the surgical point of view, investigation so far has been normal. Patient's epigastric pain is likely to be a chronic pain issue. She is sleeping well and is now discharged home. She has been explained about the alteration of her pain control.

Many Thanks,

Signed: **Designation:**

Contact: Andy Kwok **Pager Number:**

DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLEOD
DR ELAINE E POLLOCK
DR GERARD A MCKAIG
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKER
DR JOHN C MENZIES
DR LIANA MCMILLAN

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 8067

17/11/08

FAO SURGICAL RECEIVING TEAM

GRI

Dear Doctor

Re Deborah Sullivan D.O.B. 7.12.72
6 Muirhead Court
G69 6QR

Many thanks for seeing Deborah. She has a past h/o chronic pancreatitis and has previously had a nissen fundoplication for a hiatus hernia + reflux symptoms. She has been attending Mr Smith for sometime due to problems with chronic severe abdominal pain. She last saw him last week + he plans to admit her for an? ERCP, pH studies + barium. Over the last 3 days she has had problems with + severe abdominal pain with worsening nausea. She had been using fentanyl 75mcg patches + dihydrocodeine for pain but she reverted to taking pethidine over the

P10

weekend as more were no large helping.

O/E in pain.

Distressed temp 38°

P80 BP 130/80

Abdo tender + guarding in epigastrium.

Impn ↑ severe abdo pain. ?? recurrent pancreatitis.

She is devastated at being readmitted to hospital but I feel that her symps merit further investigation on an urgent basis + she requires adn analgesic review.

Yours sincerely,

Dr Jones

PS Given 10mg im metoclopramide at 12.45pm — summary sheet enclosed.

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 13/11/2008
Typed 14/11/2008
Our Ref JSS/PVT

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

As you know, Deborah was back in hospital with further vomiting and abdominal pain. We are obviously trying to work what exactly is going on and have arranged a barium meal to look at the Nissen's and to see if the anatomy looks okay. Her endoscopy looks fine.

Secondly, I would like to see if she has had a slackening of the wrap as she is getting more reflux and I thought we would get her pH motility to check this again.

Thirdly, I wondered if you could give her Metoclorpramide in addition to her Kytril to see if we can stop her sickness and prevent her vomiting after every meal.

I am hoping to get these tests arranged and see Deborah in a month's time but obviously, if she has more bother with vomiting we will need to admit her and see if we can get her done as an in-patient.

I will let you know the results of Deborah's tests as soon as they come through.

Yours sincerely

13.XII.08

Mr John S Smith
Consultant Surgeon

Department of Anaesthetics
Stobhill Hospital
Balornock Road
GLASGOW G21 3UW

CHRONIC PAIN SERVICE

Secretary Tel: 0141 201 3005
Fax: 0141 201 4167
Email: carolelivingston@NorthGlasgow.Scot.NHS.uk

CPR/CL/10638479K

Clinic: 16th November 2005
Typed: 17th November 2005

Dr MacLeod
Baillieston Health Centre
20 Muirside Road
GLASGOW
G69 7AD

Dear Dr MacLeod

Deborah Sullivan dob 7 12 72 (6128)
1 Brodie Gardens Baillieston G69 6BQ

I was pleased to meet Deborah again today in the Pain Management Clinic. I had initially seen her when she was an inpatient here at Stobhill Hospital with abdominal pain. As you are aware, she had a cholecystectomy in 1996 and before that, had had upper abdominal pain for three years. Interestingly, the nature and site of her pain have not really altered since her cholecystectomy. She describes the pain as stabbing and is present every day. There is a background ache with severe exacerbations particularly after eating meals. The pain is also bad at night. She has problems with nausea with the pain and previously had problems with vomiting. Her visual analogue pain score varies between 7 and 10/10.

We had a long chat about the impact her chronic pain has had on her life. At present, her medications are Losec 40mg daily, Tramadol 100mg qid, Transtec patch 52.5µg, Oramorph 10mg up to four times daily, Prozac 40mg daily and Metoclopramide. In the past, she has had trials of Voltarol which did not help. In addition, she has had trials of Pethidine, Dihydrocodeine and Sevredol. She has also attended the Homeopathic Hospital.

On examination, Deborah was tender to light palpation over her epigastrium. There was no superficial tenderness or allodynia.

I had a long chat today with Deborah about chronic pain, visceral pain and the theory of sensitisation of the sensory nervous system in response to chronic pain. I would suggest the following measures in the first instance:

1. Recommence Amitriptyline in a dose of 10mg at night.
2. Commence Gabapentin starting with 300mg a day for one week, increasing 300mg bd for one week and then 300mg tid. This should be continued until review at the Pain Clinic.

I also discussed Deborah trying to be maintained on only one opioid. To this end, I would suggest gradual wind down in her Tramadol dose and with a potential increase of the

Department of Anaesthetics
Stobhill Hospital
Balornock Road
GLASGOW G21 3UW

CHRONIC PAIN SERVICE

Secretary Tel: 0141 201 3005
Fax: 0141 201 4167
Email: carolelivingston@NorthGlasgow.Scot.NHS.uk

Transtec patch to the 70µg strength. This would provide some rationalisation of her analgesia. I will review her in due course.

Yours sincerely

C P Rae
Consultant in Anaesthesia and Pain Management

Consultant Anaesthetists: Dr W J MacRae, Dr C P Rae.
Pain Sisters: Sr S Calwell, Sr K Scullion. **Clinical Psychologist:** Dr M Dunbar.
Physiotherapists: Mr G MacGregor, Mr C Farish. **Secretary:** Ms C Livingston.

North Glasgow Hospitals

Department of Pathology
Pathology Report

Enquiries: 0141 211 2473

Lab No.:P,08.0019013 CHI No. 0712726128

Name:SULLIVAN DEBORAH DOB/Age:07.12.72
Post code:G69 6BN

Hosp.No(orPath.Comp.Ref.ZP): 10638479K

Consultant:MR.J.SMITH STOBHILL Location:STOBHILL WD 6

GASTRIC BIOPSY.

Clinical history

?biliary gastritis. ?Helicobacter.

Gross

A 2mm biopsy.

Microscopy

Microscopy shows a small piece of non specialised gastric mucosa with foveolar hyperplasia and an increase in smooth muscle fibres in the lamina propria consistent with chemical/biliary reflux gastritis. Helicobacters are not identified. There is no intestinal metaplasia, dysplasia or malignancy in the biopsy.

M Seywright

SK

Date collected 03.10.08
Date received 06.10.08
Date reported 07.10.08

STOBHILL HOSPITAL

OPERATION CHART

SURNAME	FORENAME	UNIT NUMBER
Sullivan	**Deborah**	10638479K
DOB: **07/12/1972**	WARD	

DATE OF OPERATION 03/10/2008

SURGEON'S NOTES

OPERATION PERFORMED

SURGEON MR J S SMITH

OPERATION: Gastroscopy and biopsy.

PROCEDURE: The gastroscope was passed. The oesophagus was normal. There was no evidence of any hiatus hernia and no weakness at the gastro-oesophageal junction and the Nissan looked intact. Entering the stomach there bile staining of the stomach mucosa. Biopsies were taken for CLOtest and also for biopsy for histology. The duodenum was entered and was normal.

SPECIAL INSTRUCTIONS

JSS/JMcN DICTATED 03/10/08 & TYPED 06/10/08–

DATE _____ SIGNATURE _____

00590

IMMEDIATE DISCHARGE LETTER

NHS
Greater Glasgow

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone : 0141 - 201 - 3000

GP COPY

First Issued: 05/10/2008 02:57
Printed: 05/10/2008 02:57

Admitted: 30/09/2008 **Discharged:** 04/10/2008
Discharged to: Home
Ward: 6
Consultant: MS C CRAIG, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES	ICD10	PROCEDURES	OPCS4
No diagnoses have been made for this patient		1. Ultrasound scan of abdomen, N/A, 01/10/2008	Uncoded

MEDICATION

No medication has been prescribed for this patient

Pharmacy Comments

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	Mr JS SMITH	09/10/2008 00:00

Outpatient Investigations	Date
No arrangements made	

Community Care	Date	Reason
No arrangements made		

GENERAL COMMENTS

Final discharge letter to follow

Dear Doctor,

Background: previous cholecystectomy
MRCP - 2 weeks ago
OGD - 8 weeks ago
Pancreatitis

This 35 year old lady was admitted with a 6 day history of severe upper abdominal pain, radiating to her back. O/E she was tachycardic with epigastric tenderness and guarding.
Bloods, ABG, CXR and AXR were all normal and abdo US showed no pathology of note. The results of the MRCP performed on 11/09/08 showed no evidence of calculus in the CBD and a unremarkable pancreatic duct.

She was discharged on 04/10/08 and is to be reviewed at Mr Smith's clinic on 09/10/08.

Kind Regards,

DNA SOPD 23/10/08

Signed: **Designation:**

Contact: Claire Shepherd **Pager Number:**

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 18/09/2008
Typed 19/09/2008
Our Ref JSS/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw Deborah in clinic today. It was disappointing to hear that her sickness and pain had returned to such an extent that she had required admission to hospital. Her endoscopy, as you know, appeared to be satisfactory when she was in and we wondered therefore if it could be a bout of pancreatitis which might be setting off all the retching. The result of the MRCP was not available today but, as you will see from my handwritten note, I wondered if you could put her on some Kytril or Granisetron to see if we can settle down her vomiting. If she fails to improve with this then I think we would be better to admit her and if you simply contact my secretary she can arrange this for Deborah.

Yours sincerely

Mr John S Smith
Consultant Surgeon

North Glasgow Hospitals

NHS
Greater Glasgow and Clyde

Patient Label

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

The patient attended SURGERY Clinic at STOBHILL

Hospital on 19/9/08 and I would advise a change to drug therapy from

KYTRIC 1mg. to two daily.

~~or additional therapy of~~ instead of previous medication

if Tri doesn't settle the oedema please phone me and

as detailed below. Full letter to follow. I will admit her.

Additional Comments: Secretary's number 0141-201-3785

DRUG (print)	DOSE	FREQUENCY	DURATION / REVIEW DATE

Yours Sincerely

Signature:

Name (print) Grade: Ext. No:

White copy to G.P. Pink copy - File this copy in Case Records

00545

Sullivan **Deborah** 10638479K
DOB: **07/12/1972** WARD

DATE OF OPERATION 07/08/2008

MISS E CANNINGS
DR A RIDDELL

OPERATION: OGD under sedation.

PROCEDURE: Consented for procedure. 5mg I.V. Midazolam sedation given. Old scar used. OGD passed into stomach. OG junction at approximately 40cm.

FINDINGS: **Oesophagus –**

Normal.

Stomach –

Mild inflammation throughout stomach.

Duodenum –

D1 and D2 normal.

No real findings for patient's symptoms.

Two core biopsies taken and two biopsies taken for Pathology.

POST-OP.: Patient returned to ward.
Can drink as tolerated.

EC/AS DICTATED & TYPED – 07 AUGUST 2008

NHS
Greater Glasgow and Clyde

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone Number: 0141 201 3000

23 Jul 2008 10638479K:14

MS DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
G69 7EP

Dear MS DEBORAH SULLIVAN

10638479K
0712726128

Arrangements have been made for your admission to Stobhill Hospital at STO-DSS DAY SURGERY under the care of MR SMITH.

Please report on 21 Aug 2008 at 12:30 to the Day Surgery Unit direct.

If you are unable to attend for this admission, please inform us by contacting MR SMITH's sec as soon as possible. Should you neglect to inform us that this admission date is unsuitable and you fail to attend for your admission, you may be removed from the waiting list and referred back to the care of your General Practitioner – referrer who will require to re-refer you in order for you to obtain another admission date.

ON THE MORNING OF ADMISSION PLEASE HAVE BREAKFAST BEFORE 7:30AM AND NOTHING TO DRINK AFTER 9:30AM EXCEPT WATER WHICH WE WOULD ENCOURAGE YOU TO DRINK UNTIL 11.30AM. TAKE YOUR USUAL MEDICATIONS AT THE USUAL TIME WITH A SIP OF WATER UNLESS OTHERWISE INSTRUCTED BY YOUR DOCTOR OR THE PRE-ASSESSMENT CLINIC. PLEASE ARRANGE FOR SOMEONE TO COLLECT YOU AND ACCOMPANY/DRIVE YOU HOME FOLLOWING YOUR PROCEDURE. PLEASE CONFIRM YOU WILL BE ATTENDING BY TELEPHONING 0141 201 3785.

Please bring any medications, in their original containers, prescribed by your General Practitioner.

Yours sincerely

Secretary

Please note that on March 26th 2006, the NHS Greater Glasgow & Clyde No Smoking Policy came into force in line with the Scottish law on smoking in public places. The full policy may be viewed at www.nhsgg.org.uk . This means that smoking is not allowed inside any NHS building, entrance, doorway, grounds or car parks. This applies to patients, visitors and staff. If you are being admitted to hospital and would like to stop smoking while an in-patient, please speak to the nursing staff about the In-Patient Stop Smoking Service. For stop smoking services or further information please call Smoking Concerns (0141 201 9825).

Visitors to Stobhill, Glasgow Royal, Western Infirmary and Gartnavel General can use the free door-to-door Eveving Visitor Transport Service. This service operates from 6pm to 10pm (Mon-Fri, except public holidays), and is available to anyone who lives in Glasgow, East Dunbartonshire, East Renfrewshire and Cambuslang/Rutherglen. Visitors can book up to one week in advance by calling 0845 128 4027 between 1pm and 4pm (Mon-Thu), or between 1pm and 3:30pm on a Friday. Priority will be given to your nearest hospital, older people (over 60), individuals living with a disability and those on a low income or in receipt of benefits.

FINAL DISCHARGE LETTER

NHS
Greater Glasgow

First Issued: 01/09/2008 08:51
Printed: 01/09/2008 08:52

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone: 0141 - 201 - 3000

Admitted: 05/08/2008 **Discharged:** 11/08/2008
Discharged to: Home
Ward: 6
Consultant: Mr DT HANSELL, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES **ICD10** **PROCEDURES** **OPCS4**

1. Nonspecific antral erythema, N/A, 07/08/2008 Uncoded

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8	12	14	18	22	PRN/Comment	Course Length	Quantity Dispensed
Paracetamol	Tab	Oral	1g						4-6hrly for pain	Indefinite	32 500mg
Omeprazole	Cap	Oral	40mg	X						Indefinite	Patients Own
Fluoxetine	Cap	Oral	40mg	X						Indefinite	Patients Own
Gabapentin	Cap	Oral	300mg bd	X				X		Indefinite	14
Metoclopramide	Tab	Oral	10mg						as required 8mg	Indefinite	28
Cyclizine	Tab	Oral	50mg						as required for nausea	Indefinite	21
Temazepam	Tab	Oral	10mg					X	1 tab at night for insomnia	Indefinite	7

Pharmacy Comments

Reviewed by pain team - pethidine stopped, fentanyl patches commenced.

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	Mr JS SMITH	6 weeks

Outpatient Investigations **Date**

No arrangements made

Community Care **Date** **Reason**

No arrangements made

GENERAL COMMENTS

This patient was admitted on 5/8/08 with upper abdominal pain and tenderness and vomiting. Abdominal ultrasound was unremarkable. She subsequently underwent an OGD. Biopsies were taken, the results for which we are awaiting. The only remarkable finding was antral erythema. A CLO test for H pylori was negative.

She was seen by the pain team on 8/8/08, who prescribed fentanyl patches (12 micrograms over 72h) for backbround pain and tramadol for breakthrough pain. They also restarted her gabapentin as she felt this helped. She was discharged with enough to last 1 week. She has been re referred to chronic pain clinic (her last attendance was in 2006), so we would be grateful if you could continue these medications until she is followed up at the clinic.

The pain team have also recommended stopping the severdol and pethidine she has been on.

We will also arrange to see her at Mr Smith's clinic once she has had an outpatient MRCP, which is being arranged to take place at the Western Infirmary.

FINAL COMMENT DICTATED 29.08.08 NSN/EM

NHS Greater Glasgow

Patient: DEBORAH SULLIVAN D.O.B: 07/12/1972 Hosp. No: 10638479K

Admitted: 05/08/2008 Discharged: 11/08/2008 Printed: 01/09/2008 08:52

GENERAL COMMENTS (continued)

Nil to add.

Yours sincerely

Dr Nawira Syed-Nahar
FY2

Signed: _____ **Designation:** _____

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 17/07/2008
Typed 21/07/2008
Our Ref AR/EM

Dr John Langan
Baillieston Health Centre
20 Muirside Road, Baillieston, Glasgow
G69 7AD

Dear Dr Langan

Deborah Sullivan ~ 07/12/1972 ~ CHI: 0712726128 ~ CRN: 10638479K
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

This lady attended Mr Smith's clinic for review today. She is well known to the surgical team and Chronic Pain Service. She had problems with chronic abdominal pain after cholecystectomy many years ago and subsequently had a Nissen's fundoplication for her on going abdominal pain and hiatus hernia; this was performed in 2005. The patient tells me that since she was last scoped just over a year ago her symptoms had quiesced. However, over the last six months she has noticed increasing abdominal pain after eating. This pain is situated in the epigastrium and radiates through to her back. This is associated with increasing abdominal flatus and bloating. Over the last eight weeks she says that she has had real problems after eating with significant amounts of bile reflux. She has noted anorexia and quite significant weight loss but no haematemesis. I note that previously she has been diagnosed with chronic pancreatitis but the origin of this is unclear.

She has not been seen by the Chronic Pain Service for some time and currently is maintained on Tramadol with Pethidine for acute attacks.

On examination today she has a large upper midline scar over a bloated abdomen. The abdomen was soft and tender over the epigastrium right upper quadrant although she was Murphy's negative. Bowel sounds were normal.

I have taken some bloods from this lady today and will check the results personally myself. We will arrange for her to have a further upper GI scope to investigate her symptoms and will review her in clinic with the results.

Yours sincerely

A RIDDELL
SHO III

46216

DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLEOD
DR ELAINE E POLLOCK
DR GERARD A MCKAIG
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKER
DR JOHN C MENZIES
DR LIANA MCMILLAN

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 8067

To receiving surgeons S. 8. 8

Re: Deborah Sullivan
7/12/72
6 Muirhead Ct

Dear dr,

Many thanks for seeing this 35 year old lady. She has been sick constantly since Sunday, not able to keep anything down. She has a history of pancreatitis due to gallstones, under the care of Mr Smith. She was due for OGD 21/8/18. She is not not passing any urine. She denies any diarrhoea.

DH - Metoclopramide PRN
Omeprazole 40mg OD
Tramadol 8 TABS DAILY
Pethidine 4 TABS DAILY.
Fluoxetine 60mg OD. OCP. CELESTE.

PMH - Chronic pancreatitis
Ndsais fundoplication 2005 for H/H.

O/E In pain
BP 135/60
HR 90

Imp Pancreatitis

Thank you DR J M Elliott
GP reg

IMMEDIATE DISCHARGE LETTER

NHS
Greater Glasgow

Stobhill Hospital
133 Balornock Road
Glasgow
G21 3UT
Telephone : 0141 - 201 - 3000

GP COPY

First Issued: 12/08/2008 13:53
Printed: 12/08/2008 13:53

Admitted: 05/08/2008 **Discharged:** 11/08/2008
Discharged to: Home
Ward: 6
Consultant: Mr DT HANSELL, General Surgery
Hospital No: 10638479K **Date of birth:** 07/12/1972
CHI: 0712726128

REGISTERED GP

Dr JOHN LANGAN
BAILLIESTON HEALTH CENTRE
20 MUIRSIDE ROAD
BAILLIESTON
GLASGOW

PATIENT

DEBORAH SULLIVAN
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
LANARKSHIRE

DIAGNOSES **ICD10** **PROCEDURES** **OPCS4**

1. Nonspecific antral erythema, N/A, 07/08/2008 — Uncoded

MEDICATION

Drug Name	Format	Route	Dose	Admin Times 8	12	14	18	22	PRN/Comment	Course Length	Quantity Dispensed
Paracetamol	Tab	Oral	1g						4-6hrly for pain	Indefinite	32 500mg
Omeprazole	Cap	Oral	40mg	X						Indefinite	Patients Own
Fluoxetine	Cap	Oral	40mg	X						Indefinite	Patients Own
Gabapentin	Cap	Oral	300mg bd	X				X		Indefinite	14
Metoclopramide	Tab	Oral	10mg						as required 8mg	Indefinite	28
Cyclizine	Tab	Oral	50mg						as required for nausea	Indefinite	21
Temazepam	Tab	Oral	10mg					X	1 tab at night for insomnia	Indefinite	7

Pharmacy Comments

Reviewed by pain team - pethidine stopped, fentanyl patches commenced.

FOLLOW UP ARRANGEMENTS

Outpatient Clinic	Consultant	Date
Surgical	Mr JS SMITH	6 weeks

Outpatient Investigations **Date**

No arrangements made

Community Care **Date** **Reason**

No arrangements made

GENERAL COMMENTS

Final discharge letter to follow

This patient was admitted on 5/8/08 with upper abdominal pain and tenderness and vomiting. Abdominal ultrasound was unremarkable. She subsequently underwent an OGD. Biopsies were taken, the results for which we are awaiting. The only remarkable finding was antral erythema. A CLO test for H pylori was negative.

She was seen by the pain team on 8/8/08, who prescribed fentanyl patches (12 micrograms over 72h) for backbround pain and tramadol for breakthrough pain. They also restarted her gabapentin as she felt this helped. She was discharged with enough to last 1 week. She has been re referred to chronic pain clinic (her last attendance was in 2006), so we would be grateful if you could continue these medications until she is followed up at the clinic.

The pain team have also recommended stopping the severdol and pethidine she has been on.

We will also arrange to see her at Mr Smith's clinic once she has had an outpatient MRCP, which is being arranged to take place at the Western Infirmary.

IMMEDIATE DISCHARGE LETTER : GP COPY

NHS Greater Glasgow

Patient: DEBORAH SULLIVAN
Admitted: 05/08/2008 **Discharged:** 11/08/2008

D.O.B: 07/12/1972 **Hosp. No:** 10638479K
Printed: 12/08/2008 13:53

Signed:

Designation:

Contact: Robert Gifford

Pager Number:

GENERAL SURGERY
DO NOT REMOVE FROM CLINIC AREA

NHS Greater Glasgow and Clyde

CLINI

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

DATE	3/2/11
CONSULTANT	SMcM
SITE	
NEW PATIENT	
RETURN PATIENT	✓

ONE BOX FROM 1-10 MUST BE TICKED FOR ALL PATIENTS IN ADDITION TO THE FURTHER APPOINTMENT INFORMATION BELOW

1	TREATMENT STARTED		6	INVESTIGATION AS IP/DC/OP	
	TREATMENT GIVEN TODAY				
	DISCHARGE			*DISCHARGE*	
2	NO (FURTHER) TREATMENT REQUIRED		7	TO RETURN FOR TREATMENT AS IP/DC/OP	
	DISCHARGE				
3	PATIENT DECLINES TREATMENT		8	PATIENT CONSIDERING TREATMENT OPTIONS	
	DISCHARGE				
4	OBSERVE & REVIEW *INCLUDING CHRONIC DISEASE MANAGEMENT*		9	ONWARD REFERRAL FOR SAME CONDITION TO	CONS
					NURSE
					AHP
					OTHER
5	SUPPLY MEDICAL DEVICE		10	DNA - DISCHARGE	
	DISCHARGE			DNA - FURTHER APPOINTMENT	

Please Tick If Further Appt Required ?

WEEKS
MONTHS

AMBULANCE TRANSPORT NEXT VISIT (CRITERIA MET)	
ADMITTED FROM CLINIC	
INTERPRETER REQUIRED	

OUTPATIENT PROCEDURE PERFORMED

		TICK
H52.2	Haemorrhoids Photocoagulation	
H52.4	Haemorrhoids Banding	
H52.3	Haemorrhoids Injection	
H52.9	Haemorrhoids Destruction	
S06.1	Excision of lesion of head or neck	
S06.2	Excision of lesion not elsewhere classified	
S47.1	Drainage of lesion of head or neck	
S47.2	Drainage of lesion not elsewhere classified	
S47.3	Incision of lesion of head or neck	
S47.4	Incision of lesion not elsewhere classified	
B12.8	Fine needle aspiration of thyroid gland lesion	
T87.9	Fine needle aspiration of lymph node	
S47.2+		
Y20.4	Fine needle aspiration NEC	
N15.6	Aspiration of epididymal cyst	
H28.9	Rigid Sigmoidoscopy	
H62.8	Diagnostic proctoscopy	
H41.9	Therapeutic proctoscopy	
G48.2+		
Y03.6	Gastric band fill	
L86.1	Sclerotherapy VV	

200910

NHS Greater Glasgow and Clyde

North Glasgow Hospitals

Stobhill Hospital
SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: Dr John Smith - STOB SURGICAL OP

Diagnostic Imaging Report
DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

VERIFIED Verified By: Dr John Shand 06/08/10 1512.
Clinical History : Dysmotility seen on barium. Is this involving entire bowel?

XR Abdomen : Transit studies were performed.

On day 5, all the capsules were clustered in the distal transverse colon or splenic flexure bar one, which was still at the hepatic flexure. By day ten, they had all passed.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UW
Exams: XR Abdomen
Exam Date: 04/08/10 Event: E-25106231

08965

NHS Greater Glasgow and Clyde

North Glasgow Hospitals

Stobhill Hospital

WS

SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: DR SJ SMITH - STOB WARD 5 HIGH DEPENDANCY

Diagnostic Imaging Report

DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

VERIFIED Verified By: DR FM BRYDEN 09/10/09 1023.
Clinical History : Revision of fundoplication. Post-op. Increased oxygen requirement.

XR Chest : Portable semi-erect film. The heart is not enlarged. It is difficult to assess the right lung due to overlying ECG leads. There is however suspicion of loss of translucency in the right lower zone which may be due to a small area of infection or aspiration. Clear left lung.

GSM

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, G21 3UW
Exams: XR Chest
Exam Date: 08/10/09 Event: E-11956350

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NHS Greater Glasgow and Clyde

Stobhill Hospital

SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: DR JS SMITH - STOB WARD 6 OUTPATIENT

Diagnostic Imaging Report
DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

VERIFIED Verified By: DR RL STEVENS 03/12/08 1646.
Clinical History : Previous Nissen's fundoplication. Repeated vomiting 8 times a day, always after eating, weight loss. ? Nissen's intact ? other problem.

Barium meal : No abnormality was demonstrated within the hypopharynx. The gastro-oesophageal junction is thought to remain subdiaphragmatic. However on several images there was a localised outpouching from the gastric fundus to the left side of the gastro-oesophageal junction. Its appearance suggests a small para-oesophageal hernia. There was initially transient hold-up to the passage of barium at the level of this para-oesophageal hernia and this was associated with multiple disordered tertiary contractions of the lower oesophagus. In addition, on lying the patient flat there was mild gastro-oesophageal reflux. Barium was not followed beyond the duodenal cap but the stomach was not distended and there was no food debris within it to suggest a delay in gastric emptying. Cholecystectomy clips noted.

fellup/see ✓ ? SOP appt

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW
Exams: Barium meal
Exam Date: 03/12/08 Event: E-11379710

08965

asgow Hospitals

NHS Greater Glasgow and Clyde

North Glasgow Hospit...

Western Infirmary

SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: DR DT HANSELL - STOB WARD 5 OUTPATIENT

Diagnostic Imaging Report

DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

VERIFIED Verified By: DR TH BRYANT 11/09/08 1149.

Clinical History :
Previous fundoplication plus cholecystectomy for gallstones. Currently epigastric and RUQ pain plus vomiting. Triangle LFT's. Ultrasound for visualisation of ducts/gallbladder bed, ? retained or recurrent ductal stone/dilatation.

MRCP :

Standard MRCP has been performed.

There is no evidence of filling defect within the common bile duct to indicate a retained calculus. The common bile duct appears normal in calibre measuring 4.5mms. Pancreatic duct also appears unremarkable. No other lesion is identified within the liver or upper abdomen.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW
Exams: MRCP
Exam Date: 10/09/08 Event: E-11217819

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NHS Greater Glasgow and Clyde

North Glasgow Hospitals

Stobhill Hospital

SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: DR R CRAWFORD - STOB A & E (WARD 7A)

Diagnostic Imaging Report
DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

SYNTAX CHECKED by: DR FM BRYDEN 18/11/08 1719 Report By: DR I CAMERON (SpR) 18/11/08 and: DR FM BRYDEN.
Clinical History : Epigastric pain for three days. Recent fundoplication.

XR Chest : Normal heart and mediastinal contours. The lung fields are clear with no evidence of free subdiaphragmatic gas.

XR Abdomen : Cholecystectomy clips are seen in the right upper quadrant. There is no evidence of perforation or obstruction. The colon is markedly faecally loaded.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW
Exams: XR Chest,XR Abdomen
Exam Date: 17/11/08 Event: E-11383600

08965

NHS Greater Glasgow and Clyde

North Glasgow Hospitals

Stobhill Hospital

SULLIVAN, Deborah

6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Referrer: - STOB A & E (WARD 7A)

Diagnostic Imaging Report

DoB: **07/12/1972**

Chi No: **0712726128**

CRIS No: **5387096**

Hosp No: **10638479K**

SYNTAX CHECKED by: DR FM BRYDEN 18/11/08 1719 Report By: DR I CAMERON (SpR) 18/11/08 and: DR FM BRYDEN.

Clinical History : Epigastric pain for three days. Recent fundoplication.

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XR Abdomen : Cholecystectomy clips are seen in the right upper quadrant. There is no evidence of perforation or obstruction. The colon is markedly faecally loaded.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW

Exams: XR Chest,XR Abdomen

Exam Date: 17/11/08 Event: E-11383600

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NHS Greater Glasgow and Clyde

North Glasgow Hospitals

Stobhill Hospital

SULLIVAN, Deborah

6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Referrer: DR DT HANSELL - STOB WARD 7A

Diagnostic Imaging Report

DoB: **07/12/1972**

Chi No: **0712726128**

CRIS No: **5387096**

Hosp No: **10638479K**

VERIFIED by: DR H GRIFFITHS 07/08/08 1134 Report By: DR GW COWELL 06/08/08 and: DR H GRIFFITHS.

Clinical History : Acute right upper quadrant pain for four day. Previous cholecystectomy and chronic pancreatitis. ? acute and chronic pancreatitis ? cholelithiasis.

US Abdomen : Previous history of cholecystectomy is noted. Views of the gallbladder bed and porta hepatis are severely limited by significant overlying bowel gas, but no intrahepatic or gross extrahepatic biliary duct dilatation is noted. The liver is of normal size and echogenicity with no focal lesions or diffuse parenchymal abnormality noted.

Both kidneys, aorta and spleen are unremarkable, and whilst bowel gas again obscures views of much of the pancreas, though the pancreatic head displays no abnormality. No free fluid is seen within the abdomen.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW

Exams: US Abdomen

Exam Date: 06/08/08 Event: E-11209786

08965

Stobhill Hospital
SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: DR PT GRANT - STOB A & E (WARD 7A)

Diagnostic Imaging Report
DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

VERIFIED Verified By: DR H GRIFFITHS 07/08/08 1153.
Clinical History : Acute right upper quadrant pain and vomiting. Last bowel motion one day previously. ? obstruction ? pancreatitis. Crepitations left base.

XR Chest : Allowing for the suboptimal inspiratory effort the heart is not enlarged. The lungs are clear. No free sub-diaphragmatic gas is demonstrated.

XR Abdomen : Cholecystectomy clips noted in the right upper quadrant. The bowel gas pattern is unremarkable with no features to suggest obstruction.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW
Exams: XR Chest,XR Abdomen
Exam Date: 05/08/08 Event: E-11208778

08965

NHS Greater Glasgow and Clyde

North Glasgow ...spitals

Stobhill Hospital

SULLIVAN, Deborah

6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Referrer: DR PT GRANT - STOB A & E (WARD 7A)

Diagnostic Imaging Report

DoB: **07/12/1972**

Chi No: **0712726128**

CRIS No: **5387096**

Hosp No: **10638479K**

VERIFIED Verified By: DR H GRIFFITHS 07/08/08 1153.

Clinical History : Acute right upper quadrant pain and vomiting. Last bowel motion one day previously. ? obstruction ? pancreatitis. Crepitations left base.

XR Chest : Allowing for the suboptimal inspiratory effort the heart is not enlarged. The lungs are clear. No free sub-diaphragmatic gas is demonstrated.

XR Abdomen : Cholecystectomy clips noted in the right upper quadrant. The bowel gas pattern is unremarkable with no features to suggest obstruction.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW

Exams: XR Chest,XR Abdomen

Exam Date: 05/08/08 Event: E-11208778

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Stobhill Hospital

SULLIVAN, Deborah

6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Referrer: DR CF CRAIG - STOB WARD 7A

Diagnostic Imaging Report

DoB: **07/12/1972**

Chi No: **0712726128**

CRIS No: **5387096**

Hosp No: **10638479K**

VERIFIED Verified By: DR RL STEVENS 01/10/08 1414.

Clinical History : Pain epigastric previous gallstone, pancreatitis, cholecystectomy ? CBD sludge.

US Abdomen : No abnormality is demonstrated within the liver, pancreas, spleen or kidney. Cholecystectomy noted. CBD measures 6.4 mm which is acceptable post cholecystectomy. There is no obvious filling defect within an ultrasound. No free fluid.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW

Exams: US Abdomen

Exam Date: 01/10/08 Event: E-11302528

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NHS Greater Glasgow and Clyde

North Glasgow Hosp

Stobhill Hospital

SULLIVAN, Deborah
6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP
Referrer: DR CF CRAIG - STOB WARD 7A

Diagnostic Imaging Report

DoB: **07/12/1972**
Chi No: **0712726128**
CRIS No: **5387096**
Hosp No: **10638479K**

VERIFIED Verified By: DR RL STEVENS 01/10/08 1414.
Clinical History : Pain epigastric previous gallstone, pancreatitis, cholecystectomy ? CBD sludge.

US Abdomen : No abnormality is demonstrated within the liver, pancreas, spleen or kidney. Cholecystectomy noted. CBD measures 6.4 mm which is acceptable post cholecystectomy. There is no obvious filling defect within an ultrasound. No free fluid.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW
Exams: US Abdomen
Exam Date: 01/10/08 Event: E-11302528

08965

NHS Greater Glasgow and Clyde

Stobhill Hospital

SULLIVAN, Deborah

6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Referrer: DR CF CRAIG - STOB WARD 7A

Diagnostic Imaging Report

DoB: **07/12/1972**

Chi No: **0712726128**

CRIS No: **5387096**

Hosp No: **10638479K**

VERIFIED Verified By: DR J SHAND 01/10/08 1724.

Clinical History : Acute epigastric pain radiating to back. Chronic pancreatitis. ? Perforation. ? Obstruction.

XR Chest : The heart is not enlarged. There is no evidence of active pulmonary disease. No free subdiaphragmatic air has been demonstrated.

XR Abdomen : Clips are noted in the right upper quadrant consistent with a previous cholecystectomy. No other abnormality is apparent.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW

Exams: XR Chest,XR Abdomen

Exam Date: 30/09/08 Event: E-11302196

08965

North Glasgow Hospitals

Kalamazoo S-10579851-12x8.25 © Copyri 2002 Tel: 0121 256 2000

West of Scotland Community Optometric Teach and Treat (WOSCOTT) Eye Clinic

NHS Greater Glasgow and Clyde

OPHTHALMOLOGY NEW PATIENT Date: 1st February 2022

ASSESSMENT FORM

0712726128 10638419
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Consultant:
DR GREGORY

Referred by:
GP Optom
Other:

Reason for referral

History & Symptoms VA ✓

BE - Very dry, started 1·5 years ago.
- Using Blink eye drops, q1h, Hybonight od.
- Feels these help a little.
- GP checked for Sjrogens - Negative result.

Medical History			**Ocular History**
Diabetes Hypertension Other: Fibromyalgia Gallstones Diabetes - Type 2 Dx ≈ 2018. HBP High cholesterol. Pancreas probs.	IHD / MI CVA / TIA	COAD / Asthma N/A.	None. No HES.

Medication	Allergies
Unknown. — Poss some missing. ~~Metm~~ Metformin Statin Glycoside Diazepam. Omeprazole Pregabalin Duloxetin. Ramipril	Penicillin.

Family History:	Social History
None.	Driver X Smoker X Vape. Occupation: U/E.

Other Relevant Information:

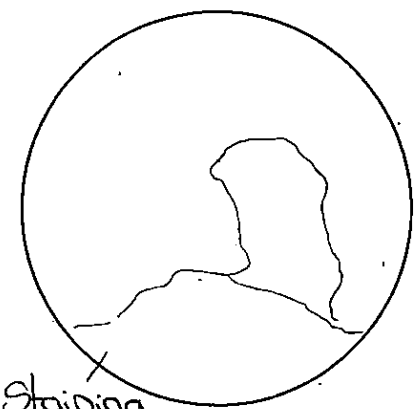
EXAMINATION A. McAulay S/N ANMA

	RIGHT	LEFT
Visual Acuity Unaided Pin Hole	6/9+1	6/9+3.
Distance Rx (if known)		
_cular Adnexa	Moderate post blepth. Few capped MGs. Full + complete blink. →	
Cornea	Hauf - 1-25ecs.	

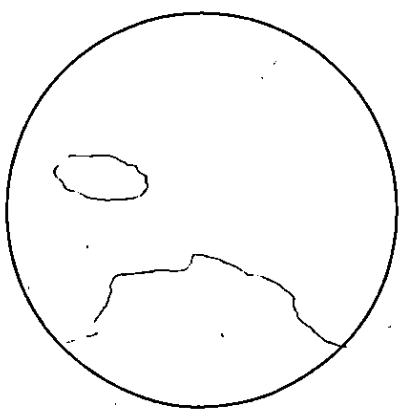
R Eyelids everted L

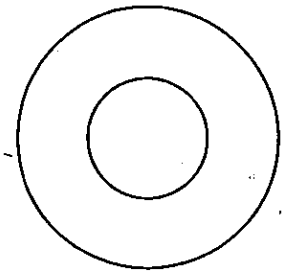
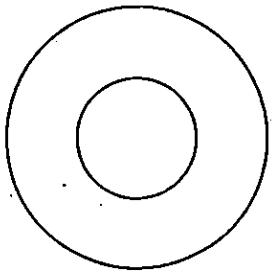
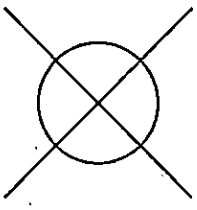
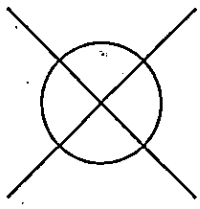
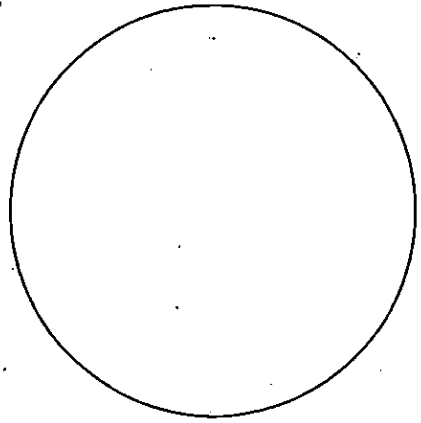
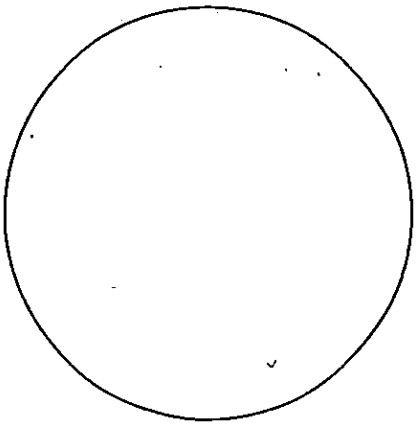
Rough appearance.

Central cyst?



Staining
mucin plaques?



Anterior chamber	Clear + quiet.	Clear + quiet.
Iris/Pupil		
IOP @ _____ Pachymetry		
Gonioscopy		
Pupil Reactions		
Dilated Yes / No	Time _____	
Lens		
Disc drawing		
Fundus		

Other Relevant Examination (CV, EOM, Amsler etc)		
Photographs Y/N		
Visual Fields		
OCT		

Provisional Diagnosis

Severe KCS.
2° Sjogren's → Negative

Investigations

Management Plan:

1. cont hyloforte PRN
2. Start g. ilubra qid BE
3. g. dexpodex qid x 2/52
4. hybonyte nocte x 2/52

tds x 2/52
bd x 2/52
od x 2/52

Review or Discharge

3/12

Examiners

Optometrist _____ (Signature) A. Chotai (Printed)

Doctor _____ (Signature) _____ (Printed)

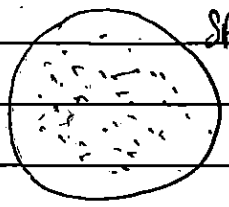
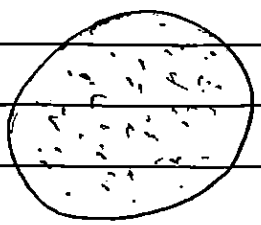
MIS 254909

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☐

Please tick ✔ appropriate directorate

0712726128 1063479.
SULLIVAN F
Deborah 07/12/1972

Date & Time		Signature, Print Name & Designation
	6/7/22	
	VA Right 6/9-2 left 6/12-3 unaided 6/12 Pinhole 6/9	RDW S/N @ 925 DOB ✓
	25mmHg Icare 19mmHg	
	25mmHg rechecked 20mmHg	@ 930
	3 month Review.	
	P.x. feels improvement BE.	
	Hylofortte PRN.	
	Blink Intensive q 2hrs BR	
	Hyloni gut nocte BR.	
	GH: good. DR checked for STGrens - negative result.	
	Meds - unchanged.	
	Mild MGD RE	
	 Sple Mucin.	 SPK. Mucin

Date & Time		Signature, Print Name & Designation
	Advised Pt to lower.	
	Stopped Chemist ran out	
	Still mucin + but improved	
	Pan.	
	Restart Pt's fds	
	~~Cont~~ ~~Blink autoinjector~~	
	Switch Blink intensive	
	to evolve Rem (Carbomer +	
	6 x daily. 0.1% sodium hyaluronate)	
	RN 3-4/12	
8/11/22		
23/11/22	VA, i care, check Tear film	
	3 month review	
	I Use Blink Carbomer 0.2% Solution ~~to~~ Evolve	
	Feeling eyes dry Better	
	Still has symptoms of Burning + irritation	
	Vision has Been sure	
	Using daily - feeling an improvement	
	SPLC 3-0 mucin	SPLC 3-0 Extinction

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

10638479K
SULLIVAN
DEBORAH
CHI-0712726128

Date & Time		Signature, Print Name & Designation
	Symptom 80% better Compliant with treatment Ocular surface improved CSF ↑ evolve review PRN Rv 6/12	
23/5/23	VA icare.	
	Right unaided Left. 6/9-3 6/9.	
	PH. 6/9.	
		G. Murray SIN
	ICARE 20mmHg 21mmHg	
	- No Improvement since November. - Using Ilube 3x daily Evolve Revive 6x daily + hylonight - Ilube can sting on insertion. R alyth L Meib Feb 23 WNL Meib Anter blepharitis Rsl.	

Date & Time		Signature, Print Name & Designation
	Wean's R+L one daily Continue with Hute 3x daily BE, Evalue Renal Gx daily + Hyknight R+L.	
	Review 2-3/12 QEEM	

Accident and Emergency Department
Stobhill Hospital

NHS
Greater Glasg
and Clyde
Stobhill Hospita
Glasgow G21 3U
Tel: 0141 201 30
Fax: 0141 201 30

10638479K

A&E No. 08025309

Surname	SULLIVAN	**Forename**	DEBORAH	**Title:** MS
Address:	6 MUIRHEAD COURT BAILLIESTON GLASGOW LANARKSHIRE	**Postcode** **Telephone:**	G69 7EP 7716310	**CHI No:**0712726128
Date of Birth:	07.12.72	**Sex:**	F	**Age:** 35 yrs

GP Name:	LANGAN JOHN		
Address:	BAILLIESTON HEALTH ... 20 MUIRSIDE ROAD BAILLIESTON GLASGOW	**Postcode** **Telephone:**	G69 7AD 0141531805(

Next of Kin	KATHLEEN SULLIVAN		
Relationship:	PARENT		
Address:	187 COMMONHEAD ROAD	**Postcode**	G34 0DS
	GLASGOW	**Telephone:**	7713743
Primary Carer:			

STOBHILL GENERAL HOSPITAL
05/08/08 E-112087778
SULLIVAN, Deborah
G207HAE 07/12/1972
AccNo: G207H12377500

Date of Attendance: 05.08.08 13:17
Date of Incident:
Presenting Complaint: SURG PEND - PANCREATITIS

7A

Triage

Tetanus Cover:

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=** **Temp=**

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

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

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Patient's name DEBORAH SULLIVEN Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 5-8-8 Time 1326 Triage Nurse NM PC SURPEN

1. Pancreatitis

Triage category 1 2 (3) 4 5

Relatives present: YES Relatives informed:

INITIAL VITAL SIGNS

at:(Time) 1348
HR: 104
BP: 131/97
RR: 24
SaO_2: 98%
Temp: 36.9
G.C.S: 15
Signed

INITIAL MANAGEMENT

Nurse _____

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS

TIME	hrs	
EYES OPEN	spontaneously 4	[1] eye closed by swelling =C
	to speech 3	
	to pain 2	
	none 1	
BEST VERBAL RESPONSE	orientated 5	Endotracheal tube or Tracheostomy = E Dysphalsa=D
	confused 4	
	inappropriate words 3	
	incomprehensible sounds 2	
	none 1	
BEST MOTOR RESPONSE	obey commands 6	Record the best arm response Paralysed =P
	localises pain 5	
	normal flexion to pain 4	
	abnormal flexion to pain 3	
	extention to pain 2	
	none 1	
COMA SCORE 15		

PUPILS	RIGHT	size (mm) Reaction	[2] +=Reacts -=No Recaction C= Eye closed SL= sluggish pupil
	LEFT	size (mm) Reaction	

LIMB MOVEMENT

ARMS	Normal power	[3] Record right (R) and left (L) seperatly if there is a difference between the two sides Fractured limb = #
	Mild weakness	
	Severe weakness	
	Extention	
	No response	
LEGS	Normal power	
	Mild weakness	
	Severe weakness	
	Extention	
	No response	

PUPIL SCALE (mm): 1 2 3 4 5 6 7

BLOOD PRESSURE mm Hg: 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90

PULSE RATE: 80 70 60 50 40 30

[4] 40 39 38 37 Temp C° 36 35 34 33 32 31 30

[5] RESPIRATORY RATE

SaO_2

[6] NURSE INITIALS

BLOOD GLUCOSE	Time					
BM STIX	BM					
PEAK FLOW	Time					
	PF					
VISUAL ACUITY	R. eye aided/unaided					
	L. eye aided/unaided					
	pH L. eye	R. eye				

Signed: _____

URINALYSIS

Urobilinogen µmol/L	Normal 3 16	33	66	131			
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Signed: _____

NURSING NOTES

Signature: _____ Time: 1400

History

Patient 35yr (F) c/o abdo pain + nausea for the past week, unable to tolerate foods & fluids.

DH

Tramadol PMH Pancreatitis
Refrecine

Allergies No/Yes

NKDA

Initial Management

02 Y/N Litres Per Min
ECG Y/N X-ray Y/N

Urinalysis:

βHCG +ve -ve
Cannula Y/N

Bloods	Y/N
U & Es	☐
FBC	☐
GL	☐
Amyl	☐
Coag	☐
Group	☐
D. Dimers	☐

Other:

Social History smoker

NOK sister Not / present

Keys / valuables

Social Services Not / contacted

MEDICAL NOTES - HISTORY and EXAMINATION

Consultant MR HANSEN Seen by S.HORN

Grade: SpR SHO SHO3 JHO Clin Assist ENP SG AS *(Please circle)* At (time) 14.10.

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

Date

5/8/8 14:30 FYI CLERIC-IN (HORN)

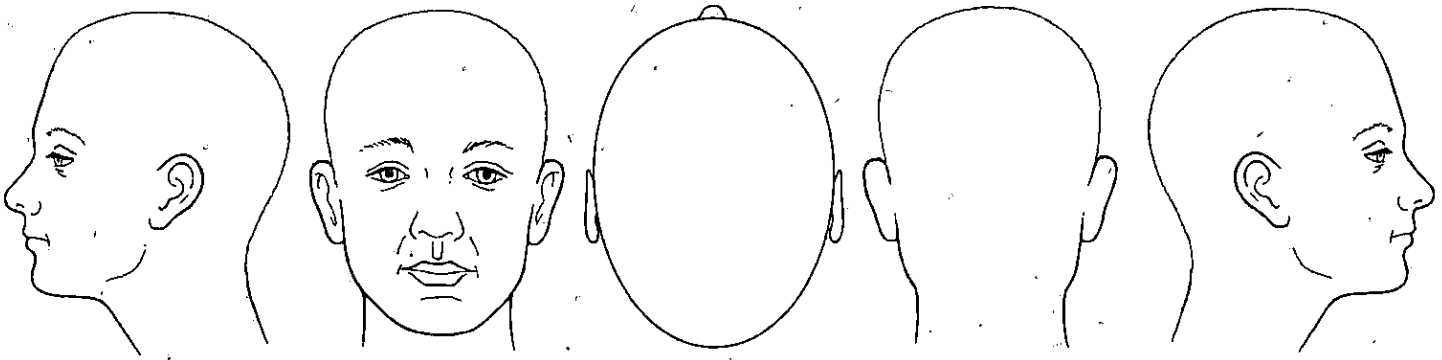
35 F GP REFERRAL ? ACUTE RUQ PAIN.

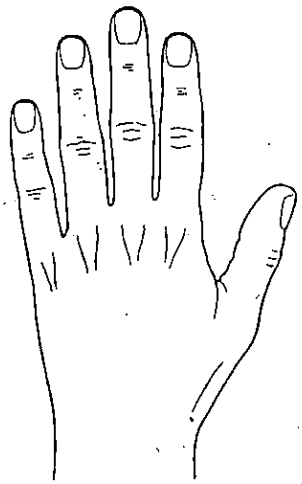
HPC/ RUQ PAIN FOR 3/7, COLICKY IN NATURE
10/10 SEVERITY
RADIATION TO BACK
ASSOC NAUSEA + VOMITING - BILE ° BLOOD
LAST BM 1/7 AGO - NORMAL °BLOOD °MUCUS
↓ APPETITE

BACKGROUND - CHRONIC PANCREATITIS
PREVIOUS GALLSTONES + CHOLECYSTECTOMY 1996
HIATUS HERNIA
FUNDOPLICATION 200
DUE OED 21/8/8 UNDER MR SMITH

PMH/ AS ABOVE
APPENDECTOMY 1996
TONSILECTOMY
°MI / IHD / DIABETES / ASTHMA.

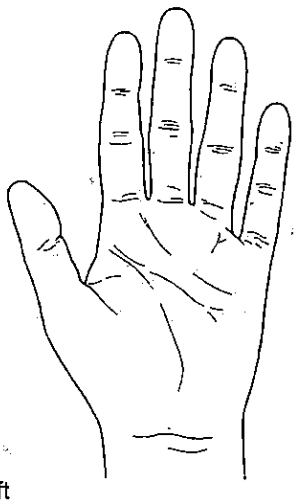
Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



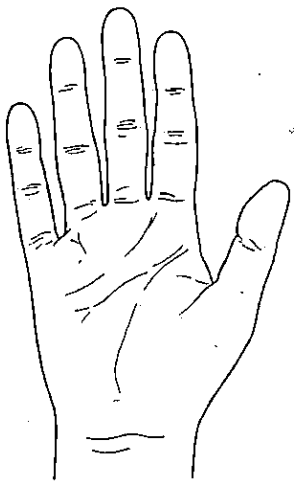


Dorsal

Left

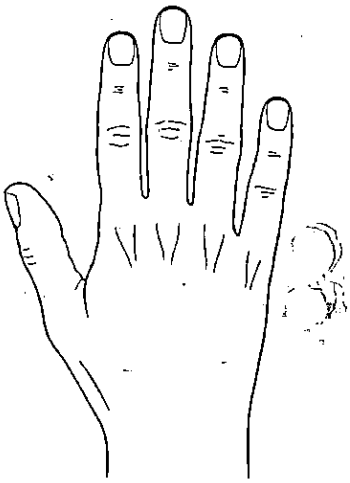


Palmar

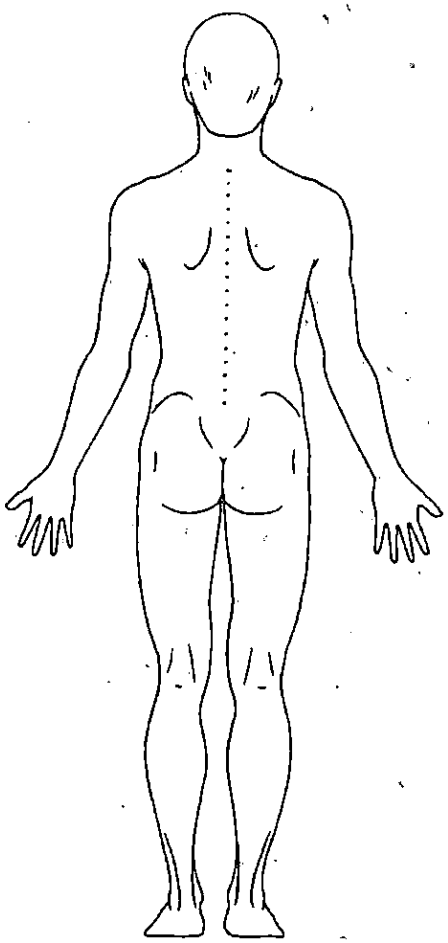


Palmar

Right



Dorsal

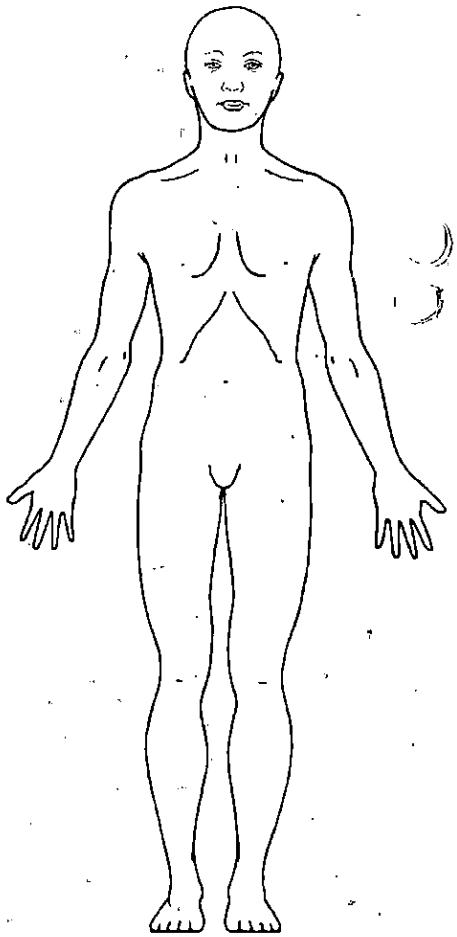


Left Dorsal

Right Dorsal

Left Plantar

Right Plantar



Signed _____

Date

6.8.08 DH confirmed

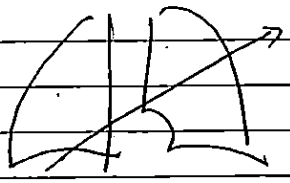
DH/ ✱ ALLERGIES - VOLTAROL ✱
OMEPRAZOLE 40mg OD
METOCLOPRAMIDE 10mg PRN
TRAMADOL 100mg ~~OD~~ PRN takes reg 100mg qid
PETHIDINE PRN takes reg 100mg m+n
FLUOXETINE 40mg OD
also Cilest (OCP)

~~JEGU~~
JSTRTON
Pharmacist.

SH/ SMOKES 15 cpd
NO ALCOHOL
UNEMPLOYED

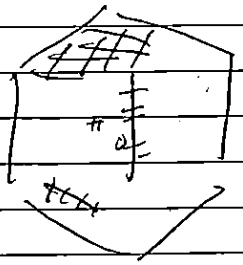
SE/ CV - NIL
RESP - NIL PREVIOUS LRTI JAN 08, JUNE 08.
GU - DSURIA, NOT PASSED URINE TODAY
° HAEMATURIA ° CLOUDINESS.

O/E/ PATIENT IN PAIN, UNABLE TO GET COMFORTABLE.
OBS - HR 104 BP 131/97 RR 24 O2 SAT 98% AIR
TEMP 36.9°C
PR PULSE - REGULAR. ° OEDEMA JVP ↔
HS I + II + 0
CHEST



CLEAR
GOOD A/E
° CREPS ° WHEEZE.

ABDO



DISTENDED
TENSE.
TENDER + GUARDING RUQ
° REBOUND
BS PRESENT

IMP/ ACUTE ON CHRONIC PANCREATITIS

PLAN/ IV ACCESS + BLOODS
IVFs
ANALGESIA + ANTI-EMETIC
CXR + AXR
NBM
CATHETERISATION
NG TUBE IF VOMITING.

HOP
FYI

Date

(McDavid) Surgical referral

35 ♀ GP referral.

4/7 Epigastric / RUQ pain
Vomiting, unable to keep fluids down.

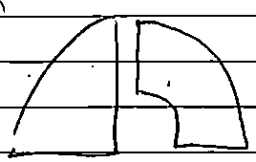
Background 1. Open fundoplication – Severe dyspepsia & hiatus hernia
2. Cholecystectomy – gallstones.
3 Chronic pancreatitis – ? 2° gallstones.
4. Chronic pain – uses oral pethidine
patient not sure if pain is 2° to pancreatitis or surgeries

S/ Not employed.
Smoker / 15/pd.
No alcohol.

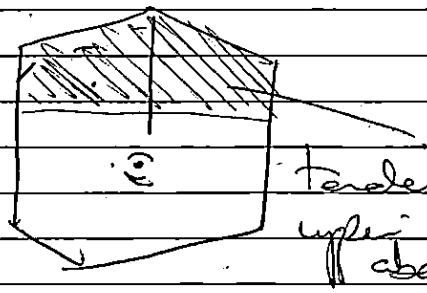
F/ Mother T2DM + 3Ds
Father T2DM age 55

S/E Pain radiates to back
Eases on sitting forward.

O/E BP. 131/97 P 104 RR 24 SaO_2 98%.
T 36.9 CRP 2.3 WCC 8.53. Hb 12.9.



Chest clear.
CXR – N° free air.



Tender upper abdomen
BS active.

LFTs Bil 13 AST +94 ALT +118 GGT +118
APhos 59.

Imp/ Chronic pain ± acute exacerbation
2° to pancreatitis Vs gastroesophageal / peptic ulcer disease

Pl/ ZA.
Analgesia - IV fluids, monitor urine output.
Omeprazole
Upper GI endoscopy.
Abdo / Liver US, Inform Upper GI team of admission.

McNAIN

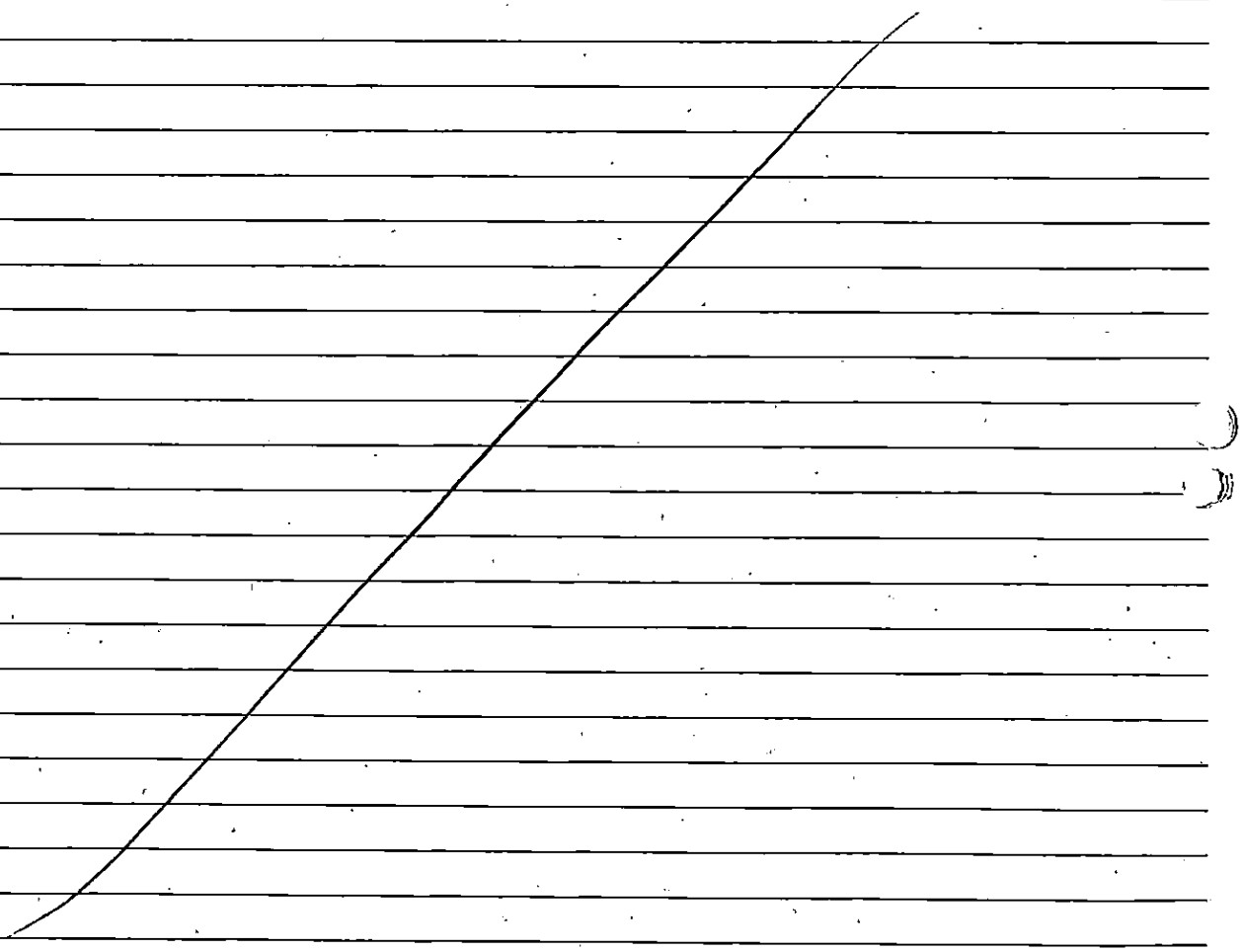
Date

WR Hansell 6/8/08 0820

Still painful in upper abdomen ? ~~Gallstones~~ CHOLECYSTITIS
Bloods checked.
→ ERCP or OGD tomorrow

USS Abdo today

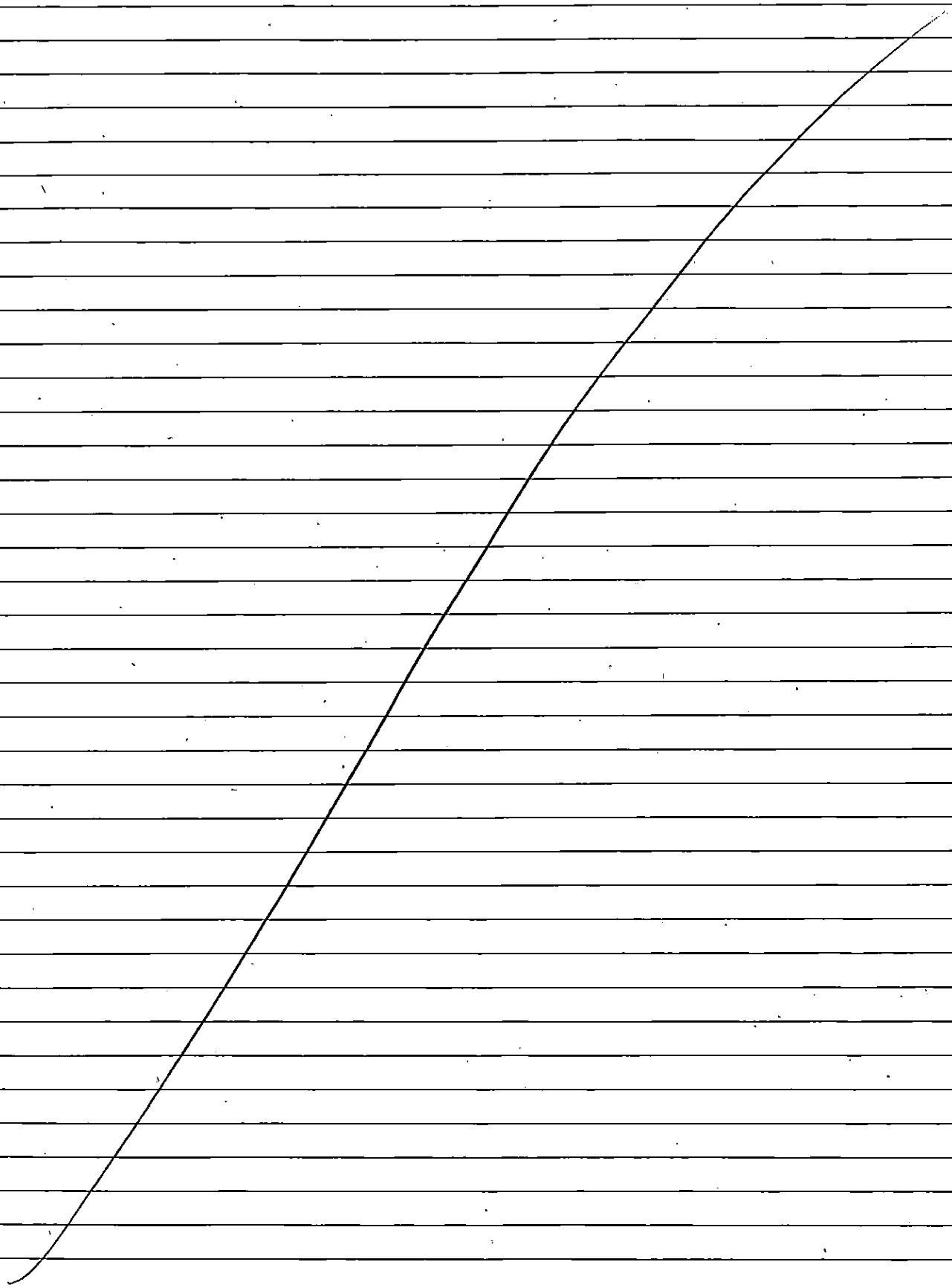
GIFFORD
5857 FY1



RESULTS PAGE

Please record all results of investigations, time, date and sign. Append all referral letters / SAS report forms, etc to this page.

Date



ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug *(BLOCK CAPITALS)*	Dose	Method of Administration	Time of Administration	Signature	Given by
5/8/16	MORPHINE	5mg	IV	14·40	[signature]	[signature]
5/8/8	CYCLIZINE	50mg	IV	14·40	[signature]	[signature]
5/8/8	MORPHINE	5mg	IV	16·20	[signature]	[signature]

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
5/8	HARTMANS	500	1°		NIL	1	[signature]		1415	[signature]	[signature]	

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

STOBHILL HOSPITAL

10638479K F
SULLIVAN
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

OPERATION CHART

SURNAME	FORENAME	UNIT NUMBER

SURGEON'S NOTES

Cons in charge: Mr Hamrell.

OPERATION PERFORMED

OGD.

SURGEON Alexis Riddell
hrs Pharmacy

IV midazolam 4mg 20mg buscopan

oesophagus: normal.

OGJ : 40cm.

Stomach :- flat erythema - antrum No bleeding
CLO biopsies taken + x2 path. biopsy
Bile reflux +. Difficult to intubate pylorus.

D1 } normal
D2 }

SPECIAL INSTRUCTIONS

DATE 7.8.8 SIGNATURE

00590

NHS
Greater Glasgow and Clyde

Stobhill Hospital

In Patient Surgery Assessment /Admission Pack

DVT RISK ASSESSMENT

LOW MEDIUM	HIGH
Ted Stockings	Yes [✓] No [ ]
Heparin	Yes [✓] No [ ]

Date of Assessment ____/____/____

Date of Admission 5 / 8 / 08

Time of Admission 5.15 pm

Date of Operation ____/____/____

Consultant MR HANSELL

WARD 7A

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Affix data label

THIS SECTION TO BE COMPLETED AT PRE- ADMISSION

Procedure / reason for admission _____

_____

Height: _____ Weight: _____ = BMI : _____ | Spo_2 ____ T ____

B.P. : _____ P _____

Are you taking any medication prescribed by your doctor ? YES ☐ NO ☐ 1

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

have you ever had:

	YES	NO	
a serious illness			2
an allergy or reaction to medicines, elastoplast etc.			3
State nature of allergy			4
diabetes			
any chest problems PFR			5
heart problems			6
high blood pressure			7
heart murmur			8
blackouts, convulsions or fits			9
jaundice / hepatitis			10
indigestion or heartburn			11
kidney or urinary trouble			12
anaemia or other blood problems			13
excessive bleeding or bruising			14
arthritis			15
muscle disease or progressive weakness			16

Do you:-

	YES	NO	
require mobility aid / have limited mobility			17
have any problems with your eyesight			18
have any problems with your hearing			19
smoke			20
have you ever used intravenous drugs			21
If a woman, are you pregnant or taking the 'pill'			22
Do you have any caps, crowns, dentures or loose teeth			23
do you drink alcohol (units per week)			24

THIS SECTION TO BE COMPLETED AT PRE-ADMISSION / ASSESSMENT

HAVE YOU ANY QUESTIONS ABOUT YOUR ADMISSION? YES ☐ NO ☐ 25

26

Hospital Admissions/Operations (please list and date)

Did you have any anaesthetic or surgical complications ? (please list) 27

Date of your last anaesthetic ? _____

Has any member of your family had problems with anaesthetics ? YES ☐ NO ☐ (please tick box) 28
-define problem _____

Is there anything else the surgeon / anaesthetist should know ? _____

_____

ASSESSMENT NURSES SIGNATURE: _____ DATE : / /

WARD NURSE SIGNATURE _____ DATE : / /

INVESTIGATIONS CARRIED OUT (please tick box)

full screen ☐ full blood count ☐ E.C.G ☐ CXR ☐ Group / retain ☐ X - Match

Other ☐ (please state)

Urinalysis _____ Clearview _____

Anaesthetic referral required: _____ YES ☐ NO ☐

Reason: _____

ANAESTHETIC DETAILS REFERRAL DETAILS:-

DR : _____ DATE : / /

ANAESTHETISTS COMMENTS:

NURSES SIGNATURE: _____ DATE : / /

SUITABILITY FOR ADMISSION

SDA ☐ NSDA ☐

THIS SECTION TO BE COMPLETED BY NURSING STAFF ONLY

SURGICAL RECEIVING UNIT WARD 2A

PRESENTING COMPLAINT:

4/7 Hx Epigastric / RUQ pain
+ vomiting

PRESENTING CONDITION ON ADMISSION: WEIGHT - 75kgs

TAL SIGNS

BP 114/73 P 77 TEMP 37° O_2 SAT 97%

PAIN SCORE 1-10 [ ] ANALGESIA GIVEN IN A&E YES [✓] NO [ ]

PAST MEDICAL HISTORY: -Open ~~crate~~ fundoplication IBS.
-Cholecystectomy - gallstones. '96
-Chronic pancreatitis 3 2° G.S. ERCP's
-Chronic pain
APPENDICECTOMY
TONSILLECTOMY.

DRUG HISTORY:

OMEPRAZOLE 40-gs O.D. SENNA. CELEST
MAXALON 10-gs PRN.
TRAMADOL 100-gs PRN.
PETHIDINE PRN
FLUOXETINE 40-gs o/o.

ALERGIES:

✱ VOLTEROL ✱

MOBILITY / LEVEL OF INDEPENDENCE:

Independent.

DIETARY HABITS / APPETITE:

- Normally - good appetite -
- WT loss -

ELIMINATION:

LBM - yesterday – normal –

Passed urine in A+E.

STOOL CULTURE YES ☐ NO ☐

URINALYSIS RESULTS NEG

MISSU _____ YES ☐ NO ☑

PREGNANCY TEST ____ +VE ☐ VE ☑

SOCAL HISTORY / CIRCUMSTANCES

Lives w/c daughter - 9yrs.

SMOKER 15 cpd YES ☑ NO ☐

ALCOHOL _____ YES ☐ NO ☑

AMOUNT: _____

MENSTRUAL CYCLE: FINISHED 2 DAYS AGO

PREGNANCY / CONTRCEPTIVE: CELEST

D.V.T. PROPHYLAXIS:

FRAGMIN YES ☑ NO ☐

TEDS YES ☑ NO ☐

Signature: [signature] S/R

Date: 5/8/08 Time: 5.30 p

NAMED NURSE: _____

NAME: (PRINTED) LORNA

WARD PRE - OPERATIVE PREPARATION

DATE OF OPERATION ____/____/____ WARD _____

Waterlow Score: _____

Name
Address

D.O. B
Unit No.

Affix data label

BASELINE OBSERVATIONS

BP _____ P _____ SO_2 _____

	YES
Consent signed	
Pre-medication given	
Fasted _____ Time last ate _____ Time last drank	
Identity band	
Case Notes ☐ X-rays ☐ Drug Kardex ☐ Obs. Chart ☐	
Operation site confirmed	
Caps / Crowns / loose teeth	
Prosthesis removed	
ntures removed / not removed	
Underwear removed	
Paper pants on patient	
Make up, nail varnish removed	
Jewellery taped / removed	
Inhalers / GTN Spray	
Allergies	
Voided urine	
Subcut heparin	
Ted stockings	
Pre-op visit	

Other relevant information :

Ward Signature: _____ Reception Signature: _____

THEATRE

:RATION PERFORMED _____

	YES	NO
DIATHERMY BIPOLAR / MONOPOLAR		
HEEL RESTS		
FLOWTRON BOOTS		
SHEEPSKIN HEEL PADS / MATS		
HEATED BED		
ARM BOARDS		
PATIENT WARMING BLANKET		

PATIENT POSITION

LATERAL RIGHT		TRENDELENBURG	
LATERAL LEFT		REVERSE	
SUPINE		LITHOTOMY	
PRONE		LLOYD DAVIS	

SPECIMENS : PATH BACT OTHER

DRAINS

CATHETER

COUNTS CORRECT

SWABS - FIRST	
- FINAL	
INSTRUMENTS	
SHARPS - NEEDLES	
- BLADES	
THROAT PACK OUT	
PACK IN SITU	

INSTRUCTIONS FOR REMOVAL:

TOURNIQUET TIME ON OFF

SPECIAL COMMENTS _____

Name of Scrub Nurse : _____ Signature of Circulating Nurse : _____

THIS SECTION MAY BE COMPLETED BY ANY MEMBER OF THE MULTIDISCIPLINARY TEAM

Named Nurse : LORNA/ANN. Fasted from : ✓

Patients Telephone No. 0141 771 6310. Spiritual needs R/C

Patients Occupation: UNEMPLOYED Next of kin: MUM - CATHERINE SULLIVAN.
(Name & Relationship to patient)

Next of kin Tel. No. 771 - 3743.
(Name & Relationship to patient)

DISCHARGE PLAN

Expected Discharge Date : / /

Actual Discharge Date:. 11 / 8 / 08

	YES	NO
Is someone available to accompany the patient home ?	✓	
Is a responsible adult available to stay with the patient for 24 hrs. post-operatively ? — SISTER MAY STAY —		✓
Does the patient have easy access to their home	✓	
Is the patient a carer? DAUGHTER 9yrs	✓	
GP letter / Prescription : ✓ IDLS to be posted.		
Outpatient appointment :		
Relatives informed :	✓	

SERVICES REQUIRED

	YES	NO
District Nurse:		✓
Social Worker:		✓
Other :		✓
Transport Requested: (Date) / /		✓

Discharge summary / comments:

Pre-op / On Admission

Signature : Pre S/R.

Ward: 7A Date: 5 / 8 / 08

Signature : Date: / /

THIS SECTION MAY BE COMPLETED BY ANY MEMBER OF THE MULTIDISCIPLINARY TEAM

COMMUNICATION SHEET/ PROGRESS NOTES

Ward ....7A....

Date	Progress / Evaluation	Signature/ Profession
5/8/08	5.30 pm. E/a via A+E 1/c 4/7 Hx	
	Epigastric pain.	
–	Hx Cholecystectomy '96 – D pancreatitis	
	2° Gallstones – ERCP's. –	
	Chronic pain since on oral pethidine/	
	tramadol.	
–	Bloods: normal – await amylase.	
–	Obs: stable as written. Pain –	
–	IV fluids as prescribed.	
–	Monitor urine output – passed urine	
	in A+E. Await RSO4/mssu.	
–	NBM	
–	c/o omeprazole	
–	? USS / PGI endoscopy.	
–	Previously under Mr Smith – now	
	due for dry surgery admission	
	21/8/08. A Rentsia.	
180db	dexana ✓	
	TEDS ✓ RN	
6/8/08	Sam slept fairly well	
	IV fluids maintained 4°.	
	RSO4 – (N)	
	Amylase 89. -> LFT's deranged.	
	for USS +/– UGIE.	
	S/C line insitu (L) arm.	

MIS 110459

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward 7A

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128
Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
	Sam	
6/8/08	oral analgesia given ½ little effect.	
	s/c analgesia given x 2 overnight	
	Vomited x1 very small amount of clear frothy fluid.	
	Apyrexial	
	MEWS score 0	
	for further review today.	
6.8.08	Analgesia	
	Usually taking reg tramadol + pethidine	
	Consider continuing these with s/c morphine as	
	per protocol and discontinue prn dihydrocodeine	
pm	Pain service.	
	Review requested of this lady previously known to the pain team (Chronic pain OPD).	
	Complaining of abdominal pain, aching in nature piercing through to back,	
	current analgesia Rx.	
	Tramadol 100mg qid	
	Pethidine 100mg tds with 100mg	
	for breakthrough.	

STOBHILL HOSPITAL

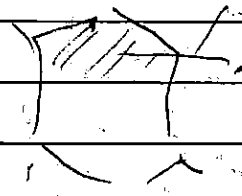
CONTINUATION CHART

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

CHRISTIAN/FORENAME	UNIT NUMBER

6/08/08 11[50].	RADIOLOGY - ABDO USS Poor views of the CBD are obtained due to overlying bowel gas. However, no intra- or gross extra-hepatic biliary dilatation is noted. The liver, kidneys, spleen + aorta are all normal. Again, bowel gas obscures views of the pancreas but no abnormality of the head is seen. No free fluid Formal report to follow JW Gunn Consultant SRI
6/8/8 1510	Deborah settled obs stable - apyrexial WCC/CRP (N) urea 1.8 alb 34 alkphos 51 GGT 86 ast 56 alt 82 RSOH (N) USS - noted Regular meds analgesic/antiemetic s/c morphine as rad IV fluids remain in situ Tolerating fluids fast 6 - ? VGIE. Pink cannula (R) hand s/c line (C) arm Mobile + self-caring Cathcart

FS
00262

7/8/08	0630 Slept fairly well	
	IV fluids maintained	
	fasted from 6am	
	? for UGIE today.	
	pethadine 100mg tabs given + orally	
	requesting morphine SIC	
	tramadol + paracetemol given Regularly	
	? refer to pain team.	
	Apyrexial	
	NEWS score 0	
	for further review today	
7/8/08	WR Hansell - 6 Dov	
	Still c/o epigastric pain radiate to back. note LI result. AST 56 ALT 82	
	O/E  tender	
	P/Gy for UGI Gastrografin test today.	
	B. Yeung ST1	
7/8/8.	Consent has obtained from the Pt for OGD +/- Biopsy. I have explained: The procedure, sedation, complications (Bleeding, perforation, infection, drowsiness after sedation) Pt have understood all and agree for the procedure.	

AK Dr
ANDY KWOK FY1

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward .....6.....

Name
A [redacted]
10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 Muirhead Court
Baillieston
GLASGOW G69 7EP

Affix data label

Date	Progress / Evaluation	Signature/ Profession
7/8/08 15.15	Returned to ward 6 following OGD and c/o test.	
	② Resumed to fluids and diet	
	③ Passing urine spontaneously	
	⑤ Observations stable. Apyrexial	
	⑥ IV fluids continue 4 hourly.	Mcmichan
15.50	Complaining of pain in abdomen. 10mg morphine given via subcut line in ⑥ arm.	
	Patient usually takes Pethidine. None in ward at present has been ordered from pharmacy	Mcmichael
23.15	Complaining of pain & nausea, requesting injections for same.	
	PETHIDINE previously given at 21.45 as per prescription also on Pethidine orally for breakthrough pain 3 hourly if required next due until at least 00.45.	
	Metoclopramide given for nausea.	
23.30	Deborah requesting cut out Morphine for breakthrough pain & have advised her she is prescribed Pethidine for breakthrough pain and she will receive this when the next dose is due 00.45.	
	Prior to 23.15 Deborah had been active	

COMMUNICATION SHEET

Ward ..... 6 .....

Date	Progress / Evaluation	Signature/ Profession
	Very buoyant and cheerful, talking with the other patients in the room, eating cake and biscuits. She had been given Pethidine 100mg - Tramadol 100mg and Paracetamol 1G at 21.45. She was also prescribed and given Temazepam 10mg. at 22^{00}.	
23.45	Has settled to sleep.	
01.30	Up to toilet & came to desk asking if it was time for the Pethidine - 100mg given	Gulatson
07^{00}	Pethidine 100mg given as per Warden	
	IV fluids continue 4hrly	Gulatson
	Pain Service	
	Reviewed today.	
	Known to pain team. Last reviewed in OPD in 2006.	
	C/o abdominal pain, piercing through to back, stabbing in nature.	
	Dw Dr Colin Rae (Chronic Pain Consultant).	
	Suggested - STOP Pethidine	
	- Commence Fentanyl patch @ 12mcg/hr. (could increase to 25mcg/hr if pain relief poor).	
	- Tramadol 100mg for breakthrough pain.	
	- Recommence Gabapentin @ 300mg tds and titrate to maximum 600mg tds.	
	Plan	#1184

MIS 110460

Barn XRay

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward ..... 6 .....

Name [redacted]
A
10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 Muirhead Court
Baillieston
GLASGOW G69 7EP

Affix data label

Date	Progress / Evaluation	Signature/ Profession
7/8/08	(1) Showered independently	
	(2) Tolerating fluids and diet	
	(3) Voiding urine spontaneously. C/O constipation Senokot x 2 tabs taken.	
	(4) Fully mobile	
	(5) Observations stable, afebrile.	
	(6) I/V fluids discontinued.	JLyons
~~22.00~~	~~given~~	
20.20	Requested analgesia, Tramadol 100mg given as prescribed	
22.00	Given Gabapentin, Paracetamol & Temazepam 10mg	
22.45	Already requesting further analgesia, I have explained to Deborah the time scale for breakthrough pain as per Prescription Kardex which she accepted.	
	Settled to sleep.	
9/8/08. 04.15	up to toilet and requested analgesia Tramadol 100mg given.	JWatson
9/8/08 13:20	FYI DAVID RUSSELL re CLO test.	
	CLO test result - (ve) negative (attached).	
	Stop Abx for suspected H-Pylori.	Dad Russell FYI

COMMUNICATION SHEET

Ward .....b.....

Date	Progress / Evaluation	Signature/ Profession
4pm	(1) Showered independently	
	(2) Tolerating fluids and diet	
	(3) Eliminating independently	
	(4) Fully mobile	
	(5) Observations stable, afebrile. No complaints of pain	
10/8/08	Settled & slept most of night following night sedation.	
Sun	Tramadol given x 1 for breakthrough pain.	
	Observations stable.	Needles/N.
10/8/08	WR Ms Craig	
	c/o headache on L side of head this a.m.	
	No blurred vision / neuro symptoms.	
	(P) Commence Serevent 10mg PRN breakthrough	
	cont Omeprazole.	
		Cund
		RY2 #4990
7pm	(1) Showered independently	
	(2) Tolerating fluids and diet	
	(3) Eliminating independently	
	(4) Fully mobile	
	(5) Observations stable, afebrile. Serevent 10mg x once today with poor effect.	
6pm	Requested Serevent 10mg again.	
11.8.8.	Nursing at 05 55.	
	Patient stable and settled and slept for	
	most of the night. Patient had night	

cont'd...

NHS Greater Glasgow & Clyde

COMMUNICATION SHEET

Ward .....6.....

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 Muirhead Court
Baillieston
GLASGOW G69 7EP
Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
11.8.8	Nursing at 0555 cont'd...	
	Sedation as prescribed. Patient once	
	requested Seredol as prescribed for	
	breakthrough pain. Observations stable	
	and a settled night. All is well.	J. (STN) Lindlay Staff Nurse
11/8/8	LOR TEAM - HANSELL	
0845	feeling better today: seen by pain team as above	
	Headache - radiating down neck. Acute pain team R/V	
	NB LFTs:	
	- CLO Negative (x48)	
	- Chase Biopsy results.	
	Plan ① Done bloods	
	② if improved → home c O/P MRCP & OPC review.	
		[signature] 1615
11/8/08	Nursing @ 14.10	
	① Independent with personal hygiene	
	② Taking fluids and diet	
	③ Passing urine spontaneously	
	④ Independently mobile around ward	
	⑤ Observations stable. Apyrexial.	
	Seredol 10mg given twice today with effect	[signature]

COMMUNICATION SHEET

Ward .....6.....

Date	Progress / Evaluation	Signature/ Profession
11/8/08	?home later if bloods ok.	Churchhard
1615	Patient discharged home. IDhS to be posted to patient and G.P. Patient has follow-up appointment at pain clinic.	Churchhard
12/8/08	- Follow up ~6 weeks at Mr Smith's clinic please. - MRCP/V arranged for this by radiology to be beforehand	(illegible) GUTTERIDGE FY1 5887

MIS 110460

NHS Greater Glasgow and Clyde

STOBHILL HOSPITAL

DAY SURGERY ENDOSCOPY

10638479K F
SULLIVAN 07/12/1972
DEBORAH
6 MUIRHEAD COURT
BAILLIESTON G69 7EP
GLASGOW
CHI-0712726128

DATE 7A

CONSULTANT mr Hansell.

A. ASSESSMENT

1. CURRENT MEDICATION omeprazole, maxalon, Tramadol, pethidine fluoxetine
2. MEDICAL PROBLEMS open fundoplication, cholecystectomy Pancreatitis ERCP's chronic pain, appendisectomy Tonsilectomy IBS
3. PAST HISTORY OF HEPATITIS OR JAUNDICE No ☑ Yes ☐
4. DISCHARGE ARRANGEMENTS - Escort No ☐ Yes ☐ Who back to
   Overnight No ☐ Yes ☐ Who ward 6

PATIENTS DECLARATION

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

Patients signature _____

B. PREPARATION

1. LAST ATE OR DRANK	Time	drank 4am		
2. IDENTITY BAND	yes			
3. CASENOTES/ADMISSION PACK	✓			
4. DENTURE/CROWNS/CAPS/BRIDGE	N/A			
5. BOWEL PREPARATION (If required)	N/A			
6. UNDERWEAR JEWELLERY REMOVED	yes			
7. ALLERGIES	NO			
8. BASELINE OBSERVATIONS	Pulse	79	Blood Pressure	134/82

PROBLEMS/NEEDS

COMMENTS

Signature Cutdell HP

ONCE ONLY PRESCRIPTIONS

Date	Time	Drug	Dose	Route	Signature	Given by	Time given
7/8/08	10.20 am	MIDAZOLAM	4 mg	IV	[signature]	CH	1030
7/8/08	10.30 am	Buscopan	20mg	IV	[signature]	CH	1080

ENDOSCOPY

PROCEDURE OGD + CLO Test + biopsies

SEDATION	No ☐	Yes ☑		SPECIMENS
THROAT SPRAY	No ☑	Yes ☐	Time _____	PATH ☑ BACT ☐ CLO ☑
PATIENT POSITION	Left Lateral ☑			
DIATHERMY	Yes ☐	No ☑		NAMED NURSES SN Mathieson Senga McDonald RN

COMMENTS

RECOVERY

POST ENDOSCOPY OBSERVATIONS

TIME	11 (10)	Req Post	10 40	11.10 AM	IN												
ILSE			92	79	OB												
BLOOD PRESSURE	102/65	/	110/79	125/87	JC	/	/	/	/	/	/	/	/	/	/	/	/
SA O2	98		99	97	HA												
RESPIRATORY RATE			16	14	RT												
OXYGEN			2	(A)													
SEDATION SCORE			1	A													
VENFLON			✓	✓													
NURSES INITIALS	SJ		JM	EW													

SEDATION SCORE

A = ASLEEP
0 = ALERT
1 = RESPONDS TO VERBAL COMMAND
2 = RESPONDS TO PAINFUL STIMULI
3 = UNRESPONSIVE

MULTIDISCIPLINARY NOTES

DATE / TIME

7/8/08 1045 Pt awake returned to ward

DISCHARGE	YES	NO
1. STABLE VITAL SIGNS	☐	☐
2. CANNULAE REMOVED	☐	☐
3. ABLE TO DRESS, SIT AND WALK UNAIDED	☐	☐
4. TOLERATING FOOD AND FLUIDS	☐	☐
5. INSTRUCTIONS GIVEN SEDATION	☐	☐
6. GP LETTER GIVEN BEFORE DISCHARGE	☐	☐
7. FOLLOW UP APPOINTMENT	☐	☐

DISCHARGE AT _____ TO _____ CARE

NURSE'S SIGNATURE _____

CONSENT FORM

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Special requirements (e.g. other language / Communication method) .....

Proposed operation, investigation or other treatment. **(BLOCK CAPITALS)**

OGD +/- BIOPSY +/- CLO

.....

I have explained the procedure named on this form to the patient in the terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any sign if cant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedure above).

An information leaflet/tape has been provided No

..... (Title)

Signature of Practitioner .....

Name / Designation (Print) ANDY KWOK FY1

Date 7 / 8 / 8

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*
(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- that the examination for the purposes of teaching will not be undertaken without my consent
- to the emergency administration of blood or blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature ..... Date ...../...../.....

Additionally you have to agree or disagree the following:-	Agree	Disagree
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT AGREEMENT FOR TREATMENT

Signature: D E Sullivan ..... Date 7/8/08

Name (Print): DEBORAH E. SULLIVAN

CONFIRMATION OF CONSENT
(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: ..... Print name.....

Date ...../...../.....

PRESCRIPTION FORM

Hospital Name: STOBHILL

PATIENT DETAILS

Nam... 10638479K
Hosp SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
DOB GLASGOW G69 7EP
CHI-0712726128

Height:

Weight:

Surface area:

Date of Admission: 5/8/8

Date of writing discharge prescription: __/__/__

Consultant Name: MR HANSELL

Ward: 7A

Date and time this form prepared: 5/8/8 Time: 1450

Sheet No 1

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

VOLTAROL

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin	☐	TPN:	☐
PCA and other infusions	☐	Enteral Nutrition:	☐
Anticoagulants: Heparin	☐	Oxygen Therapy:	☐
Oral	☐	Other:	
Topical:	☐		

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
5/8/8	Temazepam	10mg	PO	22⁰⁰		BRaul	21.15
7/8/08	TEMAZEPAM	10mg	PO	22⁰⁰		Jubilee	22⁰⁰
8/8/08	TEMAZEPAM	10mg	PO	22⁰⁰	S. Tordino	Jubilee	
9/8/08	TEMAZEPAM	10mg	PO	21³⁰	S. Tordino	Jubilee	21.45
10/8/8	Stopped.	10mg	O	10⁰⁰		JC	10:00

REWRITTEN 9/08/08

PATIENT'S NAME: DEBORAH SULLIVAN

Parenteral Drugs: Regular Prescription

ADMINISTRATION

DATE → 5 6 7 9 10
MONTH → 8 8 8 8 8

A DRUG: CLEXANE
DOSE: 20mg | ROUTE: S/C | DATE: 5/8/18
SIGNATURE OF DOCTOR:
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800 ✓ AM SM KM
2200-2400
Other time

B DRUG
DOSE | ROUTE | DATE
SIGNATURE OF DOCTOR
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

C DRUG
DOSE | ROUTE | DATE
SIGNATURE OF DOCTOR
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

Other time.
0700-0900
1200-1400
1600-1800
2200-2400
Other time

D DRUG
DOSE | ROUTE | DATE
SIGNATURE OF DOCTOR
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Parenteral Drugs: Regular Prescription

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

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

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

PATIENT'S NAME: DEBORAH SULLIVAN

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE: 6 7 8 9 10
MONTH: 8 8 8 8 8

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

J DRUG: OMEPRAZOLE
DOSE: 40mg | ROUTE: O | DATE: 5/8/8 | STOPPED DATE:
SIGNATURE OF DOCTOR: S | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

K DRUG: FLUOXETINE
DOSE: 40mg | ROUTE: O | DATE: 5/8/8 | STOPPED DATE:
SIGNATURE OF DOCTOR: S | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

L DRUG: CILEST
DOSE: 1 tab | ROUTE: oral | DATE: 6/8/08 | STOPPED DATE:
SIGNATURE OF DOCTOR: S. Tavdro | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: OCP
FOR DOCTORS USE ONLY

M DRUG: TRAMADOL
DOSE: 100mg | ROUTE: ORAL | DATE: 6/12/08 | STOPPED DATE: 8/8
SIGNATURE OF DOCTOR: S. Tavdro | STOPPED INITIALS: SRA
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE: 6 7 8 9 10
MONTH: 8 8 8 8 8

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

N DRUG: PETHIDINE
DOSE: 100mg | ROUTE: ~~oral~~ IM | DATE: 6/8/08 | STOPPED DATE: 8/8 | INITIALS: P-A
SIGNATURE OF DOCTOR: S. Tordoff
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

P DRUG: PARACETAMOL
DOSE: 1g | ROUTE: O | DATE: 6/8/08 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

R DRUG: Cicaprendtin
DOSE: 300mg | ROUTE: O | DATE: 8/8 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

S DRUG: Fentanyl
DOSE: 12 micrograms | ROUTE: Topical | DATE: 8/8/8 | STOPPED DATE: | INITIALS:
SIGNATURE OF DOCTOR:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Change every 72 hrs
FOR DOCTORS USE ONLY

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

PATIENT'S NAME: deborah sullivan

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

T

DRUG: Amoxicillin

DOSE: 1g | ROUTE: O | DATE: 9 7 8 | STOPPED DATE: 9/8/08

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: *CLO test Negative

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

V

DRUG: Ciprofloxacin

DOSE: 500mg | ROUTE: O | DATE: 9.8 | STOPPED DATE: 9/8/08

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: *CLO test Negative

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

W

DRUG:

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

X

DRUG:

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY →

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY →

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY →

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY →

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

PATIENT'S NAME: deborah sullivan

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Other time

0700-0900

1200-1400

1600-1800

2200-2400

Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME: DEBORAH SULLIVAN

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: PARACETAMOL — STOPPED DATE: 5/8/08 INITIALS: BM
DOSE: 1g | ROUTE: O/N | INDICATION: PAIN/PYREXIA
SIGNATURE OF DOCTOR | MAX.FREQUENCY: QDS | DATE: 5/8
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: ORAL IF ROUTE AVAILABLE

DATE	5/8	6/8																										
TIME	22	10	01	10																								
DOSE	1g	1g																										
GIVEN BY	BP	BP																										
	PO	PO																										

NN DRUG: DIHYDROCODEINE — STOPPED DATE: 6/8/08 INITIALS: SLCK
DOSE: 60mg | ROUTE: O | INDICATION: PAIN
SIGNATURE OF DOCTOR | MAX.FREQUENCY: QDS | DATE: 5/8
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE	5/8	6/8																										
TIME	22	10	01	10																								
DOSE	60 mg	60 mg																										
GIVEN BY	BP	BP																										
	PO	PO																										

PP DRUG: MORPHINE — STOPPED DATE: 6/8/08 INITIALS: MD
DOSE: 10mg | ROUTE: S/C | INDICATION: PAIN
SIGNATURE OF DOCTOR | MAX.FREQUENCY: AS PROTOCOL | DATE: 5/8
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE	5/8	6/8	6/8	6/8	6/8	7/8																						
TIME	20 10	01 15	55 7	40 12	35 17	15 40																						
DOSE	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg																						
GIVEN BY	BP	BP	C	C	C	KA																						
	SLC	SLC	SLC	SLC	SLC	SLC																						

RR DRUG: CYCLIZINE — STOPPED DATE: 6/8/08 INITIALS: SLCK
DOSE: 50mg | ROUTE: O/N/IM | INDICATION: N+V
SIGNATURE OF DOCTOR | MAX.FREQUENCY: 8 | DATE: 5/8
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DATE	5/8	6/8	7/8	7/8	7/8	8/8																						
TIME	01 10	17	35	20	14 55	06 40																						
DOSE	50 mg	50 mg	50 mg	50 mg	50 mg	50 mg																						
GIVEN BY	BP	C	BP	BP	BP	BP																						
	PO	IM	PO	PO	PO	PO																						

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

SS DRUG: TRAMADOL — STOPPED DATE: — INITIALS:
DOSE: 100mg | ROUTE: | INDICATION:
SIGNATURE OF DOCTOR: | MAX.FREQUENCY: QDS | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE																															
TIME																															
DOSE																															
GIVEN BY																															

TT DRUG: PETHIDINE — STOPPED DATE: 8/8/08 — INITIALS: SLT
DOSE: 100mg | ROUTE: ~~IM~~ PO | INDICATION: 6/8/08
SIGNATURE OF DOCTOR: S Jordan | MAX.FREQUENCY: As required 3hr | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: PO. PO PO

DATE	7/8	7/8	8/8																												
TIME	0100	1850	0130																												
DOSE	100 mg	100 mg	100 mg																												
GIVEN BY	BP	[illegible]																													

VV DRUG: METOCLOPRAMIDE — STOPPED DATE: — INITIALS:
DOSE: 10 Mg | ROUTE: IV | INDICATION: NAUSEA
SIGNATURE OF DOCTOR: [signature] | MAX.FREQUENCY: ~~TDS~~ 8h | DATE: 7/8/08
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: IV IV

DATE	7/8	7/8																													
TIME	0545	2323																													
DOSE	10 mg	10 mg																													
GIVEN BY	C	[illegible]																													

WW DRUG: TRAMADOL — STOPPED DATE: — INITIALS:
DOSE: 100mg | ROUTE: O | INDICATION: Pain
SIGNATURE OF DOCTOR: [signature] | MAX.FREQUENCY: 4 times/day | DATE: 8/8
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

2008

DATE	08 08	08 08	8/8	8/8	8/8	8/8																									
TIME	2020	0415	1140	1600	2300	0700																									
DOSE	100 mg	100 mg	100 mg	100 mg	100 mg	100 mg																									
GIVEN BY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]																									

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

Nurse/Midwife Administration by Protocol — Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN
6/8/08	Lactulose	10ml	PO	2130	B. Paul	B Paul	2130
8/8/08	Tramadol	2 tabs	PO	1220hr	[signature]	TC	1220hr

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:

Milligram =	**mg**	Gram	= **g**
Millilitre =	**ml**	Microgram:	**to be written in full.**
		Units:	**to be written in full.**

Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.

5. Method of administration should be abbreviated as follows:

Intravenous	= **IV**	Oral	= **O**
Subcutaneous	= **SC**	Per rectum	= **PR**
Inhalations	= **INH**	Topical	= **TOP**
Sublingual	= **SL**	Nasogastric	= **NG**
Intramuscular	= **IM**	Vaginal	= **PV**
Intradermal	= **ID**		

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

Codes for Non-Administration of Drugs

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

Ver 7, 07/2005

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	
Address	10638479K SULLIVAN F DEBORAH 07/12/1972 6 MUIRHEAD COURT BAILLIESTON GLASGOW G69 7EP
Hospital Nc	CHI-0712726128
DOB	

Admitted	Date 5/8/06	Ward 7A
Transferred	Date _____	Ward _____
Transferred	Date _____	Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

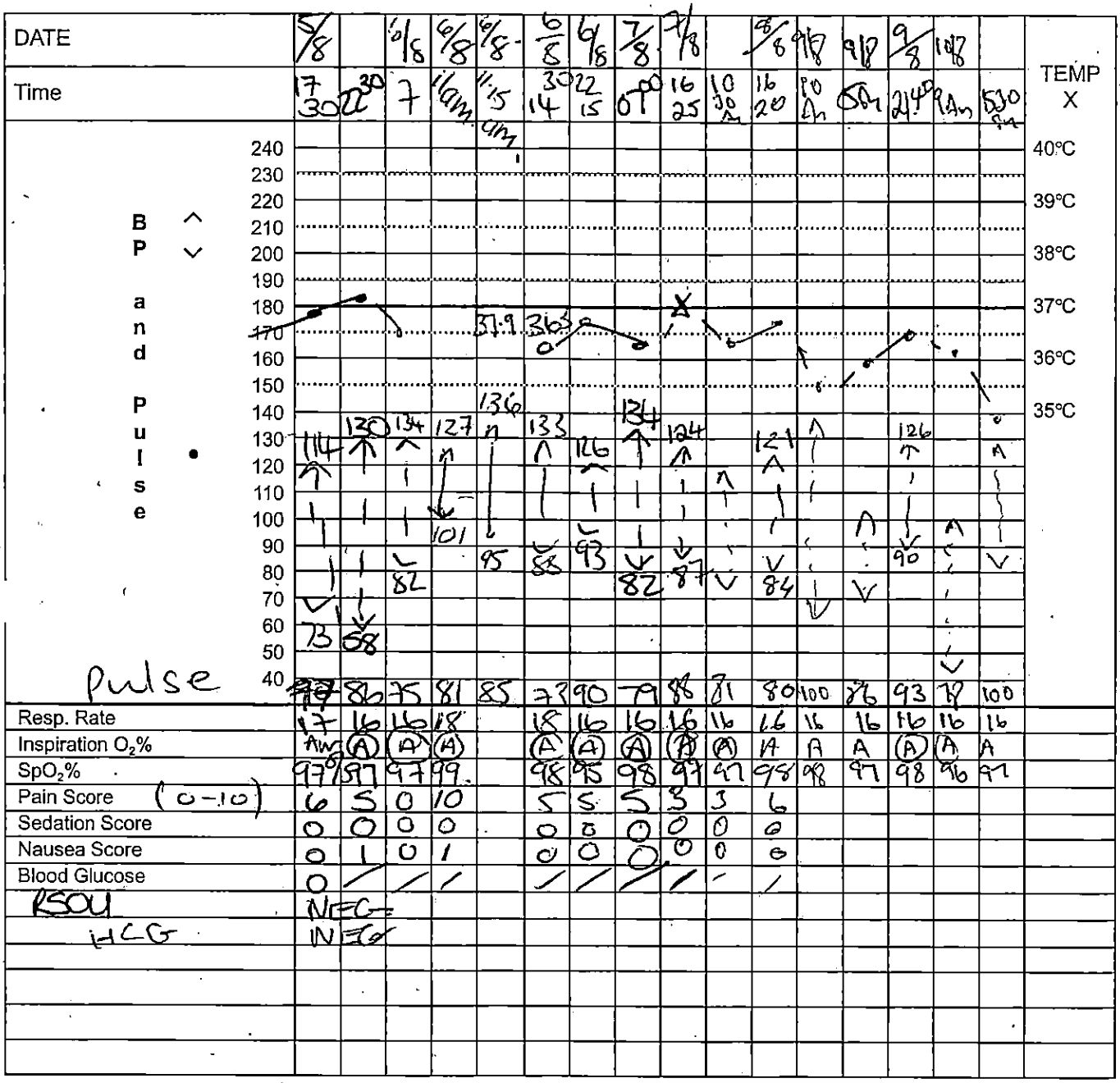
Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.



MEWS																		
	Resp. Rate	0	0	0			0	0	0		0		0		0			
	Pulse	0	0	0			0	0	0		0		0		0			
	Systolic BP	0	0	0			0	0	0		0		0		0			
	GCS / AVPU	0	0	0			0	0	0		0		0		0			
	Urine Output	0	0	0			0	0	0		0		0		0			
	Temp.	0	0	0			0	0	0		0		0		0			
	SpO_2%	0	0	0			0	0	0		0		0		0			
	TOTAL	0	0	0			0	0	0		0		1		0			

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

DATE	12/8	11/8																	TEMP X
Time	22:30	06	09 50																
240																			40°C
230		36.1																	
220																			39°C
BP ^ 210																			
BP v 200																			38°C
190																			
and 180																			37°C
170	o	x																	
160																			36°C
150																			
Pulse 140		120	131																35°C
130																			
• 120		↑																	
110	102																		
100	↑	1	1																
90																			
80	↓	v	v 88																
70	82	86																	
60																			
50																			
40																			
	87	93	89																
Resp. Rate	16	16																	
Inspiration O_2%	AIR	(A)	(A)																
SpO_2%	98	97	98																
Pain Score																			
Sedation Score																			
Nausea Score																			
Blood Glucose																			

MEWS																			
	Resp. Rate	0																	
	Pulse	0																	
	Systolic BP	0																	
	GCS / AVPU	0																	
	Urine Output	0																	
	Temp.	0																	
	SpO_2%	0																	
	TOTAL	0																	

Calling Criteria

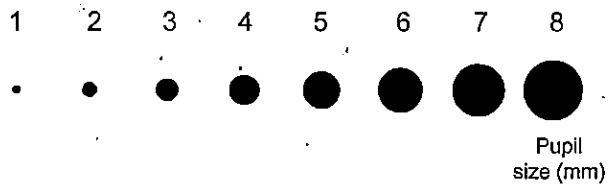
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

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

Glasgow Coma Scale



DATE																				
Time																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
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PUPILS		R Size																		= reacts —no reaction c. eyes closed
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LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
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		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

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STOBHILL HOSPITAL

NHS Greater Glasgow and Clyde

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6hr = 22 Drops/min.
4hr = 30 Drops/min. 8hr = 15 Drops/min.

IN[illegible] CRIPTION SHEET

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

FORENAME	Unit No.

No. 0181327

DATE 8/5/08

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	Serial No. / Batch No.	Given by
Hartmans	500	1755hrs (Prescribed over telephone)	2°	2000	[signature]	08D 173T3	AM.
5% DEXTROSE	500	2000 cd	4°	12mn	[signature]	08E 1 1E 1C 04/11	B
HARTMANS	500	12mn	4°	0400	[signature]	08D 17T 3T 03/11	B
HARTMANNS	500	0400	4°	0800	[signature]	08D1 TT 3T 03/11	BP
5% Dextrose +20mmol KCl	500	0800	4°	1415	[signature]	08D1 4E1B exp 3/11	G
(N) saline	500	1425	4°	1830	S. Tordoff	08F0 2T3K 5/11	HH.
5% Dextrose	500	1830	4°	2230	[signature]	08E1 1E1C exp 4/11	G
(N) SALINE	500	2300	4°	0310	[signature]	08F0 2T3K 05/11	BP
5% DEXTROSE	500	0310	4°	0710	[signature]	08E 11E 1C 04/11	B

THIS DOCUMENT MUST BE RETAINED

STOBHILL HOSPITAL

NHS Greater Glasgow and Clyde

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

IN: :RIPTION SHEET

S: FORENAME | Unit No.

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6hr = 22 Drops/min.
4hr = 30 Drops/min. 8hr = 15 Drops/min.

DATE 6/8/8

No. 0181327

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	Serial No. / Batch No.	Given by
5% DEXTROSE	500	07 10	4°	13.45		08E 11E 1C 054/11	B
7/8/8 (N) Saline		14.00	4	18.15		4/2011 08E01 T3T	M IW
5% Dextrose		18.15	4			080 29EIF 3/11	RQ
(N) Saline	500ml	22 20	4 hours			08E 01T 3T	
8/8/08 (N) Saline	500ml	02 30	4 hours			08E 01T 3T	
5% Dextrose	500ml	06 30	4 hours	1035		08D 29C 1F	
(N) Saline	500ml	1035	4°	1230		08E20 1T3T 4/4	

MIS 147933

PATIENT

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Glasgow Royal Infirmary

NHS Greater Glasgow and Clyde

NUTRITIONAL SCREENING TOOL

Weight [Kgs]: 45kg.

Height [metres]: 5'10

B.M.I.:

Please circle only one score in each section					
Date	5/8				
BODY WEIGHT					
Normal (no recent weight changes)	0	0	0	0	0
Recent Unintentional Weight Loss (< 6Kgs)	(3)	3	3	3	3
Underweight/Weight Loss >6Kgs	5	5	5	5	5
APPETITE					
Good - Finishes 3 meals per day	0	0	0	0	0
Reduced - Leaving quarter of meals & fluids	2	2	2	2	2
Poor - Leaving half of meals & fluids	(3)	3	3	3	3
Little/no appetite, refusing /unable to eat/drink	5	5	5	5	5
ABILITY TO EAT / DRINK					
No difficulties, eating & drinking independently	(0)	0	0	0	0
Requires assistance	2	2	2	2	2
Difficulty swallowing and/or chewing	5	5	5	5	5
SKIN CONDITION					
Healthy	(0)	0	0	0	0
Some red pressure areas	2	2	2	2	2
Superficial breaks in pressure areas	4	4	4	4	4
Multiple deep pressure sores	5	5	5	5	5
GUT FUNCTION					
Normal	0	0	0	0	0
Persistant nausea	2	2	2	2	2
Nausea/vomiting/diarrhoea/constipation	(3)	3	3	3	3
Diarrhoea >3 days/unable to tolerate food	5	5	5	5	5
MEDICAL CONDITION					
No impairment to food intake	(0)	0	0	0	0
Minor surgery/mild infection	2	2	2	2	2
Major surgery/GI disease/CVA/Chronic illness	4	4	4	4	4
Severe inf./Sepsis/Cancer/Burns>15%/Multiple injuries	5	5	5	5	5
Total	9				

TOTAL [REFER TO ACTION PLAN]

IF YOU FEEL THAT YOUR PATIENT REQUIRES DIETETIC INTERVENTION DESPITE THE SCORE, PLEASE CONTACT THE DIETITIAN TO DISCUSS.

Action Plan

Low Risk
0 – 5

Encourage normal diet
Check weight weekly
Re-assess if condition changes

Medium Risk
6 – 9

Commence 3 day Food Record Chart
Check weight twice weekly
Re-assess after 3 days

Beatson Oncology Centre:
Refer to Medium Risk Flow Chart

Intake / weight increasing → Continue to encourage oral diet

Intake / weight not increasing → Refer to dietitian

High Risk
10 +

Refer to Dietitian and Medical Staff

Beatson Oncology Centre:
Refer to High Risk Flow Chart

*during latter stages of palliative treatment weighing of patients to assess nutritional status may not be appropriate as weight loss is a symptom of the underlying disease

Date	Weight	Score	Date seen by Dietitian	Refer to Dietetic Care Plan
31/1/18	Fasting due to condition	+	NAV referred / No started on	3day food chart

North Glasgow Hospitals

NHS Greater Glasgow and Clyde

Pressure Sore Risk Assessment Documentation Form

Patient Name: Deborah Sullivan

Case Record Number: _____ Ward: 7A

Waterlow Risk Assessment			Initials AM	C												
			Date 5/8	6/8												
			No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average	0		0	0												
	Above average	1															
	Obese	2															
	Below average	3															
Continence:	Completely catheterised	0															
	Occasionally incontinent	1		0	0												
	Cath. Incontinence of faeces	2															
	Doubly incontinent	3															
Skin type-visual risk areas:	Healthy	0															
	Tissue paper/dry	1															
	Oedematous clammy (temp↑)	1		0	0												
	Discoloured	2															
	Broken spot	3															
Mobility:	Fully	0															
	Restless/fidgety	1		0	0												
	Apathetic	2															
	Restricted	3															
	Inert/traction	4															
	Chairbound	5															
Age/Sex:	Male/Female	½		2	2												
	14-49	1															
	50-64	2		1													
	65-74	3			1												
	75-80	4															
	80+	5															
Appetite:	Average	0															
	Poor	1		3	2												
	NG Tube/fluids only	2															
	nbm – Anorexic	3															
Special risks – tissue malnutrition:	eg Terminal cachexia	8															
	Cardiac failure	5															
	Peripheral vascular disease	5		1	1												
	Anaemia	2															
	Smoking	1															
Neurological deficit:	Motor-sensory paraplegia eg diabetes, MS, CVA	4-6			0												
Major surgery/trauma:	Orthopaedic Below waist, Spinal	5			0												
	On table > 2 hours	5															
Medication:	Cytotoxics, High dose steroids Anti-inflammatory	4			0												
TOTAL SCORE				7	6												

Score: <10 = low risk; 10-14 = at risk; 15 – 19 = high risk 20+ = very high risk

DAILY PRESSURE AREA SKIN ASSESSMENT CHART

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

Grade one = blanching hyperaemia
Grade two = non blanching hyperaemia/superficial break
Grade three = through to subcutaneous tissue
Grade four = through to underlying muscle
Grade five = through to bone or presence of necrotic tissue

Date Skin Assessment	Skin Broken		Site of Damage	Grade of Damage	Signature
6/8	Yes	(No)			G

ENSURE ALL ACTION IS DOCUMENTED IN THE NURSING CARE PLAN

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

Acute Services Division

Hospital / Department | Stobhill 7A

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: .....

Ward: .....

CHI number: .....

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

.....

.....

.....Unit/Hospital number .....

Contents

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

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

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 5/8/08	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type ***	Drugs for mental illness 1	Blood pressure / water, tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		0						
				TOTAL SCORE		4						
				ACTION(S) TAKEN Enter action code(s)		1						
SCORE 2-8 = LOW, 9-12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE		AM						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	DATE	DATE	DATE	DATE	DATE	DATE	DATE
	LOW, MODERATE AND HIGH RISK							
1	Prevention and general safety precautions discussed with patient and family.	5/8/19						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE							

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

WATER TABLETS (DIURETICS) are such as Bendroflumethiazide, Furosemide and Co-amilofruse:

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

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

ESTRICTED 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.

STOBHILL HOSPITAL – ACUTE PAIN SERVICE - Page Sister: 1184

NHS Greater Glasgow and Clyde

OBSERVATION CHART FOR THE ADMINISTRATION OF

SUBCUTANEOUS ANALGESIA Deborah Sullivan. 1063847K.

Date	Time	Sedation Score	Resp. Rate	Pain Score	Dose of Analgesia administered	Pain Score (After 1 hr)	Comments	Sign
5/8	20·00	0	17	9	10mg	5		B
6/8	01·15	0	17	10	10mg	Asleep		B
6/8	0755	0	18	10	10mg	asleep		CM
6/8	1240	0	18	10	10mg			Catchlo
6/8	1735	0	18	10	10mg			Catchlo

PAIN SCORE

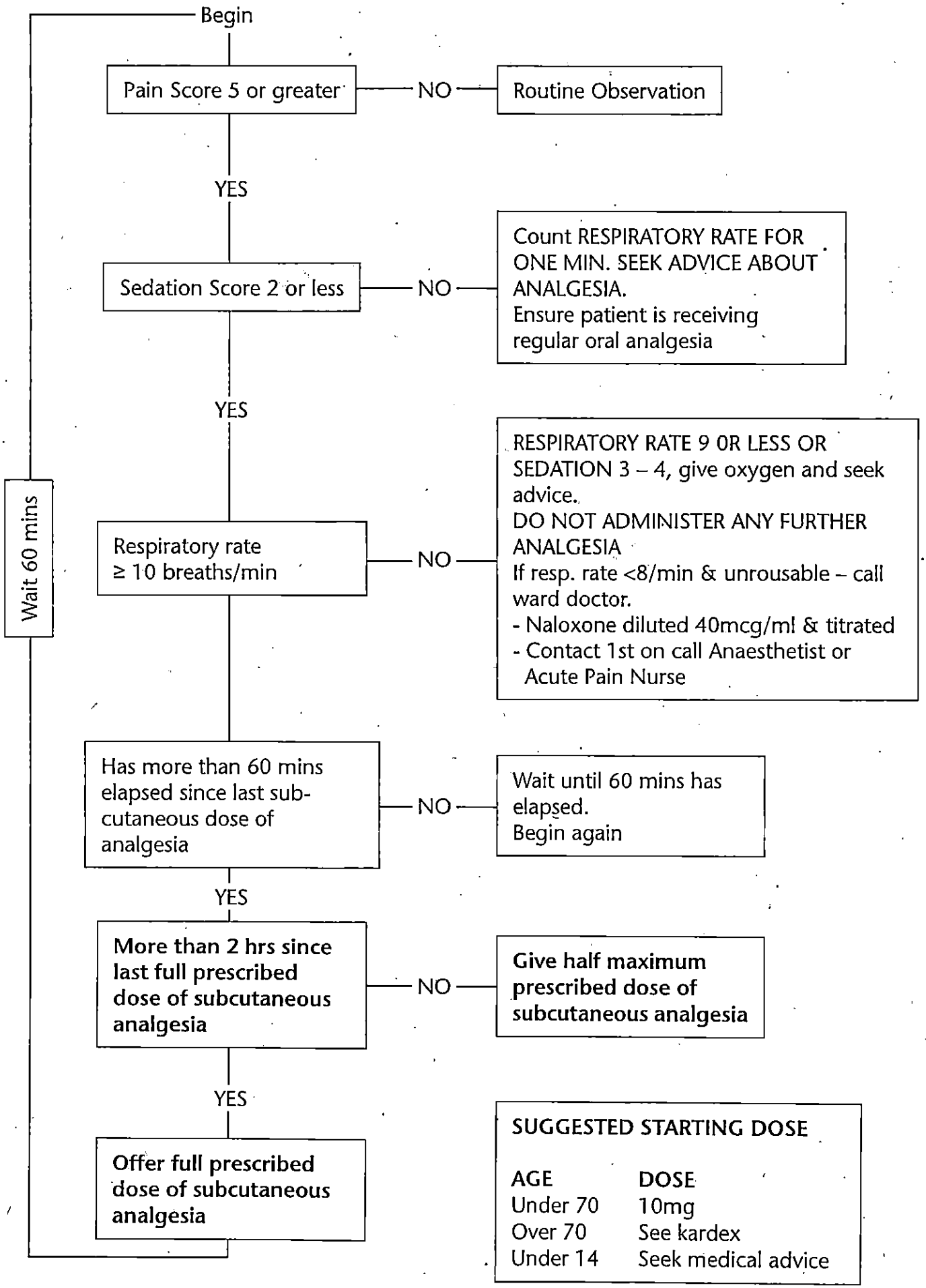
0 5 10

No pain Worse Pain Ever

SEDATION SCORE

0 = Awake
1 = Alert
2 = Responds to verbal command
3 = Responds to painful stimuli
4 = Unresponsive and unrousable
5 = Normal sleep

STOBHILL HOSPITAL
SUBCUTANEOUS ANALGESIA PROTOCOL ALGORITHM



PATIENT: MOVING AND HANDLING CARE PLAN

Patient's Details:	Deborah Sullivan	Named Nurse:	Lorna	If Patient is totally independent, tick here and go to date box.	✓

BODY BUILD				Problems with comprehension, behaviour, co-operation (specify):
Obese		Tall		
Above average		Medium	✓	
Average	✓	Short		
Below Average		Weight	Kg	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
RISK OF FALLS				
High		Low	✓	

Into Bath or shower.

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT	✓	BED BATH	
Ambulift		Parker		People 1		2		Additional Information:			
Shower Chair		Variable Height									
Other (specify)		Fixed Height									
		Shower									

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓
People 1	2	3		People 1	2		Additional Information:							
				Walking Aid (specify)										

Toiletting

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓
People 1	2	3		People 1	2		Additional Information:							
				Walking Aid (specify)										

Walking.

NO WALKING		MANUAL SUPPORT		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓
		People 1	2	Distance Walked/Additional Information:							
		Walking Aid (specify)									

Move up/down bed.

HOIST (specify)				HANDLING AIDS		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓
People 1	2	3		Sliding aid (fabric)		Additional Information:							
				Rope ladder									
				Hand blocks									

Sit up over side of bed.

ROPELADDER		SWIVEL CUSHION		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓

Move on/off bed pan.

HOIST		ROLL PATIENT		PATIENT BRIDGES		MONKEY POLE		N/A	✓

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID		SLIDING AID - FABRIC		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	✓

Other Instructions.

Date Assessed:	5/8/05					
Assessor's Signature:	AMM					
Proposed Review Dates:	—					

nto Bath or shower.

HANDLING AID	WHICH BATH	ASSISTANCE	SUPERVISION	INDEPENDENT	BED BATH
Ambulift	Parker	People 1	2	Additional Information:	
Shower Chair	Variable Height				
Other (specify)	Fixed Height				
	Shower				

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Toiletting

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Walking

WALKING	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
	People 1 2	Distance Walked/Additional Information:			
	Walking Aid (specify)				

Move up/down bed.

HOIST (specify)	HANDLING AIDS	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	Sliding aid (fabric)	Additional Information:			
	Rope ladder				
	Hand blocks				

Sit up over side of bed.

ROPE LADDER	SWIVEL CUSHION	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Move on/off bed pan.

HOIST	ROLL PATIENT	PATIENT BRIDGES	MONKEY POLE	N/A

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID	SLIDING AID - FABRIC	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Other Instructions.

Date Assessed						
Assessor's Signature						
Proposed Review Dates						

Name: Deborah Sullivan Ward: 7A Date: 5/8/08 Case Record No.:

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
9/8/08	Yc	Independent		
		Bed bath		
5/8	amw	Assisted wash	9/8/08	Yc.
5/8	amw	Oral hygiene		
		Pressure care		
		2.NUTRITION Score (9)		
5/8	amw	Fasting Allow sips only.	6/8	C
9/8	Yc	Normal Diet		
		Special Diet / Modified Diet		
6/8	C	Fluids	7/8	C
7/8	PB	-fast 6am.	8/8	Yc.
		3.ELIMINATION		
5/8	BP	Independent		
5/8	amw	Commode	5/8	BP
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY Score:		
5/8	amw	Fully Independent/fully mobile Low falls risk		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
6/8	C	Waterlow daily (if score is over 10+) (7)		
		TPR } 7 x 4		
		BP } 7 x 4		
5/8	amw	Pain Score } +MEWS ongoing		
		Fluid Balance } ongoing		
6/8	C	MEWS		

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
5/8	amm	IV Infusion Fluids as prescribed		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
		IV access: ∞ IV cannulae (R) wrist (Pink) ∞ others	6/8	S
5/8	B	S/C line (L) arm		
6/8	S	(R) hand - pink cannula		
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
5/8	amm	RSOH/-MSSU ✓ (N) HCG-neg	5/8	R
5/8	B	USS (E)		
5/8	S	UGIE (D)		
		9.SLEEP		
6/8	S	promote restfull sleep		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
5/8	amm	Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		
6/8	S	NOK -		
		see nursing notes		

Initial Care Plan seen and agreed by patient: Yes ☑ N/A ☐

Signature of nurse: amm **Date:** 05/08/05

 ANN MAGUIRE

STOBHILL HOSPITAL

ATION CHART

SURNAME

UNIT NUMBER

10638479K
SULLIVAN
DEBORAH
CHT-0712726128

18 SEP 2008

DID NOT ATTEND

13 NOV 2008

Vomiting —
ate Tx side 2x/day
void ++. — Plasturelve ++

acid at back of throat unable
to sleep eating on key side.
lost 1½ stone in weight

18 DEC 2008

DNA 19 FEB 2009

pain. — sleep → thro' to back
excruciating — awake at 4am. wake up
— vomiting helps — vomit every day
Granstan has helped sedation.
reflux — live on porridge / oral

F2
00262

16 APR 2009 smoker 10/day.

weight - lost ½ stone. feel - OK
loose. -
TRAMADOL
PATCHES - FENTANYL - ? morphine.
- tape to help. no muscle pain/12

? refer gynaecological review.

GASTROSCOPY

13 AUG 2009

reflux - heartburn -
No vomiting -
Tablets Nexium - 2 x 2mg/day
Acoactic -
Metoclopramide 1 3x/day.

(1) Bonjela swallow
(2) pH + motility

MRI - ? inflammatory
Tramadol + fentanyl patch

STOBHILL HOSPITAL

SURNAME

10638479K
SULLIVAN
DEBORAH
CHI-0712726128

ON CHART

IIT NUMBER

10 DEC 2009

10 JUN 2010

15 JUL 2010

29 JUL 2010

DNA

E-Pacer PATIENT REPORT

Time 14:11 Date 30/09/2008

PATIENT AND INCIDENT DETAILS

Incident number	PA002722541-001
Name	DEBORAH SULLIVAN
Age	35
Date of birth	07/12/1972
Gender	Female
Incident location	[illegible]
Incident post code	[illegible]
Incident type	[illegible]
Call received	[illegible]
Call passed	[illegible]
Crew mobile	[illegible]
Crew at scene	[illegible]
Crew left scene	[illegible]
Receiving hospital / destination	[illegible]

PRIMARY SURVEY

RESPONSE

AVPU	Alert

AIRWAY

Airway assessment	Clear

BREATHING

Breathing rate	Normal
Respiratory rate	

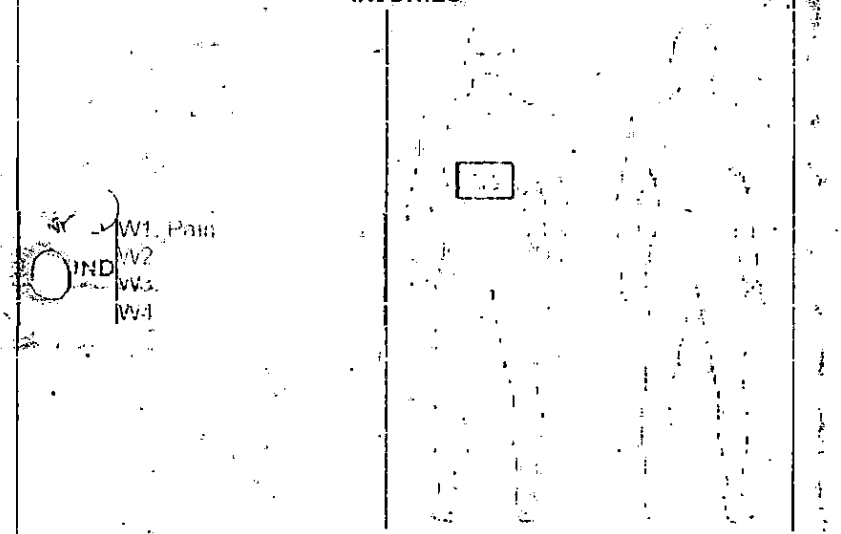
CIRCULATION

Pulse rate	Fast
Most peripheral pulse found	Radial
Cap refill rate	
Skin colour	Pale
Skin texture	Dry

C-SPINE INJURY

Suspicion of C-Spine injury	[illegible]

INJURIES



AMPDS

Final code	[illegible]

GCS

Final GCS eye response	[illegible]
Final GCS verbal response	[illegible]
Final GCS motor response	[illegible]

VITAL SIGNS

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

13:58	112	18	[illegible]	[illegible]	[illegible]	[illegible]	15	[illegible]	-

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Medication	PARACETAMOL [illegible] TRAMADOL
Last eaten	6 hrs

FINAL OBSERVATION AND COMMENTS

URGENT CALL TO [illegible]
FEMALE [illegible]
ABDO PAIN [illegible]
PT HAS BEEN VOMITING [illegible]
BEEN UNABLE TO [illegible]
WAITING TO [illegible]
SURGERY ON A [illegible]
GULLET IN [illegible]
DAYS

RI[illegible]

[illegible]
[illegible]

Accident and Emergency Department
Stobhill Hospital

Greater Glasgow and Clyde
Stobhill Hospital
Glasgow G21 3UW
Tel: 0141 201 3076
Fax: 0141 201 3051

A&E No. 08032003

10638479K

Surname	SULLIVAN	**Forename**	DEBORAH	**Title:** MS
Address:	6 MUIRHEAD COURT BAILLIESTON GLASGOW LANARKSHIRE	**Postcode**	G69 7EP	**CHI No:**0712726128
		Telephone:	7716310	
Date of Birth:	07.12.72	**Sex:**	F	**Age:** 35 yrs

GP Name:	LANGAN JOHN		
Address:	BAILLIESTON HEALTH ... 20 MUIRSIDE ROAD BAILLIESTON GLASGOW	**Postcode**	G69 7AD
		Telephone:	01415318050

Next of Kin	KATHLEEN SULLIVAN		
Relationship:	PARENT		
Address:	187 COMMONHEAD ROAD	**Postcode**	G34 0DS
	GLASGOW	**Telephone:**	7713743

Primary Carer:

Date of Attendance: 30.09.08 14:39
Date of Incident:
Presenting Complaint: SURG PEND - ABDO PAIN

Triage **Tetanus Cover:**

Allergies:

P= **BP=** / **RR=** **Sat=** **BM=** **Temp=**

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

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

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46216

DR JOHN J LANGAN
DR JUNE GOLDIE
DR MOIRA C M MACLEOD
DR ELAINE E POLLOCK
DR GERARD A MCKAIG
DR JENNIFER DOW
DR JULIE P ELLOR
DR CHRISTINE A WALKER
DR JOHN C MENZIES
DR LIANA MCMILLAN

Baillieston Health Centre
20 Muirside Road
Baillieston
Glasgow G69 7AD
Tel: 0141 531 8050
Fax: 0141 531 8067

Shettleston Health Centre
420 Old Shettleston Road
Glasgow G32 7JZ
Tel: 0141 531 6240
Fax: 0141 531 8067

0712726128

SULLIVAN
DEBORRH
07/12/1972
Dr J Goldie
Baillieston Health

0712726128

SULLIVAN
DEBORRH
07/12/1972
Dr J Goldie
Baillieston Health

30/9/08.

Dear Dr, (Acute Surgical Learning)

This lady is well known to Mr Smith and she suffered a known ? She has not settled she has had pain + vomiting over the weekend

Yours sincerely

Jane

Acute Services Division

Surgery and Anaesthetic Directorate

Department of General Surgery
OUTPATIENTS CLINIC - STOBHILL

Mr J S Smith's Out Patient Clinic

Stobhill Hospital
133 Balornock Road
GLASGOW
G21 3UW

Secretary: Mrs Eileen Mitchell
Direct Line: 0141 201 3785

NHS
Greater Glasgow and Clyde

Clinic 18/09/2008
Typed 19/09/2008
Our Ref JSS/EM

Dovecote23/09/08

Dr John Langan
Baillieston Health Centre
20 Muiralde Road, Baillieston, Glasgow
G69 7AD

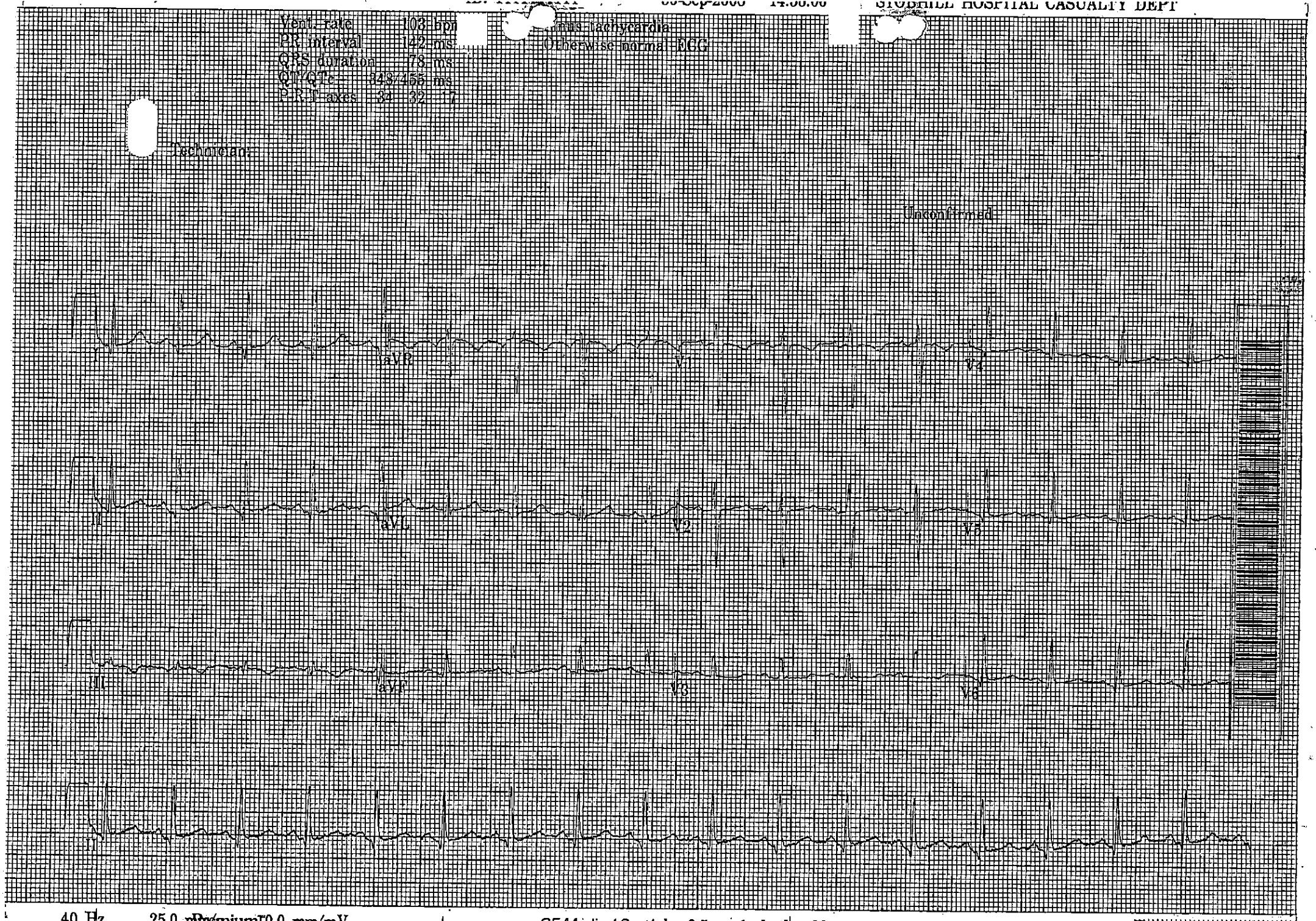
Dear Dr Langan

~~Deborah Sullivan 07/12/1972 CHI: 0712726128 CRN: 10638679K~~
6 Muirhead Court, Baillieston, Glasgow, G69 7EP

I saw Deborah in clinic today. It was disappointing to hear that her sickness and pain had returned to such an extent that she had required admission to hospital. Her endoscopy, as you know, appeared to be satisfactory when she was in and we wondered therefore if it could be a bout of pancreatitis which might be setting off all the retching. The result of the MRCP was not available today but, as you will see from my handwritten note, I wondered if you could put her on some Kytril or Granisetron to see if we can settle down her vomiting. If she fails to improve with this then I think we would be better to admit her and if you simply contact my secretary she can arrange this for Deborah.

Yours sincerely

Mr John S Smith
Consultant Surgeon


Vent. rate 103 bpm
PR interval 142 ms
QRS duration 78 ms
QT/QTc 343/455 ms
P/R/T axes 34 32 17
Sinus tachycardia
Otherwise normal ECG
Technician:
Unconfirmed
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
II
40 Hz
25.0 mm/mm
10.0 mm/mV

Patient's name Deborah Sullivan Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 20/9/8 Time 14.40 Triage Nurse RC PC Sovg/pnd abdo pain

BM ✓ Hx pancreatitis

Triage category 1 2 (3) 4 5

Relatives present: No Relatives informed:

INITIAL VITAL SIGNS

at:(Time) 14⁴⁰
HR: 127
BP: 109/91
RR: 20
SaO_2: 97% (R)
Temp: 36.0°C
G.C.S: 15
Signed: A Cuny

INITIAL MANAGEMENT

Nurse AC

Oxygen started _____ %: Signed _____ ECG: Signed AC

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

TIME	hrs									1
EYES OPEN	spontaneously	4								eye closed by swelling =C
	to speech	3								
	to pain	2								
	none	1								
RESPONSIVENESS: BEST VERBAL RESPONSE	orientated	5								Endotracheal tube or Tracheostomy = E Dysphasa=D
	confused	4								
	inappropriate words	3								
	incomprehensible sounds	2								
	none	1								
BEST MOTOR RESPONSE	obey commands	6								Record the best arm response
	localises pain	5								
	normal flexion to pain	4								
	abnormal flexion to pain	3								Paralysed =P
	extention to pain	2								
	none	1								
	COMA SCORE 15									
PUPILS RIGHT	size (mm)									2 += Reacts -=No Reaction C= Eye closed SL= sluggish pupil
	Reaction									
PUPILS LEFT	size (mm)									
	Reaction									
L ARMS	Normal power									3 Record right (R) and left (L) seperatly if there is a difference between the two sides Fractured limb = #
	Mild weakness									
	Severe weakness									
	Extention									
	No response									
MOVEMENT LEGS	Normal power									
	Mild weakness									
	Severe weakness									
	Extention									
	No response									
BLOOD PRESSURE mm Hg	230									4 40
	220									39
	210									38
	200									37 Temp C°
	190									36
	180									35
	170									34
	160									33
	150									32
	140									31
	130									30
	120									
	110									
	100									
	90									
PULSE RATE	80									
	70									
	60									
	50									
	40									
	30									
PUPIL SCALE (mm) 1 2 3 4 5 6 7	RESPIRATORY RATE									5
	SaO_2									
	NURSE INITIALS									6

BLOOD GLUCOSE BM STIX	Time	14⁴⁰			
	BM	5.2			
PEAK FLOW	Time				
	PF				
VISUAL ACUITY	R. eye aided/unaided				
	L. eye aided/unaided				
	pH L. eye	R. eye			

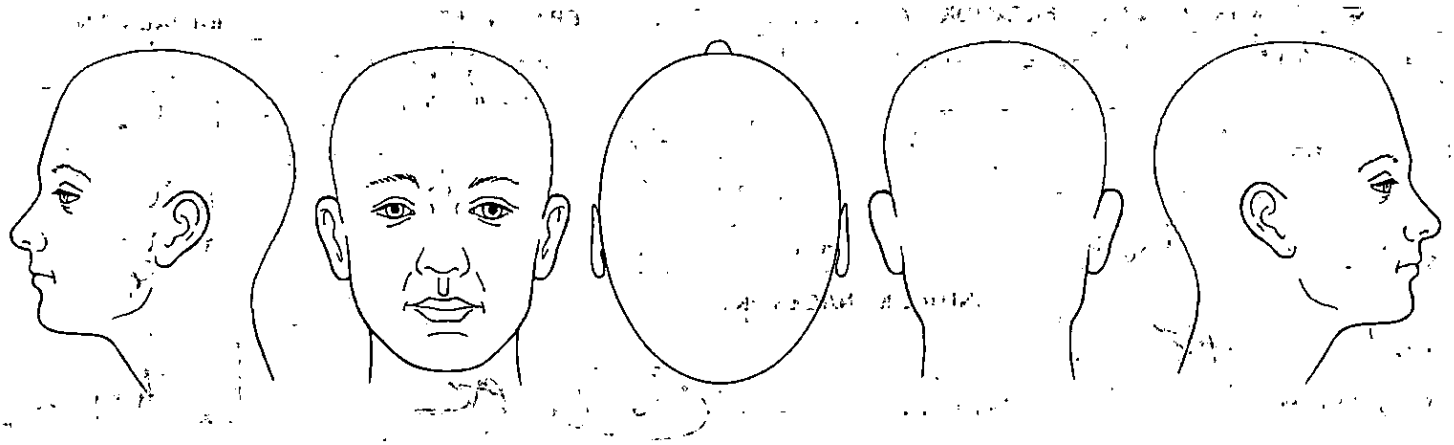
Signed: A Cuny

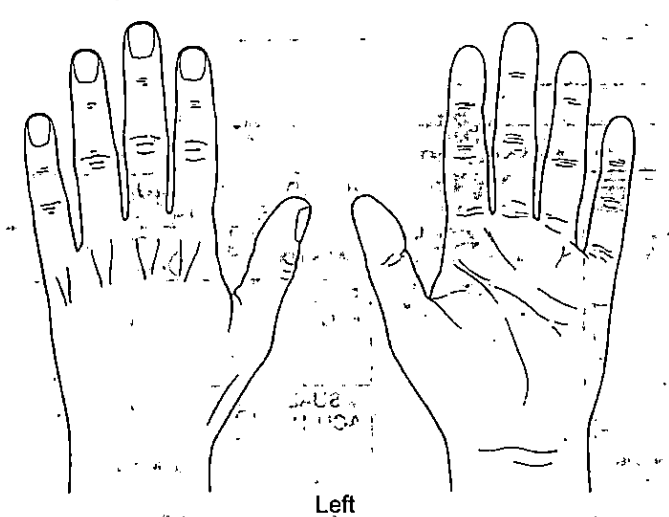
URINALYSIS awaited

Urobilinogen µmol/L	Normal 3 16	33	66	131			
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

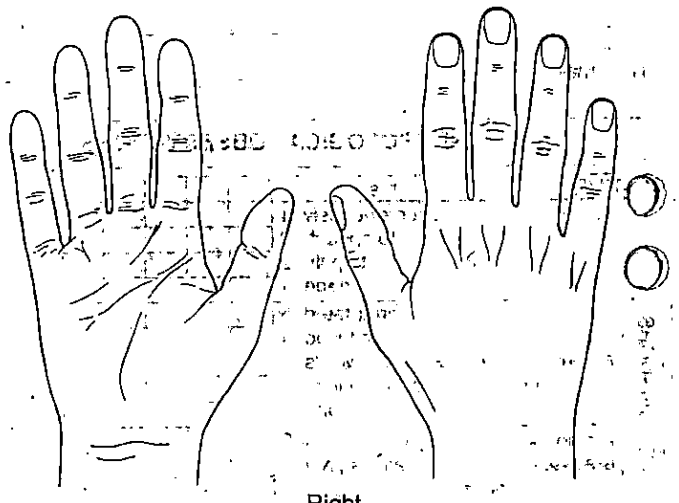
Signed: _____

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds

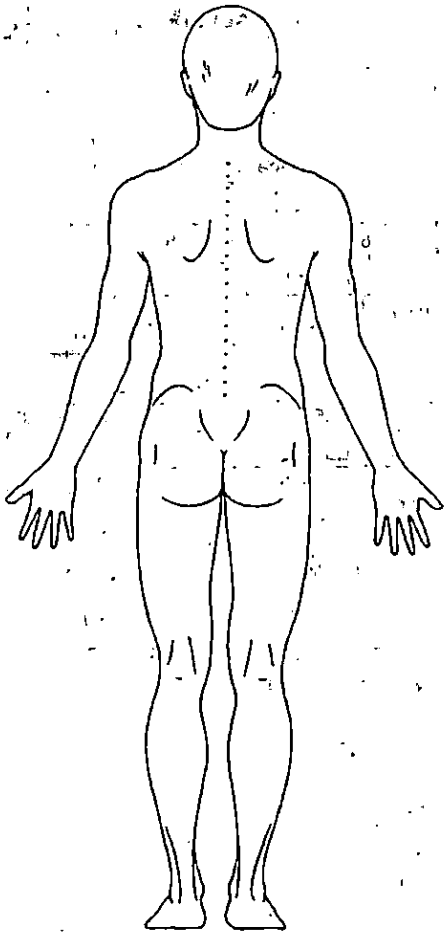


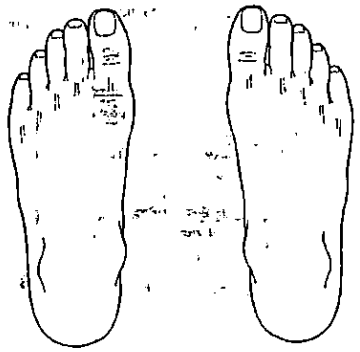


Dorsal Left Palmar

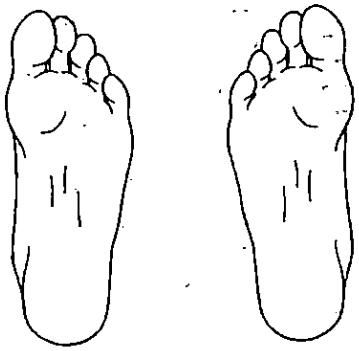


Palmar Right Dorsal

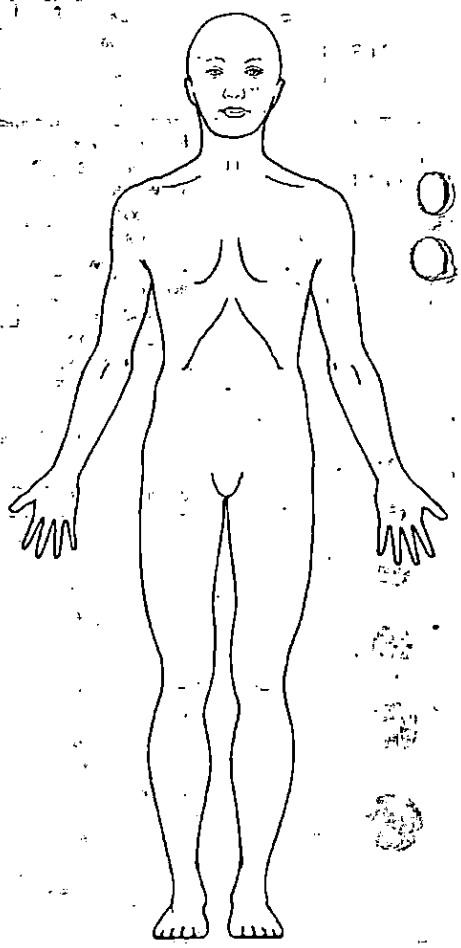




Left Dorsal Right Dorsal



Left Plantar Right Plantar



Signed _____

NURSING NOTES

Signature: A Cumming Time: 1445

Initial Management
02 Y/N Litres Per Min
ECG Y/N X-ray Y/N
Urinalysis:

History Pt known to Mr Smith - recent endoscopy - normal + MRCP - awaiting result.
Severe upper abdo pain + vomiting since Fri - °urinary symptoms °change bowel habit
Pain ↑ severity, unable to keep fluids down

DH fluoxetine, omeprazole, tramadol, metaclopramide, fentanyl patches,

Allergies NKDA No/Yes

BHCG +ve -ve
Cannula Y/N
Bloods Y/N
U & Es ☐
FBC ☐
GL ☐
Amyl ☐
Coag ☐
Group ☐
D Dimers ☐

PMH/Previous stomach surgery, pancreatitis, cholecystectomy; Other: IBS,

Social History smokes 15 cpd °alcohol lives ∫ daughter

NOK Not / present
Keys / valuables
Social Services Not / contacted

MEDICAL NOTES - HISTORY and EXAMINATION

Consultant _____ Seen by _____

Grade: SpR SHO SHO3 JHO Clin Assist ENP SG AS *(Please circle)* At (time) _____

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

Date

30/09/08 4:00 pm (35) ∫ Surgical RTC abdo pain

① previous chole cystectomy 12 years ago * appendectomy
② MRCP - 2/52 ago @ WIG - °results yet:
③ OGD recently - 8/52 - inflammation - Biopsies taken -
④ [redacted]
⑤ pancreatitis - chronic 2° to damage to duct of pancreas see GS

HPI
Severe upper abdo pain. 6/7 mainly epigastric, radiating through to back,
A/W nausea, vomiting °bilious, feeling hot + cold.
pain been on + off for weeks

Last BM 2/7 °urinary S. °vaginal discharge.
other sys (N)

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

Dhx * allergy to Voltarol *
fluoxetine
MARALON
TRAMADOL
CAPROMENTIN ?
LOSEC.

SH
smoker 10CPD
alcohol
lives w daughter *

O/E HR 127 109/91 RR 20 sat 97% on RA
afebrile

abdo : soft tender ++ epigastrium
chest : clear. open gastrostomy
CVS : tachy
CEGA : sinus tachy otherwise. BSC

bloods.

FBC (N) Coag (N)
U+E, LFTs CRP (N) GGT 113
Amylase 86
CXR (N)

ABG:
H 43.4
pCO2 5.9
PO2 10.1
lact 0.9
Sat 97%
HCO3 24.9
BE -6

CXR } NAD
AXR

impression : ? ? chronic pancreatitis
? Gastritis

P/ NBM
2/ IVF
3/ analgesia - MORPHINE / TRAMADOL
4/ ABGs
5/ CXR / AXR
6/ IV LOSEC.
7/ chase MRCP / biopsy results.
8/ admit FA

1/10/08 Abdo US
Nil of note
CBD 6mm (acceptable post-cholecystectomy)

MUSAAB

Date

MEDICAL NOTES - HISTORY and EXAMINATION *(cont)*

Date

RESULTS PAGE

Please record all results of investigations, time, date and sign. Append all referral letters / SAS report forms, etc to this page.

Date	

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug (BLOCK CAPITALS)	Dose	Method of Administration	Time of Administration	Signature	Given by
30/9	MORPHINE	10mg	I.V.			4.00pm
30/9	MAXALON	10mg	I V	1635		
30/9	LOSEC	40 mg	I V	1635		

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
30/9	Hartmans	500		start								08P2T3
30/9	5% dext	500		start								
1/9	5% dextrose	500		1 hr								
	Hartmans	500		1 hour								

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

NHS
Greater Glasgow and Clyde

Stobhill Hospital

In Patient Surgery Assessment /Admission Pack

DVT RISK ASSESSMENT

LOW MEDIUM HIGH		
Ted Stockings	Yes ☐	No ☐
Heparin	Yes ☐	No ☐

Date of Assessment 30 / 9 / 08

Date of Admission 30 / 9 / 08

Time of Admission 6pm

Date of Operation ___ / ___ / ___

Consultant Miss Craig

WARD 7A

1063847K F
SULLIVAN 07/12/1972
DEBORAH
6 MUIRHEAD COURT
BAILLIESTON G69 7EP
GLASGOW
CHI 0712726128

Affix data label

THIS SECTION TO BE COMPLETED AT PRE-ADMISSION

Procedure / reason for admission _____

_____

Height: _____ Weight: _____ = BMI : _____ | Spo_2 ____ T ____

B.P. : _____ P _____

Are you taking any medication prescribed by your doctor ? YES ☐ NO ☐ 1

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

have you ever had:	YES	NO	
a serious illness			2
an allergy or reaction to medicines, elastoplast etc.			3
State nature of allergy			4
diabetes			
any chest problems PFR			5
heart problems			6
high blood pressure			7
heart murmur			8
blackouts, convulsions or fits			9
jaundice / hepatitis			10
indigestion or heartburn			11
kidney or urinary trouble			12
ıaemia or other blood problems			13
excessive bleeding or bruising			14
arthritis			15
muscle disease or progressive weakness			16

Do you:-	YES	NO	
require mobility aid / have limited mobility			17
have any problems with your eyesight			18
have any problems with your hearing			19
smoke			20
have you ever used intravenous drugs			21
If a woman, are you pregnant or taking the 'pill'			22
Do you have any caps, crowns, dentures or loose teeth			23
do you drink alcohol (units per week)			24

THIS SECTION TO BE COMPLETED AT PRE-ADMISSION / ASSESSMENT

HAVE YOU ANY QUESTIONS ABOUT YOUR ADMISSION? YES ☐ NO ☐ 25

26

Hospital Admissions/Operations (please list and date)

Did you have any anaesthetic or surgical complications ? (please list) 27

Date of your last anaesthetic ? _____

Has any member of your family had problems with anaesthetics ? YES ☐ NO ☐ (please tick box) 28

-define problem _____

Is there anything else the surgeon / anaesthetist should know ? _____

_____

ASSESSMENT NURSES SIGNATURE: _____ DATE : / /

WARD NURSE SIGNATURE _____ DATE : / /

INVESTIGATIONS CARRIED OUT (please tick box)

full screen ☐ full blood count ☐ E.C.G ☐ CXR ☐ Group / retain ☐ X - Match

Other ☐ (please state)

Urinalysis ☐ Clearview ☐

Anaesthetic referral required: _____ YES ☐ NO ☐

Reason: _____

ANAESTHETIC DETAILS REFERRAL DETAILS:-

DR : _____ DATE : / /

ANAESTHETISTS COMMENTS:

NURSES SIGNATURE: _____ DATE : / /

SUITABILITY FOR ADMISSION

SDA ☐ NSDA ☐

THIS SECTION TO BE COMPLETED BY NURSING STAFF ONLY

SURGICAL RECEIVING UNIT WARD 2A

PRESENTING COMPLAINT: Severe upper abdo pain and vomitting since Fri. Change in bowel habit.

PRESENTING CONDITION ON ADMISSION: Severe upper abdo pain and vomiting.

VITAL SIGNS

BP 134/88 P 94 TEMP 37.4°C O_2 SAT 98%

PAIN SCORE 1-10 [ ] ANALGESIA GIVEN IN A&E YES [x] NO [ ]

PAST MEDICAL HISTORY: pancreatitis, cholecystectomy IBS

DRUG HISTORY: FLUCKEYINE
MAXALON
TRAMADOL
LOSEC

ALERGIES:
* Voltarol *

MOBILITY / LEVEL OF INDEPENDENCE:

fully mobile / independent

DIETARY HABITS / APPETITE: ↓ food intake 2/52.

ELIMINATION: PASSING URINE NORMAL
CONSTAPATION 3/7

STOOL CULTURE YES ☐ NO ☐

URINALYSIS RESULTS ☐

MISSU _____ YES ☐ NO ☐

PREGNANCY TEST _____ +VE ☐ VE ☐

SOCAL HISTORY / CIRCUMSTANCES

LIVES WITH DAUGHTER.

SMOKER 12 daily YES ☑ NO ☐

ALCOHOL _____ YES ☐ NO ☑

AMOUNT: _____

MENSTRUAL CYCLE: ON THE PILL.

PREGNANCY / CONTRCEPTIVE: _____

D.V.T. PROPHYLAXIS:

FRAGMIN YES ☐ NO ☐

TEDS YES ☐ NO ☐

Signature: R Nichol Date: 30 / 9 / 08 Time:

NAMED NURSE: _____

NAME: (PRINTED) _____

WARD PRE - OPERATIVE PREPARATION

DATE OF OPERATION ____/ ____/ ____ WARD _____

Waterlow Score: _____

Name
Address

D.O. B
Unit No.

Affix data label

BASELINE OBSERVATIONS

BP _____ P _____ SO_2 _____

	YES
Consent signed	
Pre-medication given	
Fasted _____ Time last ate _____ Time last drank	
Identity band	
Case Notes ☐ X-rays ☐ Drug Kardex ☐ Obs. Chart ☐	
Operation site confirmed	
Caps / Crowns / loose teeth	
Prosthesis removed	
ntures removed / not removed	
Underwear removed	
Paper pants on patient	
Make up, nail varnish removed	
Jewellery taped / removed	
Inhalers / GTN Spray	
Allergies	
Voided urine	
Subcut heparin	
Ted stockings	
Pre-op visit	

Other relevant information :

Ward Signature: _____ Reception Signature: _____

THEATRE

ERATION PERFORMED _____

	YES	NO
DIATHERMY BIPOLAR / MONOPOLAR		
HEEL RESTS		
FLOWTRON BOOTS		
SHEEPSKIN HEEL PADS / MATS		
HEATED BED		
ARM BOARDS		
PATIENT WARMING BLANKET		

PATIENT POSITION

LATERAL RIGHT		TRENDELENBURG	
LATERAL LEFT		REVERSE	
SUPINE		LITHOTOMY	
PRONE		LLOYD DAVIS	

SPECIMENS : PATH BACT OTHER

DRAINS

CATHETER

COUNTS CORRECT

SWABS - FIRST	
- FINAL	
INSTRUMENTS	
SHARPS - NEEDLES	
- BLADES	
THROAT PACK OUT	
PACK IN SITU	

INSTRUCTIONS FOR REMOVAL:

TOURNIQUET TIME ON OFF

SPECIAL COMMENTS _____

Name of Scrub Nurse : _____ Signature of Circulating Nurse : _____

THIS SECTION MAY BE COMPLETED BY ANY MEMBER OF THE MULTIDISCIPLINARY TEAM

Named Nurse : _____ Fasted from : _____

Patients Telephone No. 0141 771 6317 Spiritual needs R/C

Patients Occupation: / Next of kin: CATHLEEN (MUM)
(Name & Relationship to patient)

Next of kin Tel. No. 0141 771 3743
(Name & Relationship to patient)

DISCHARGE PLAN

Expected Discharge Date : / /

Actual Discharge Date:. 4 / 10 / 08

	YES	NO
Is someone available to accompany the patient home ?	✓	
Is a responsible adult available to stay with the patient for 24 hrs. post-operatively ?	✓	
Does the patient have easy access to their home	✓	
Is the patient a carer? PAYMASTER.	✓	
GP letter / Prescription : IDLS still to be done.		
Outpatient appointment : SOP (MR SMITH 9/10/08	TBA.	
Relatives informed :	✓	

SERVICES REQUIRED

	YES	NO
District Nurse:		—
Social Worker:		—
Other :		—
Transport Requested: (Date) / /		

Discharge summary / comments:

Pre-op / On Admission

Signature : R McNeil

Ward: 6 Date: 30 / 9 / 08

Signature : _____ Date: 4 / 10 / 08

THIS SECTION MAY BE COMPLETED BY ANY MEMBER OF THE MULTIDISCIPLINARY TEAM

COMMUNICATION SHEET/ PROGRESS NOTES

Ward ....7A.....

Date	Progress / Evaluation	Signature/ Profession
30/9/08.	Patient admitted to ward from casualty with abdo pain and vomitting. Putted NBM, IV fluids commenced ? Gastritis or Chronic pancreatitis. S/C Cyclizine initiated morphine given with good effect. History taken & Cx plans completed	R Mehta (SN)
1/10/08	X-ray review	
~~30/9~~ 1am	CXR - note abnormal curvature of right diaphragm	
	nil else of note	
	AXR - ? stent in RUQ.	
	- faecal loading + prominent bowel loops	
	? dilated recto-sigmoid.	
	No urgent abnormality seen. For senior review	
	please	Mehta FY1 4083
1/10/08	S/c Morphine given regularly. IV fluids continue. Passing urine well. Remains NBM.	B Paul
1/10/08	ABG O_2 11.6 lact 0.8	
7am	pCO_2 (6.4) 17 CO_3 25.9	
	17 (45.3) on air	Mehta SHO FY1
1/10/08	Ltr Ms Craig	
	H^x Revisited	Leitch
	Plan - USS. ? CBD sludge	Clifford FY1 5857

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward .....

Name Deborah Sullivan
Address

D.O.B 7.12.72
Unit No. 1063847 9K

Affix data label

Date	Progress / Evaluation	Signature/ Profession
1.10.08	DH confirmed c pt	
	fluoxetine 40mg m	
	Omeprazole 40mg m	
	gabapentin 600mg tid (confirmed c pt 2x300mg tid)	
	tramadol 100mg qid	
	paracetamol 1g qid	
	movicol T bd (if req'd)	
	granisetron 1mg bd – recently started	JSINGTON pharmacist
1/10/08	(2) fasting for abdominal ultrasound.	
	(1) Showered independently	
	(3) Passing urine spontaneously	
	(5) observations stable. Apyrexial	
	attended for Abdominal Ultrasound – Nil of Note	
	see over.	
	(2) Resumed to fluids and diet. IV fluids still in progress	
	For review at ward round tomorrow.	S/N C Macdonald
2/10/08	Slept for long periods.	
	IV fluids continue to 4hrly	

COMMUNICATION SHEET

Ward ....b....

Date	Progress / Evaluation	Signature/ Profession
2/10/08	Vomited x1 (mouthful orange juice)	
	S/C Morphine 10mg given as requested	
	at 22.45 and 01.40	J Watson
2/10/08	1) Independent with personal hygiene	
15.20	2) Fasting for theatre	
	3) passing urine spontaneously	
	4) fully mobile	
	5) observations stable & appropriate	
	6) I.V fluids running as charted.	
	patient continues to request	
	regular analgesia.	C Lyle
21.05	Pink cannula sited right hand	JR C-W.
3/10/08	Slept well for most of the night	
	IV fluids continue 6 hrly.	
	S/C Morphine given as per Nardex	
	Fasting for ? theatre	J Watson
3/10/08	PHARMACY	
12.40pm	Please note Drug Hx confirmed on	
	01/10 - patient normally takes Granisetron 1mg bd -	
	has been Rx'd 1mg tid. Also has been Rx'd	
	Ondansetron 4mg prn. Please review & consider	
	stopping prn ondansetron & changing Granisetron	
	to 1mg bd. Thanks.	
	Robin Shergold	
	(PRE-REG PHARMACIST)	

MIS 110460

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward 6

Name: [redacted]
Addr 0638479K
SULLIVAN
DEBORAH F
6 MUIRHEAD COURT 07/12/1972
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128
D.O.B
Unit No: [redacted]

Affix data label

Date	Progress / Evaluation	Signature/ Profession
3/10/08 16.50	1) Shaved independently 2) Fasting per theatre 3) Observations stable Apyrexial. settled since return from theatre No issues post.	E Lyle
~~22.00~~	~~When administering~~	
21.35	Requested & given Morphine 10mg S/C	
22.00	When administering her medication I noted Deborah had been written up for a Fentanyl Patch 75mg. I asked her when this had been started she informed me she had been started on patches during her previous admission in August There is no mention of this either in her medical clerk-in or Pharmacy discussions Her patch was due changed on 30/9/08. To date Deborah has been on Gabapentin 600mg TID, Tramadol 100mg QID Paracetamol 1G QID. as well as regular S/C Morphine for analgesia and Granisetron 1mg T.I.D., Metoclopramide 10mg TID. as well as PRN Cyclizine or Ondansetron. I have not changed her Fentanyl Patch as	

COMMUNICATION SHEET

Ward .....

Date	Progress / Evaluation	Signature/ Profession
	she has just been given all her oral analgesics plus S/C Morphine. Could this lady please be referred to Pain Team (to whom she is well known) for guidance on her pain control and to clarify anti-emetics. Deborah was also at theatre today. — there is no mention of what was carried out and whether or not she needs to carry on with IV fluids. I have therefore asked the FY1 on Night to prescribe more fluids for overnight.	[illegible]
22^{50}	Again requesting S/C Morphine, 1 hour 15 mins since previous injection, discussed with FY1. offered Temazepam 10mg, same given with good effect, also asking for "something" for sickness. I advised Deborah she had had her anti emetics at 22^{00}.	
4/10/08	01^{40} up to toilet then came to desk asking for analgesia. Morphine 10mg given S/C. Deborah ~~was~~ was asleep within 5 mins. 07^{00} has slept well.	
	Oral analgesia given	[illegible]
4/10/08	WR Mr McMahon	
	Analgesia renewed - regular meds unclear	
	Explained yesterdays results - (N)	
	. Allow home + RWat 80(?) = but MIS	[illegible]
	suction would prefer to remain as IP +	see Mr [illegible]

MIS 110460

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward ..... 6 .....

Name
Address
10638479K F
SULLIVAN
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI 0712726128
D.O.B
Unit No:

Affix data label.

Date	Progress / Evaluation	Signature/ Profession
4/10/08	① Independant with personal hygiene.	
	② Breakfast taken this am.	
	⑥ I.V. fluids discontinued.	
	Morphine given x 1.	
	See note re ward round.	
	Venflon & S/C line removed.	
	③ Observations stable.	
	Home today.	
	For SOP Thursday 9/10/08 (MR SMITH)	
	— To be arranged.	Staples S/N.

Accident and Emergency Department
Stobhill Hospital

NHS
Greater Glasgow and Clyde
Stobhill Hospital
Glasgow G21 3UW
Tel: 0141 201 3076
Fax: 0141 201 3051

14

A&E No. 08037373

10638479K

Surname	SULLIVAN	**Forename**	DEBORAH	**Title:** MS	
Address:	6 MUIRHEAD COURT BAILLIESTON GLASGOW LANARKSHIRE	**Postcode** **Telephone:**	G69 7EP 7716310	**CHI No:**0712726128	
Date of Birth:	07.12.72	**Sex:**	F	**Age:** 35 yrs	

GP Name:	LANGAN JOHN		
Address:	BAILLIESTON HEALTH ... 20 MUIRSIDE ROAD BAILLIESTON GLASGOW	**Postcode** **Telephone:**	G69 7AD 01415318050

Next of Kin	KATHLEEN SULLIVAN		
Relationship:	PARENT		
Address:	187 COMMONHEAD ROAD	**Postcode**	G34 0DS
	GLASGOW	**Telephone:**	7713743

Primary Carer:

STOBHILL GENERAL HOSPITAL
17/11/08 E-11383600
SULLIVAN, Deborah
G207HAE 07/12/1972
AccNo: G207H12583211

Date of Attendance: 17.11.08 14:47
Date of Incident:
Presenting Complaint: SURG PEND - PANCREATITIS

Triage **Tetanus Cover:**

Allergies:

P= BP= / RR= Sat= BM= Temp=

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

Drugs Prescribed

Date	Drug	Dose	Route	Signature	Given By	Time

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E-Pacer PATIENT REPORT

Time	14:30	Date	17/11/2008

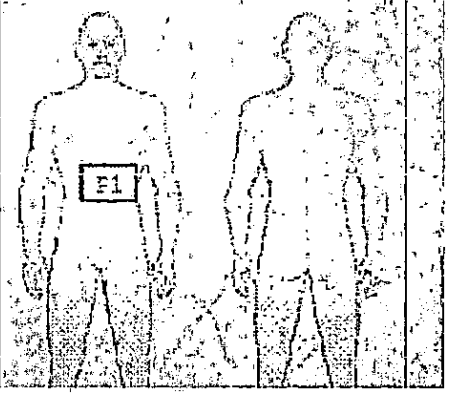
PATIENT AND INCIDENT DETAILS

Incident number	PA002773831:001
Name	DEBROAH SULLIVAN
Age	35
Date of birth	07/12/1972
Gender	Female
Incident location	6 MUIRHEAD COURT BAILLIESTON GLASGOW
Incident post code	G69 7EP
Incident type	EMG
Call received	17/11/2008, 14:04
Call passed	17/11/2008, 14:06
Crew mobile	17/11/2008, 14:07
Crew at scene	17/11/2008, 14:13
Crew left scene	17/11/2008, 14:17
Receiving hospital and department	STOB Stobhill HOSPITAL

PRIMARY SURVEY

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

INJURIES



AMPDS

Initial code	33C06	Transfer/Interfacility, Emergency, Response Requested
Final code	01A01	Abdominal Pain, Patient Alert

GCS

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

VITAL SIGNS

Time (min)	Time (hr)	Pulse bpm	Resp. rpm	BP mm Hg	Cap refill (secs)	Peak flow %	Blood sugar mmol / l	Temp °C	SpO2 %	GCS Total	RTS	Pain score
	14:13	80	18	130 / 80	<2 secs	-	-	-	-	15	7.560	-

EYES AND PUPIL SIZE AND REACTION

	Left	Right
Pupil size	Normal	Normal
Pupil reaction	Normal	Normal

AMPLE

Allergies	None
Medication	SEE GP LETTER
Past history	AS PER GP LETTER
Last eaten	2½ hrs
Events prior	ABDO PAIN

DRUGS, GASES AND PAIN RELIEF

Pain before	Drug / gas given	Time given	Dose given	Route	Batch No	Pain after
	Entonox	14:13	25/60	Inh	-	-

EMERGENCY SERVICES ON SCENE

Paramedic	Technician

PATIENT HANDOVER

On arrival at scene	Standing
Scene removal	Walking
Transportation	Lying
Care delivery at hospital	Trolley
Time of handover	14.45

FINAL OBSERVATION AND COMMENTS

999 CALL (ABDO PAIN) PT C/O PAIN FOR 3/7 >PAIN TODAY SEE GP LETTER, EN ROUTE TO HOSPITAL PAIN EASING WITH DRUG THERAPY

Report ID [illegible] 4/30-8bbd

Device ID [illegible]

Patient's name Deborah Sullivan Age _____ Date of Birth _____

NURSING DOCUMENTATION - ACCIDENT & EMERGENCY DEPARTMENT

Date 17/11/10 Time 14 45 Triage Nurse _____ PC Sun Post abscess R H10 pericentesis

Triage category 1 2 3 4 5

Relatives present: Relatives informed:

INITIAL VITAL SIGNS

at:(Time) 15:20
HR: 91
BP: 120/85
RR: 19
SaO_2: 98
Temp: 37.4
G.C.S:
Signed LT

INITIAL MANAGEMENT

Nurse (ARAPAHOE)

Oxygen started _____ %: Signed _____ ECG: Signed _____

Signed _____

Other _____

Treatment _____

NEUROLOGICAL OBSERVATIONS

RESPONSIVENESS	TIME	hrs								1
	EYES / PEN	spontaneously 4								eye closed by swelling =C
		to speech 3								
		to pain 2								
		none 1								
	BEST VERBAL RESPONSE	orientated 5								Endotracheal tube or Tracheostomy = E Dysphaisa=D
		confused 4								
		inappropriate words 3								
		incomprehensible sounds 2								
		none 1								
	BEST MOTOR RESPONSE	obey commands 6								Record the best arm response
		localises pain 5								
		normal flexion to pain 4								Paralysed =P
		abnormal flexion to pain 3								
		extention to pain 2								
		none 1								
	COMA SCORE 15									
	PUPILS	RIGHT size (mm)								2
		RIGHT Reaction								+=Reacts -=No Recaction C=Eye closed SL=sluggish pupil
		LEFT size (mm)								
		LEFT Reaction								
LIMB MOVEMENT	ARMS	Normal power								3
		Mild weakness								Record right (R) and left (L) seperatly if there is a difference between the two sides
		Severe weakness								
		Extention								
		No response								
	LEGS	Normal power								Fractured limb = #
		Mild weakness								
		Severe weakness								
		Extention								
		No response								
	PUPIL SCALE (mm) 1 2 3 4 5 6 7	BLOOD PRESSURE mm Hg 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90								4 40 39 38 37 Temp C° 36 35 34 33 32 31 30
		PULSE RATE 80 70 60 50 40 30								
		RESPIRATORY RATE								5
		SaO_2								
		NURSE INITIALS								6

BLOOD GLUCOSE	Time	15:50			
BM STIX	BM	4.7			
PEAK FLOW	Time				
	PF				
VISUAL ACUITY	R. eye aided/unaided				
	L. eye aided/unaided				
	pH L. eye	R. eye			

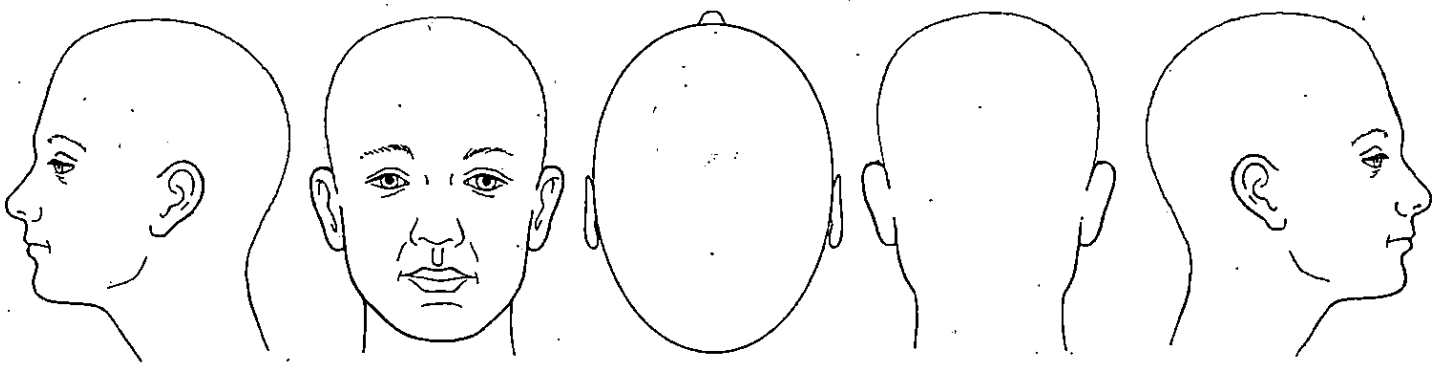
Signed: _____

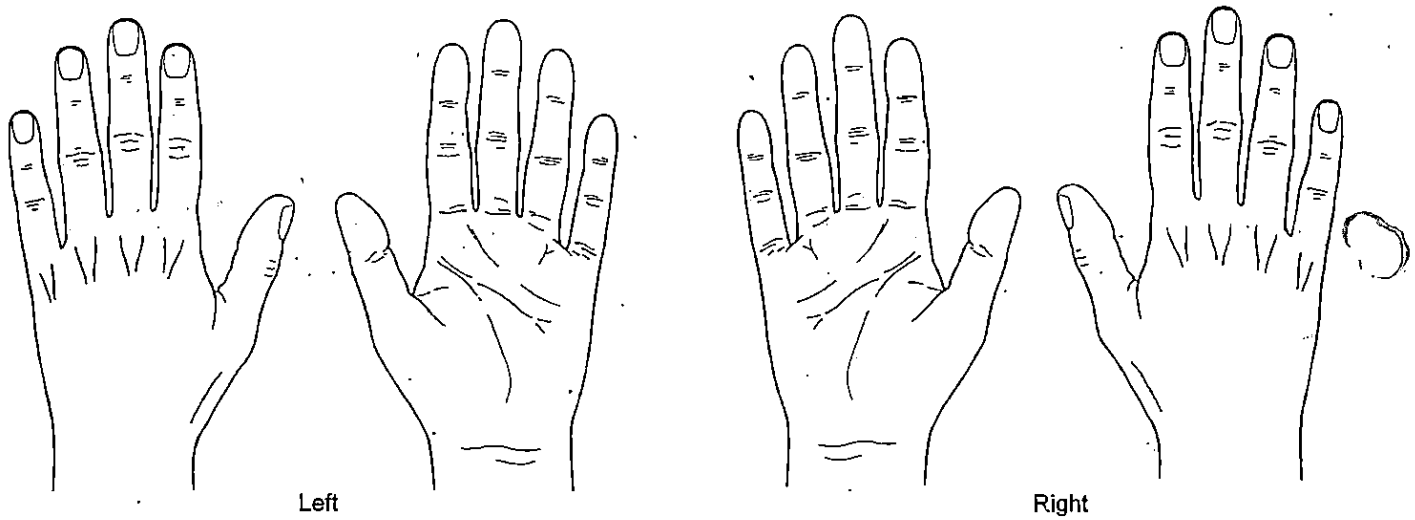
URINALYSIS

Urobilinogen µmol/L	Normal 3	16	33	66	131		
Protein gm/L	Neg	Trace	0.30 +	1 ++	3 +++	>20 ++++	
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
Blood	Neg	Non Haem	Haem Trace	Small +	Mod ++	Large +++	
Specific Gravity	1.000	1.005	1.010	1.015	1.020	1.025	1.030
Ketones mmol/L	Neg	Trace 0.5	Small 1.5	Mod 4	Large 8	Large 16	
Bilirubin	Neg	Small +	Mod ++	Large +++			
Glucose mmol/L	Neg	5.5 Trace	14 +	28 ++	55 +++	111 ++++	
Nitrites	Neg	Positive					
Leucocytes	Neg	Trace	Small +	Mod ++	Large +++		
BHCG	+ ve	- ve					

Signed: _____

Please annotate area of: Tenderness / Bruising / Swelling / Abrasions / Lacerations / Incised wounds



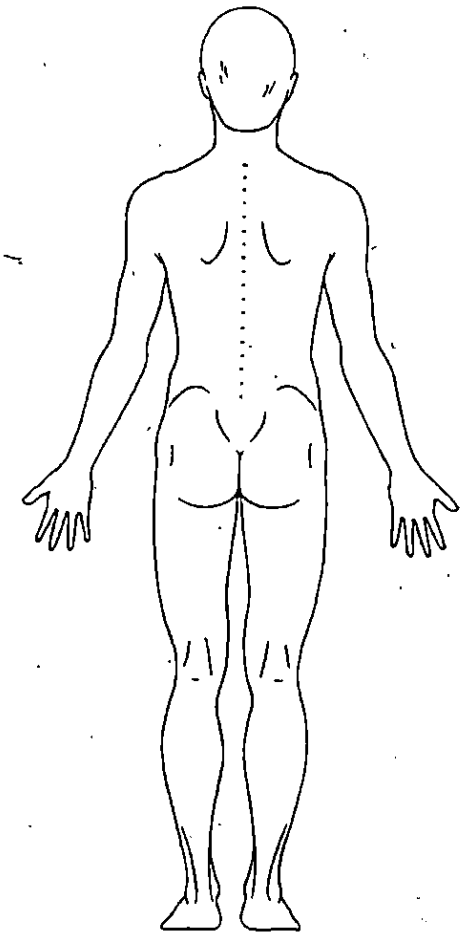


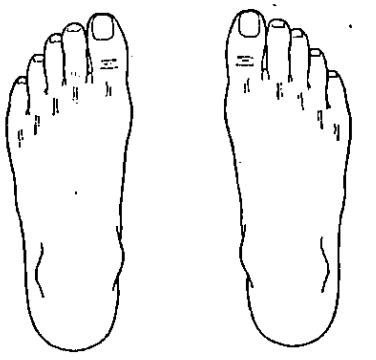
Left

Dorsal Palmar

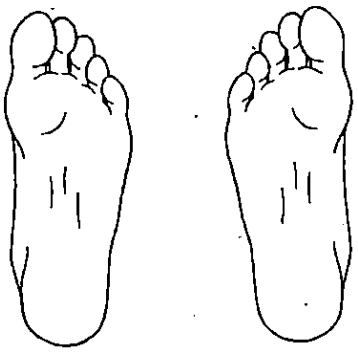
Palmar Dorsal

Right

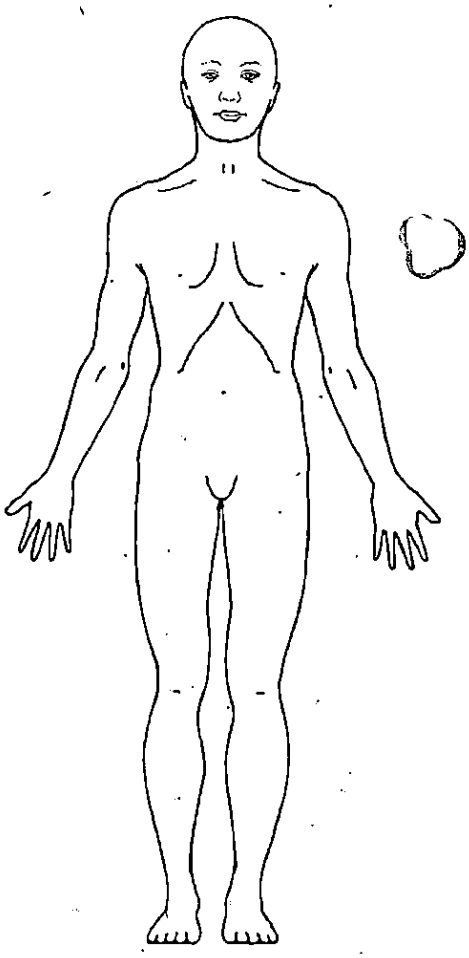




Left Dorsal Right Dorsal



Left Plantar Right Plantar



Signed _____

NURSING NOTES

Signature: [illegible] Time: 15.40

History Severe abdominal pain radiating through to back and left shoulder and nausea. Symptoms began on Friday night and still present.
PMH = chronic pancreatitis

DH See doctors letter / repeat prescription
VOLTAROL (DICLFONEC NA)

Allergies No/Yes

Initial Management
02 Y/N Litres Per Min
ECG Y/N X-ray Y/N

Urinalysis:

βHCG +ve -ve
Cannula Y/N

Bloods	Y/N
U & Es	☐
FBC	☐
GL	☐
Amyl	☐
Coag	☐
Group	☐
D. Dimers	☐

Other:

ocial History
Lives with daughter
Out of work due to health
Smoke 10 a day
doesn't drink

NOK Kathleen Sullivan (mother) 041-771-3743

Not / present
Keys / valuables
Social Services Not / contacted

MEDICAL NOTES - HISTORY and EXAMINATION

Consultant _____ Seen by _____

Grade: SpR SHO SHO3 JHO Clin Assist ENP SG AS *(Please circle)* At (time) _____

KEY TO CLINICAL NOTES
1 - HISTORY OF
2 - ON EXAMINATION
3 - X-RAY FINDINGS
4 - TREATMENT GIVEN
5 - DISPOSAL
6 - NAME OF MEDICAL OFFICER

Date

PC upper abdo pain ↑ seen 7/10
→ started Fri/day sudden 7pm
→ same as pancreatic pain before

HPC → Vomited + worthy ++
→ Gall bladder out in Kgo ago
→ had 5× per year episods, after operation
→ Symptoms gone up, vomiting not as bad as other
→ nurse in early
→ not eaten for last few days
→ a bit constipated → pieces of paper Tilley
→ on potadon for pain.
→ since hydrocortisone had worse spells of pancreatitis
→ no alcohol

PMH
→ Open fundoplication 2005
→ Many co-proxitus, in for 3 months
→ appendicectomy Kgo ago

Date

no DM no epilepsy, no RF, no TB, no asthma

SH → smoke 1g/day
→ no alcohol
→ Galesten
→ works with marina

FH → Mother got DM + Dad DM
→ grandparents had DM

PMH.

~~Pethidine~~
~~Omeprazole~~
~~Gaviscon~~

Senna 7.5mg : 2t on
lactulose 3.5g/5ml 15ml bd
Paracetamol 500mg : 1g qds
Omeprazole 40mg om
Manitol 1.5g bd.

Glen on 11/11/08.

Gabapentin 300mg : 2t tds
Dihydrocodeine Tartrate 30mg 1-2 prn
Flucloxacillin 2g : 2t om
Granisetron 1mg bd
Fentanyl 75 Micrograms/hour → stopped now
Temazepam 10mg on/prn
Cilest (OCP) : 1 om

Confirmed 18/11/08 with GP letter/pt.
CMcMaster MePharms

Allergy Voltarol
→ Stomach upset

Spine

Cardio
No murmurs
No pedals

Resp
no problems
no lung
no asthma

Date

abdo

→ epigastric pain
→ constipated
→ started last few moments
→ no radiation
→ might last ↓ step ½ in past hour
→ no vomiting

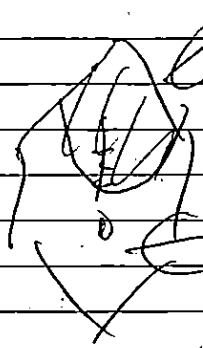
Urine

no burning
no pain

EXAM

A

B



Sleepy, tachypnoeic
guarding RUQ

Sat on room air

C HR 114/40

D GCS 15/15

Plan

bloods ✓
fundoscopy ✓
Morphine ✓
AXR + CXR

Imp

→ acute on chronic pancreatitis
→ ? biliary disease / gallbladder complication

Date

17/11/08 16:45 Surgical F42 Review

- long complex hx well known to Mr Smith
- since Friday severe epigastric pain, radiating to back
- vomiting +++ foodstuffs & bilious
- has been taking fentanyl, DHC & pethidine
- bowels - constipated
- no urinary Sx

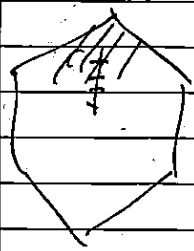
PMH: cholecystectomy '96
nissen fundoplication '05
chronic pancreatitis

DH: dihydrocodeine PRN
gabapentin 800mg TID
fluoxetine 40mg OD
granisetron 1mg BD
fentanyl 75mcg/hr patch every 72hrs
omeprazole 40mg OD
Movicol BD
lactulose 15ml BD

fluoxetine

OE: well, orxias

hr 91 BP 120/85 apyrexial
rr 19 sao 98%



abdo soft
tender epigastrium, guarding +++
no palpable masses/hernias
BS (N)

chest clear
HS I + II + 0

urinalysis: -ve

bloods:
Hb 12.6 Na 134 LFTs (N)
WCC 9.9 K+ 4.3
plat 302 Cl 103 CRP 3.8
urea 2.8
creat 58 amylase 91

AXR: faecal loading nil else

RESULTS PAGE

Please record all results of investigations, time, date and sign. Append all referral letters / SAS report forms, etc to this page.

Date

Inp: recurrent epigastric pain ?cause

Plan: admit 7A
analgesia
antiemetic
?Mr Smith r/v Mané to speed up pre-organised lx.

SMH2
4090

ONCE ONLY PRESCRIPTIONS (INCLUDING TETANUS PROPHYAXIS)

Date given	Drug *(BLOCK CAPITALS)*	Dose	Method of Administration	Time of Administration	Signature	Given by
17/11/18	MORPHINE	5mg	IV	3:40		MATT DORE
17/11/18	CYCLIZINE	50mg	IV	3:40		MATT DORE
17/11/18	MORPHINE	5mg	IV	3:50		MATT DORE

PARENTERAL FLUID PRESCRIPTION SHEET

Date	FLUID	Volume	Time to run	Rate mls/hr	ADDED DRUGS	Quantity	Doctors Signature	Added by	Start time 24hr Clock	Put up by	Checked by	Serial/ Batch no
17/11/18	~~SALINE~~	500ml		40								
17/11/18	HARTMANNS	500ml		40					16:30			08105

N.B. IF USING A SYRINGE DRIVER/INFUSION PUMP PLEASE USE THE "PRESRIPTION AND ADMINISTRATION SHEET FOR MEDICINES GIVEN BY SYRINGE DRIVER/INFUSION PUMP"

REFUSAL TO REMAIN UNDER HOSPITAL CARE

I wish to take my discharge. I appreciate that this is against the advice and wishes of the Consultant or his or her deputy looking after me. I acknowledge that I have been informed of the risks of doing so and I accept full responsibility for my actions and any consequences arising from them.

Name *(print)* _____ Signature _____

I confirm that I have explained to the patient the risks that might arise out of his / her decision to take his / her own discharge.

Date _____ Signature _____
(Medical Practitioner)

DISCHARGE DETAILS (NURSING)

Treatment _____

_____

_____ Signed _____

(Please put initials in box)

Crutches ☐ Return appointment ☐ Advice Card ☐ Medication ☐

Escort to ward ☐ Relatives informed ☐ IRIS ☐ Transport ☐ Time booked _____

Discharged with _____ Admitted / transfered to _____

Time discharged _____ Signed _____

NHS
Greater Glasgow and Clyde

Stobhill Hospital

In Patient Surgery Assessment /Admission Pack

DVT RISK ASSESSMENT

LOW MEDIUM HIGH		
Ted Stockings	Yes ☒	No ☐
Heparin	Yes ☑	No ☐

Date of Assessment ____/____/____

Date of Admission 17 / 11 / 08

Time of Admission 5.15 pm

Date of Operation ____/____/____

Consultant Mr Craig

WARD 7A

10638479K F
SULLIVAN
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Affix data label

THIS SECTION TO BE COMPLETED AT PRE- ADMISSION

Procedure / reason for admission _____

Height: _____ Weight: _____ = BMI : _____ Spo_2 ____ T ____

B.P. : _____ P _____

Are you taking any medication prescribed by your doctor ? YES ☐ NO ☐ 1

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

have you ever had:

	YES	NO	
a serious illness			2
allergy or reaction to medicines, elastoplast etc.			3
State nature of allergy			4
diabetes			5
any chest problems PFR			6
heart problems			7
high blood pressure			8
heart murmur			9
blackouts, convulsions or fits			10
jaundice / hepatitis			11
digestion or heartburn			12
kidney or urinary trouble			13
anaemia or other blood problems			14
excessive bleeding or bruising			15
arthritis			16
muscle disease or progressive weakness			

Do you:-

	YES	NO	
require mobility aid / have limited mobility			17
have any problems with your eyesight			18
have any problems with your hearing			19
smoke			20
have you ever used intravenous drugs			21
If a woman, are you pregnant or taking the 'pill'			22
Do you have any caps, crowns, dentures or loose teeth			23
do you drink alcohol (units per week)			24

THIS SECTION TO BE COMPLETED AT PRE-ADMISSION / ASSESSMENT

HAVE YOU ANY QUESTIONS ABOUT YOUR ADMISSION? YES ☐ NO ☐ 25

Hospital Admissions/Operations (please list and date) 26

Did you have any anaesthetic or surgical complications ? (please list) 27

Date of your last anaesthetic ? _____

Has any member of your family had problems with anaesthetics ? YES ☐ NO ☐ (please tick box) 28
-define problem _____

Is there anything else the surgeon / anaesthetist should know ? _____

_____

ASSESSMENT NURSES SIGNATURE: _____ DATE : / /

WARD NURSE SIGNATURE _____ DATE : / /

INVESTIGATIONS CARRIED OUT (please tick box)

full screen ☐ full blood count ☐ E.C.G ☐ CXR ☐ Group / retain ☐ X - Match ☐

Other ☐ (please state)

Urinalysis _____ Clearview _____

Anaesthetic referral required: _____ YES ☐ NO ☐

Reason: _____

ANAESTHETIC DETAILS REFERRAL DETAILS:-

DR : _____ DATE : / /

ANAESTHETISTS COMMENTS:

NURSES SIGNATURE: _____ DATE : / /

SUITABILITY FOR ADMISSION

SDA ☐ NSDA ☐

THIS SECTION TO BE COMPLETED BY NURSING STAFF ONLY

SURGICAL RECEIVING UNIT WARD 2A

PRESENTING COMPLAINT:

3/7 Hx Severe epigastric pain.
→ back.
Vomiting +++

PRESENTING CONDITION ON ADMISSION:

VITAL SIGNS

BP 128/85 P 56 TEMP 36° O_2 SAT 97%

PAIN SCORE 1-10 3 ANALGESIA GIVEN IN A&E YES ☑ NO ☐

PAST MEDICAL HISTORY: CHOLECYSTECTOMY '96
NISSEN FUNDOPLICATION '05
CHRONIC PANCREATITIS.
— MULTIPLE ADMISSIONS '/c ABDO PAIN - WELL KNOWN TO MR SMITH -

DRUG HISTORY:

DF118
GABAPENTIN
FLUOXETINE
GRANISETRON
FENTANYL 75mg patch (removed on Friday — took Pethidine instead)
LOSEC
MOVICOL
LACTULOSE
Pethidine

ALERGIES:

✱ VOLTEROL ✱ 'UPSETS STOMACH'

MOBILITY / LEVEL OF INDEPENDENCE:

— INDEPENDENT —

DIETARY HABITS / APPETITE:

— NORMALLY GOOD APPETITE — VOMITING - 3/7. ? WT LOSS. 1 STONE

ELIMINATION:

STOOL CULTURE YES ☐ NO ☐

URINALYSIS RESULTS ☐

MISSU _____ YES ☐ NO ☐

PREGNANCY TEST ____ +VE ☐ VE ☐

- Bowels moved Sunday
  - feels constipated

- No probs. w/c micturition

SOCAL HISTORY / CIRCUMSTANCES

LIVES w/c DAUGHTER 10 years old.

SMOKER 10 cpd. YES ☑ NO ☐

ALCOHOL _____ YES ☐ NO ☑

AMOUNT: _____

MENSTRUAL CYCLE: - 2 WEEKS AGO

PREGNANCY / CONTRCEPTIVE: = COCEST PILL

D.V.T. PROPHYLAXIS:

FRAGMIN YES ☑ NO ☐

TEDS YES ☑ NO ☐

Signature: A Rebik. Date: 17/11/08 Time: 5.20 p

NAMED NURSE: _____

NAME: (PRINTED) _____

WARD PRE - OPERATIVE PREPARATION

DATE OF OPERATION ____/ ____/ ____ WARD _____

Waterlow Score: _____

Name
Address

D.O. B
Unit No.

Affix data label

BASELINE OBSERVATIONS

BP _____ P _____ SO_2 _____

	YES
Consent signed	
Pre-medication given	
Fasted _____ Time last ate _____ Time last drank	
Identity band	
Case Notes ☐ X-rays ☐ Drug Kardex ☐ Obs. Chart ☐	
Operation site confirmed	
Caps / Crowns / loose teeth	
Prosthesis removed	
ntures removed / not removed	
Underwear removed	
Paper pants on patient	
Make up, nail varnish removed	
Jewellery taped / removed	
Inhalers / GTN Spray	
Allergies	
Voided urine	
Subcut heparin	
Ted stockings	
Pre-op visit	

Other relevant information :

Ward Signature: _____ Reception Signature: _____

THEATRE

'ERATION PERFORMED _____

	YES	NO
DIATHERMY BIPOLAR / MONOPOLAR		
HEEL RESTS		
FLOWTRON BOOTS		
SHEEPSKIN HEEL PADS / MATS		
HEATED BED		
ARM BOARDS		
PATIENT WARMING BLANKET		

PATIENT POSITION

LATERAL RIGHT		TRENDELENBURG	
LATERAL LEFT		REVERSE	
SUPINE		LITHOTOMY	
PRONE		LLOYD DAVIS	

SPECIMENS : PATH BACT OTHER

DRAINS

CATHETER

COUNTS CORRECT

SWABS - FIRST	
- FINAL	
INSTRUMENTS	
SHARPS - NEEDLES	
- BLADES	
THROAT PACK OUT	
PACK IN SITU	

INSTRUCTIONS FOR REMOVAL:

TOURNIQUET TIME ON OFF

SPECIAL COMMENTS _____

Name of Scrub Nurse : _____ Signature of Circulating Nurse : _____

THIS SECTION MAY BE COMPLETED BY ANY MEMBER OF THE MULTIDISCIPLINARY TEAM

Named Nurse : ELAINE Fasted from : ✓

Patients Telephone No. 0141 771 6310 Spiritual needs CATHOLIC

Patients Occupation: ✓ Next of kin: MUM - KATHLEEN SULLIVAN
(Name & Relationship to patient)

Next of kin Tel. No. 771 3763
(Name & Relationship to patient)

DISCHARGE PLAN

Expected Discharge Date : / /

Actual Discharge Date:. / /

	YES	NO
Is someone available to accompany the patient home ?	✓	
Is a responsible adult available to stay with the patient for 24 hrs. post-operatively ?		✓
Does the patient have easy access to their home	✓	
Is the patient a carer? DAUGHTER - 10 YEARS OLD.	✓	
GP letter / Prescription :		
Outpatient appointment :		
Relatives informed :		

SERVICES REQUIRED

	YES	NO
District Nurse:		
Social Worker:		
Other :		
Transport Requested: (Date) / /		

Discharge summary / comments:

Pre-op / On Admission

Signature :

Ward: 7B Date: / /

Signature : [signature] Date: 17 / 11 / 08

THIS SECTION MAY BE COMPLETED BY ANY MEMBER OF THE MULTIDISCIPLINARY TEAM

COMMUNICATION SHEET/ PROGRESS NOTES

Ward ~~7A~~

Date	Progress / Evaluation	Signature/ Profession
17/11/08	5.30pm E/A via A+E 1/c 3/7 Hx epigastric pain + vomiting.	
	– known to Mr Smith – multiple admissions 1/c abdo. pain	
	– Attends pain clinic – next appt. 3rd December.	
	– Bloods (N) Obs stable. Apyrexial.	
	– Pain score 3 – Given IV morphine in A+E.	
	– Patient removed fentanyl patch on Friday and took pethidine tablets instead.	
	– Amit: RSOU/ MSSU/ HCQ	
	– IV fluids maintain. Allow fluids + diet – FAST for bx for RIV.	
		✗ Rattle
18/11/08	Fluid allowed Jejunal overnight	
	for review AM.	
	Requesting Pethidine Tablets none	
	available in the Hospital.	
	Other meds as prescribed	Cyd.

MIS 110459

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward ....7a....

Name DEBORAH SULLIVAN
Address

D.O. B
Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
18/11	WR	
8:35	Still complaining epigastric pain	
	- Obs stable.	
	(P). Pain team r/v	KCarroll FY2 #4076.
18/11	WR Miss Craig for f+d.	
	pain team r/v.	SHO RG4090
18/11/08	Pharmacy	
9.30am	On OCP; consider for ↑ dexane to 40mg od - ✱ cons/senior review✱	
4	Pain review awaited: ↑ dihydrocodeine to 60mg qds while awaited ? prn PO morphine	
5/1	Clo n+v; on regular Kytril @ home (order awaited). Add prn metoclopramide/cyclizine?	
	CMT Master MRPharms	

COMMUNICATION SHEET

Ward .....7a.....

Date	Progress / Evaluation	Signature/ Profession
18/11/8.	Pain team nurse informed. Will review her chronic pain later today. AL TYI 5800	
18/11/8	Pain Service, Reviewed today Deborah Sullivan is well known to the pain service I have spoken to Dr Langan GP @ Ballieston Health Centre re Pethidine Tablets. I would suggest commencing Fentanyl 75mcg with 30mg of DF118 for breakthrough Pt has a appt with Dr Rao Chronic Pain Consultant 3/12/08.	S. Caldwell Pain Sister
18/11/8.	D/W Pain Team Nurse Pt has hx of poor attendance for her pain clinic and non-compliant. She has been receiving strong opoid as repeat prescription and been missing/cancelling her pain OP appointment (for 8 yrs). Pain team worry about pethedin use	
	(P) D/W Senior. for fentanyl 75mg and DF118 for breakthrough. AL TYI 5800	

MIS 110460

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sullivan	Deborah	

12/11/02	Sleeping most of Day. Eating and drinking ? Home later.	EOE

F3

00262

E

NHS Greater Glasgow and Clyde

STOBHILL HOSPITAL

DAY SURGERY ENDOSCOPY

DATE 30/4/09

CONSULTANT Ms Cannings

Unit No. _____

Name

Address

DOB

10638479K F
SULLIVAN
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

A. ASSESSMENT

1. CURRENT MEDICATION Losec, Gramisteron, Tramadol fentanyl patch, fluoxetin
2. MEDICAL PROBLEMS Poor fundiplcation, Depression Chronic pancreatitis
3. PAST HISTORY OF HEPATITIS OR JAUNDICE No ☑ Yes ☐
4. DISCHARGE ARRANGEMENTS Escort No ☐ Yes ☑ Who Sister
   Overnight No ☐ Yes ☑ Who A I A.

PATIENTS DECLARATION

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

Patients signature D E Sullivan

B. PREPARATION

1. LAST ATE OR DRANK	Time 7am	✓
2. IDENTITY BAND		✓
3. CASENOTES/ADMISSION PACK		✓
4. DENTURE/CROWNS/CAPS/BRIDGE	none	✓
5. BOWEL PREPARATION (If required)		—
6. UNDERWEAR JEWELLERY REMOVED		✓
7. ALLERGIES	NKO known	—
8. BASELINE OBSERVATIONS	Pulse 87 / Blood Pressure 101/74	

PROBLEMS/NEEDS

COMMENTS

Signature Noonan

Deborah Sullivan

ONCE ONLY PRESCRIPTIONS

Date	Time	Drug	Dose	Route	Signature	Given by	Time given
30/4	1420	Midazolam	10 mgs	IV			

ENDOSCOPY

PROCEDURE Endoscopy

SEDATION No ☐ Yes ☑

THROAT SPRAY No ☑ Yes ☐ Time ____

PATIENT POSITION Left Lateral ☑

DIATHERMY Yes ☐ No ☑

SPECIMENS

PATH ☑ BACT ☐ CLO ☐

x1

NAMED NURSES

Barlow

Bradley

COMMENTS Patient drowsy on stage. discomfort.

RECOVERY

POST ENDOSCOPY OBSERVATIONS

TIME	1430	1445	1500	1515		1545											
PULSE	90	87	80	84		88											
BLOOD PRESSURE	89/64	101/68	99/67	104/71	/	103/76	/	/	/	/	/	/	/	/	/	/	/
SA O2	93	91%	91%	92													
RESPIRATORY RATE	R	R	R	R													
OXYGEN	air	/	/	/													
SEDATION SCORE	A	~~A~~ 0	~~A~~ 0	0													
VENFLON (Hand)		in situ	in situ	in situ													
NURSES INITIALS	SH	C	C	SH		SH											

SEDATION SCORE

A = ASLEEP
0 = ALERT
1 = RESPONDS TO VERBAL COMMAND
2 = RESPONDS TO PAINFUL STIMULI
3 = UNRESPONSIVE

MULTIDISCIPLINARY NOTES

DATE / TIME

DISCHARGE

		YES	NO
1.	STABLE VITAL SIGNS	✓	
2.	CANNULAE REMOVED	✓	
3.	ABLE TO DRESS, SIT AND WALK UNAIDED	✓	
4.	TOLERATING FOOD AND FLUIDS	✓	
5.	INSTRUCTIONS GIVEN SEDATION	✓	
6.	GP LETTER GIVEN BEFORE DISCHARGE	✓	
7.	FOLLOW UP APPOINTMENT	✓	

DISCHARGE AT 1630 TO Sister CARE

NURSE'S SIGNATURE S McDonald

CONSENT FORM

10638479K
SULLIVAN
DEBORAH F
07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Special requirements (e.g. other language / Communication method) .....

Proposed operation, investigation or other treatment.
(BLOCK CAPITALS)

..... CARDIOSCOPY .....

.....

I have explained the procedure named on this form to the patient in the terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any sign if cant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedure above).

An information leaflet/tape has been provided .....

..... (Title)

Signature of Practitioner .....

Name / Designation (Print) .....

Date 30 / 04 / 03

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*
(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- that the examination for the purposes of teaching will not be undertaken without my consent
- to the emergency administration of blood or blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature ..... Date ...../...../.....

Additionally you have to agree or disagree the following:-	Agree	Disagree
that information and/or images kept in records may be used anonymously or education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT AGREEMENT FOR TREATMENT

Signature: ..... Date ...../...../.....

Name (Print): .....

CONFIRMATION OF CONSENT
(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: ..... Print name.....

Date 30/07/04

Acute Services Division

Pre Op Assessment Unit

Department of Anaesthesia

Specialty: Anaesthesia

NHS Greater Glasgow and Clyde

Hospital Name	Stobhill Hospital

Patient Details		GP Details	
Name	SULLIVAN, DEBORAH	Name	LANGAN, JOHN
Address	6 Muirhead Court Baillieston GLASGOW G69 7EP	Address	BAILLIESTON HEALTH CENTRE 20 MUIRSIDE ROAD BAILLIESTON GLASGOW G69 7AD
Correspondance Address	,	Telephone	
Correspondance Postcode		CRN Number	10638479K
Telephone	7716310	Consent	Yes
CHI Number	0712726128	Sensitivity	Sensitive
Sex	Female	Consultant Name	MR SMITH
Date of Birth	07/12/1972	Requires Transport	No

Next of Kin / Person to Notify	Next of Kin	Person to Notify
Name	KATHLEEN SULLIVAN	
Address		
Landline	0141-771-3743	
Mobile		
Relationship	MOTHER	

Assessment Details					
Assessor	CATHERINE OCONNOR	Grade	5	Date	02/10/2009
Ward	6				

Surgery / Procedure Attending For
LAPAROTOMY, TIGHTENING OF PREVIOUS NISSANS REPAIR.

Anaesthetic History	
1. Previous GA	
Have you had a General Anaesthetic before?	Yes
Were there any problems?	No

2. Previous LA	
Have you had a Local Anaesthetic before?	Yes
Were there any problems?	No

3. Dentition Risk	
Do you have any loose teeth, caps or dentures?	Yes
Details	BOTTOM BACK LEFT MOLAR CHIPPED DENTIST AWARE AND DEALING

4. Reduced neck movement	
Do you have any neck or jaw stiffness?	No

5. Other Risk	
Has anybody in your family had a serious reaction to an anaesthetic?	No

6. Heartburn	
Do you suffer from heartburn or indigestion?	Yes
Is it relieved by medication?	Yes
Do you have a hiatus henia?	Yes
Do you have acid reflux?	Yes
How often does it occur?	daily

7. Sickle Cell Disease (risk factor)	
Do you have sickle cell disease?	No
Are there risk factors for sickle cell disease?	No

Surgical History	
8. Affects suitability for DSU or SDA	
Have you ever had surgery?	Yes
Details of relevant surgical history	NISSAN PROCEDURE CHOLYCYSTECTOMY
Will this affect the suitability for DSU?	No
Have you ever had a serious surgical or anaesthetic complication?	No

Cardiovascular							
9. Hypertension							
Do you have high blood pressure?	No						

10. Arrhythmias							
Symptoms:	Irregular heartbeat	No	Palpitations	Yes	Atrial Fibrillation	No	
How often does it occur?	less often than mont						
Are they assosciated with exercise?	No						
Does it cause you to faint?	No						

11. Angina	
Do you suffer from Angina?	No

12. Heart Attack	
Have you had a heart attack?	No

13. Heart Murmur	
Do you have a heart murmur?	No

14. Blackouts	
Do you suffer from blackouts?	No

15. Heart Failure	
Have you been diagnosed with heart failure?	

Respiratory	
16. Asthma / Bronchitis / COPD / Emphysema	
Do you have asthma, bronchitis, COPD, or emphysema?	No

17. URTI (Upper Respiratory Tract Infection)

Have you recently had a cold?	No

Neurological	
18. Stroke	
Have you had a stroke or TIA?	No

19. Epilepsy	
Do you have epilepsy?	No

20. Neurological Disease	
Do you have any neurological or muscular disease?	No

21. Physical Disability	
Do you have a physical disability?	No

Haemotological	
22. Bleeding Disorder	
Do you suffer from prolonged bleeding or excessive bruising?	

23. Previous DVT	
Have you had a DVT?	No

24. Anaemia	
Do you suffer from anaemia?	No

Miscellaneous	
25. Kidney Disease	
Do you have renal failure?	No

26. Liver Disease	
Do you have liver disease or suffer from jaundice?	No

27. Diabetes	
Do you have diabetes?	No

28. Arthritis	
Do you have arthritis?	No

29. Other	
Do you have any serious physical / psychiatric illness or learning difficult not already mentioned?	

Exercise Tolerance	
30. What best describes your level of fitness?	Climbs stairs with stopping

Social History		
31 How many units of alcohol each week?	0.00	units/week

32. Smoker	
Do you smoke?	No
Are you an ex-smoker?	Yes
Ex-smoker details	20 CPD STOPPED 3 WEEKS AGO

33. Drug Abuse	
Do you currently or have you ever used intravenous or recreational drugs?	No

34. Pregnant	
LMP	
Are you pregnant?	No
Could you be pregnant?	No
Details	

35. Language	
Can the patient speak English?	Yes

Drug History
36. Drugs
List all drugs (including herbal remedies and complimentary medicines)
OMEPRAZOLE 20mg GRANISETRON 1mg GABAPENTIN 300mg LACTULOSE, MOVICOL, PARACETAMOL, TEMAZEPAM 10mg, IMIPAMINE 25mg FENTANYL PATCH DIAZEPAM 5mg TRAMADOL 50mg

Does the patient take any of the following?	
Anticoagulants	No
Clopidogrel	No
Aspirin	No

OCP	No
Digoxin	No
Amiodarone	No
Lithium	No
Diuretics	No
MAOIs	No

37. Herbal Remedies	
Are you taking any herbal remedies or complimentary medicine?	No

38. Steroids	
Have you taken regular oral steroids in the last year?	No

39. Allergies	
Do you have any allergies?	No

Implants	
40. Pacemaker	
Do you have a pacemaker?	No

41. Prosthesis	
Do you have any implants?	No

42. Coronary stents	
Have you had coronary artery stents inserted?	No

Examination			
43. Age (years)	36		
Weight (kg)	75		
Height (m)	1.80	BMI	23

44. Risk of sleep apnoea	
Do you suffer from daytime sleepiness, restless sleep or witnessed breath holding during sleep?	No
How likely are you to fall asleep or doze in the following situations?	
a) Sitting and reading	
b) Watching TV	
c) Sitting inactive in a public place	

d) As a passenger in a car for an hour without a break	
e) Lying down to rest in the afternoon when circumstances permit	
f) Sitting and talking to someon	
g) Sitting quietly after lunch without alcohol	
h) In a car while stopped for a few minutes in traffic	
Status based on sleep apnoea score	Score

45. Blood Pressure			
Systolic/Diastolic BP	102	/	80

46. Pulse		
Pulse Rate	100	/ min
Rhythm	Regular	

47. Oxygen Saturation	98	%

48. Urine Analysis	
Result	
Details	

49. VTE Risk			
Is patient at risk of VTE?	Yes	Do they require prophylaxis?	Yes

Day Surgery Criteria	
50. Day Surgery Criteria	
Is the procedure suitable for day surgery?	No

Investigations		
Investigation	Required	Requested
FBC	Yes	Yes
U&Es	Yes	Yes
ECG	Yes	Yes
ECHO	No	No
TFT	No	No

Hb Electrophoresis	No	No
Sickle Dex Test	No	No
PEFR	No	No
PFT	No	No
Temperature	No	No
Coag	No	No
Thrombophilia screen	No	No
Pregnancy Test	No	No
Digoxin level	No	No
Lithium level	No	No
Glucose	No	No
HbA1c	No	No
PFT	No	No
LFT	Yes	Yes
C-Spine X Ray	No	No
Group & Save	Yes	Yes
Cross Matching	No	No
CRP	No	No
Amylase	No	No
MRSA Screening	No	No
Chest X-ray	No	No
Calcium	No	No

Pre-op Assessment Summary	
Assessor	CATHERINE OCONNOR
Grade	5
Summary	

36 YEAR OLD LADY FOR ?LAPAROTOMY AND TIGHTENING OF PREVIOUS LAP NISSEN UNDER MR SMITH IN WARD 6 06/1/09

PMH

LONG STANDING PROBLEM WITH REFLUX WHICH SETTLED INITIALLY WITH LAP NISSENS BUT HAS RETCHING AND VOMITING CONSTAN RECENTLEY.

ABDOMINAL PAIN ATTENDS PAIN CLINIC.

AGROPHOBIA ANXIETY AND PAPATATIONS. ECG TODAY.

PREVIOUS GA NO KPROBLEMS

SUITABLE FOR SDA AND GA.

Referrals and Type of admission - Recommended Admission pathway		
Referral by Nurse to:	Anaesthetist	No
	Surgeon	No
	Haematologist	No
	Cardiologist	No
	GP	No
	Cardiac Technician Pace Reset	No
	Cardiac Technician Pace Check	No
Nurse to arrange the attendance of:	Carer	No
	Interpreter	No
Nurse to:	Inform ward staff regarding the risk of alcohol withdrawl	No
Referral by Anaesthetist to:	Surgeon	No
	Haematologist	No
	Cardiologist	No
	Cardiac Technician	No
	GP	No
Type of admission to be decided by:		
Type of Admission:		
Admission Deferred:	No	

Advise to take usual anti-reflux medication	No
Dispensed Ranitidine as per PGD directive	No
Refer to smoking cessation clinic	No
Advise not to take "intravenous or recreational drug(s)" during the 24 hours before surgery (related to 33. Drug Abuse).	No
Anticoagulant advice	No
Clopidogrel advice	No
Aspirin advice	No
OCP advice	No
Provide Herbal Medicine Advice	No
Arrange for dialysis the day before surgery	No
Ensure facilities for dispensing methadone are available, if the patient is taking methadone.	No
Print PEER Advice Sheet	No
Print ECG Advice Sheet	No

Anaesthetist Assessment	
Anaesthetist	

Grade	
Summary	

NHS Greater Glasgow & Clyde

NHS Greater Glasgow and Clyde

COMMUNICATION SHEET

Ward .....

Nar
Adc
10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

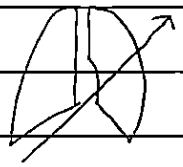
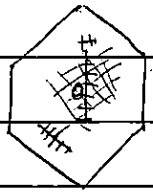
D.C.
Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
6/10/9.	FYI CLERK-IN.	
	(36) ♀ A/A for diagnostic laparoscopy +/- open fundoplication.	
	PMH.	
	laparotomy + fundoplication	
	cholecystectomy	
	tonsillectomy.	
	appendicectomy.	
	chronic pancreatitis.	
	DH.	
	Allergic to Amoxicillin + Voltarol ✱ rash.	
	As per Kardex	

COMMUNICATION SHEET

Ward .....

Date	Progress / Evaluation	Signature/ Profession
	Social.	
	lives with daughter	
	ex smoker	
	tee-total.	
	Systemic Enq.	
	Resp - nil.	
	CVS - nil.	
	GU - nil	
	Abdo - diarrhoea / constipation, dyspepsia.	
	O/E	
	CVS HR 78 Reg Resp. 	
	HS I + II + 0.	
	good AIE	
	vesicular BS.	
	Abdo.  Abdo soft	
	mild periumbilical tenderness	
	BS ✓.	
	(P) Theatre today.	
	Kardex.	Fiona Burns FY1 4158.

COMMUNICATION SHEET

Ward .....

Name
Address

D.O. B
Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
6-10-09	Theatre A-Dr Bill MacRae S-Mr J Smith / Dr A Pittall	
	OPEN POSTERIOR CERVICAL REPAIR & ANTERIOR FUSION (GA)	
	upper midline scar	
	dissection of muscle + previous scarring	
	bleeding from bone capsule settled c 2x surgicel + diathermy.	
	(R)+(L) cervical isolated & sutured behind oesophagus to upper vertebrae c 2x nonabs. sutures-	
	anterior way: stomach wrapped anterior to & sutured to (R) cervical c 2x nonabsorbable sutures.	
	bleeding vessels in muscle clipped divided + ligated.	
	haemostasis.	
	wound closed c 1x looped vicryl to dermal needs.	
	clips to staples.	
		1613.

COMMUNICATION SHEET (CONT.)

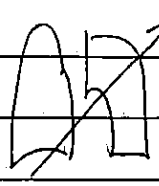
Ward .....

Date	Progress / Evaluation	Signature/ Profession
6/10/9	Pharmacy	
3.10pm	Drug history from pr / PODS;	
*	Diazepam 5mg bd → IV 2.5mg bd but monitor for ADRs	
	Gabapentin 600mg tds	
	Paracetamol 1g qds → IV if needed	
*	Tramadol 50-100mg qds → IV if needed / if to continue with epidural.	
	Imipramine 75mg bd.	
*	Granisetron 1mg bd → IV ondansetron 4mg bd if needed	
	fentanyl 75 microg patch, changed every 72 hrs, changed today.	
	Temazepam 10mg on	
	Movicol up to qds as needed.	
	Lactulose bd	
	* alternative IV routes where possible if PO not available.	
	Consider ↑ to clexane 40mg when floc/coag available.	
	CM°Master (4653)	
6/10/09	*NURSING*	
1800	Admitted to HDU at 1410 ofa recovery - Following: open revision hindoplication. Is on 4 Litres O2 via Face mask - SpO2 - 97-100%, BP at 1800 - 124/92 - temp 37°C. IV fluids in situ 40. 10 units UOD suite theatre - 225-500mls. Epidural in situ - at 10mls/hr, pain score 8/10 at 1700 - Anaesthetist asked to review - given 5mls 0.25%	(RN)

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
SULLIVAN	DEBORAH	

	Marcain and Oxycodone - pain score now 0/10. Post-op bloods taken by JHO. Tegaderm to wound notes. Fluids as charted. Fentanyl patch in situ. Jane Smith (RN)
7/10/09	EYI Asked to see patient re SaO_2 94% on 35% O_2 (Venturi). 36 ♀ open posterior crural repair + anterior fixation today - states has been feeling SOB since returning from theatre. chest tightness when breathes in - anterior upper part of chest. no radiation to neck/arm. no nausea/vomiting - c/o cough. non productive. no haemoptysis. - previous PNA x 2 - last PNA 6/12 ago + pleurisy - ex smoker - stopped 5/52 ago. smoked ~ 15 years ~ 10/day. - no known lung disease O/E - HR ~120. RR ~20  chest clear. no wheeze/creps good air entry bilaterally. Sats 94% on 35%.

F3
00262

(P) Monitor Sats.
Keep on 35%.
ABG given ↓ sats + past hx smoking. Flanagan FY1 (44083)

FY2 review

7/10/04

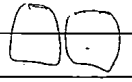
14:8

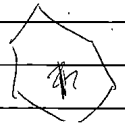
(86) Open Fundoplication 6/10/04
+ Ex Smoker

SaO_2 ↓ 95% – started 28% O_2
SaO_2 95% ↑ O_2 35%

Patient indistressed – SOB since theatre ↓ at present
pleuritic chest tightness no radiating
°palpitations °chest pain
Abdominal pain – cannot feel around wound
epidural in situ.

O/E sitting up
BP 102/70 Pulse 130bpm – has been all day SaO_2 96% on 35%

Chest  HS I + II rr
↓ RE bases nil added. °oedema.

Abdo 

Plan/ Sit patient up
ABGs 35% H+ 4.1

PTO

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sullivan	Deborah	

7/10/09 ABGs on 35% Ht 41
PCO_2 6-5 ↑
PO_2 11.1
HCO_3 30

ECG – sinus tachy nil acute
Physio to review asm
Bloods past – Hb ~~Hct~~ 10.6 WCC 11.0
Plat 258
Na 136 Kt 4.0 Urea 3.4 Creat 65
Mag 0.67 ESR 8.9
Magnesium replacement.

Syringe R42 4 only.

7/10/09. Nursing @ 0520.

SHO asked to review regarding ↓ sats.
ABG's obtained. on 35%. Ht 41 PCo2 6.5.
PO2 11.1 HCO3 30. advised to ↓ FIo2 to 28%.
Sats remain 92-94% on 28% via respiflow.
Coughing & expectorating dirty green sputum.
sample obtained for C&S.

③ Cardiovascularly BP 100-122/65-83.
HR remains tachycardic ↑140 at times
remains in sinus. borderline pyrexia
37.2 - 37.7 paracetamol 1g IV as prescribed.

④ IV fluids continue 125mls/hr. urine

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7/10/09. Nursing Cont'd.

④ output variable 30-275mls/hr. Mg++ protocol commenced as Mg++ 0.67mmols on post op bloods. 8mmol loading dose + 20mmol thereafter.

⑤ Pain problematic overnight. Deborah has chronic pain issues, pain scoring 0-8, Epidural insitu. infusing 10mls/hr ↑ 12mls/hr @ 2030 hrs. 3ml top up aswell at this time as pain score 8. Dermatone levels T8(L) T7(R) Pain score ↓ 5 Dermatone levels T7 bilaterally. Pain Score ↑ 7 @ 0145. Dermatone levels T10 bilaterally - 3ml top up given with effect. Pain score ↑ 8 @ 0420 Dermatone Levels T5(L) T7(R). further 3ml top up. appears settled at time of writing. IV paracetamol 1g also given as prescribed. 2 x 100mg IV tramadol also as prescribed. Unable to take usual oral pain relief as nil by mouth. Fentanyl patch insitu.

⑥ Wound dressing left intact.

⑦ FIo2 remains 28% via respiflow, air entry audible although quiet to bases. Sats 92% - 94%. Encouraged to cough & expectorate.

⑧ Nil nausea.

⑨ Nil PR.

⑩ Slept for short periods overnight, changing position in bed with little assistance. pressure areas intact. Ted stockings insitu.

D Ross RGN

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
SULLIVAN	Deborah	

07/10/09

09.00 Pain Review

Abdominal review, ? Ileus. Abdo Examination, bowel sounds slightly low. CT(KUB) → Bat. Clinical update & discussed. Asked RGN/Nursing staff if ok to take Gabapentin & Edluar. ÷ No contraindication to taking the Gabapentin & would encourage this to assist with both acute & chronic elements of pain. To check with surgeon to ensure that this is ok surgically.

D. McCready
CMS Anaes

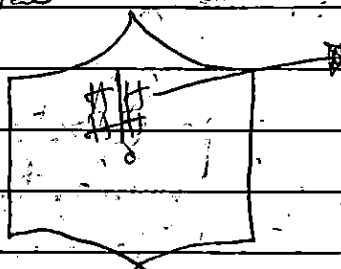
07/10/09 WR Riddell

Hx revisited

BP varying 100-122/65-83. Some tachycardia 140

Dropped SaO_2 overnight. now 92-94% on 28% O_2

Appraisal



Bowels otherwise soft non-tender

Plan: Continue in HDU today, close bloods.

No food and fluids

E. Burnie
R4/1253

Physio 10.45am

s/ Feeling better now up to sit in chair. Remembers post-op physio regime from previous admission

o/ Up to sit. SaO_2 93% on 28% O_2 via Ace-mask. HR 122. BP 26/min. Apyrexial.

- Ausc: (R) ✓ ✓ ✓ (L) ↓ ↓ ↓ Good A/E except sl. quiet to (L) middle zone.
- Cough: lost by pain.

R/ - Insp. holds. - Supported huffs/coughs. // c/e expectorated x 1 small, purulent sec^n. SaO_2 ↑ 98% post Rx.

Plan / - Review p.m.

J. Bridgwater (Senior Physio)

Physio 4pm

s/ Feeling very sore. ~~air. O_2 mask removed.~~

o/ In bed. SaO_2 95% on ~~3l via nasal~~ air. cannulae. HR 117. BP 103 Apyrexial. Ausc: becoming dull ~~73~~ to bases.

R/ - Insp. holds. - Supported huffs/coughs. // c/e expectorated x 1 small purulent sec^n. SaO_2 93-96% during Rx.

Plan / - Review a.m.

PB (Senior P.T)

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sullivan	Debbie	

7/10/09	3) Cardiovascularly Stable HR 106 - 133 Sinus Rhythm Temperature temp 37.0 - 37.7c
	4) IV fluids @ 6° Urine Volumes good 60 - 350 mls/hr Can have oral fluids & Soups and pudds ordered
	5) Epidural in situ running @ 8mls/hr Pain posterior today Has required Top ups x 2 by anaesthetist with good effect Demerol book 7+ bilaterally @ 18° Catheter site satisfactory No motor block
	6) Ward satisfactory - Tegaderm intact
	7) RR 31/5 Sp02 94 - 98% Air entry audible b apices ⓛ base ↓ Coughing and expectorating mucopurulent secretions Sen by Physio
	8) N/V nausea / vomiting
	9) Nil PR fluctus Prone to constipation Normally takes movicol - Not prescribed as yet See on ward round a.m.
	10) Pressure areas intact Independent with mobility
2030	Pain score 8 :: 5ml bolus given, ↑ 9 :: anaesthetist contacted, awaiting review.
0230	Pain remains problematic further nurse top up given, block patchy, SB on call anaesthetist IV Midazolam & Bupivicaine top up given

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00262

8/10/9	Referred ICU Anaes Sr	
0300	MRP ✕ ++ Pain Pain score 10/10	
	BG – had epid insertion – 2/7 ago	
	epidural insertion – been working well.	
	Pain mainly over wound site – deep / tightness	
	Same pain as before – Paracetamol 1g qds required	
	intermittently.	
	GCS 15	
	Blocks – T10 Bilaterally so ↓	
	Given – 5ml 0.25% bupivicaine epidurally	
	0.5mg midazolam IV.	
	10 min later – Pain much more comfortable	
	Pain score 1/10. – able to sleep.	
	✱Nursing✱	
0400 (3)	Monitoring sinus tachy, normotensive, apyrexial.	
(4)	IV crystalloids infusing 6hrly, vols good, taking oral fluids.	
(5)	Pain problematic most of night (see previous entry), epidural bag replenished infusing 12mls/hr, dermatone levels variable T5, T6, patchy ✕ missed segment (L) side x 2 nurse top ups given ✕ little effect IV Tramadol ✕ Paracetamol, oral Diazepam ✕ Gabapentin ✕ little effect. Tearful ✕ pain score ↑ 9 ∴ anaethetist contacted Bupivicaine top-up given ✕ 0.5mgs IV Midazolam, now more settled.	
(6)	Wound intact.	
(7)	Desaturating on 4lits ✕ no reserve ∴ O_2 ↑	

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sullivan	Deborah	1063847 9K

cont

8·10·09	35% via respiflo, sats 97%, air entry audible but midzones dull, coughing but not expectorating	
(8)	No c/o nausea, regular oral Kytril as R/	
(9)	BNO, no flatus O/N.	
(10)	Pressure areas intact, moving around bed fairly well	
	Mood low, tearful & anxious, reassurance given.	
	?	
08/10/09	R Jeelkar ST3	
0430	called to see again re T+ Pain	
	Score 10/10	
	Abdo Soft – wound appears ok. Back Now T_{12} Elect	
	BP 130/90 HR 120 – Sinus tachy	
	Note Sats < 92% on 35% FiO_2 → good cough.	
	Chest:- clr & midzones + bases.	
	Fluids: epidural top up: – 8ml 0.25% Naropin	
	IV Tramadol 100mg	
	+ midazolam 1mg	
	again 1 hour later – top up effective.	
	Pain score 2/10 now.	
	Epidural running 12ml/hr. (0.125mg bupiv + 2mcg/ml fent)	
–	12.5mg in 4h: approx	
	12.5mg at 3am + 2mg at 4am.	
	Tape for another 50mg bupiv until 7am.	
		6023

F3
00262

8/10/09 Called to review re pain ++

OSW 2 days post open fundoplication

Pain ↑ severe last night

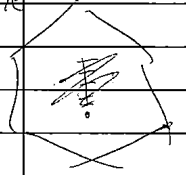
central abdominal pain around wound – constant pain

severity 10/10 → 2/10 with epidural top up

nausea ++

BP 110/70 Pulse 112bpm sinus SaO_2 94% RA RR 12 Temp 36.5°C

O/E



Mod-o soft wound dsgn

tender around wound

BS ✓

Imp / recurrent abdo pain

Plan / anaesthetic review thanks

If doesn't settle ? CT abdo pelv.

0630 O_2 ↑ 40% sats 94%

Physio 1-10pm

S/ Feeling sore. Pain Team in regular attendance. Patient consents to physio.

O/ SaO_2 95% on 40% O_2 via face-mask.

HR 117 - ~~BP 122/88~~. Appears tired.

- Ausc: (R) (L)

✓ ✓ V. quiet to bases.

✓ ✓

↓ ↓

- Cough: expectorating indep into tissues.

R/ – Deep br. ex's. Good efforts from patient but "nodding off" during session.

– Cough.

cont =>

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sullivan	Deborah	

8/10/09 cont.

Physio cont

Plan 1 – Will review again 4pm. J. Bridgwater (Senior Physio)

Physio 4pm

S/ Feeling better than earlier p.m. Now managing to cough up a bit more.

O/ In bed. SaO_2 93% on 35% O_2 via face mask. HR 117.

R/ Chest clearance techniques: patient worked well c insp holds. Cough strong but dry at present time. (Had expectorated a large, brownish sec^n into tissue just immed. prior to session.) – SaO_2 ↑ 96% post-Rx.

Plan 1 = Review a.m. Mobilise ASAP.

J.B.
(Senior P.T.)

8/10 WR Glen

patient still in pain

HR 120 Sats 95% on 35% O_2 aggressive bloods sent

plan: ABG

CXR

physio

pain team

[signature]

Bleep 5843

F3
00262

8.10.09	Nursing notes at 17:15hrs	
③	Cardiovascularly NIBP 109-150/76-102,	
	HR in sinus tachycardia, no ectopics	
	noted, 117-128 bpm. Temp: 35.7°C - 36.2°C.	
⑦ ✱	O2 ↓ 35% from 40% via. respi-flow	
	saturations 90% - 95%. Patient now	
	on 4 litres via. nasal cannula.	
	Saturations now 93% - 94%. RR: 12-24.	
	Air entry audible, quite to bases.	
	Patient coughing and expectorating.	
⑤	Pain remained a problem this	
	morning. Seen by pain sister, see	
	previous entry. Epidural continues	
	at 12mls/hr, dermatone levels	
	(L) T6 and (R) T6-T7. No motor block.	
	Patient scoring pain 4-7/10 throughout	
	morning. Patient more settled	
	this afternoon after a long period	
	of being asleep (patient rousable	
	throughout). Oral Tramadol being	
	withheld while epidural insitu. Oral	
	Paracetamol given as prescribed.	
⑥	Wound intact, undisturbed.	
④	IV fluids continue at 85mls/hr,	
	urine volumes 100-400mls/hr via.	
	catheter. Patient tolerating oral	
	fluids * to remain on a sloppy diet *	
⑧	No nausea, no vomitting	
⑨	Nil PR	
⑩	Teds insitu. Assisted with wash this	cont'd

STOBHILL

10638479K
SULLIVAN
DEBORAH F 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

UATION CHART

SURNAME	ME	UNIT NUMBER

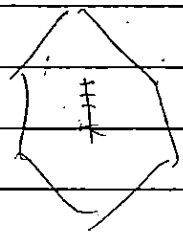
8.10.09 Nursing notes continue

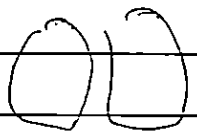
morning. Up to sit in chair for short period, patient too sore to sit up. Pressure areas intact. Family up to visit. SJ

9/10/09 Surgical review
0800

Patient reports severe pain, abdominal pain & (R) shoulder pain - crushing pain. constant - pain maximal lower ant wall
Scoring 8/10
° Nausea

O/E BP 120/82 Pulse 112bpm sinus RR 12
SaO_2 93% 28%.





JAE bases

- Patient epidural TU/9. block - top up 3ml/h. at 4am epidural 12ml/hr.
- Tramadol being withheld
- Fentanyl patch

additional analgesia - Gabapentin regular & paracetamol

P/n / D/W anest anaesthetist re additional analgesia required, she will review.

SJ Unit RN2
J 4094

FS
00262

09/10/09	Nursing 0500hrs	
③	Cardiovascularly:- NIBP 102-126/63-87. HR in sinus tachycardia 110-120bpm, regular, nil ectopics noted. Temp 36.9°C-37.8°C.	
④	IV crystalloids insitu 6°↓8°. Urine output 110-330mls/hr via urethral catheter. Urine cloudy in appearance, tve blood, protein $ nitrites, mssu sent to microbiology for C$S	
⑤	Epidural infusion insitu 12mls/hr 3ml boluses given via epidural as noted in epidural chart. Dermatone levels (A) T7-T8 (R) nil block nil motor block epidural catheter site intact $ checked regularly. Oral paracetamol gabapentin given as prod. Marcain top up given by anaesthetist, oral tramadol $ buscopan given as per anaesthetist's instructions as noted on epidural chart. Patient c/o abdominal pain radiating to (R) shoulder. Surgical SHO $ anaesthetist aware.	
⑥	Abdominal laparotomy wound intact c/c tegaderm, bruising around wound noted	
⑦	SpO2↓89% on FiO2 4l/min via nasal cannula c/o 35% FiO2 via resp/o SpO2 95%-96% RR 17-20 air entry audible to all lung fields. Patient coughing $ expectorating mucopurulent secretions	
⑧	Nil c/o nausea c/N. Tolerating oral fluids c/N.	
⑨	Nil PR	
⑩	Patient not slept well c/N though appears drowsy but rousable. Mobilising independently in bed (std) (Hanson RN)	

09/10/09	Nursing 0500hrs	
③	Cardiovascularly:- NIBP 102-126/63-87. HR in sinus tachycardia 110-120bpm, regular, nil ectopics noted.	
	Temp 36.9°C-37.8°C.	
④	IV crystalloids insitu 6°↓8°. Urine output 110-380ml/hr via urethral catheter. Urine cloudy in appearance, +ve blood, protein & nitrites, MSSU sent to microbiology for C&S.	
⑤	Epidural infusion insitu 12ml/hr @ 3ml boluses given via epidural as noted in epidural chart. Dermatone levels ⓛ T7-T8 ⓡ nil block nil motor block epidural catheter site intact & checked regularly. Oral paracetamol gabapentin given as prod. Marcain top up given by anaesthetist, oral tramadol & buscopan given as per anaesthetist's instructions as noted on epidural chart. Patient c/o abdominal pain radiating to ⓡ shoulder. Surgical SHO & anaesthetist aware.	
⑥	Abdominal laparotomy wound intact c/c tegaderm, bruising around wound noted	
⑦	SpO_2 ↓89% on FiO_2 4l/min via nasal cannula c/o 35% FiO_2 via resp/o SpO_2 95%-96% RR 17-20 air entry audible to all lung fields. Patient coughing & expectorating mucopurulent secretions	
⑧	Nil c/o nausea c/v. Tolerating oral fluids c/v.	
⑨	Nil PR	
⑩	Patient not slept well c/v though appears drowsy but rousable. Mobilising independently in bed (std) (Hourly c/v)	

STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER
Sullivan	Deborah	D638479K

09/10/09	Nursing Observations (Ctd)	
	Ted stockings in situ, pressure areas intact & clean	SN
PHYSIO 09/10/09 @ 9.30am	Sill Pt still feeling little sore but in general pain well controlled. Comments to Rx.	
	Sill lying in bed ↑ ≈ 45° head raise	
	on 4l O_2 via n/c SpO_2 91%.	
	HR 117 BP 129/79 Apyrexial RR 14.	
	Assc: (R) ✓ (L) ✓ AE +ve	
	✓ ✓ quiet @ bases.	
	↓ ↓	
	cough v. dry Ctx (I)	
	Resp Phys holds. // nil expectorated	
	supported huffs/cough // cough sounds v. dry @ present with T 95%	
	Pt rev Hkis pm. ? Inj mobilise.	J Murray (SCPT).
9/10/09	WR Mr Smith	
	still abdominal pain, radiating to shoulder	
	CRP 283 WCC 9.1 other bloods stable	
	HR 120, apyrexial	
	plan: ? epidural out can then go to ward	
	eating & drinking	
	stop fluids & catheter as eating	
	& drinking, with good urine output	
09/10/09 PHYSIO @ 11.10am	Sill Pt keen to mobilise epidural out. not ↑ to Rehab	Kathy Rodgers FY1 584
	Oil UTS in chair on 4l O_2 via n/c SpO_2 96%	
	Took O_2 off to mobilise.	
	STS: (I)	
	Stds unsupported ↓ supp x 2 WBOs.	J Murray (SCPT)

F3
00262

PHYSIO. 09/10/09 Cont	gait ex 1 min ADL from bed → nursing station. - good steady pace remained balanced c/o SOB returned pt to chair sats 7 95%	
AM	Mobilising well chest remains unproductive.	
PM	n/v report pt is moving onto ward c/v tomorrow to monitor chest.	J Murtagh (Surg)
9.10.09	Nursing notes at 12:15hrs	
③	Cardiovascularly NIBP 113-132/81-94, HR in sinus tachycardia, nil ectopics, 121-133 bpm. Temp: 35.8°C - 36.9°C.	
④	IV fluids discontinued today, catheter removed today as instructed by Mr Smith. *Not yet passed urine spontaneously* Tolerating oral fluids and sloppy diet.	
⑤	Epidural discontinued, catheter removed, blue tip seen. Commenced on PCA, patient using well. Oral Paracetamol, Trammadol & Gabapentin given as prescribed.	
⑥	Wound intact, undisturbed.	
⑦	Saturations 97% on 4litres via. nasal cannula. RR: 22-26. Air entry audible, quite to bases. Patient coughing and expectorating.	
⑧	No nausea, no vomitting.	
⑨	Nil PR	
⑩	Teds insitu. Assisted with wash. Pressure areas intact. Up to sit in chair. Walked with physios.	S/N

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COMMUNICATION SHEET

Ward ..5.....

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
09/10/09 PHYSIO @ 4.00pm	Sill Pt has now been moved into ward 5 on PCA patient using well. c/o painful (R) shoulder.	
	O/E SaO_2 86% note pt not wearing N/C should be on 4l O_2	
	HR 117	
	Ausc R / L	
	✓ / ✓ quiet at bases.	
	/ / nil added sounds heard.	
	↓ / ↓	
	Coughing : Expectorating dirty sputum (I)	
	Pt'l deep br exs // good technique expectorated	
	Cough // large brown secretion	
	Sill rec'd forward to r/v chest.	J Shanahan (Physio)
	Nursing 0430	
10/10/09	(S) obs - stable O_2 SAT 94% - 97% on	
	4L O_2 via N/C on.	
	pain score 9	
	(E) ventolin nebs - PCA renewed	
	used moderately	
	slept well	
10/10/09	S/ In a lot of pain but managing to CXE (I)	
1650	using physio exercises. Consented to Rx	
Physio	O/ SaO_2 88% on (A) & 96% on 2L O_2 via N/C	

COMMUNICATION SHEET

Ward ..... 5 .....

Date	Progress / Evaluation	Signature/ Profession
15/10/09 (cont)	Rusc. A/E t/out	
	Nil added	
	Managing to CKE (I)	
	Rx, (1) R/V of ACBT	
	A, No need for further PT intervention this w/end	
	P, R/V on Monday by ward PT	
	To mobilise (I) over w/end	
	M. Rice (MHAIRI RILEY SEN/ KOT PT)	
16/10/09	Nursing	
(1)	Immersion bath taken. Independent w/c oral hygene	
(2)	F & T tolerated.	
(3)	Voiding urine.	
(4)	Independently mobile.	
(5)	Obs. are charted. 2L Cont at rate 94%. Pain ongoing. PCA Stopped for short time as no venous access. Recommenced. Pt. Seen to be pressing buttons on machine as she says she "is not getting any morphine" Advised by nursing staff not to touch machine as it is very dangerous and could cause problems w/c administration of medicines. Will monitor.	

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COMMUNICATION SHEET

Ward 5

10638479K
SULLIVAN
DEBORAH
CHI-0712726128
Unit No.

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Date	Progress / Evaluation	Signature/ Profession
10/10/09	(Cont.)	
	R/V by physio. See previous page.	
⑨	Wound dressed ½ mepore.	
	Venflon resited ⓛ Arm. Bandaged.	
	Settled @ this time.	
		(S/N)
	18[00] hrs.	
	Venflon resited x 2. PCA	
	renewed. Appears to be	
	running well.	
		(S/N)
11/10/09	2) Fluids & diet tolerated	
0330	3) Voiding urine spontaneously.	
	No bowel activity reported.	
	4) Fully mobile.	
	5) Observations stable apyrexial	
	Mews 0 Pain 4.	
	Continues on PCA using well.	
	7) Wound dressing intact.	
	9) Night sedation taken & appears	
	to have slept well.	

COMMUNICATION SHEET

Ward .....5.....

Date	Progress / Evaluation	Signature/ Profession
11/10/9	WR OGSTON (Retrospect)	
	Pt. well - still has some pain.	
	Obs stable.	
	Bloods - CRP not ↓	
	(P)	
	Re-check CRP	
	Continue	M F41
		4296 LOGAN
11/10/9	Nursing:	
(1)	Independent ✓ all personal	
	care:	
(2)	F+D tolerated.	
(3)	Voiding urine.	
(4)	Independently mobile.	
(5)	Obs are charted. Pain	
	score ongoing. MEWS 0.	
	PCA discontinued after	
	discussion ✓c Sr. Kate	
	Scullion. She recommends	
	oral analgesia @ present	
	and to monitor. S/c morphine	
	to be given if required.	
	Deborah aware of this.	
(7)	Wound dressing intact.	
	Settled @ this time.	
	Pt. for outpt. appt. @ pain clinic	(SN)
	will be arranged by Sr. Scullion.	

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COMMUNICATION SHEET

Ward 5

Name

MS D SULLIVAN

6 MUIRHEAD COURT
BAILLIESTON
GLASGOW
G69 7EP

Affix data label

Date	Progress / Evaluation	Signature/ Profession
12/10/09	N/ursing Care at 0415 am	
	(2) patient tolerating f+d	
	(3) passing urine - states its sore when she passes, trace of blood only in MSU. will pass on to day staff.	
	(4) mobile independently	
	(5) obs stable afebrile. c/o pain x2 morphine given v/c effect.	S/N
	(7) wound dry + intact.	Oundle
12/10/9	WR: Dr Riddell.	
	Pt. c/o flank pain + dysuria.	
	Urine dipstick showed haematuria. MSSU sent.	
	Cipro started for 3 days.	
	CRP ↓	
	(P) Recheck bloods.	
FHYAO	? (H) tomorrow	Kara Burns BURNS FYI
13/10/09 20am	Sll Deborah in good spirits keen for (H) tomorrow. Reports she has been c+e (I) + mobilising (I) over weekend.	4158
	sll lie → sit (I)	
	STS (I)	

COMMUNICATION SHEET

Ward .....

Date	Progress / Evaluation	Signature/ Profession
12/10/09 Physio Cont	all ft mob (I) ind and from bed → stairs : slow + steady +/o.	
	chair ftx T ↓ ≈ 8 steps (I) handrail : step through pattern safe + steady +/o.	
	C+/O gait grx 11 pt (I) ↑ probs	
	(2) chair ftx 11 pt (I) ↑ probs	
	(3) gave pt exercise booklet + went over exercises to do post abdo surgery advised to do little + often throughout the day 11 pt (I) ↑ pain.	
	All ft Gs now (I) mobile no further physio issues	
	All d/c from physio : (H) tomorrow!	J Shimmock (SCOT)
12.10.9	Nursing at 15[25].	
1)	Independently showered	
2)	eating and drinking	
3)	Eliminating spontaneously	
4)	mobile	
5)	obs stable mews (1) pt slightly hypotensive	
6)	pain score 10 given s/c 10mg morphine with good effect. No complaints offered - for OPD Pain review on ward commenced on cipro x 3 daily ∞ ?UTI	
7)	wound dressing intact.	
11)	settled and uncomplaining	Patel

MIS 110460

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COMMUNICATION SHEET

Ward OS

Name Deborah
Address Sullivan

D.O.B 07/12/72
Unit No. 1063847 9K

Affix data label

Date	Progress / Evaluation	Signature/ Profession
13/1/09	Nursing night	
	Appeared fairly settled.	
	C/o abdo pain - Required two	
	doses of Morphine 10mg S/C	
	overnight.	
	Independently mobile.	
	Obs stable. Apyrexial.	
	Commenced on oral antibiotic.	
	Nursing@	
	Nursing@ 1245	
	① Independent with personal hygiene	
	this morning.	
	② Tolerating fluids & diet.	
	③ voiding urine spontaneously.	
	④ Independently mobile	
	⑤ observations stable, and as charted.	
	MEWS=0, Apyrexial. Pain score=9	
	⑪ Pain score=9, sub cut morphine	
	given as per Kardex	
	Patient settled at present.	

COMMUNICATION SHEET

Ward .....

Date	Progress / Evaluation	Signature/ Profession
13/10/9	WR: Dr Falconer.	
	Still c/o colicky abdo pain	
	Explained that all her analgesia can cause spasmodic	
	pains in the bowel.	
	Encouraged to avoid morphine if possible.	
	Obs stable, apyrexial.	
	CRP falling now.	
	(P) Recheck bloods tomorrow	
	? (H) tomorrow.	Fiona Burns BURNS FYI 4158.
14/10	Nursing.	
	Oral analgesia taken.	
	Still c/o abdo pain spasmodic.	
	Slept for long period.	
	For home later today c/c	
	pain team follow up.	
14/10	Nursing day	(S/N)
	observations satisfactory	
	remains apyrexial.	
	Independent with ADL's	
	Wound redressed with mepore.	
	Clips to be removed on Friday	
	16/10/09 by practice nurse patient	
	aware.	
	Discharge meds given and	
	explained.	
	F/U 6/8 weeks will recover by	

NHS Greater Glasgow & Clyde

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COMMUNICATION SHEET

Ward ..... 5 .....

10638479K
SULLIVAN
DEBORAH
CHI-0712726128

Unit No.

Affix data label

Date	Progress / Evaluation	Signature/ Profession
	post	

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Ward: 5 Date: 11/10/09 Case Record No.:

CARE PLAN

		1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
11/10/09		Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		2.NUTRITION		
		Fasting		
		Normal Diet		
11/10		Special Diet / Modified Diet		
		3.ELIMINATION		
11/10		Independent		
		Commode		
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
11/10		Fully Independent/fully mobile		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
11/10		Waterlow daily (if score is over 10+)		
~	~	TPR		
~	~	BP		
~	~	Pain Score		
		Fluid Balance		

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
		IV Infusion		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
11/10/05		IV access: ∞ IV cannulae ∞ others		
11/10/05		PCA		
		7.WOUND CARE		
11/10/05		Nopore		
		8.SPECIMENS/INVESTIGATIONS		
		9.SLEEP		
11/10/05		On night sedation.		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
11/10/05		Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☑

Signature of nurse: [signature] **Date:** 11/10/05

STOBHILL HOSPITAL – ACUTE PAIN SERVICE - Page Sister: 1184

NHS Greater Glasgow and Clyde

OBSERVATION CHART FOR THE ADMINISTRATION OF

SUBCUTANEOUS ANALGESIA Deborah Sullivan 7/12/72.
1063879K.

Date	Time	Sedation Score	Resp. Rate	Pain Score	Dose of Analgesia administered	Pain Score (After 1 hr)	Comments	Sign
11/10/9	18[15]	0	17.	9.	10mgs			
11/10/09	012[30]am	0	R 16.	9	10mgs			
12/10/09	06[15]am	0	17	10	10mgs			
12/10	12[30]	0	16.	10	10mgs			
13/10	09[20]	0	17	9	10mg			
13/10	14[35]	0	16	10	10mg			
13/10	1900		16	8	10mg			

PAIN SCORE

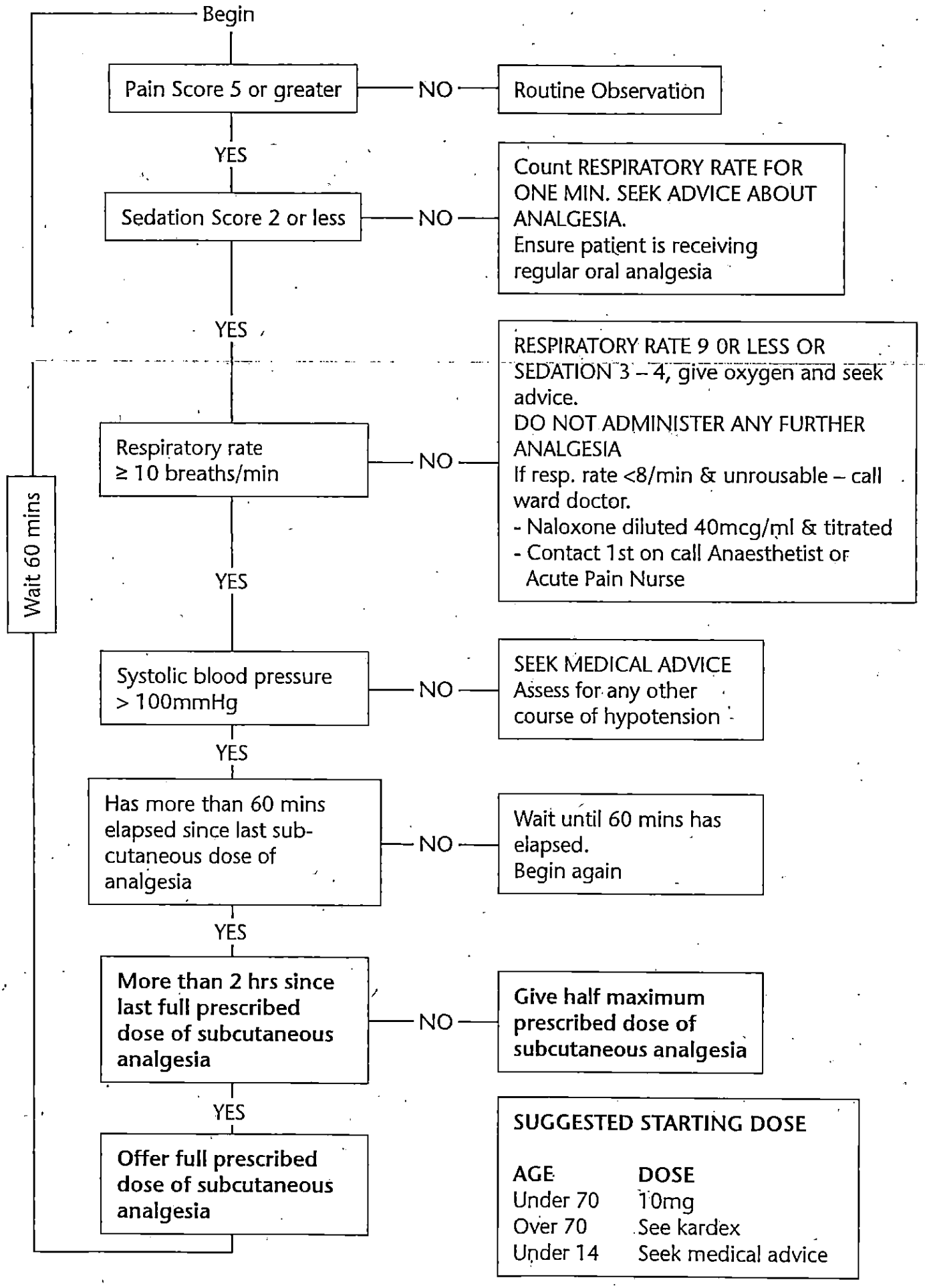
0 5 10

No pain Worse Pain Ever

SEDATION SCORE

0 = Awake
1 = Alert
2 = Responds to verbal command
3 = Responds to painful stimuli
4 = Unresponsive and unrousable
5 = Normal sleep

STOBHILL HOSPITAL
SUBCUTANEOUS ANALGESIA PROTOCOL ALGORITHM



Stobhill Hospital

NHS Greater Glasgow and Clyde

NOT TO BE FILED UNTIL DISCHARGE

Name: Deborah Sullivan. Unit No.: 1063847 9 K.

Date:	6/10/09	7/10/9	8/10	9/10	10/10	11/10	12/10	13/10				
Time of Result:	Post-op	8am	8am	8.00								
WCC 4-11	11.0	7.86	9.26	8.70	7.93	7.00	8.93	9.48				
Hb M - 13-18 F - 11.5-16.5	10.6	9.7	(9.1)	(9.1)	9.4	(9.7)	10.1	(10.3)				
Plat 150-400	258	245	232	247	297	376	(410)	(450)				
Hct 0-37-0-47	.331	0.308	0.298	.293								
Na 135-145	136	135	138	138	139	140	141	140				
K 3-5-50	4.0	3.7	3.7	3.6	4.9	4.1	4.4	4.5				
Cl 97-107	107	101	102	99	99	98	100	101				
Bic 23-30												
Urea 2-5-8.0	3.4	2.5	(1.8)	(1.6)	2.3	2.6	3.0	3.0				
Creat. 40-130	65	62	55	51	59	56	61	66				
Amylase ..... <100												
CRP .....<10	8.9	(170)	(283)	(293)	(287)	(240)	(161)	(98)				
ESR (MCG)... AGE 12	0.67	1.27	0.81	0.72	0.80	0.88						
Adj. Ca ... 2-2-2-6	2.43		2.36	2.43	2.5	2.55	2.52					
Phosphate 0-7-1-4	1.22		1.11	0.94	1.31	(1.58)	1.37					
Tot. Prot. ..62-82	60	54	(58)	(60)	64	67	71	74				
Albumin 36-55	31	27	(28)	(27)	29	30	(31)	(32)				
Alk. Phos. 80-280	60	63	73	(75)	93	99	107	105				
Gamma GT ..<50	113	(141)	(137)	(110)	116	119	(126)	(134)				
Bil 3-22	7	12	10	8	9	6	5	5				
AST 12-48	105	91	42	23	16	14	13	12				
ALT 3-55	72	(97)	(76)	50	38	31	(24)	20				
~~UA~~ URATE ..... ~~200-520~~			0.18									
Glucose ..3-0-5-5												
PT 10-14	11	12	13	13	13	13	12					
APTT 25-37	28	30	30	29	30	29	26					
TT 11-15	14	15	15	14	12	12	11					
FIB 200-400	295	406	(521)	551	479	521	(491)					
NB CK			(+790)									
APTT RATIO												
Drain Amylase	0200	0900	12.30									
H^+ 36-43	41	40	44									
PO_2 .....10.5-13.5	11.1	9.9	14.4									
PCO_2 ..... 4.6-6.0	6.5	6.6	6.7									
HCO_3 20-28	30	30	28									
	35%	28%	40%				0.95					

MIS 109801/Stob

PRESCRIPTION FORM

Hospital Name: Stobhill

PATIENT DETAILS

Name: [redacted]

CHI: 1063847 9K
SULLIVAN F
DEBORAH 07/12/1972

Hosp: 6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP

DOB: CHI-0712726128

Height: 1.8

Weight: 75kg 6/10/09

Surface area:

Date of writing discharge prescription: __/__/__

Ward: [illegible]

Date of Admission: 6/10/09

Consultant Name: [illegible]

Date and time this form prepared: __/__/__ Time:

Sheet No:

2nd Prescription in use Yes or NO

DRUG SENSITIVITIES

Amoxicillin (rash)

Diclofenac

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin	☐	TPN:	☐
PCA and other infusions	☑	Enteral Nutrition:	☐
Anticoagulants: Heparin	☐	Oxygen Therapy:	☐
Oral	☐	Other:	
Topical:	☐		

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF PRESCRIBER	GIVEN BY	TIME GIVEN
6/10/09	1) AMOXICILLIN	3g	Epidural		[signature]	J Calweil	12.00
6/10/09	MIDAZOLAM	0.5mg	IV	1720	[signature]	MM	1720
7/10/09	MAGNESIUM	8mmol	IV	0230	[signature]	DR/AH'E	0230
7/10/09	MAGNESIUM	2ommol	IV	0255	[signature]	AH'E/DR	0300
7/10/09	Tramadol	100mg	IV	2045	[signature]	AH'E/AB	2045
8/10/9	Midazolam	0.5mg	IV	0245	[signature]	RJ	0245
8/10/9	Tramadol	100mg	IV	0430	[signature]	AH'E/AB	0430
8/10/9	midazolam	1mg	IV	0430	[signature]	RJ	0430
8/10/9	midazolam	0.5mg	IV				
8/10/9	midazolam	0.5mg	IV				
8/10/9	BUPIVICAINE .25%	3ml	epidural	9.40	[signature]	K Smith	09.40
8.10.09	Bupivicaine 0.5%	6ml	Epidural	1300	[signature]	K Smith	0300
8/10/9	Tramadol	100mg	PO	1900	[signature]	A Shaw	19.00
9/10/9	TRAMADOL	100mg	PO	0415	[signature]	A Shaw	04:15
09/10/9	Buscopan	20mg	PO	0500	[signature]	A Shaw	0500 am

PATIENT'S NAME:

ADMINISTRATION

Parenteral Drugs: Regular Prescription

DATE: 6 7 8 9 10 11 12 13

MONTH: 10 10 10 10 10 10 10 10

Other time / 0700-0900 / 1200-1400 / 1600-1800 / 2200-2400 / Other time

A DRUG: CLEXANE

DOSE: 20 mg. | ROUTE: S/C | DATE: 6/10 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER: Fiona Burns

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR PRESCRIBERS USE ONLY

B DRUG: PARACETAMOL

DOSE: 1 Gram | ROUTE: I.V. | DATE: 6/10/09 | STOPPED DATE: 8/10 | STOPPED INITIALS: ICh

SIGNATURE OF PRESCRIBER:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR PRESCRIBERS USE ONLY

C DRUG: FENTANYL 6µg/ml + BUPIVACAINE 0.125% 1ml/hr

DOSE: 6-12ml/hr | ROUTE: Epidural | DATE: 6/10/09 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: see Enclosed Chart

FOR PRESCRIBERS USE ONLY

D DRUG: FENTANYL PATCH

DOSE: 75Mcgs | ROUTE: TOP | DATE: 6/10/9 | STOPPED DATE: | STOPPED INITIALS:

SIGNATURE OF PRESCRIBER:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR PRESCRIBERS USE ONLY

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE: 6 7 8 9 10 11 12 13 14

MONTH: 10 10 10 10 10 10 10 10 10

J DRUG: GABAPENTIN.
DOSE: 600mg | ROUTE: PO | DATE: 6/10/9.
SIGNATURE OF PRESCRIBER: FionaBurns.
STOPPED DATE: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 — AS AS
1200-1400
1600-1800 — AS
2200-2400
Other time

K DRUG: PARACETAMOL
DOSE: 1g | ROUTE: PO | DATE: 6/10/9.
SIGNATURE OF PRESCRIBER: FionaBurns.
STOPPED DATE: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

L DRUG: IMIPRAMINE
DOSE: 75mg | ROUTE: PO | DATE: 6/10/9.
SIGNATURE OF PRESCRIBER: FionaBurns.
STOPPED DATE: 9/10 | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 — AS AS
1200-1400
1600-1800
2200-2400
Other time

M DRUG: TRAMADOL
DOSE: 50mg | ROUTE: PO | DATE: 6/10/9
SIGNATURE OF PRESCRIBER: FionaBurns
STOPPED DATE: 9/10 | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM
FOR PRESCRIBERS USE ONLY

Other time
0700-0900 — 9 9 9
1200-1400 — 9 AS 9
1600-1800 — 9 9 9
2200-2400 — 9 9
Other time

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

Oral and Other Drugs: Regular Prescriptions

DATE → 7 8 9 10 11 12 13 14
MONTH → 10 10 10 10 10 10 10 10

N

DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 6/10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: FionaBurns | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CM

Time								
Other time								
0700-0900	y.	AS	AS	W6	✓	✓	✓	✓
1200-1400	✓							
1600-1800								
2200-2400	TAKE	✓	W6	✓	✓	✓	✓	
Other time								

FOR PRESCRIBERS USE ONLY

P

DRUG: GRANISETRON
DOSE: 1mg | ROUTE: PO | DATE: 6/10/9 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: FionaBurns | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CM

Time								
Other time								(4)
0700-0900	✓	AS	AS	W6	✓	✓	✓	✓
1200-1400								
1600-1800								
2200-2400	TAKE	✓	W6	✓	✓	✓	✓	
Other time								

FOR PRESCRIBERS USE ONLY

R

DRUG: fentanyl patch
DOSE: 75 micrograms / 72hrs | ROUTE: | DATE: 8/10/9 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: [signature] | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: change every 72hrs. CD

Time								
Other time								
0700-0900	X	X	AS	X	X	✓	X	X
1200-1400								
1600-1800								
2200-2400								
Other time								

FOR PRESCRIBERS USE ONLY

S

DRUG: PARACETAMOL
DOSE: 1g | ROUTE: O | DATE: 8/10/9 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: [signature] | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Time								
Other time						04 37		
0700-0900		X	AS	W6	✓	✓	✓	✓
1200-1400		X	AS	✓	✓	✓	✓	
1600-1800		AS	✓	✓	✓	✓	✓	
2200-2400		✓	TAKE	✓	✓	✓		
Other time								

FOR PRESCRIBERS USE ONLY

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE: 9 | 10 | 11 | 12 | 13 | 14
MONTH: 10 | 10 | 10 | 10 | 10 | 10

T
DRUG: TRAZODONE
DOSE: 100mg | ROUTE: O | DATE: 9/10/09 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900: X | 10 | 09 30 | ON | SS | MM
1200-1400: AS | MM | MM | DEP | EP
1600-1800: AS | MM | MM | EP | EP
2200-2400: WH | ON | SS | MM
Other time

V
DRUG: IMIPRAMINE
DOSE: 150mg | ROUTE: O | DATE: 9/10/09 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800: 4
2200-2400: WH | ON | SS | MM
Other time

W
DRUG: TEMAZEPAM
DOSE: 10mg | ROUTE: O | DATE: 9/10/09 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400: WH | ON | SS | MM
Other time

X
DRUG: CIPROXIN
DOSE: 500 | ROUTE: PO | DATE: 12-10 | STOPPED DATE:
SIGNATURE OF PRESCRIBER: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: 3 MG FOR UTI
FOR PRESCRIBERS USE ONLY

Other time
0700-0900: X | BS | MM
1200-1400
1600-1800
2200-2400: SS | MM
Other time

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

← FOR PRESCRIBERS USE ONLY →

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

← FOR PRESCRIBERS USE ONLY →

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

← FOR PRESCRIBERS USE ONLY →

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

← FOR PRESCRIBERS USE ONLY →

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF PRESCRIBER | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR PRESCRIBERS USE ONLY →

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF PRESCRIBER

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR PRESCRIBERS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: STEMETIL — STOPPED DATE: — INITIALS:
DOSE: 12.5mg | ROUTE: I.M. | INDICATION: NAUSEA
SIGNATURE OF PRESCRIBER: [illegible] | MAX.FREQUENCY: 8 hourly | DATE: 6/10/09
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	
TIME	
DOSE	
GIVEN BY	

NN DRUG: ONDANSETRON — STOPPED DATE: — INITIALS:
DOSE: 4mg | ROUTE: I.V. | INDICATION: NAUSEA
SIGNATURE OF PRESCRIBER: [illegible] | MAX.FREQUENCY: 8 hourly | DATE: 6/10/09
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: * 2nd line *

DATE	6/10
TIME	0715 AM
DOSE	4mg
GIVEN BY	CAB SMC

PP DRUG: Temazepam — STOPPED DATE: 11/10 — INITIALS: PP
DOSE: 20mg PO | ROUTE: | INDICATION: Night sedation
SIGNATURE OF PRESCRIBER: [illegible] | MAX.FREQUENCY: Once at night | DATE: 6/16/9
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: IF ALLOWED ORAL INTAKE.

DATE	
TIME	
DOSE	
GIVEN BY	

RR DRUG: Tramadol 1 — STOPPED DATE: 11/8/09 — INITIALS: [illegible]
DOSE: 100mg | ROUTE: IV PO | INDICATION: Pain
SIGNATURE OF PRESCRIBER: [illegible] | MAX.FREQUENCY: 6HRLY | DATE: 6/10/9
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	6/10 7/10/09
TIME	2130 03 30
DOSE	100mg 100mg
GIVEN BY	RN AKE DE

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

SS
DRUG: Piriton
DOSE: 4mg | ROUTE: PO | INDICATION: Itch
SIGNATURE OF PRESCRIBER: [signature] | MAX.FREQUENCY: TID | DATE: 7/10/09
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Chlorpheniramine.
STOPPED DATE: | INITIALS:

DATE	TIME	DOSE	GIVEN BY
8/10	1200	4mg	[illegible]
9/10	0830	4mg	[illegible]

TT
DRUG: (1mg/ml) MORPHINE
DOSE: Bolus 1mg | ROUTE: PCA | INDICATION: PAIN
SIGNATURE OF PRESCRIBER: [signature] | MAX.FREQUENCY: Locout 5 mins | DATE: 8-10-09
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: 11/10 | INITIALS: SDL

DATE	TIME	DOSE	GIVEN BY

VV
DRUG: MORPHINE
DOSE: 10mg | ROUTE: SC | INDICATION: PAIN
SIGNATURE OF PRESCRIBER: Jane Cumisd | MAX.FREQUENCY: as per protocol | DATE: 11/10/09
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

DATE	TIME	DOSE	GIVEN BY
11/10	1815	10mg	CE
11/10	0830	10mg	DM
12/10	1230 pm	10mg	EA
12/10	0615 am	10mg	DM
12/10	1230	10mg	DL
12/10	1820 pm	10mg	DL
13/10	0210 pm	10mg	DL
13/10	0900	10mg	DL
13/10	1400	10mg	DL
13/10	1900	10mg	DL

WW
DRUG: BUSCOPAN
DOSE: 20mg | ROUTE: O | INDICATION: Abdo/Pain
SIGNATURE OF PRESCRIBER: [signature] | MAX.FREQUENCY: 8° | DATE: 13/10/09
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
STOPPED DATE: | INITIALS:

DATE	TIME	DOSE	GIVEN BY
13/10	1310	10mg	[illegible]
13/10	1140 pm	20mg	[illegible]

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

Nurse/Midwife Administration by Protocol — Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN
10/10	Peppermint Water	10ml	O	4pm	[signature]	[signature]	4pm
11/10	Peppermint Water	10ml	PO	10pm	[signature]	[signature]	10pm

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Sign your full name clearly against each prescription entry.

4. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes.

5. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

6. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

7. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat No.00548 Ver 8, 01/2009

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	Deborah
Address	Sullivan
Hospital No.	1063847 9 C
DOB	07/12/72

Admitted Date _____ Ward 5

Transferred Date _____ Ward _____

Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

DATE	9/10/09	//	10/10.	45	10/10	//	11/10		12/10				13/10		//		TEMP X
Time	21:40	//	12	5 pm	22	//	16 30	9 50 pm	1120	150	1650	21 45	1100	1600	//		

BP ^ v and Pulse •

240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

40°C 39°C 38°C 37°C 36°C 35°C

Resp. Rate	18		16	17	16		16	16	18	19	18	16	18	17			
Inspiration O_2%	4L		2L	2L	2L		A	A	A	A	A	A	A	A			
SpO_2%	96		97	95	97		93	90	93	97	97	98	97	96			
Pain Score	9		0	6	5		4	5						3			
Sedation Score			0	0	0		0	0									
Nausea Score			0	0	0		0	0									
Blood Glucose			0	0	0		0	0									

MEWS																	
	Resp. Rate	0		0	0	0		0	0	0	0	0	0	0	0			
	Pulse	1		0	0	0		1	0	1	2	1	1	0	0			
	Systolic BP	0		0	0	0		1	0	1	0	0	0	0	0			
	GCS / AVPU	0		0	0	0		0	0	0	0	0	0	0	0			
	Urine Output	0		0	0	0		0	0	0	0	0	0	0	0			
	Temp.	0		0	0	0		0	0	0	0	0	0	0	0			
	SpO_2%	0		0	0	0		1	0	1	0	0	0	0	0			
	TOTAL	1		0	0	0		3	0	3	2	1	1	0	0			

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

BD 065

DATE	14/10																	
Time	1830																	TEMP X
BP ^ v and Pulse • 240																		40°C
230																		
220																		39°C
210																		
200																		38°C
190																		
180																		37°C
170	9																	
160																		36°C
150																		
140																		35°C
130																		
120	100																	
110																		
100	A																	
90																		
80	1																	
70																		
60	V																	
50																		
40	60																	
Resp. Rate	16																	
Inspiration O_2%	A																	
SpO_2%	95																	
Pain Score	2																	
Sedation Score	0																	
Nausea Score	0																	
Blood Glucose	/																	

MEWS																		
	Resp. Rate	0																
	Pulse	0																
	Systolic BP	0																
	GCS / AVPU	0																
	Urine Output	0																
	Temp.	0																
	SpO_2%	0																
	TOTAL	0																

Calling Criteria

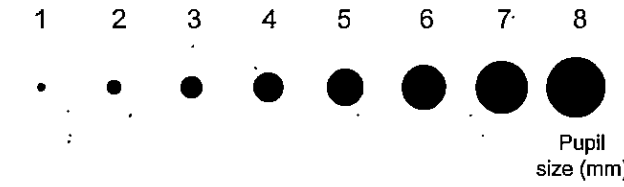
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

DATE																			
Time																			
COMA SCALE	E Eyes open	Spontaneously	4																Eyes closed by dwelling = C
		To speech	3																
		To pain	2																
		None	1																
	V Best verbal response	Orientated	5																Endotracheal tube or tracheostomy = T
		Confused	4																
		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
		R Reaction																	
		L Size																	
		L Reaction																	
LIMB MOVEMENT	ARMS	Normal power																	Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																	
		Severe weakness																	
		Spastic flexion																	
		Extension																	
		No response																	
	LEGS	Normal power																	
		Mild weakness																	
		Severe weakness																	
		Extension																	
		No response																	

Glasgow Coma Scale



DATE																			
Time																			
COMA SCALE	E Eyes open	Spontaneously	4																Eyes closed by dwelling = C
		To speech	3																
		To pain	2																
		None	1																
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		Spastic flexion																	
		Extension																	
		No response																	
	LEGS	Normal power																	
		Mild weakness																	
		Severe weakness																	
		Extension																	
		No response																	

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

STOBHILL HOSPITAL
24 HOUR FLUID CHART

NHS Greater Glasgow and Clyde

DATE: 9.10.09

SURNAME	CHRISTIAN / FORENAME	UNIT NO.
Sullivan	Deborah	106384 79K

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
TEA	250	62	8am.	80				
		62	9am.	400				
TEA	200	1-1	10 am.	275				
			11 am.	250				
MILK	200		12 noon		catheter removed			
			1pm.					
TEA	150		2pm.	U.T				
			3pm.					
			4pm.					
Refused Dinner/Tea	150		5pm.					
			6pm.	U.T				
			7pm.					
			8pm.					
Hot Choc	100		9pm.					
			10pm.	P.U.				
			11pm.					
			12 mid.					
			1am.	P.U				
			2am.					
			3am.					
			4 am.					
			5 am.	P.U.				
			6am.					
			7 am.					
TOTALS	1050	124		1005				
TOTAL INTAKE	1174				1005		TOTAL OUTPUT	

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results		Time
Serum :	Urea	
	Sodium	
	Potassium	
	Chloride	
	Bicarbonate	
	Creatinine	
Urine :	Urea	
	Chloride	

129198/2

STOBHILL HOSPITAL – ACUTE PAIN SERVICE - Page Sister: 1184

OBSERVATION CHART FOR THE ADMINISTRATION OF

~~SUBCUTANEOUS ANALGESIA~~ → EPIDURAL

NHS Greater Glasgow and Clyde

Date	Time	Sedation Score	Resp. Rate	Pain Score	Dose of Analgesia administered	Pain Score (After 1 hr)	Comments	Sign
8/10/9	0245			10/10	5ml 0.25% chrocaine epidurally	1		
8/10/9	0430			10/10	8ml 0.25% chrocaine			

PAIN SCORE

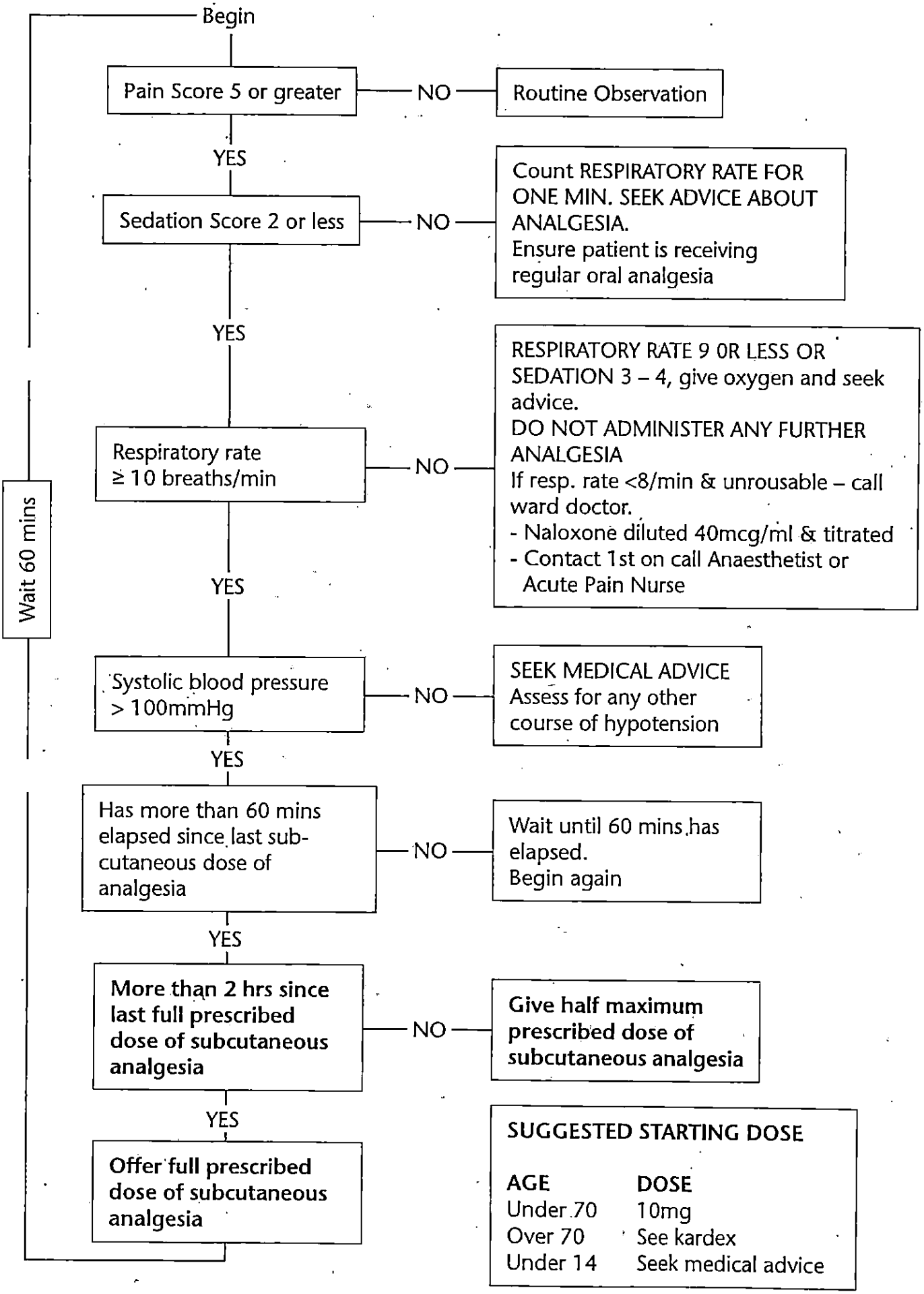
0 5 10

No pain Worse Pain Ever

SEDATION SCORE

0 = Awake
1 = Alert
2 = Responds to verbal command
3 = Responds to painful stimuli
4 = Unresponsive and unrousable
5 = Normal sleep

STOBHILL HOSPITAL
SUBCUTANEOUS ANALGESIA PROTOCOL ALGORITHM



Nutrition Profile

NHS Greater Glasgow and Clyde

Na	Date of admission: / /
Ad 10638479K SULLIVAN F DEBORAH 07/12/1972 6 MUIRHEAD COURT BAILLIESTON GLASGOW G69 7EP	Time:
Dc CHI-0712726128	HOSPITAL: Stobhill
CHI number:	Ward: 5
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.80 m/ft Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 75 kg/~~stones~~ Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg/stones. Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Eating and drinking likes and dislikes (including appetite and/or NBM status):

No preferences.

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☑ No ☐

Please state: Soft diet

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☑

Please specify all factors:

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

Please state:

Profile completed by: Name (PRINT): G GALL Signature: [signature] Date: 11/10/05

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Malnutrition Universal Screening Tool ('MUST')

Date	11/10/09	14/10								
Initials	[illegible]	[illegible]								
Height (see page 1)		Weight	75K	74.3						
Oedema or ascites present Y/N	N	N								
BMI	23	23								

'MUST'

Step 1: BMI Score (refer to chart on page 4) 20 (>30 = Obese) ..... 0 18.5 - 20 ..... 1 <18.5 2	0	0								
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0	0								
Step 3: Acute Disease Effect Score If patient is acutely ill **and** there has been or is likely to be no or virtually no food intake for > 5 days ..... Score 2 Not applicable ..... Score 0	0	0								
Step 4: Overall Risk of Malnutrition Total:	0	0								

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK** - *Routine Clinical Care* • Repeat screening. Hospital Acute .....1.....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK** - *Observe* • Document dietary intake for 3 days on a Food Record Chart. • If no improvement in intake: - Encourage oral intake. - Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK** - *Treat** • Refer to Dietitian **and** document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks **and** offer full cream milk to drink with and between meals. • Monitor **and** review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Complete nursing checklist for swallowing difficulties if appropriate.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).

Referral Services

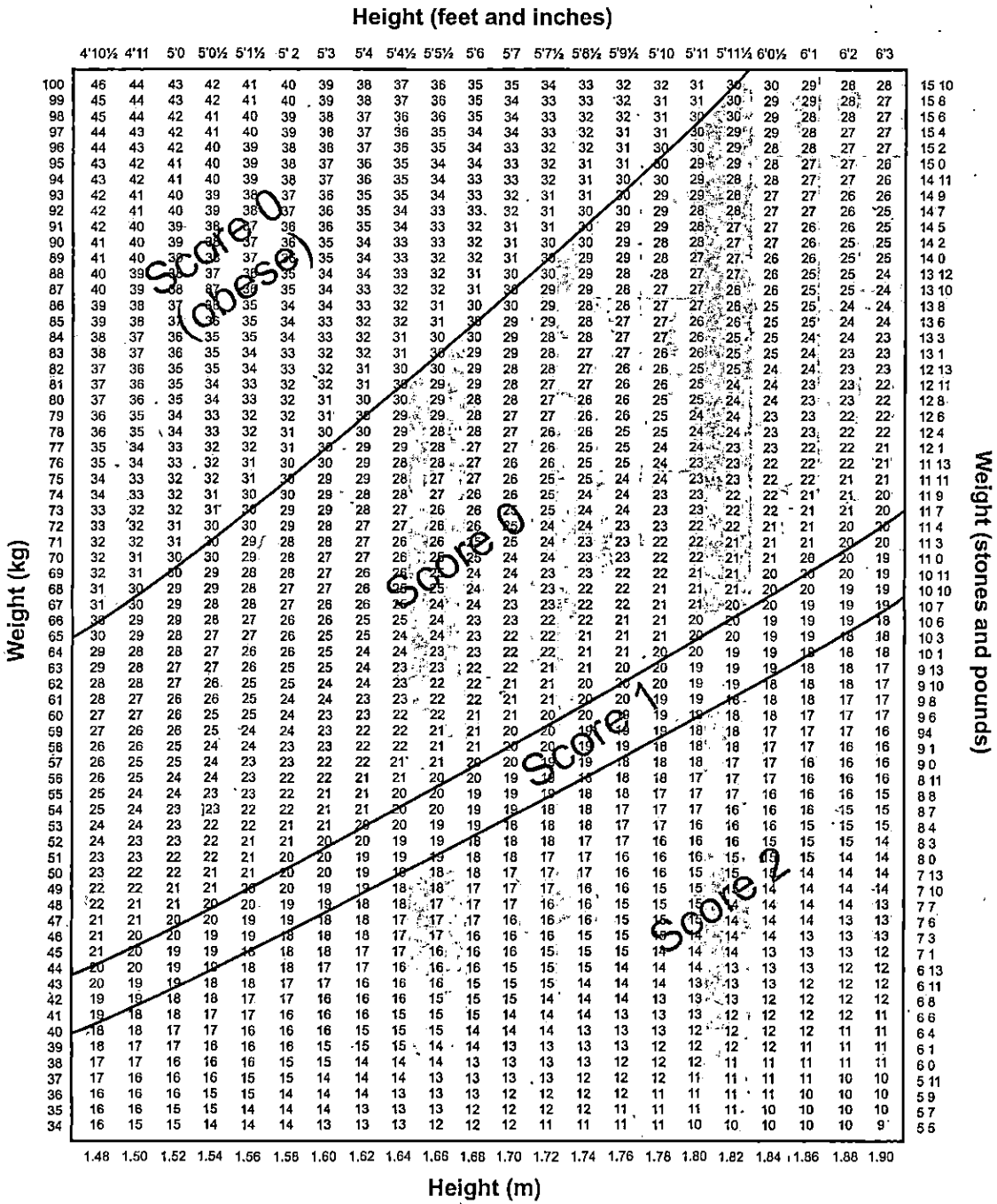
Dietitian	Date: / /	Outcome:
Speech and Language Therapy	Date: / /	Outcome:
Occupational Therapy	Date: / /	Outcome:
Dental Service	Date: / /	Outcome:

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Review date	Name (PRINT) Signature/Designation
11/10/17	0	On sloppy diet no issues		
		weigh weekly	18/10	

N.B. Ensure discharge plan includes most recent 'MUST' score and any necessary follow-up requirements.

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 W't loss <5%	Score 1 W't loss 5-10%	Score 2 W't loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

VI MEDICAL ILLUSTRATION • NUTRITION & DIET • 12366/01.09.08
STORES ORDER CODE 41850

10638479K
SULLIVAN
DEBORAH F
07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Patier

North Glasgow Hospitals

ore Risk Assessment Documentation Form

NHS Greater Glasgow and Clyde

Case Record Number: _____ Ward: 5

Waterlow Risk Assessment		Initials	1	2	3	4	5	6	7	8	9	10	11	12	13	14
		Date	10/10													
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average 0 Above average 1 Obese 2 Below average 3		0													
Continence:	Completely catheterised 0 Occasionally incontinent 1 Cath. Incontinence of faeces 2 Doubly incontinent 3		0													
Skin type-visual risk areas:	Healthy 0 Tissue paper/dry 1 Oedematous clammy (temp↑) 1 Discoloured 2 Broken spot 3		0													
Mobility:	Fully 0 Restless/fidgety 1 Apathetic 2 Restricted 3 Inert/traction 4 Chairbound 5		0													
Age/Sex:	Male/Female ½ 14-49 1 50-64 2 65-74 3 75-80 4 80+ 5		1 1													
Appetite:	Average 0 Poor 1 NG Tube/fluids only 2 nbm – Anorexic 3		0													
Special risks – tissue malnutrition:	eg Terminal cachexia 8 Cardiac failure 5 Peripheral vascular disease 5 Anaemia 2 Smoking 1		✓													
Neurological deficit:	Motor-sensory paraplegia 4-6 eg diabetes, MS, CVA		–													
Major surgery/trauma:	Orthopaedic Below waist, Spinal 5 On table > 2 hours 5		–													
Medication:	Cytotoxics, High dose steroids 4 Anti-inflammatory		/													
TOTAL SCORE			2													

Score: <10 = low risk; 10-14 = at risk; 15 – 19 = high risk 20+ = very high risk

DAILY PRESSURE AREA SKIN ASSESSMENT CHART

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

Grade one = blanching hyperaemia
Grade two = non blanching hyperaemia/superficial break
Grade three = through to subcutaneous tissue
Grade four = through to underlying muscle
Grade five = through to bone or presence of necrotic tissue

Date Skin Assessment	Skin Broken		Site of Damage	Grade of Damage	Signature
	Yes	No			

ENSURE ALL ACTION IS DOCUMENTED IN THE NURSING CARE PLAN

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

/ING AND HANDLING CARE PLAN

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Patient's De

Named Nurse: Yall

If Patient is totally independent, tick here and go to date box. ✓

BODY BUILD			
Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight	Kg
RISK OF FALLS			
High		Low	

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

nto Bath or shower.

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT		BED BATH
Ambulift		Parker		People 1		2		Additional Information:		
Shower Chair		Variable Height								
Other (specify)		Fixed Height								
		Shower								

ransfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
People 1	2	3		People 1	2		Additional Information:						
				Walking Aid (specify)									

oiletting

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
People 1	2	3		People 1	2		Additional Information:						
				Walking Aid (specify)									

Walking.

NO WALKING		MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
		People 1	2		Distance Walked/Additional Information:						
		Walking Aid (specify)									

Move up/down bed.

HOIST (specify)				HANDLING AIDS		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
People 1	2	3		Sliding aid (fabric)		Additional Information:						
				Rope ladder								
				Hand blocks								

Sit up over side of bed.

ROPELADDER		SWIVEL CUSHION		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT

Move on/off bed pan.

HOIST		ROLL PATIENT		PATIENT BRIDGES		MONKEY POLE		N/A

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID		SLIDING AID - FABRIC		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT

Other Instructions.

Date Assessed:	11/10/09					
Assessor's Signature:	Yall					
Proposed Review Dates:	18/10/09					

Into Bath or shower.

HANDLING AID	WHICH BATH	ASSISTANCE	SUPERVISION	INDEPENDENT	BED BATH
Ambulift	Parker	People 1	2	Additional Information:	
Shower Chair	Variable Height				
Other (specify)	Fixed Height				
	Shower				

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Toiletting

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Walking

WALKING	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
	People 1 2	Distance Walked/Additional Information:			
	Walking Aid (specify)				

Move up/down bed.

HOIST (specify)	HANDLING AIDS	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	Sliding aid (fabric)	Additional Information:			
	Rope ladder				
	Hand blocks				

Sit up over side of bed.

ROPE LADDER	SWIVEL CUSHION	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Move on/off bed pan.

HOIST	ROLL PATIENT	PATIENT BRIDGES	MONKEY POLE	N/A

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID	SLIDING AID - FABRIC	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Other Instructions.

Date Assessed:						
Assessor's Signature:						
Proposed Review Dates:						

Acute Services Division

Hospital / Department Stobhill

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: 10638479K SULLIVAN DEBORAH

Ward: 5

CHI number: .. CHI-0712726128 .....Unit/Hospital number .....

Contents

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

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

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 11/10/04	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	1						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s)		1						
SCORE 2 - 8 = LOW, 9 - 12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE								

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE 11/10	DATE	DATE	DATE	DATE	DATE	DATE
Action code	**LOW, MODERATE AND HIGH RISK**							
1	Prevention and general safety precautions discussed with patient and family.	✓						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE	[signature] RN 18/10.						

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

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

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

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

STRICTED 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.

Stobhill Hospital

NHS Greater Glasgow and Clyde

Name
Address Debrah Sullivan

D.O.B.

Unit No.

Patient Controlled Analgesia

Pain Service - Weekdays 09.00-17.00 Pain Management Sister Page 1184
Out of hours - Contact 1st on-call Anaesthetist Page 4932

Ward HDU
Date 9.10.09.

PCA Prescription

Date	Time	Drug	Bolus dose (mg)	Dose duration (mins)	Lock-out (mins)	Continuous infusion (mg/hr)	Prescribed by
10.09	10am	MORPHINE	1mg	STAT	5MINS	✓	KJ Carter

Anaesthetist signature.....

PCA Prescription Changes

Date	Time	Drug	Bolus dose (mg)	Dose duration (mins)	Lock-out (mins)	Continuous infusion (mg/hr)	Changed by accredited staff

nical Management

- Administer oxygen while on PCA as prescribed in post-operative instructions.
- Do not administer further opioids whilst on PCA unless prescribed by Acute Pain Team / On Call Anaesthetist.
- Ensure Naloxone (Narcan) 400 mcg/ml is available at all times.
- Do not position pump above site of IV and ensure PCA has dedicated given set, with anti-syphon device.
- PCA key to be kept with controlled drug keys, not in pump.

Points of Emphasis

- Always consider multi-modal analgesia, ie PR/O Paracetamol ± NSAID "on a regular basis".
- Carry out regular pain scores.
- For nausea ± vomiting administer anti-emetic always. For further details, refer to Post-operative Nausea and Vomiting Protocol.
- Check and record post-op observation $^1/_4$ hourly for one hour, $^1/_2$ hourly for two hours, hourly for 4 hours and then 4 hourly thereafter.

Potential Problems

- Refer to back of chart.

Patient Controlled Analgesia Observation Chart

Sedation Score

0 = awake

S = normal sleep

1 = drowsy, easy to rouse: eyes open to speech or light shake

2 = sedated, difficult to rouse
eyes open only to vigorous shaking

3 = unconscious, unrousable

Pain Score

Please use "X" to record patients VAS 0 -- 10
0 = No pain 10 = Worst pain possible

"Nurse" pain score (patients unable to give VAS)

0 = no pain at rest, no pain on movement

1 = no pain at rest, slight pain on movement

2 = intermittent pain at rest, moderate pain on movement

3 = continuous pain at rest, severe pain on movement

Date/ Time	Resp. Rate	Sed' score	Setup Check	VAS Rest X (0 2 4 6 8 10)	VAS Movement X (0 2 4 6 8 10)	0-3 pain score	Vol' remain	PONV Score	Treat for PONV	Initials
.10 10.00	22	0	✓	*	*		49	—	—	AS
600	20	0	✓	*	*	0	14	—	—	ef
1820	18	0	✓	x	x	0	11			ef
1900	17	0	✓	x	x	0	8			ef
7/10/09 2245	21	0	✓	x	x	9	50 mls	New Syringe		CM/
7/10/09 0640	20	0	✓	x	x	3	28	✓	✓	W
	Stopped due to venflon tissued.					5	19.6	0	0	W MCK
1145	19	0	✓	x	x	5	18	0	0	W
1p	19	0	✓			5	17	0	0	W
2 30 pm	18	0	✓			5	16	0	0	W
	DESTROYED 17mls - SYRINGE					RENEWED				
345 pm		0	✓			8	50 mls	New Syringe		W/S.
	No venflon.									
545 pm	18	0	✓			6	47.5	0	0	W
1pm	17	0	✓			0	46	0	0	W
2140	18	0	✓			0	31 ml	0	0	
10 0900	17	0	✓			0	13	0	0	
0900	17	0	✓			6	0	0	0	
0900		0	✓			5	52mls	0	0	W/CR.
1000	16	S	✓			5	48mls	0	0	W
Noon	16	S	✓			5	48mls	0	0	W
	DISCONTINUED				14mls destroyed					

Patient Controlled Analgesia Observation Chart

Date/ Time	Resp. Rate	Sed' score	Setup Check	VAS Rest X 0 2 4 6 8 10	VAS Movement X 0 2 4 6 8 10	0-3 pain score	Vol' remain	PONV Score	Treat for PONV	Initials

Protocol for Inadequate Analgesia

To be implemented by nursing staff accredited by pain management service only

Criteria

- "Nurse" Pain Score 2 or 3
- Sedation Score less than 2
- Respiratory rate 12 or above
- Patient is receiving prescribed oxygen

Protocol

- Check that the patient understands use of PCA Reinforce the use of PCA
- If Pre-set Bolus is 0.5mg = Give a 1mg bolus
- If Pre-set Bolus is 1mg = Give a 2mg bolus
- If Pre-set Bolus is 2mg = Give a 2mg bolus

Action

- Check and record at 5 minutes, 15 minutes and 30 minutes following bolus ---
- Respiratory Rate
- Sedation Score
- Oxygen saturation
- Pain Score

A maximum of 3 bolus doses can be administered over a one hour period at 15 minute intervals.
If after 2 boluses pain remains uncontrolled consider altering the patients pre set bolus.

- If pre set bolus 0.5 OR 2mg contact pain service for advice.
- Pre-set bolus is 1mg = change to a 2mg pre-set bolus Ensure lockout is set to a 5 min lockout.
- Increase frequency of observations to hourly
- If sedation score increases to 2 or 3 = decrease bolus and follow advice on front of P.C.A. chart
- If ineffective contact pain service for advice.

Recording of clinician override Bolus administration

Time/Date	Resp. Rate	Sedation Score	Pain Score	Bolus Given	Given by Accredited staff	Checked by

Potential Problems

- **RESPIRATORY DEPRESSION** = respiratory rate less than 8 per minute and / or difficult / impossible to rouse (sedation score 2 or 3).
- Remove P.C.A. handset and call Anaesthetist (life support and arrest call if not breathing)
- Ensure adequate airway and give oxygen 8 litres per minute by mask
- Give Naloxone (NARCAN) 0.4 mg IM or 0.1 mg IV and repeat if no response after 5 minutes
- **INADEQUATE ANALGESIA:**
- Check I.V. site, ensure that the patient understands technique.
- Call pain service for advice if I.V. site is nt the problem.
- Accredited staff follow inadequate analgesia protocol on back of this chart.
- **NAUSEA / VOMITING:** Administer anti-emetrics for Nausea as prescribed. Assess effectiveness. Consider alternative anti-emetic if ineffective.

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STOBHILL HOSPITAL

CONTINUATION CHART

SURNAME	CHRISTIAN/FORENAME	UNIT NUMBER

EPIDURAL NOTES

	See subcut chart overleaf for overnight management.
0900.	Pain Score
	Pain +++.
	BP 156/102. Resps 16. Sats 95%
	Block T11(L), No Block evident on (R)
	No motor Block.
	Top up 50mg Fentanyl in 5ml 0.25% Marcaine @
	0930.
	0935 – Dr Miller in attendance. Further 3mls 0.25%
	marcaine prescribed and given.
0950.	Patient asleep, more comfortable when wakened. Scoring
	pain @ 5/10. Falling back to sleep very quickly :.
	no further intervention at this time.
	? Possibility of ↑ rate. I will discuss with Dr Miller
	K Scrivia.
	Ward Nurse.
12.30.	Pain + +. Saw Dr Miller.
	Block. — No block on (R) – low block to (L) T9.
	Up sitting – moved back into bed.
	Looks heavy round her eyes. No pinpoint pupils noted
	Plan — to give 5mls of 0.5% bupivacaine.
1330.	Good result from top up. Patient now sleeping
18.30	Pain 10/10
	Block T9 Bilateral, bolus dolus given
	at this time
	B.P. 111/78 P: 124

F3
00262

S/N

1846.	Pain Score 10/10, very tearful Block T9(L) T10(R) HR 133, NIBP 122/75 RR 20 5mls v 0.5% marcain given Tramadol one - gk	
08/10/09 2015hrs	Patient scoring pain 7/10 on movement. Pain in abdominal area. NIBP 117/73, HR 117, RR 18, SpO_2 95%. D/w senior staff nurse, 3ml nursing bolus given. Dermatone levels (L) T12-L1 (R) NB, nil mdx block epidural catheter site intact. further vital signs as per HDU observation chart. ERouisas (S/N)	
9/10/09 01:05am	Patient pain score 9/10, General abdominal area. 3ml top up given at 01:05pm. BP 116/77, HR 110. Resps 16.	
15~~25~~ 09/10/09 03~~25~~	Patient c/o abdominal pain radiating to (R) shoulder. Anaesthetist unable to attend, Surgical SHO reviewed patient & contacted anaesthetist who will review patient when able. 3ml nursing bolus given. Patient still scoring pain 9/10. BP 100/82, HR 115, RR 14, SpO_2 95%, Dermatone levels (L) T7/8, (R) NB, nil mdx block, epidural catheter site intact. ERouisas (S/N)	
9/10/09 0415	TANNER / ANAESTHETICS (#1023) central abd pain radiating to shoulders. not a new pain. describes it as a generalised pain + with colicky element does not feel like trapped wind. feels like usual "pancreas" pain abd: distended. soft. tender ++ central abd + RUQ. BS ✓ if guarding a rebound. EPIDURAL Block → (R) = T_{11} + (L) = T_{11} to ica IMP: (1) Low epidural block (2) ? colicky acid pain PLAN: 1/ give Tramadol 100mg PO. PB. — duly awake 2/ Lansoprazole 20mg PO. PB 3/ Epidural top up → 5ml 0.5% levobupivacaine PB.	(delay in review due to critically ill patient)

TANNER #1023

HDU NHS Greater Glasgow and Clyde

Date 9/10/09 Post op day (4th) Name Deborah Sullivan Hosp No 1063847 9 DOB 7/12/72 Consultant Mr Smith

Op/Diagnosis Laparotomy & Open Fundoplication PMH Cholycystectomy, Pancreatitis, Agraphobic Physciological Problems

Time	08/01	09/02	10/03	11/04	12/05	13/06	14/07	15/08	16/09	17/10	18/11	19/12	20/13	21/14	22/15	23/16	00/17	01/18	02/19	03/20	04/21	05/22	06/23	07/00
FiO_2	4l/t			4l/t																				
Mode	N.C.			N.C.																				
SaO_2	93%			97%																				
Resp. rate	26			22																				
Air Entry	✓✓			✓✓																				
Secretions	C&E			NIL																				
Pain/sedation	4	O		7	O																			
BM	–			–																				
MEWS	–			–																				
Rhythm	ST/			ST/																				
CVP	NIL			NIL																				
MAP	(106)			(92)																				

Walk with physio

Temp. 132 → 122 → 131

BP 117 → 113

Pulse 94 → 85 → 81

TEMP: 36.9 → 35.8

Epidural	12 mls			6 mls	OFF																				
PCA																									

PCA (mls left) 49 mls

Ward round AM Buscopan, Fluids Epidural □, ? Tramadol, Imipramine, Temazepam,

PM Fluids off, catheter out

		INPUT (mls)									Previous 24hr balance	OUTPUT (mls)									
		ORAL	NG	BLOOD/ Plasma	IVI(1)	IVI (2) /TPN	IVI (3) /TPN	IVI (3)/ Drugs	Hourly total	Cumulative	Balance -ve 15-20	Cumulative	Hourly total	Urine	NG	Stoma/ bowels	Drain 1	Drain 2	Drain 3		
08	01	250			62				312	312		80	80	80						01	08
09	02				62				62	374		480	400	400						02	09
10	03	200			OFF				200	574		755	275	275						03	10
11	04									574		1005	250	250	(catheter out)					04	11
12	05	200							200	774		1005								05	12
13	06																			06	13
14	07																			07	14
15	08																			08	15
16	09																			09	16
17	10																			10	17
18	11																			11	18
19	12																			12	19
20	13																			13	20
21	14																			14	21
22	15																			15	22
23	16																			16	23
00	17																			17	00
01	18																			18	01
02	19																			19	02
03	20																			20	03
04	21																			21	04
05	22																			22	05
06	23																			23	06
07	00																			00	07

Date 9/10/09 Post op day (4th) Name Deborah Sullivan Hosp No 1063847 9K DOB 7/12/72 Consultant Mr Smith

HDU NHS Greater Glasgow and Clyde

ABGs									Biochem				HAEM				LFTs	
Time									Time				Time				Time	
FiO_2									Na				Hb				Alb	
H+									K				WCC				Bili	
pCO_2									Cl				Plt				AST	
pO_2									Bic				INR				ALP	
Bic/BE									Urea				PT				ALT	
Hb									Cr				PTT				GGT	
K									Glucose									
Na									PO_4									
Time									Mg									
FiO_2									Aca									
H+									Tca									
pCO_2									Protien									
pO_2																		
Bic/BE																		
Hb																		
K																		
Na																		

Times to use when commencing charts: **GGH** **0800-0700**

Line surveilance	Date inserted	Lines due changed	Urinalysis
Central			Waterlow
Peripheral 1			Weight
Peripheral 2			
Urinary catheter			
Arterial			
Epidural			
Tracheostomy			
0_2 circuit			

Date	Fluid	Vol (mls)	Time to run	Rate (mls/hr)	Added drugs	Quantity	Doctors signature	Added by	Start time 24 hr clock	Finish time	Put up by	Checked by	Serial / batch no.

Date 8·10·04 Post op day (3) Name Deborah Ilivan Hosp No 10638479K DOB 7-12-72 Consultant Smith

Op/Diagnosis laparotomy & open fundoplication

PMH Cholecystectomy, pancreatitis, physciological problems, agraphobic

Time	08/01	09/02	10/03	11/04	12/05	13/06	14/07	15/08	16/09	17/10	18/11	19/12	20/13	21/14	22/15	23/16	00/17	01/18	02/19	03/20	04/21	05/22	06/23	07/00
FiO_2	40%			40%		40%	↓4l/min	35%	35%	35%	↓4l/min		4L		4L		4L	4L		4L 35%	35%		25%	
Mode	R.F.			R.F.		R.F.	↑35%	R.F.	R.F.	R.F.	N.C.		N/C		N/C		N/C	N/C		N/C	RAOB6		RAO	
SaO_2	95%			95%		95%	90%	90%	96%	93%	93%		91%		95%		93%	94%		93%	94%	96%	95%	
Resp. rate	18			18		12	18	12	24		22		12 18		17		20	13		14	20		19	
Air Entry	✓✓			✓✓		✓✓			✓✓		↓↓		✓✓		✓✓					✓✓	✓✓			
Secretions	NIL			NIL		NIL	S	S	CdE		CdE		NIL		NIL			NIL		CLE	NIL		S	
Pain/sedation	7/10			4/0		6/0	S	S	5/10		5/0	9/10	7/10 0		1			8/10 1		7/10	9/10 0			
BM	—			—		—		—	—		—													
MEWS	—			—		—		—	—		—													
Rhythm	ST/			ST/		ST/	ST/	ST/		ST/	ST/		SR/NIL		SR/NIL		SR/NIL	SR/NIL		SR/NIL	SR/NIL		SR/NIL	
CVP	NIL			NIL		NIL	NIL	NIL		NIL	NIL													
MAP	(110)			(106)		(91)	(94)	(91)	(99)	(94)	( )		(72)		(88)		(90)	(90)		(92)	(97)		(87)	

CXR ABG ABG up from bed Back to bed 3ml bolus

Temp. 150 133 124 127 113 116 116 109 117 117 112 123 123 122

BP 102 90 76 82 78 80 80 81 63 68 79 80 71

TEMP 36.2 36.1 35.7 35.9 31.8°C 31.2°C 30.3°C 30.9°C 36.9°C

Epidural	12 ml/s			12 ml/s		12 ml/s		12 ml/s		12 ml/s	12 ml/s		12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s	12ml/s

* 3ml epidural top up

* 3ml epidural top up 100hrs

Ward round ... AM

PM

		INPUT (mls)									OUTPUT (mls)									
		ORAL	NG	BLOOD/ Plasma	IVI(1)	IVI (2) /TPN	IVI (3) /TPN	IVI (3)/ Drugs	Hourly to total	Cumulative	Previous 24hr balance / Balance	Cumulative	Hourly total	Urine	NG	Stoma/ bowels	Drain 1	Drain 2	Drain 3		
08	01	200			85				285	285		175	175	175						01	08
09	02				85				85	370		275	100	100						02	09
10	03	200			85				285	655		375	100	100						03	10
11	04				85				85	740		475	100	100						04	11
12	05				85				85	825		625	150	150						05	12
13	06				85				85	910		775	150	150						06	13
14	07				85				85	995		975	200	200						07	14
15	08				85				85	1080		1195	220	220						08	15
16	09	200			85				285	1365		1595	400	400						09	16
17	10	200			85				285	1650		1995	400	400						10	17
18	11				85				85	1735		2115	120	120						11	18
19	12	100			85				185	1920		2195	80	80						12	19
20	13				80				85	2005		2320	125	125						13	20
21	14				85				85	2090		2570	250	250						14	21
22	15	100			85				185	2275		2720	150	150						15	22
23	16				85				85	2360		2920	200	200						16	23
00	17				62				62	2422		3300	380	380						17	00
01	18				62				62	2484		3550	250	250						18	01
02	19				62				62	2548		3680	130	130						19	02
03	20	50			62				112	2660		3800	120	120						20	03
04	21				62				62	2722		3910	110	110						21	04
05	22				62				62	2784		4090	180	180						22	05
06	23				62				62	2846		4170	100	100						23	06
07	00				62				62	2908	1572	4480	310	310						00	07

MIS 110299

Date 8·10·04 Post op day (3) Name Deborah Hivan Hosp No 1063844K DOB 7·1·42 Consultant SMITH

ABGs									Biochem				HAEM				LFTs	
Time									Time				Time				Time	
FiO_2									Na				Hb				Alb	
H+									K				WCC				Bili	
pCO_2									Cl				Plt				AST	
pO_2									Bic				INR				ALP	
Bic/BE									Urea				PT				ALT	
Hb									Cr				PTT				GGT	
K									Glucose									
Na									PO_4									
Time									Mg									
FiO_2									Aca									
H+									Tca									
pCO_2									Protien									
pO_2																		
Bic/BE																		
Hb																		
K																		
Na																		

Times to use when commencing charts:

GGH	**0800-0700**
Stobhill	**0800-0700**
GRI	**0100-0000**

Line surveilance	Date inserted	Lines due changed	Urinalysis
Central			Waterlow
Peripheral 1			Weight
Peripheral 2			
Urinary catheter			
Arterial			
Epidural			
Tracheostomy			
0_2 circuit			

Date	Fluid	Vol (mls)	Time to run	Rate (mls/hr)	Added drugs	Quantity	Doctors signature	Added by	Start time 24 hr clock	Finish time	Put up by	Checked by	Serial / batch no.

MIS 110299

Date 7/10/09 Post op day 1st Name Deborah Si"ison Hosp No 1068479K DOB 7/18/62 Consultant Mr Smith

Op/Diagnosis Open revision of fundoplication

PMH Chronic Pain - acute pancreatitis, tonsilectomy, open fundoplication, chole, appendicectomy

Time	08/01	09/02	10/03	11/04	12/05	13/06	14/07	15/08	16/09	17/10	18/11	19/12	20/13	21/14	22/15	23/16	00/17	01/18	02/19	03/20	04/21	05/22	06/23	07/00
FiO_2	28%		28%		28%		31%		31%		31%			31%		35%	35%		35%		35%	40%	40%	
Mode	RA		RA		RA		MC		NC		NC			NC		RF	RF		RF		RF		RFlow	
SaO_2	93		97%		97%		96%		95%		94%			95%	89%		96%		96%		96%	98%	94%	
Resp. rate	22		18		28		18		17		20			17		12		12	14		12		12	
Air Entry	VV		VV		VV				VV					VV		VV		VV	VV		VV		VV	
Secretions	nil				nil		nil		nil		CTE			Cough		S		S	S		S		S	
Pain/sedation	8						S		4					8		S	9	S	9		S		S	
BM																								
MEWS							S		ST					ST		ST			ST		ST		3	
Rhythm	SR		SR		SR		SR		SR		SR			Reg		Reg			Reg		Reg		Reg	
CVP																								
MAP														87	94	80			94	96	94		102	

Temp. / BP / Pulse

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

41 40 39 38 37 36 35

109 118 108 193 188 114 109 73 60 100 132 92

37.2 37.7 37.1 37.3 37.2

3ml top up * IV Tramadol 100mg/50ml 0.9% Sod Chloride 50ml over 15 min as directed * 3ml top up * 0.9% Sod Chloride 2% Lidocaine Bupivacaine top up * Bupivacaine top up * 5mg Oxycodone

Ward round AM

PM

		INPUT (mls)									Previous 24hr balance	OUTPUT (mls)									
		ORAL	NG	BLOOD/ Plasma	IVI(1)	IVI (2) /TPN	IVI (3) /TPN	IVI (3)/ Drugs	Hourly total	Cumulative	Balance	Cumulative	Hourly total	Urine	NG	Stoma/ bowels	Drain 1	Drain 2	Drain 3		
08	01	150			125				275	275		155	155	125					30	01	08
09	02				125				125	400		485	330	300					30	02	09
10	03	150			125				275	675		740	255	225					30	03	10
11	04				125				125	800		990	250	220					30	04	11
12	05	150			125				125	925		1240	250	220					30	05	12
13	06				125				275	1200		1595	355	325					30	06	13
14	07	150			125				275	1475		1975	380	350					30	07	14
15	08				85				85	1560		2280	305	275					30	08	15
16	09				85				85	1645		2560	280	250					30	09	16
17	10	100			85				185	1830		2690	130	100					30	10	17
18	11				85				85	1915		2780	90	60					30	11	18
19	12				85				85	2000		3210	430	400					30	12	19
20	13				85				85	2085		3240	30	30						13	20
21	14				85			202	287	2372		3270	30	30						14	21
22	15	100			85				185	2557		3670	400	400						15	22
23	16				85				85	2642		4080	410	410						16	23
00	17				85				85	2727		4320	240	240						17	00
01	18				85				85	2812		4380	60	60						18	01
02	19				85				85	2897		4490	110	110						19	02
03	20				85				85	2982		4590	100	100						20	03
04	21				85				85	3067		4690	100	100						21	04
05	22				85			102	187	3254		4780	90	90						22	05
06	23				85				85	3339	-ve	5105	325	325						23	06
07	00				85				85	3424	1831	5255	150	150						00	07

Line surveilance	Date inserted	Lines due changed	Urinalysis
Central			Waterlow
Peripheral 1			Weight
Peripheral 2			
Urinary catheter			
Arterial			
Epidural			
Tracheostomy			
0_2 circuit			

Date	Fluid	Vol (mls)	Time to run	Rate (mls/hr)	Added drugs	Quantity	Doctors signature	Added by	Start time 24 hr clock	Finish time	Put up by	Checked by	Serial / batch no.

Date 7/10/09 Post op day 1st Name Deborah Sc''ivon Hosp No 1068[illegible]79K DOB 7/12/72 Consultant MrSmith.

Greater Glasgow and Clyde

ABGs									Biochem				HAEM				LFTs	
Time									Time				Time				Time	
FiO_2									Na				Hb				Alb	
H+									K				WCC				Bili	
pCO_2									Cl				Plt				AST	
pO_2									Bic				INR				ALP	
Bic/BE									Urea				PT				ALT	
Hb									Cr				PTT				GGT	
K									Glucose									
Na									PO_4									
Time									Mg									
FiO_2									Aca									
H+									Tca									
pCO_2									Protien									
pO_2																		
Bic/BE																		
Hb																		
K																		
Na																		

Times to use when commencing charts:

GGH	**0800-0700**
Stobhill	**0800-0700**
GRI	**0100-0000**

Ward round AM ? Bloods. PX IVF. NBM.

PM

* Fentanyl patch ✗
* Jui to get cloxacil ✓

		INPUT (mls)									Previous 24hr balance	OUTPUT (mls)										
		ORAL	NG	~~BLOOD/ Plasma~~	IVI (1)	IVI (2) /TPN	IVI (3) /TPN	IVI (3)/ Drugs	Hourly to total	Cumulative	Balance	Cumulative	Hourly total	Urine	NG	Stoma/ bowels	Drain 1	Drain 2	~~Drain~~		
08	01			MgSO4																01	08
09	02																			02	09
10	03																			03	10
11	04																			04	11
12	05																			05	12
13	06																1000			06	13
14	07				3000				3000	3000		1055	1055	805			1000			07	14
15	08				125				125	3125		1395	340	300			250			08	15
16	09				125			100	225	3350		1935	540	500					40	09	16
17	10				125				125	3475		2230	295	255					40	10	17
18	11				125				125	3600		2495	265	225					40	11	18
19	12				125				125	3725		2670	175	135					40	12	19
20	13				125				125	3850		2795	125	85					40	13	20
21	14				125			100	225	4075		2895	100	60					40	14	21
22	15				125				125	4200		2985	90	60					30	15	22
23	16				125			100	225	4425		3110	125	95					30	16	23
00	17				125				125	4550		3230	120	90					30	17	00
01	18				125				125	4675		3535	305	275					30	18	01
02	19				125				125	4800		3665	130	100					30	19	02
03	20			104	125				229	5029		3725	60	30					30	20	03
04	21			83	125			102	310	5339		3805	80	50					30	21	04
05	22			83	125				208	5547		3875	70	40					30	22	05
06	23			83	125				208	5755		4020	145	115					30	23	06
07	00				125			100	125	5880		4095	75	45					30	00	07
											+VE 1785										

Cumulative +VE 1785 mls.

*Allergic Amoxicillin Voltarol.

HDU NHS Greater Glasgow and Clyde

Date 6/10/09 Post op day TH. Name Deborah Sullivan. Hosp No 10638479K DOB 7/12/72 Consultant Mr Smith

Op/Diagnosis open Rowden fundoplication PMH chronic pain = acute pancreatitis fundoplication, chole, appendicectomy

Time	08/01	09/02	10/03	11/04	12/05	13/06	14/07	15/08	16/09	17/10	18/11	19/12	20/13	21/14	22/15	23/16	00/17	01/18	02/19	03/20	04/21	05/22	06/23	07/00
FiO_2							4L/5	4L	4L	4L	4L/5		4L/5		4L/5		28%/35%	35%	35%/28%		28%		28%	
Mode							FM	FM	FM	FM	FM		FM		FM	NC	RFlo	RFlo	RFlo		RF		RF	
SaO_2							100%	99%	97%	96%	97%		96%		95%		94%	95%	96%		96%		93%	
Resp. rate							14	20	20	22	18		22		22		22	18	24		22		24	
Air Entry																					IE			
Secretions							NIL	NIL	NIL	NIL	NIL		NIL		NIL		NIL	NIL	NIL	CTE	S	CTE	NIL	
Pain/sedation							0	0	0	0			9		5									
BM								5.9																
MEWS								ST	NIL	NIL											ST		ST	
Rhythm							SI/NIL	NIL	ST	ST	SI/NIL		SI/NIL		SI/NIL		SI/NIL	ST/NIL	ST/NIL		Req		NIL	
CVP																								
MAP								(112)	(117)	(103)			(92)		(86)		(77)	(81)	(75)		(78)		(71)	

*Admitted HDU at 17:10

*ECG *

Sputum Sample *

Temp. / BP / Pulse

Epidural ml/hr							6	10	10	10	10	10	NR	12	12	12	12	12	12					

Post op bloods

0.25% 15ml

5ml Group Hydrocortisone

5ml Group Hydrocortisone

Date 6/10/09 Post op day TH. Name Deborah Sullivan Hosp No 0638479K DOB 7/12/72 Consultant Mr Smith

Greater Glasgow and Clyde

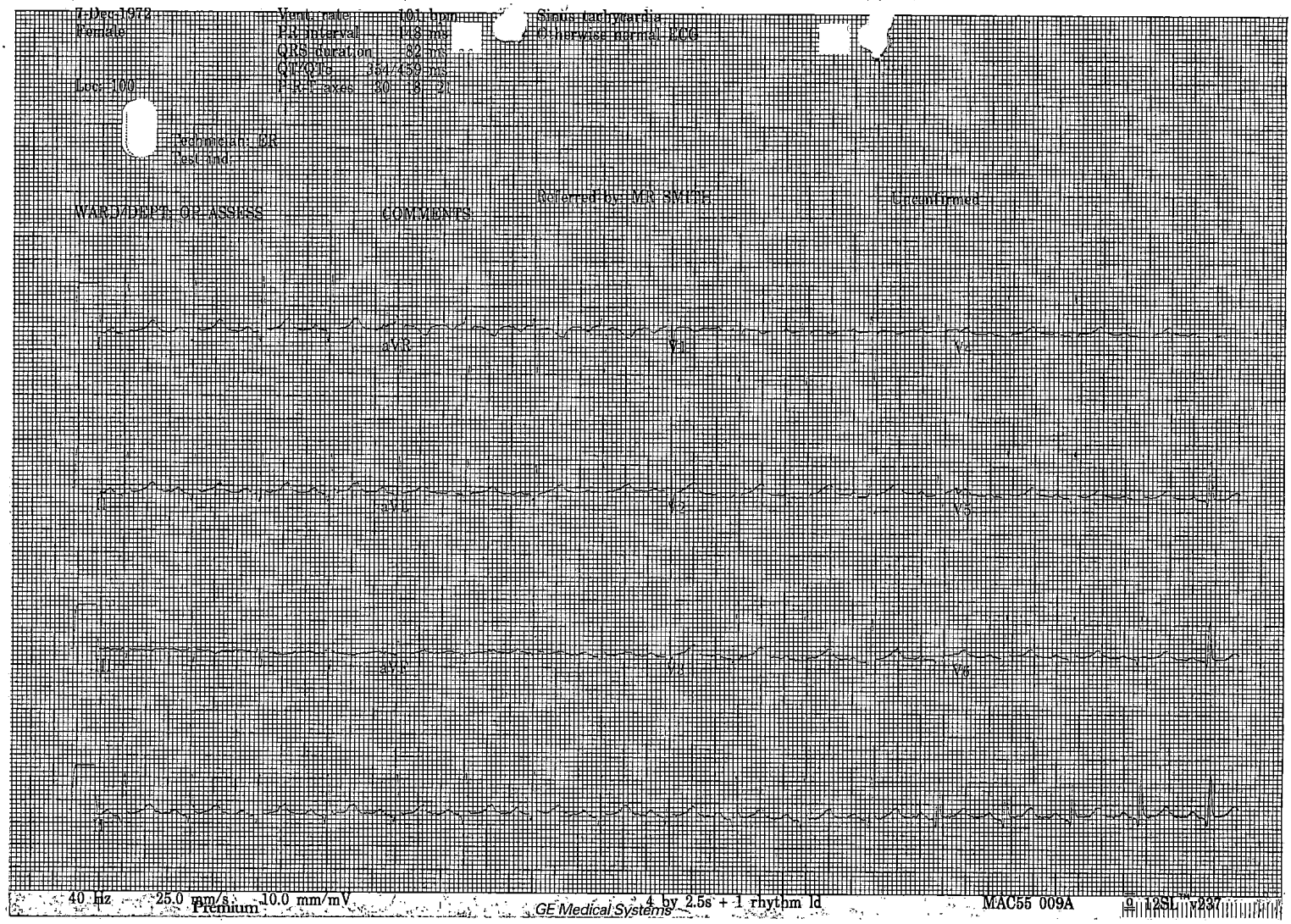
ABGs									Biochem				HAEM				LFTs	
Time									Time				Time				Time	
FiO_2									Na				Hb				Alb	
H+									K				WCC				Bili	
pCO_2									Cl				Plt				AST	
pO_2									Bic				INR				ALP	
Bic/BE									Urea				PT				ALT	
Hb									Cr				PTT				GGT	
K									Glucose									
Na									PO_4									
Time									Mg									
FiO_2									Aca									
H+									Tca									
pCO_2									Protien									
pO_2																		
Bic/BE																		
Hb																		
K																		
Na																		

Times to use when commencing charts:

GGH	**0800-0700**
Stobhill	**0800-0700**
GRI	**0100-0000**

Line surveilance	Date inserted	Lines due changed	Urinalysis PROTEIN - Blood +++ NITRE POSITIVE.
Central			Waterlow
Peripheral 1			Weight
Peripheral 2			
Urinary catheter			
Arterial			
Epidural			
Tracheostomy			
0_2 circuit			

Date	Fluid	Vol (mls)	Time to run	Rate (mls/hr)	Added drugs	Quantity	Doctors signature	Added by	Start time 24 hr clock	Finish time	Put up by	Checked by	Serial / batch no.


7-Dec-1972
Female
Loc: 100
Vent. rate 101 bpm
PR interval 148 ms
QRS duration 82 ms
QT/QTc 354/459 ms
P-R-T axes 30 18 2
Sinus tachycardia
Otherwise normal ECG
Technician: GR
Test ind:
Referred by: MR SMITH
Unconfirmed
WARD/DEPT: OP ASSESS
COMMENTS
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
V
40 Hz 25.0 mm/s 10.0 mm/mV
Premium
GE Medical Systems
4 by 2.5s + 1 rhythm ld
MAC55 009A
12SL™ v237

Patient Agreement to Investigation or Treatment

NHS Greater Glasgow and Clyde

CONSENT FORM

PATIENT DETAILS (OR PRE-PRINTED LABEL)

Hospital/Clinic/GP Practice .....

Patient's surname/family name :.....

Patient's first nai

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date of Birth___ Gender: Male ☐ Female ☑

NHS/ CHI Numb _____

Special requirements (e.g. other language/communication method) .....

.....

Responsible practitioner: Mr J Smith

Job title: Consultant Surgeon

STATEMENT FOR PRACTITIONER

(to be filled in by practitioner with appropriate knowledge of proposed procedure- see guidance notes)

Describe proposed operation, investigation or other treatment.
Where appropriate specify site or side: (WRITTEN IN FULL)

DIAGNOSTIC LAPAROSCOPY +/- OPEN REVISION FUNDOPLICATION.

I have explained the procedure named on this form to the patient in terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any significant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedures above).

Signature of practitioner: .....

Name/Designation (Print) ..... A. RADIC .....

Date 6.../.10../..09.....

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*

(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.
- That examination for the purpose of teaching will not be undertaken without my consent.

I have been told about additional procedures which may become necessary during treatment. I have sted below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- to the emergency administration of blood or blood products

Additionally you have to agree or disagree the following:-	**Agree**	**Disagree**
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue or other biological material not essential for my diagnosis or iture treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT REFUSAL FOR BLOOD PRODUCTS

Please sign here if you refuse to consent to the emergency administration of blood or blood products. Even if this results in death.

Signature: ..... Date ...../...../.....

Practitioner Signature: ..... Date ...../...../.....

PATIENT/PARENT* AGREEMENT FOR TREATMENT

Signature: D E Sullivan Date 6/10/09

Name (Print): DEBORAH E SULLIVAN

Peri-Operative Care Plan

NHS Greater Glasgow and Clyde

P[redacted]
10638479K
SULLIVAN
DEBORAH F 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Date: 6/10/09.
Ward: 6
Consultant: Mr Smith
Proposed operation:

Baseline Observations

Water Low Score:	Pulse:	BP:	Temp:	SPO2:	Resp.	Height: Weight:	BMI:
	112	113/80	36	98%	16		

These checks must be made immediately prior to administration of pre-med.

Pre-operative checks comments:	Ward comments:	Reception
Identify band correct (name, date of birth, hospital number, ward	✓	✓
Consent signed and dated	✓	✓
Fasted from:	Food: MN Fluid m	Water with tablets 7a
Correct site surgery marked and prepared	—	—
Allergies/sensitivities and reaction	✗ Amoxicillin Vomited – Nausea	✓
Medical conditions, i.e. other relevant information:		
Inhalers/Sprays	Nil used	—
Blood Glucose (if relevant)	—	—
Antiembolitic Treatment e.g. TEDs	✓	✓
Implants insitu e.g. pacemaker, joint replacements	Nil	—
Dentures / loose teeth, Caps, Crowns	Broken tooth Bottom Left	
Hearing Aid, Spectacles and Hair pieces remaining in situ (contact lenses to be removed) - please state		—
Others (please state)		
Make up/nail polish removed	✓	—
Jewellery/body piercing taped/removed	✓	—
Underwear removed/disposable pants	✓	Bra removed
Voided urine/catheter insitu		✓
Documentation (case notes, nursing notes, prescription charts, ECG, X-ray, Blood results)		
Premedication given:	Nil prescribed.	

Please sign once check completed:

Ward Nurse:	Reception Practitioner:	Anaesthetic assistant/Theatre Practitioner
MTTB		

Time into Reception: _____

Operational Data	Time into Anaesthetic Room 0945 Time into Theatre 0945 Time out of Theatre	Scrub Practitioner En S M'Donald Circulating Practitioner V Allen Anaesthetic Assistant Julie Arthur

ANAESTHETIC ROOM

Blood Availability check	Anaesthetic Practitioner has confirmed with Anaesthetic that X matched blood is:- Required ☐ Available ☐ Grouped and Saved ☐ *(tick or cross as necessary)*	
Psychological care given to allay anxiety	Verbal & Non Verbal Communication given ☑ Explanation of expected events/routine given ☐ Communication adapted to meet needs of the patient ☐ Certificate of Incapacity ☐	
Safe Application, Preparation and Use of Equipment	SP02 ☑ Position Rotated Hourly ☐ Arterial Line ☐ CVP Line ☐ Temperature probe ☑	Infusion Device Numbers
	ECG ☑ Warming Device Warming Blanket	
	NIBP ☑ Other	

THEATRE

Information given in Scrub Nurse and Senior Circulating Nurse by Anaesthetic Nurse	Scrub nurse must check patient ID band with consent ☑ Patient Allergies ☑ Prosthesis ☐ Other ☐ Name Scrub Practitioner En S M'Donald
Operation Site & procedure safety check	Scrub Nurse and Senior Circulating Nurse confirms with Surgeon the procedure to be performed ☑ Correct Site and Site of operation ☑
Safe positioning and prevention of injury to Skin, Joints and Nerves	Moving Aids - Pat Slide ☑ Roll Board ☐ Sliding Sheets ☐ Hover mattress ☐ Other ☐ _____ **DIATHERMY PAD MUST BE CHECKED WHEN RE-POSITONING PATIENT**

Position(s)	1- Supine	Torrence Score Key
Skin Integrity e.g. Pressure Ulcer, Red, Broken, Bruise **Pre- operative** Skin Check + Torrence Score	dry flaky skin on both legs	
Risk Assessment Tool - Name and Score **Post operative** Skin Check + Torrence Score	✓	
Positioning Devices e.g. Pillow, Wedge, Stirrups, Rolls etc. Positioning Devices (type, position)	✓	
Padding e.g. Heel, Pads, Headrest, Gel Pads etc. Padding (type, position)	Heel Resto	
Arm Position e.g. By side, Arm Boards, Over Abdomen. Secured By e.g. Ties, J Board Arm Position and Security (type, position)	2N arm boards	

N.B ARM BOARDS MUST BE PLACED AT LESS THAN 90 DEGREES TO AVOID INJURY

Measures to reduce the risks of Compartment Syndrome

LEGS IN LITHOTOMY OR LLOYD DAVIS POSITION MUST BE LOWERED EVERY 3 HOURS FOR A MINIMUM OF 5 MINUTES Remove compression stockings pre operatively

Position	Time legs positioned	Time legs lowered and duration	Time legs lowered and duration	Removal of Comp. Stockings prior to surgery

DVT Prophylaxis

Elastic Compression Stockings ☑ Sequential Compression device _____ mmhg

Flowtron Boots ☐ _____ mmhg

Safe use and application of Intraoperative equipment to prevent injury

Diathermy - Monopolar Bi polar

Monopolar return eletrode - Site R Thigh

Skin site assessed - meets safety criteria ☑ Skin prepared - N/A ☐ Clipped ☐ Dry Shaved ☐

Tourniquet - Checked ☐ Padding applied ☐

	Position	Time inflated	Pressure	Time deflated	Time inflated	Pressure	Time deflated
Site 1							
Site 2							

Skin Preparation to reduce the risk of infection

Correct site(s) to be checked with Surgeon ☑

Site	Skin	Prepping Solution
Site 1-	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☑ Chlorhexidine Acetate ____ ☐ Chlorhexidine ____ ☐ Betadine Alcohol ☐ Other ☐
Site 2-	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ____ ☐ Chlorhexidine ____ ☐ Betadine Alcohol ☐ Other ☐

Aseptic Technique to reduce risk of infection

Drain(s) Inserted ☐

	Type	Site	Size	Secured with
Drain 1				
Drain 2				
Drain 3				

Urinary Catheter ☐

Type	Site	Size	Ballooned Inflated with	Pepping Solution
foleys	urethral urinary	12fg	10mls saline mls	transeept

Wound Closure/Dressings

	Site	Wound Closure	Dresssing	Other
1	Abdominal	Staples	Tegaderm	
2				

Wound Bath - Sterile Saline 0.9% ☑ Other ☐ _____

Pack left in situ

Site	Type	Size	Number

OPERATION PERFORMED

open Revision Fundoplication.

THEATRE

OPERATION PERFORMED _____

	YES	NO
DIATHERMY BIPOLAR/MONOPOLAR		
HEEL RESTS		
FLOWTRON BOOTS		
SHEEPSKIN HEEL PADS/MATS		
HEATED BED		
ARM BOARDS		
PATIENT WARMING BLANKET		

PATIENT POSITION

LATERAL RIGHT		TRENDELENBURG	
LATERAL LEFT		REVERSE	
SUPINE		LITHOTOMY	
PRONE		LLOYD DAVIS	

TOURNIQUET TIME ON OFF

SPECIAL COMMENTS _____

SPECIMENS: PATH BACT OTHER

DRAINS

CATHETER

COUNTS	CORRECT
SWABS - FIRST Ian Campbell	✓
- FINAL Ian Campbell	✓
INSTRUMENTS	—
SHARPS - NEEDLES	✓
- BLADES	/
THROAT PACK OUT	
PACK IN SITU	

INSTRUMENTS FOR REMOVAL:

Name of Scrub Nurse: E M S M'Donald Signature of Circulating Nurse: _____

TRACEABILITY STICKERS

Post Operative Instructions

Oxygen: 4 ltrs/min - [illegible]

Fluids: [illegible]

Other: [illegible]

Anaesthetist's Signature: [illegible]

Surgeons Notes

Signature of Surgeon:

Nursing Notes 6/10/09

Seen by Dr Mac see at 11[30] am. Patient Complaining of pain increasing. Unable to get Proper dermatome levels at present, Dr McCrae tried as well.

45 Lidocaine Inj up 2% given by Dr McCrae at 11.30 am.

Left side T9/ L1

Right side T9/ L1.

Patient still complaining of pain at 11.45 am. epidural derm, levels checked again as recorded above. Seen by SR pain nurse, epidural will be commenced shortly. Epidural commenced at 12 md

Readymade given to patient.

Diamorphine 3mg ~~of ep~~ via epidural line given by SR. Saba pain control nurse. at 12 MD.

12.55 - legs appear mottled. THEATRE informed AWAIT review - SIB MR SMITH - NO problems noted

1305 - PAIN score 9. Anaesthst on call asked to review

13.15. Reviewed by Dr McKinnon, at Epidural top up given at 13.15 Gs chartea on epidural form by Dr McKinnon. Epidural also increased to 10 mls/hour. Also explained that patient has been tachycardic since arrival in recovery. 105-114 bpm. Patient was tachycardic pre-op-eratively and intraoperatively. Patient remains settled at 13.50. Observations all stable. Can return to HDU. Dr McKinnon will see her there.

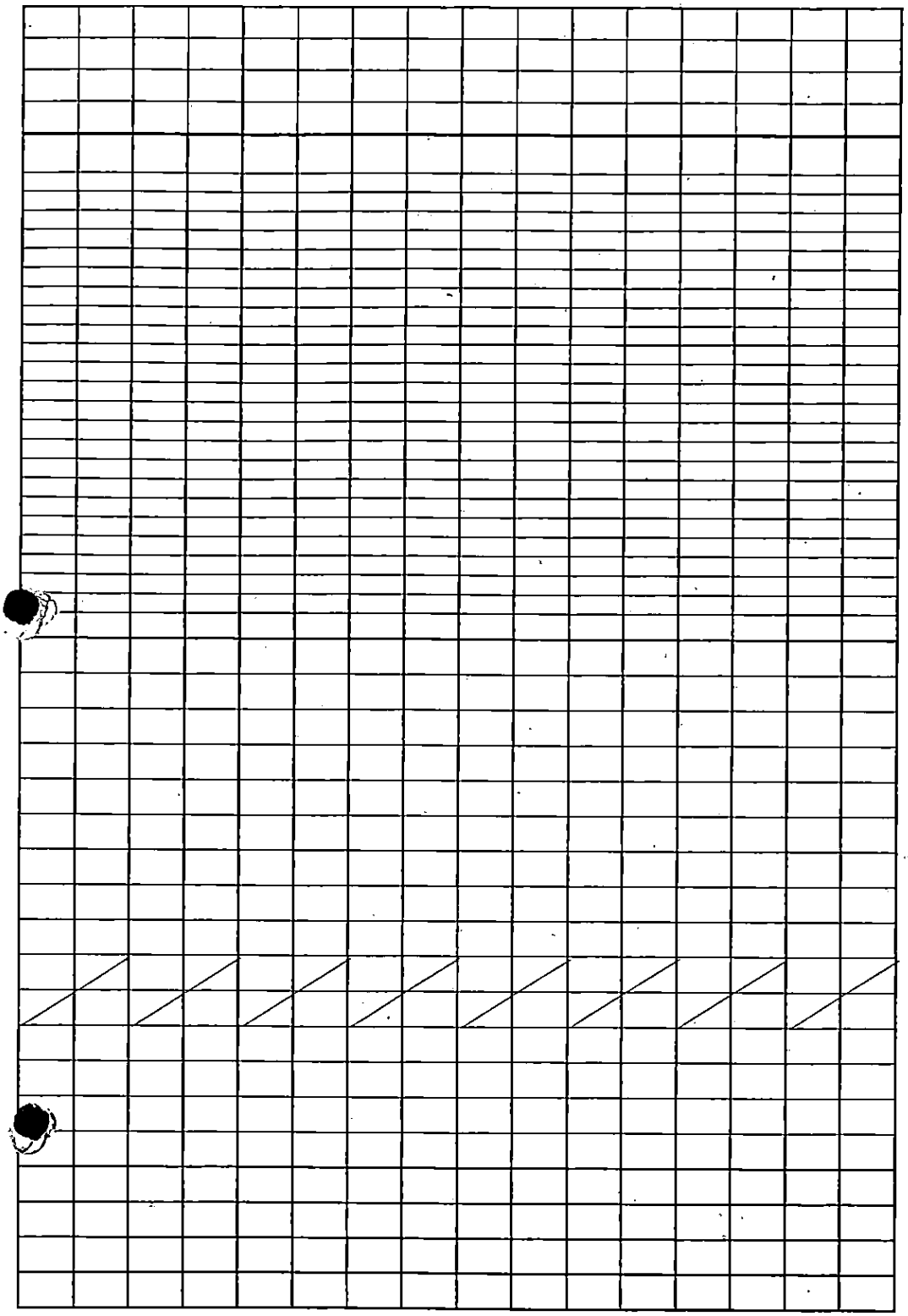
[signature]

Drugs & Route	Time
~~Bupivacaine~~ top up ~~5mls 2%~~	11 30
Lidocaine 2% x 5ml	11 20
Diamorphine 3mg via epidural	12 15

Time	11 20	11 35	11 50	12 05	12 20	12 35	12 50	13 05	13 20	13 35
SPO_2	96%	99%	98%	99%	99%	99%	99%	98%	98%	98%
Airway Type	1	1	1	1	1	1	1	1	1	1
Resp. Rate	16	20	16	16	20	20	24	16	18	
O_2 Therapy	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L
Sedation score	1	1	1	1	1	1	1	1	1	1
E.C.G	110	106	105	106	107	104	109	110	114	118
Wound score	1	1	1	1	1	1	1	1	1	1
Core Temp:	36.4°									
Pain score	↑	10	10	10	10	7	9	9		7
P.O.N.V.	0	0	0	0	0	0	0	0	0	0
Hrs Urine Volume					35mls		220			350
Total Volume										
Urine Volume. (Total from 7H.)	200 ml.				255		455			805
	TE	TE	HM	HM		AM	AM	AM	AM	HM

I.V. Fluids from Theatre

	Time	Type of Fluid	Volume	Batch No.	Signature
1	12.10	Hartmanns Solution	500ml	08L22T35 11/2011.	T. Howard
2					
3					
4					
5					



KEYS

AIRWAY TYPE

1 Spontaneous
2 Guedel
3 NASO - pharangeal
4 L.M.A.
5 E.T.T.
6 Double lumen ET.T.
7 Tracheostomy

WOUND SCORE

0 Dry and intact
1 Slight staining
2 Moderate staining
3 Saturation/Pad req.

PAIN SCORE

0 No pain at rest, no pain on movement
1 No pain at rest, slight pain on movement
2 Intermittent pain at rest, moderate pain on movement
3 Continuous pain at rest, severe pain on movement

SEDATION SCORE

0 Awake
S Normal sleep
1 Drowsy, easy to rouse: eyes open to speech or light shake
2 Sedated, difficult to rouse: eyes open only to vigorous shaking
3 Unconscious, unrousable

PONV ASSESSMENT

0 None
1 Mild nausea
2 Moderate Nausea
3 Severe Nausea
4 Patient Vomiting

MEWS	
Pulse	
Resp. Rate	
Temp	
Avpu	
Urine Output	
Systolic BP	
$Sp0_2$%	
Total	

Waterlow Score
See Chart

Discharge Criteria Achieved Yes / No - see Nursing Notes

Recovery Practitioner Signature: _____

NHS
Greater Glasgow and Clyde

Anaesthetic Record

Stobhill Hospital

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

date & time	drug, dose & route	signature	given by	time given
6/10/09	Ran Gaben und ord medication ✓			

Pre-op instructions

Operation: Re di- Nissen.

Date: 6/10/09.

NCEPOD category 1 2a 2b 3 (4)

Pre-operative Assessment

Age: 36yr Ht: 1.8m. Wt: 75kg BMI:

ASA Grade: 1 (2) 3 4 5 E

CVS

Exercise tolerance

BP 113/80.

HR 112

RS Spo2 98%

Smoker

Airway

MP fair.

Dentition [illegible]

Expected to be difficult yes/(no)

Anaesthetic History

Gen i

Medications Gaviscon.
Gabapentin -
Omeprazole
Paracet
Tramadol Fentanyl
Fetyl 75µg Ranitidine

Other relevant information

Reflux

NSAIDS ✓

Allergies → Amoxicillin - rash

Fasted ✓ (No Coma)

Hb	Na+ 136	ECG/ Q SR-I
WCC	K+ 6.5	
Plts	Cl- 101	
PT/INR	Ur 5.1	CXR
APTT	Cr 75	
TT	Glucose	Other
Fib		
G+S/X MATCH		

Assessor: Date: 6/10/09

Grade: Medical Student

Explanation of risks/techniques

GA + pain.
in anaesthetic Room → Epidural!

Supervising Consultant: Informed Y/N

Significant perioperative event ? (describe on back page)

Theatre: 2

Equipment

Machine checks: Anaesthetic room / Theatre — Circle / Bain / Other — Machine used 3293

Vascular Access (describe type, size and site)

Peripheral: 20G IVC; 18G (R) Forearm.

Arterial:

Central:

Regional (additional space is available on back page)

Type of block	Site	Needle used	Catheter
Technique: Epidural	Sitting - (aseptic)	Tuohy 18G (on (skin)	5cm Catheter → 11cm

09" Start. ? Tuohy Used

Last dose of LMWH a.m.

Airway

Facemask

Oral/Nasal Airway — Spont/(IPPV)

LMA — size ..... — Throat pack

(ETT) — size 8.0 — ☐ in ☐ out

DLT — size ..... 20cm 6 Fr.

Easy to hand ventilate (Y)/N

Intubation: (easy) awkward difficult

(comments) 1st Att ✓

Laryngoscopy grade (1) 2 3 4

Intra-operative Care

Supine / Lithotomy / Lateral / Prone / Head up / Head down

E[illegible]are / Pressure points

Warming: Fluids / Blanket / Hat

Fluids

(2) 1/2 R - 1000ml + Gelofusine 500ml

(3) Gelofusine 1,000ml

Events

A Paracetamol 1g

B

C

D

E

F

G

H

Anaesthetist(s)

☑ Con ☐ SAS ☐ Trainee (+ Grade)

☑ ☐ ☐

Surgeon(s) [illegible]

Hartmann's 500											
Midazolam 2											
Propofol 150	(O₂/Air/THA → Half)										
Morphine 2	2		2								
Ketamine 40	10		20		10						
Atracurium 15	5 + 3		2		2						
Fentanyl - Neostig 2.5/Gly 0.5											
Fluids/Events	①		②		③						
Time:	09:30		10:30		11:30						

- Pre-O_2 ☑
- RSI ☐

- ECG ☐
- SpO_2 ☐
- NIBP ☐
- $ETCO_2$ ☐
- ET Agent ☐
- All Above ☑
- PNS ☐

- AIR ☐
- N_2O ☐
- ISO ☐
- SEVO ☐
- DES ☑
- TIVA ☐

240 220 200 180 160 140 120 100 80 60 40 20

FiO_2	1.0	0.5		0.49		0.47					
SpO_2	99	98		98		98					
$ETCO_2$		68		65		6.3					
ET Agent		6.8		6.1		7.0					
CVP											
Temperature		35.9		36.1		36.4					
Urine output		50		20		40					
Blood loss						250					

Anaesthetist's signature

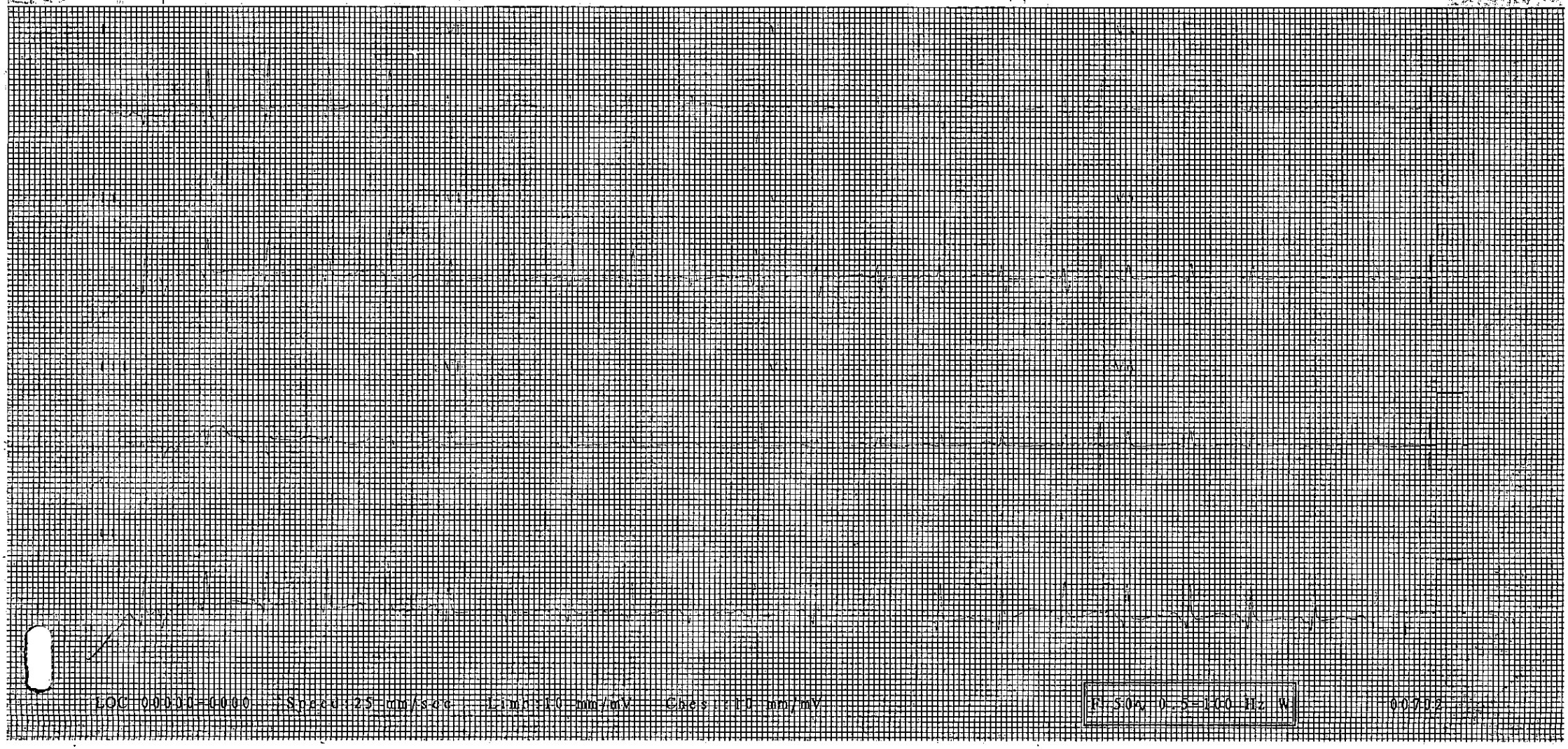
Anaesthetic notes

NCEPOD category		
	1	Presents for immediate surgery.
	2a	Must present for surgery within 4hrs.
	2b	Must present for surgery within 24hrs.
	3	Urgent, cannot wait for next elective list but can wait >24hrs.
	4	Elective procedure.

Dept:

Oper:

Requested by:



NORTH GLASGOW UNIVERSITY HOSPITAL DIVISION

STOBHILL

INTENSIVE I.V.

SURNAME

FORENAME

DATE

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

SHEET UMBER

RATE FOR 500ml
1HR =120 DROPS/min
4HR = 30 DROPS/min
6HR = 22 DROPS/min
8HR = 15 DROPS/min

NHS Greater Glasgow

FLUID / ADDITIVE DRUG	VOL / DOSE	COMMENCE	DURATION	FINISH	SIGNATURE	SERIAL NO / BATCH NO	GIVEN BY
Hartmanns	500	16.10	6°			09D2 8T5K 3/12	AS
5% DEXTROSE	500	10/10	6°	16.10		09E24 EXP 2012	SW
HARTMANNS	500	22.00	6°	05:55 am		09G24 T5D EXP 06/12	CM AB
5% dextrose *9/10/09*	500	05:55 am	6°			09G24EW EXP 2012	AB CM

NORTH GLASGOW UNIVERSITY HOSPITAL DIVISION

STOBHILL HOSPITAL

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

SURNAME SULLIVAN	UNIT NUMBER
FORENAME DEBORAH	
DATE 6/10/09	

RATE FOR 500ml
1HR =120 DROPS/min
4HR = 30 DROPS/min
6HR = 22 DROPS/min
8HR = 15 DROPS/min

NHS Greater Glasgow

FLUID / ADDITIVE DRUG	VOL / DOSE	COMMENCE	DURATION	FINISH	SIGNATURE	SERIAL NO / BATCH NO	GIVEN BY
5% Dextrose	500	16 20	4°	20²⁰		090 18C1X 3/12	JL WM
HARTMANNS	500	20²⁰	4°	12·25		08L 22T 3C 11/11	AMcE
HARTMANNS	500	12·25	4°	0915		08L22 T3C 2011	AMcE
5% Dextrose	500	0915	4°			09C2 1 EIR 2012	AMcE DR
HARTMANNS	500	0910	4°	12·10		08L22T3C 11/2011	AC
HARTMANNS	500	12·10	4° 6 hrs	2300		Exp 12	SL
~~D 5%~~ 5% DEXTROSE	500ml	2300	6°			09 E2 4EIW 2012	AMcE AB
HARTMANNS	500ml		6°				

Stobhill Hospital
Epidural Observation Chart

Advice: Office Hours - Acute Pain Sister Page 1184
Out of Hours - On call Anaesthetist Page 4932

10638479K
SULLIVAN
DEBORAH
CHI-0712726128
D.O.B 7/12/72

NHS
Greater Glasgow and Clyde

Standard Management

- Give oxygen as charted, unless discontinued by Doctor.
- A functioning IV cannula must be in place while epidural infusion is in progress and for 12 hours after epidural opioid is discontinued.
- If epidural opioid is used DO NOT give any other opioid unless ordered by an anaesthetist.
- Nurse semi-sitting in bed. Sitting out of bed and mobilisation are possible if there is no postural hypotension or leg weakness.
- Step-down analgesia, give non-opioid oral analgesia as soon as able to take oral fluids, discontinue epidural when oral analgesia is established.

Chart 1

Trouble Shooting / Potential Problems

Hypotension

- Consider ALL potential reasons for Hypotension.
- If Hypotension is related to epidural infusion, call pain service/ anaesthetist.
- Reduce or stop epidural infusion.
- Lie patient flat / raise legs only.
- Give oxygen 6 litres per minute, ensure airway is adequate.
- Fluids = seek medical advice.
- Give ephedrine 15mg IM or 6mg IV.
- Consider atropine 0.3 - 0.6mg IV if pulse less than 50bpm.

Respiratory Depression

- Respiratory rate less than 8bpm AND/OR difficult to rouse (sedation score 2 or 3).
- Stop epidural infusion.
- Call pain service/anaesthetist. Life support arrest, call if not breathing.
- Ensure adequate airway / give oxygen 8 litres per minute.
- Give naloxone (NARCAN) 0.4mg IM or 0.1mg IV and repeat if no response after 5 minutes.
- Pain service/anaesthetist review of pain control.

Leg Movements

- If patient unable to bend/move legs following initial recovery of power:
  1) Stop infusion.
  2) Contact pain service and/or anaesthetist.

Itch

- Contact pain service for advice.

Nausea and Vomiting

- Administer anti emetics as per PONV protocol.
- Contact pain service if uncontrolled.

Block Problems

Problem	Action
Low Block and patient in pain	• Increase infusion rate by 2-4ml/hr. If ineffective, contact pain service/ anaesthetist for 'top-up'.
High Block	• Reduce infusion according to observation. • Stop infusion if block level above T3.
Unilateral Block	• Turn patient onto side with low/no block. • Increase infusion rate with patient on side. • If ineffective, contact pain service/ anaesthetist for 'top-up'.
No Block/ No Pain	• No action continue infusion. • Monitor B/P and Heart Rate.
No Block/ With Pain	• Increase infusion rate. • Give non-opioid analgesia if prescribed, ie Diclofenac and/or Paracetamol. • Inform pain service/anaesthetist if pain remains uncontrolled.

Catheter Related Problems

Problem	Action
Catheter Leak	• Inform pain service • Cover epidural insertion site with a sterile dressing.
Removal of Catheter	• 12 hours after and at least 4 hours before next dose of enoxaparin. • If any other anticoagulant is used or if patient is bleeding, **do not remove catheter, contact pain service for advice.**
Filter Disconnection	• Contact pain service 1st On call anaesthetist
Catheter Migration	• Stop infusion if patient complaining of tingling in tongue, tinnitus or twitching. Contact pain service / anaesthetist.
Catheter "Fell out"	• Inform pain service for alternative analgesia **if unable** to take oral analgesia or alternative not prescribed.

NB *If the patient has a history of heart disease, exercise caution when discontinuing infusion. Suggest slow reduction in infusion rate prior to discontinuing epidural infusion.*

ain Score -

sk patient to rate pain intensity out of 10
= no pain, going up to 10 = worst possible pain.
ssess pain on deep breathing / coughing / movement.
ecord an x under appropriate number.

;edation Score -

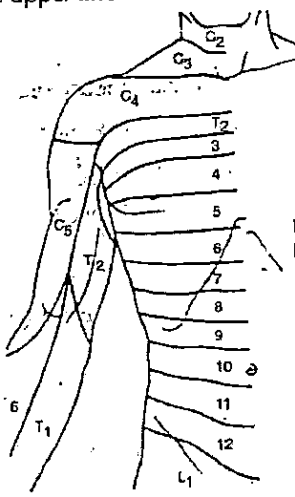
1 = awake
2 = normal sleep
3 = drowsy, easy to rouse: eyes open to speech or light shake
2 = Sedated, difficult to rouse: eyes open only to vigorous shaking
3 = unconscious, unrousable.

Upper and Lower Wound Level - T6 - T10

Epidural Catheter Level - C Tn/11

Aim to keep top block height at - C T6

Maximum upper block height, reduce or stop infusion if level above upper line.



BLOCK HEIGHT
DERMATOME CHART

Minimum lower block height, increase rate if level below lower line.

Opioid in bag? (YES) NO

Observations:
Routine = Hourly for 4 hours, Two Hourly for 4 hours, 4 Hourly if stable
Bupivacaine Bolus = B/P every 5 minutes for 30 minutes, then hourly/routine if stable
Fentanyl Bolus = Respiratory rate and sedation score every 5 minutes for 30 minutes, then hourly for 4 hours and routine if stable. Monitor oxygen saturation continually.
NB: Once established and stable, the block level can be recorded 12 hourly.

Insertion:
L.O.R AT 5cm cms
CATHETER AT 11cm cms at skin
DIFFICULTY DURING INSERTION (NO)
CATHETER GAUGE 18G
Anaesthetist's Signature:

Date/ Time	Resp. Rate	Sed' Score	Inf' Rate	Pain Score on Movement 0 2 4 6 8 10	Block Level LEFT	Block Level RIGHT	Leg Movement *Key PTO LEFT	Leg Movement *Key PTO RIGHT	Cath Site	PONV Score 4 hrly	Initials
6/10/09	16	1	8	X	T9	T9	0	0	SATIS		SSaba Pump Commenced
6/10/09			Epidural Diamorphine 3mg								SSaba 12.00
6/10/09 20		1	6mls	X	T6-7	T6	0	0		0	A Mowry
2255 6/10/09 24		1	8mls	X	T7	T10	0	0		0	Amery
3.15	16	1	8mls	X	T10	T10	0	0		0	TEllacott
13.30	18	1	8		T10	T10	0	0		0	TEllacott
13:45	20	1	10mls	X	T10	T10	0	0	SATIS	0	TEllacott
1420	14	0	10mls		T5	T5	0	0	✓	0	Jackie Jenkins
1500	21	0	10mls		T4	T4	0	0	✓	0	Jackie Jenkins
1600	22	0	10mls		T7	T6	0	0	✓	0	Jackie Jenkins
1700	18	0	10mls	X	T6	T5	0	0	✓	0	Jackie Jenkins
1745	18	5	10mls	* (124/92)	T6	T6	0	0	✓		Rossi
2000	22	1	10mls	X	T8	T7	0	0	✓	0	Rossi
	Top up		3mls. BP 122/83								
				117/86.							
				125/82.							
2090			12mls.	*							
2255	24	1	12mls	*	T8	T7	0	0	✓	0	Rossi
0145	23	0	12mls	*	T10	T10	0	0	✓	0	Rossi
Top up 3mls.				BP 99/68.							
				102/70							
0420	21	1	12mls	*	patchy T5	T7	0	0	✓	0	AME
0815	19	0	12mls	*	T9	T6	0	0	✓	0	SW
10-45	19	0	12		T7	T6	0	0	✓	0	SW
1045	3mls boluses given										

See back of chart for Clinical Notes and Analgesia Pain

Date/ Time	Resp. Rate	Sed' Score	Inf' Rate	Pain Score on Movement 0 2 4 6 8 10	Block Level LEFT	Block Level RIGHT	Leg Movement *Key PTO BELOW LEFT	Leg Movement *Key PTO BELOW RIGHT	Cath Site	PONV Score 4 hrly	Initials
12 10	20	BP 108/70		HL 118 SpO2 98							
12 15	19	BP 107/70		HL 119 SpO2 98							
12 20	19	BP 100/72		HL 116 SpO2 98							
12 25					0	0	T3/4	T4			
12 30	20	BP 114/75		HL 114 SpO2 98							
12 30		BP 91/61		HL 114 SpO2 98							
15.30	23	0	12	BP 110/65 X	T7	T8	✓	✓	✓		SH
16.20	17			BP 94/62 X							SH
16 30	16	SpO2 95		BP 97/63 HL 115							
16 35	16	SpO2 96		BP 99/66 HL 116							
16 40	16	SpO2 93		HL 101/70 HL 114							
16 45	20	SpO2 93		92/52 HL 116							
1650	18	SpO2 95		116/66 HL 115							
16 55	20	SpO2 95		92/55 HL 119							
17.00	22	0	12	NB	T4	T4	0	0	✓	✓	
2100	16	5	12mls	X	T5 patchy	T6	0	0	✓	0	AHE
0200	14	0	12mls	X	T5 patchy	T4	0	0	✓	0	AHE
0330		Bag replenished									
06:00	12	0	12mls	X			0	0	Not seen		
0900	16	0	12ml/h	BP 156/101 X	T10/11	No BI	0	0	✓	0	KS
0930	16			Top up	148/102		Reps	20	Sat	95%	KS
0935	16			Post Top up	149/116			22		94%	KS
0940	19				142/97			19		94%	KS
0945					140/99			18	✓	94%	KS
0950					136/98			17		94%	KS
0955					139/102		0	0		96%	KS
12.00				*	T6	T7	0	0		✓	AS
1300			Top up	BP 128/90	NB	T9	0	0			✓
1305				BP 138/93							
1310				BP 139/94							
1315				BP 128/88							
1320				BP 122/88			1	0			KS
17.00	19	0	12mls	*	T6	T6	0	0	✓		AS
18.30	21	0	12mls	*	T9	T9	0	0	✓		AS
2040	12	0	12mls	X	T12/L1	NB	0	0	INTACT	0	EMorrison
2045	18	0	12mls	3ml bolus given BP 117/73 HR 117 SpO2 95% RR 18							EMorrison
2200	22	0	12mls	X	T7	T9	0	0	INTACT	0	EMorrison

Volume discarded from bag when infusion discontinued = Signed / checked by = 1) 2)

Coagulation checked prior to catheter removal ? YES NO

Key for Leg Movements

Modified Bromage Score

0	No motor block
1	Partial motor block
2	Almost complete motor
3	Complete paralysis

PONV Score

0	None
1	Mild Nausea
2	Moderate Nausea
3	Severe Nausea
4	Patient is Vomiting

Please commence oral analgesia as soon as the patient is able to take oral fluids.

The epidural infusion can be discontinued when the patient is established on oral analgesia, (usually after 24 hours of oral analgesia and epidural infusion) unless otherwise stated on analgesia plan. PTO for clinical notes/analgesia plan.

Clinical Notes Top-ups and Pain Service Review

Date	Time	Notes	SIGN
6/10/09		Pain Service Came to see in recovery; c/o pain 10/10. Dermatome levels T9/T9 Left & Right. Pump started @ 8mls/hr. I have given 3mg diamorphine epidural bolus.	J. Saber
	13:15	Snr c/o pain Block T10 R & L. 3ml + 3mls x 0.25% levobupivacaine given. Infusion ↑ 10ml/h.	#4932 MMacKinnon
	17:15	Block T6/7 bilaterally. C/o pain at top of wound site 5mls x 0.25% levobupivacaine given. 0.5mg IV midazolam given as very anxious	MMacKinnon
	20:10	3ml top up given Dermatome T8(L) T7(R). pain score 9.	
	20:30	Pain scores improving with top-up. Rate ↑ to 12ml/h	4932. MMacKinnon
7/10/09	01:45	3ml top up as pain score 7. Dermatome levels ✓ T10 bilaterally.	
	04:20	patchy block (L) side ∴ 3ml top-up given	
	08:15	3mls top-up as pain score (8) Block as noted	
7:10:09.	am.	Pain Service Up sitting. Pain ++ @ proximal end of wound. Pain score 10/10. Block T10 bilaterally. BP 100/74 Resps 20. Sats 97%. Fentanyl top-up 50mcg in 5mls 0.9% NaCl. given @ 11:50am. Further top up 5mls 0.25% Ropivicaine. Pain score ✓ 1/10. No motor block.	
	12:25	Pain free Obs stable.	ICSurber Pain Nurse
	16:40	Pain again at top of wound site. Block T8/9 Bilaterally. 50mcg fentanyl given.	MMacKinnon
		Pain ++ 5mls x 0.25% Marcain top-up.	
	20:00	Score 8 ∴ 3ml bolus given	
	20:40	5mls x 0.25% Marcain given top-up	MMacKinnon

MIS 157534

Epidural Observation Chart

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

NHS
Greater Glasgow and Clyde

Advice: Office Hours - Acute Pain Sister Page 1184
Out of Hours - On Call Anaesthetist Page 4932

Standard Management:

- Give oxygen as charted, unless discontinued by Doctor.
- A functioning IV cannula must be in place while epidural infusion is in progress and for 12 hours after epidural opioid is discontinued.
- If epidural opioid is used DO NOT give any other opioid unless ordered by an anaesthetist.
- Nurse semi-sitting in bed. Sitting out of bed and mobilisation are possible if there is no postural hypotension or leg weakness.
- Step-down analgesia, give non-opioid oral analgesia as soon as able to take oral fluids, discontinue epidural when oral analgesia is established.

Chart 2

Trouble Shooting / Potention Problems

Hypotension

- Consider ALL potential reasons for Hypotension.
- If Hypotension is related to epidural infusion contact anaesthetist.
- Reduce or stop epidural infusion.
- Lie patient flat / raise legs only.
- Give oxygen 6 litres per minute by face mask, ensure airway is adequate.
- Fluids = seek medical advice.
- Give ephedrine 15mg IM **or** 6mg IV.
- Consider atropine 0.3-0.6mg IV if pulse less than 50bpm.

Respiratory Depression

- Respiratory rate less than 8bpm AND/OR difficult to rouse (sedation score 2 or 3).
- Stop epidural infusion.
- Call pain service/anaesthetist. Life support arrest call if not breathing.
- Ensure adequate airway / give oxygen 8 litres per minute by face mask.
- Give naloxone (NARCAN) 0.4mg IM or 0.1mg IV and repeat if no response after 5 minutes.
- Pain service/anaesthetist review of pain control.

Leg Movements

- If patient unable to bend/move legs following initial recovery of power:
  1) Stop infusion.
  2) Contact pain service and/or anaesthetist.

Itch

- Contact pain service for advice.

Nausea and/or Vomiting

- Administer anti emetics as per PONV protocol.
- Contact pain service if uncontrolled.

Block Problems

Problem	Action
Low Block	• Increase infusion rate by 2-4ml/hr. If ineffective, • Contact pain service/anaesthetist for "top-up".
High Block	• Reduce infusion according to observation. • Stop infusion if block level above T3.
Unilateral Block	• Turn patient onto side with low/no block. • Increase infusion rate with patient on side. • If ineffective contact pain service/ anaesthetist for "top-up".
No Block/ No Pain	• No action continue infusion. • Monitor B/P and Heart Rate.
No Block/ With Pain	• Increase infusion rate. • Give non-opioid analgesia if prescribed, ie Diclofenac and/or Paracetamol. • Inform pain service/anaesthetist if pain remains uncontrolled.

Catheter Related Problems

Problem	Action
Catheter Leak	• Inform pain service. • Cover epidural insertion site with a sterile dressing.
Removal of Catheter	• 12 hours after and at least 4 hours before next dose of enoxaparin. • If any other anticoagulant is used or if patient is bleeding, **do not remove catheter, contact pain service for advice.**
Filter Disconnection	• Contact pain service / Duty anaesthetist for advice.
Catheter Migration	• Stop infusion if patient C/O tingling in tongue, tinnitus or twitching. Contact pain service/anaesthetist.
Catheter "Fell Out"	• Inform pain service for alternative analgesia **if unable** to take oral analgesia or alternative not prescribed.

NB *If the patient has a history of heart disease, exercise caution when discontinuing infusion. Suggest slow reduction in infusion rate prior to discontinuing epidural infusion.*

Pain Score -
ask patient to rate pain intensity out of 10.
0 = no pain, going up to 10 = worst possible pain.
Assess pain on deep breathing / coughing / movement.
Record an **x** under appropriate number.

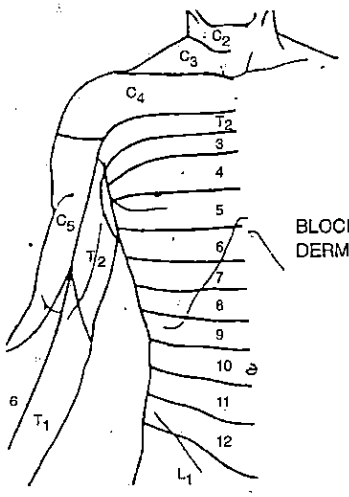
Sedation Score -
0 = awake
S = normal sleep
1 = drowsy, easy to rouse: eyes open to speech or light shake
2 = sedated, difficult to rouse: eyes open only to vigorous shaking
3 = unconscious, unrousable

Upper and Lower Wound Level - _____

Epidural Catheter Level - _____

Aim to keep top block height at - _____

Maximum upper block height, reduce or stop infusion if level above upper line.



BLOCK HEIGHT DERMATOME CHART

Minimum lower block height, increase rate if level below lower line.

Opioid in bag? YES NO

Observations: **Routine** = Hourly for **8 hours**, Two Hourly for **4 hours**, **4 Hourly if stable.**
Bupivacaine Bolus = B/P every 5 minutes for 30 minutes, then hourly/routine if stable.
Fentanyl Bolus **Bolus** = Respiratory rate and sedation score every 5 minutes for 30 minutes, then hourly for 4 hours and routine if stable. Monitor oxygen saturation continually.
NB Once established and stable block level can be recorded **12 hourly**.

(rtd)

Date/ Time	Resp Rate	Sed' Score	Inf' Rate	Pain Score on Movement 0 2 4 6 8 10	Block Level LEFT	Block Level RIGHT	Leg Movement *Key PTO LEFT	Leg Movement *Key PTO RIGHT	Cath	PONV Score 4 hrly	Initials
09/10/09	0100	1	12ml/h	X	T7/8	NB	0	0	IN THEA	0	[illegible]
09/10/09	0800	1	12ml/h	X	T7/8	NB	0	0	IN THEA	0	[illegible]
09/10/09	0830	1	12ml/h	3ml bolus given BP 120/82, PR 74, RR 15, Sp02 95%							[illegible]
09/10/09	0900	1	12ml/h	X							
9/10/9	0615	EPIDURAL TOP UP: 5ml of 0.5% LEVOBUPIVACAINE.									[illegible]
10.00			Rate ↓ 6mls/hr								
12.00			Epidural catheter removed - Blue tip witnessed. [illegible] Zenda								

See back of chart for Clinical Notes and Analgesia Plan

Date/ Time	Resp Rate	Sed' Score	Inf' Rate	Pain Score on Movement 0 2 4 6 8 10	Block Level LEFT	Block Level RIGHT	Leg Movement *Key PTO LEFT	Leg Movement *Key PTO RIGHT	IV	PONV Score 4 hrly	Initials

Clinical Notes Top-ups and Pain Service Review

Date	Time	Note	Sign

Stobhill Hospital

NHS
Greater Glasgow and Clyde

NOT TO BE FILED UNTIL DISCHARGE

Name: DEBORAH SULLIVAN Unit No.: 1063847 9K.

Date:													
Time of Result:													
WCC	4-11												
Hb	M - 13-18 F - 11.5-16.5												
Plat	150-400												
Amylase	<100												
CRP	<10												
Na+	135-145	136											
K+	3-5-50	4·5											
Cl-	98-108	101											
Bic	21-28												
Urea	2.5-7.5	5·1											
Creat.	57-113	75.											
Glucose	3.5-5.5												
Bilirubin	3-22	·5											
AST	<40	20											
ALT	<50	22											
G-GT	<55	(75)											
Alk. Phos.	40 -150	69											
Protein	60-80	74											
Albumin	32-45	37.											
Globulin	22-33												
Ca	2.1-2.6												
Adj Ca	2.1-2.6												
PO4	0.7-1.4												
PT	9-12												
APTT	25-37												
TCT	11-15												
H+	35-45	41											
PO2	12-15	11.1											
PCO2	4.4-5.6	6.5											
HCO2	20-28	30											

MIS 109801-STB

Critical Care Discharge Summary

NHS Greater Glasgow

Name of nurse discharging patient: Arlene Shaw

Contact Number: 14151

Patient Name

DOB

Hospital Number

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Reason for admission to ~~ITU~~/HDU: Laparotomy & open fundoplication
PMH: Cholycystectomy, Pancreatitis, Agrophobic, Physciological problems.

Number of days in ~~ITU~~/HDU: 4 Date discharged: 9.10.09

Time discharged:

Respiratory

Was the patient ventilated? ~~Yes~~ / No

Number of days ventilated

Date of extubation (state time if less than 24hrs) / /

Tracheostomy present? Yes / No

Date tracheostomy performed / / Date inserted / /

Make Size Date due changed / /

Respiratory rate bpm Saturation %

Oxygen requirements 4lit %

☐ Mask ☑ Nasal Cannula ☐ Humidified

Secretions: ☐ Mucoid ☐ Purulent ☐ None

Suction required? Yes / No Size of suction catheter FG

Type of Suction: ☐ Nasopharyngeal ☐ Oral ☐ Tracheal

Unit physiotherapist aware of discharge? Yes / ~~No~~

Page No.

Receiving physiotherapist aware of transfer Yes / ~~No~~

Page No.

Cardiovascular

Heart rate 121-133 Rhythm ST BP 113-132 / 81-94 CVP _____ Temp _____ Apyrexial

Anti-arrythmic drug therapy ~~Yes~~ / No Type _____

Frequency of observations 4°-6°

Central venous access ~~Yes~~ / No Number of days in situ _____ Site _____

Peripheral access Yes / ~~No~~ Number of days in situ _____ Site (R) hand

Renal

Fluid replacement: ☑ Oral ☐ Intravenous ☐ Nasogastric

Urine output _____ mls/hr **Previous days balance:** Input _____ Output _____ mls

Catheter in situ? ~~Yes~~ / No Removed at 11.00am

Fluid balance to be recorded? Yes / No

Did the patient receive renal replacement therapy? Yes / No

Discontinued Yes / No Date discontinued / /

Neurological State

☑ Alert Responds to: ☐ Voice ☐ Pain ☐ Unresponsive

GCS if relevant

gitated? ~~Yes~~ / No

Comments _____

_____

Level of mobility Good

Nutrition

☐ NG ☐ NJ ☐ PEG ☐ TPN

☑ Normal Diet ☑ Oral Fluids

Feed type _____ Rate _____ mls/hr

☐ NIDDM ☐ IDDM Blood Sugar _____ mmols Time _____

Bowels last opened Not yet opened.

Wounds

Wounds present? Yes / ~~No~~ Site Abdo.

Drains present? ~~Yes~~ / No Site _____

Wound care chart? ~~Yes~~ / No

Pressure areas Intact

Pressure relieving mattress required? ~~Yes~~ / No Type _____

Pain Control

Pain score 4-6/10 Site of pain Abdo.

* PCA, Tramadol, Paracetamol, Gabapentin.

Analgesia prescribed? Yes / ~~No~~ Type * Last administered _____

Infection Control Measures

Isolation required? ~~Yes~~ / No

Organism identified _____ Site _____

Bacteriological screen? ~~Yes~~ / No

Relatives

Next of kin Kathleen Sullivan Relationship Mother

Notified of discharge? Yes / ~~No~~

Contact number 0141 771 3743

Documentation

Casenotes? Yes / ~~No~~ X rays? ~~Yes~~ / No

Property: ☐ Listed with patient ☐ In safe ☐ Other

Comments _____

MEWS score on discharge _____

Last known Haematology		Last known Biochemistry	
Date	9 / 10 / 09	Date	9 / 10 / 09
Hb	9.1	Na^+	138
WCC	8.70	K^+	3.6
Platelets	247	Bicarbonate	
INR		Urea	1.6
PT	13	Creatinine	57
PTT	29	Glucose	

Last known Arterial Blood Gases	
Date	/ /
PO_2	
PCO_2	
H^+	

Notes

* Epidural catheter removed at 12.0'clock. (clexane not to be given til 4hrs after)

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: MS D SULLIVAN Unit number: CHI number: 6 MUIRHEAD COURT BAILLIESTON GLASGOW G69 7EP	Ward: 5 Discharge destination: Home **Estimated Discharge Date** (1) 14/10/09 **Estimated Discharge Date** (2) / / Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		dm	
Relative/carer informed	✓		dm	
Others informed: Care Home		✓	dm	
Transport arranged				
Own transport (preferred option)	✓		dm	
Ambulance-1 man/ 2 man am/pm		✓	dm	
Other: Flight, Air ambulance etc.		✓	dm	
Discharge medication				
Discharge prescription completed	✓		dm	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓	dm	
Medication received	✓		dm	
Medication explained to patient and/or relative/carer	✓		dm	
Own medication returned to patient		✓	dm	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	dm	
Informed of discharge				
Social work/ Other agencies/Home help		✓	dm	
Physiotherapist		✓	dm	
Occupational Therapist		✓	dm	
Dietician		✓	dm	
Speech and Language Therapist		✓	dm	
Clinical Nurse specialist e.g. Care Home Liaison		✓	dm	
Liaison/ District Nurse/Practice Nurse	✓		dm	Practice nurse wound review.
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓		dm	
Patients clothing available for day of discharge	✓		dm	
Valuables e.g. cashier		✓	dm	
Intravenous cannula removed	✓		dm	
Equipment ordered (inc. walking aids) in place for discharge		✓	dm	
Part 2 Discharge letter - Required		✓	dm	
- Completed	✓		dm	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓			6/8 weeks.
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets		✓		

Time of Discharge: 12.00

Nurse's signature: dm'Cullen **Designation:** SN **Date:** 14/10/09

FORM NUMBER 0005752

Patient Assessment/Comments

Mobility: Independently mobile

Personal hygiene/Dressing: Independent with ADL'S

Continence: Catheter in situ: Yes ☐ No ☑
Type: Size:
Date of change:

Continence details: fully continent

Dietary requirements: Normal diet

Communication / Swallowing: Communicates well

Mental state: Alert + orientated

Skin condition/Waterlow Score: Skin intact

Wound care/Stoma care: Wound dry and intact
Mepore applied
Clips to be removed friday 16/10/09

Special Instructions for Patient (e.g. Exercise, Diet, Wounds, Others)

Wound dry and intact
to attend GP Practice nurse on
Friday 16/10/09 for removal of
clips.

Others/Follow-up arrangements
will require F/U 6/8 weeks will receive
through post

Progress discussed with patient: Yes ☑ No ☐
Progress discussed with relative/carer: Yes ☐ No ☑

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse: JM Allen 14/10/09

Date and signature of Patient/Carer: [signature]

Diagnosis:
Laparotomy + open
Fundoplication
7 days ago

TOP COPY TO - Patient; OTHER COPIES TO - G.P., District Nurse, Case Notes

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☑ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☐ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: Deborah Sullivan

Address: 6 Muirhead Court
Balliston

Discharge Address: SIA

CHI number: 0712786128

Unit number: 1063847K D.O.B 7/12/72

Telephone:

Next of kin: Kathleen Sullivan

Relationship: Mother

Address:

Telephone: 0141 771 3743.

Ward: 5

Telephone: 0141/ 201 / 3777

Admission date: / /

Final discharge/transfer date: 14/10/09

Named Nurse:

Consultant: Mr Smith

G.P. Dr J Langan

Address: Balliston H/C
20 Muirside Road.
Balliston.

Telephone:

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care), State package requested and time of first visit.

Service:	Service:
Contact number:	Contact number:
Service details:	Service details:

Additional/Transfer Information (including equipment/adaptions)

No equipment required

Immediate Discharge and Medicine Prescription Form - Confidential

Glasgow Royal Infirmary
Glasgow G4 0SF
Telephone: 0141 211 4000

Ref. No: 111268

NHS Greater Glasgow and Clyde

Name of GP: J. LANGAN
Surgery/Health Centre: BAILLIESTON H.C.

label to all 4 copies

Patient: 10638479K SULLIVAN F DEBORAH 07/12/1972
Address: 6 MUIRHEAD COURT BAILLIESTON GLASGOW G69 7EP CHI-0712726128
DOB:
Weight: 7/12/72 CHI no:

~~RAH SULLIVAN~~
~~IRHEAD COURT~~
~~G69 7EP~~
~~1638479K~~

Ward: 5 Tel:
Consultant: CRAIG
Named Nurse: CLAIRE
Specialty: SURGERY
Admission date: 6 / 10 / 09
Mode of admission: Elective ☑ Emergency ☐ Transfer ☐
Source of Admission
Discharge date: 13 / 10 / 09

NURSE TO COMPLETE
Out Patient appointment date:
Diagnosis informed (circle) Patient Relative
Circle support services set up:
District Nurse Home Help Health Visitor
Oncology referral Hospice: day care OR home care
Discharge address if not Home:

WARD USE ONLY
Medication Rec. on Ward by:
Checked against kardex:
Issued by: Date:
Signature of Recipient:
All known drug sensitivities / adverse reactions:

Reason for Admission, Diagnosis	Treatment, Investigations, Operations	Complications
Laparotomy + Open fundoplication.		

New Drug	New Dose	MEDICINE	Form	Dose	TIMES FOR ADMINISTRATION: am 8	md 12	pm 2	pm 6	pm 10	Other times	Course length
		FENTANYL PATCH	PATCH	75 micrograms	✓						7days
		PLEASE SUPPLY TWO (2) PATCHES.									
		TO BE APPLIED ON 16/10/09 AND 19/10/09.									
		EVERY 72 HRS									

Medicines Discontinued	Reason if known e.g. side effect	Other Information

Prescribers name: FIONA BURNS Signature: FionaBurns Date 13 / 10 / 09
Designation: FY1 Pager number: 4158

PHARMACY USE ONLY
Clinical Pharmacy Check ☐ Professional Check ☑

Quantity supplied	Dispensing Details
2	Janssen-Cilag

Dispensed by: JC Date: 13 / 10 / 09
Checked by: MRD
Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:
Medication Collected by:

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; Yellow copy - Patient

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

Immediate Discharge and Medicine Prescription Form - Confidential

Glasgow Royal Infirmary
Glasgow G4 0SF
Telephone: 0141 211 4000

Ref. No: 111268

NHS Greater Glasgow and Clyde

Name of GP: J LANGAN
Surgery/Health Centre: BAILLIESTON H.C.

label to all 4 copies

Patient: 10638479K SULLIVAN F
Addres: DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128
DOB:
Weight 7/12/72 CHI no:

~~DEBORAH SULLIVAN~~
~~6 MUIRHEAD COURT~~
~~G69 7EP~~
~~1063847 9K~~

Ward: 5 Tel:
Consultant: CRAIG
Named Nurse: CLAIRE
Specialty: SURGERY
Admission date: 6 / 10 / 09
Mode of admission: Elective ☑ Emergency ☐ Transfer ☐
Source of Admission
Discharge date: 13 / 10 / 09

NURSE TO COMPLETE

Out Patient appointment date.....
Diagnosis informed (circle) Patient Relative
Circle support services set up:
District Nurse Home Help Health Visitor
Oncology referral Hospice: day care OR home care
Discharge address if not home:.....

WARD USE ONLY

Medication Rec. on Ward by:
Checked against kardex:
Issued by: Date:
Signature of Recipient:
All known drug sensitivities / adverse reactions:

Reason for Admission, Diagnosis	Treatment, Investigations, Operations	Complications
Laparotomy + Open fundoplication.		

New Drug	New Dose	MEDICINE	Form	Dose	TIMES FOR ADMINISTRATION am 8	md 12	pm 2	pm 6	pm 10	Other times	Course length
		FENTANYL PATCH	PATCH.	75 micrograms	✓						7days.
		PLEASE SUPPLY TWO (2) PATCHES.									
		TO BE APPLIED ON 16/10/09 AND 19/10/09.									
		EVERY 72 HRS.									

Medicines Discontinued	Reason if known e.g. side effect	Other Information

Prescribers name: FIONA BURNS Signature: fionaBurns Date 13 / 10 / 09
Designation: FY1 Pager numb: 4158

PHARMACY USE ONLY

Clinical Pharmacy Check ☐ Professional Check ☐

Quantity supplied	Dispensing Details
2	Janssen-Cilag

Dispensed by: JC Date: 13 / 10 / 09
Checked by: [illegible]

Non-childproof containers required: Yes ☐ No ☐
Medicine compliance aids required: Yes ☐ No ☐
Specify:

Medication Collected by:

White copy - G.P.; Pink copy - Case Notes; Blue copy - Pharmacy; Yellow copy - Patient

You must use a ballpoint pen and fully complete this form or the prescription will not be dispensed

NHS
Greater Glasgow and Clyde
New Patients

Acute Services Division
Stobhill Hospital
Chronic Pain Clinic

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI 0712726128

Patient's Name		Date 3/12/1

Clinicians are aware that emotions play an important part of most illnesses. If your clinician knows about these feelings he/she will be able to help you more.

This questionnaire is designed to help your clinician to know how you feel. Read each item and **tick (✓)** the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.

I feel tense or 'wound up'		**I feel as if I am slowed down**	
Most of the time	✓	Nearly all the time	
A lot of the time	3	Very often	✓
From time to time, occasionally		Sometimes	2
Not at all		Not at all	
I still enjoy the things I used to enjoy		**I get a sort of frightened feeling like 'butterflies' in the stomach**	
Definitely as much as I used to		Not at all	
Not quite so much	3	Occasionally	
Only a little		Quite often	3
Hardly at all	✓	Very often	✓
I get a sort of frightened feeling as if something awful is about to happen		**I have lost interest in my appearance**	
Very definitely and quite badly	✓	Definitely	✓
Yes, but not too badly	3	I don't take as much care as I should	3
A little, but it doesn't worry me		I may not take quite as much care	
Not at all		I take just as much care as ever	
I can laugh and see the funny side of things		**I feel restless as if I have to be on the move**	
As much as I always could		Very much indeed	
Not quite so much now	✓ 1	Quite a lot	✓ 1
Definitely not so much now		Not very much	
Not at all		Not at all	
Worrying thoughts go through my mind		**I look forward with enjoyment to things**	
A great deal of the time		As much as every I did	
A lot of the time	✓ 2	Rather less than I used to	2
From time to time but not too often		Definitely less than I used to	✓
Only occasionally		Hardly at all	
I feel cheerful		**I get sudden feelings of panic**	
Not at all		Very often indeed	✓
Not often	1	Quite often	3
Sometimes	✓	Not very often	
Most of the time		Not at all	
I can sit at ease and feel relaxed		**I can enjoy a good book or radio or TV programme**	
Definitely		Often	
Usually	2	Sometimes	3
Not often	✓	Not often	
Not at all		Very seldom	✓

Now check you have answered all the questions.

A 13 D 15

Acute Services Division

Anaesthetics

NHS Greater Glasgow and Clyde

Glasgow Unified Pain Form Part B: Medical History

Patient details

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Name:

Address:

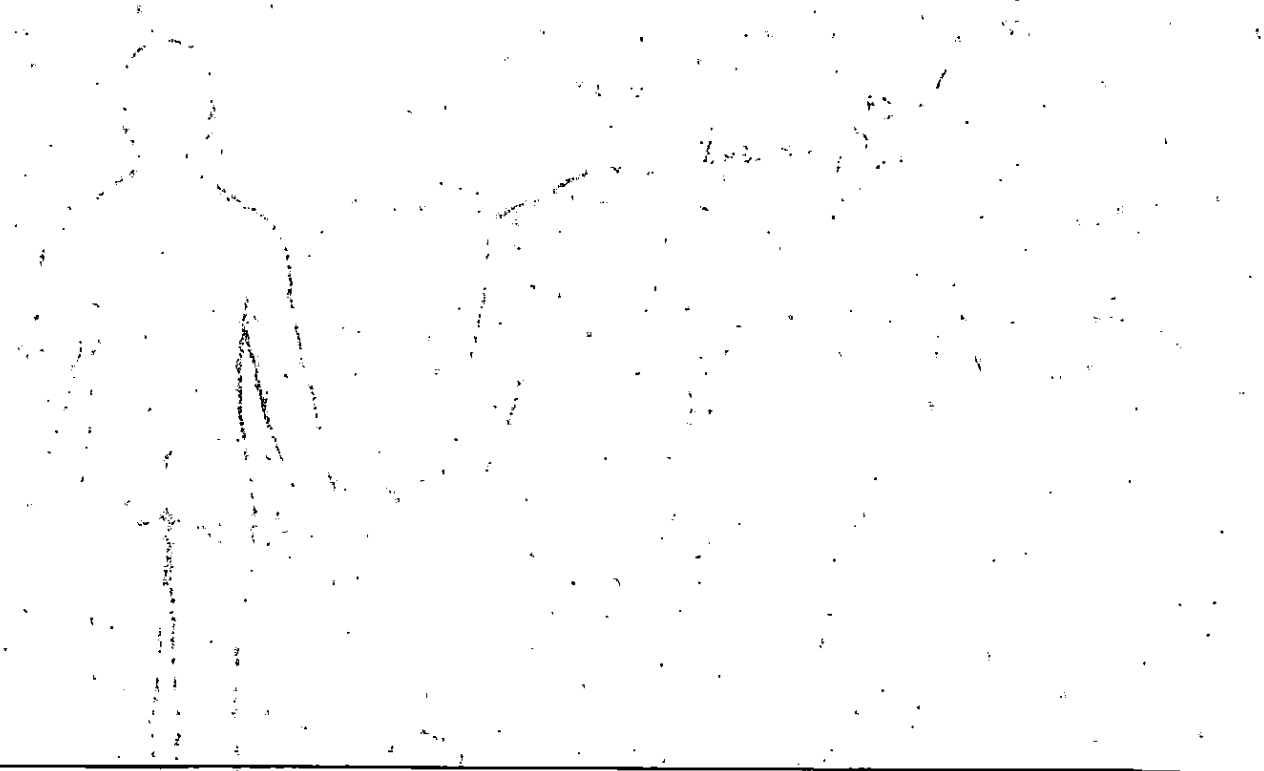
Telephone:

D.o.B.: Unit no:

Use address label

1. Pain History

Any further details not covered in questionnaire, including operations, investigations, previous pain clinic treatment, etc.



2. Patient assessment of pain

Meaning of pain, hopes and expectations, fears.

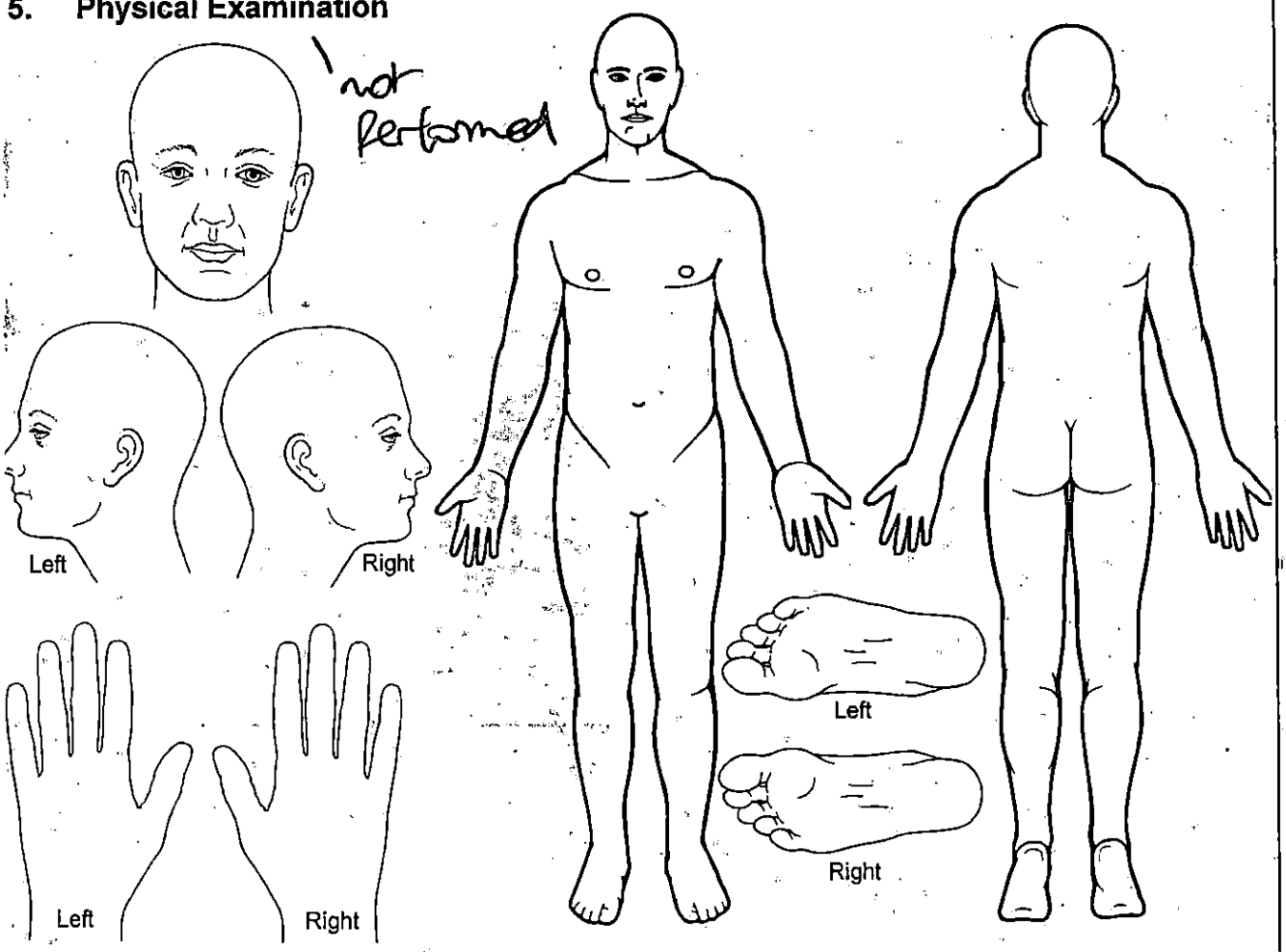
3. Past Medical History

4. Social History

Including employment history, home circumstances, social/family support, litigation, normal daily activity and limitations/interference.

Not in employment.
V. difficult to go out – depression + pain
Sleep v. poor. Stays awake all night.
Previous abusive relationship.

5. Physical Examination



6. Impression

Chronic abdominal pain
Depression / anxiety
Inappropriate opioid intake

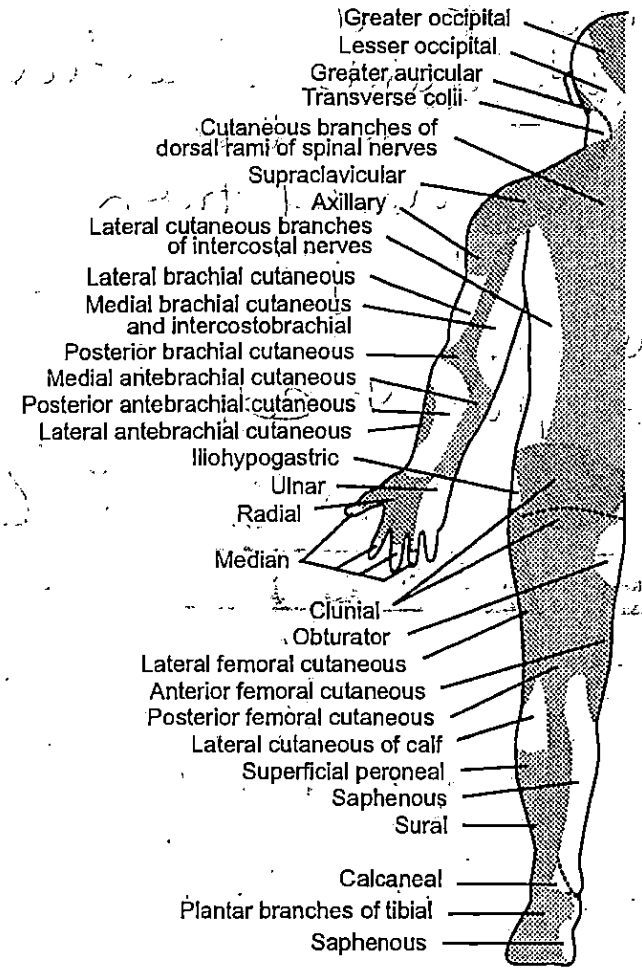
7. Initial treatment plan

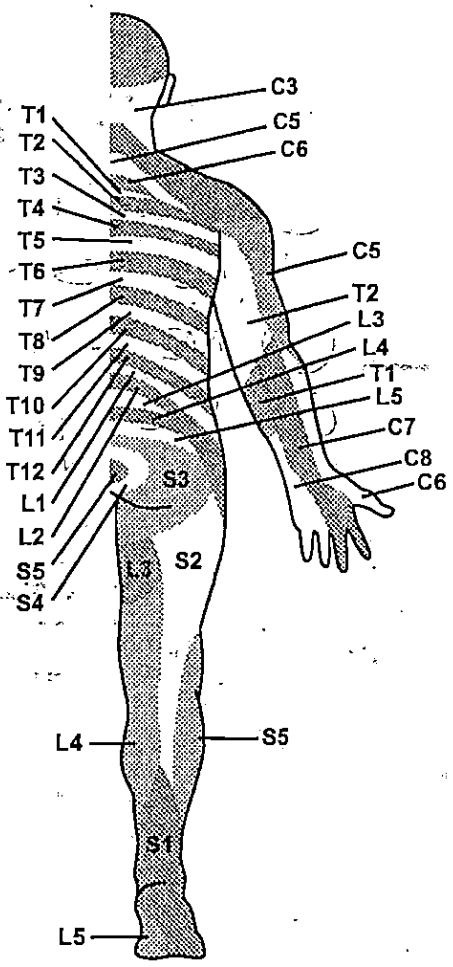
① Clinical psychology referral
② Monitoring of ~~[illegible]~~ opioids in pain clinic
— nurse clinic
③ Convert DHC to tramadol then plan to reduce strength
④ NO formulae.
⑤ Info given re patient ed

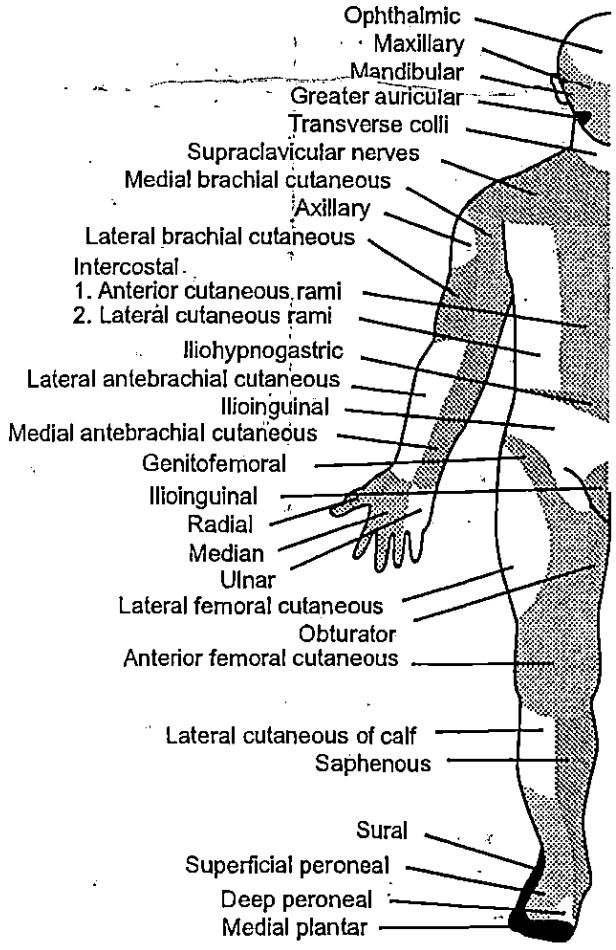
Cbe

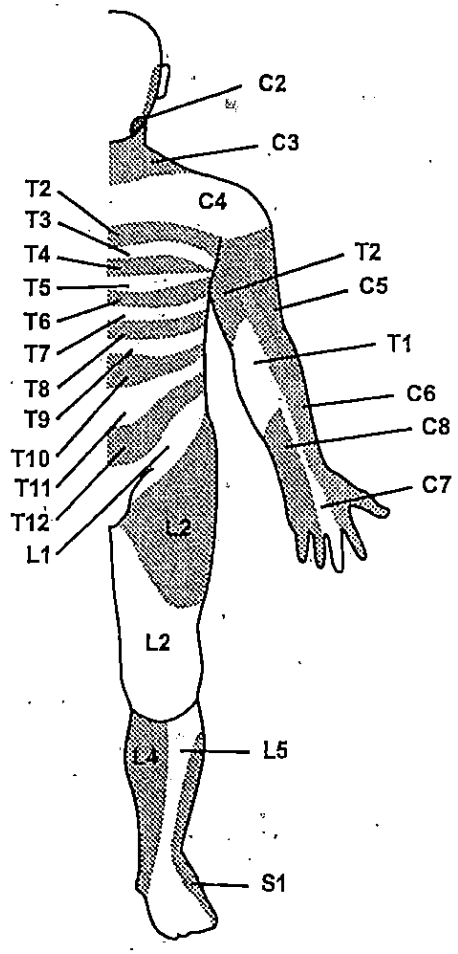
8. Ongoing Treatment Record (Use continuation sheets as required)

Date	Seen by	Notes	Action









SGH 1106

VI MEDICAL ILLUSTRATION • ANEAS • 7388

Stobhill Hospital

Anaesthetic Department

NHS Greater Glasgow and Clyde

Glasgow Unified Pain Form Part A: Patient Questionnaire

Patient details

Hospital:

Name: Deborah Sullivan

Address: 6 Muirhead ~~Rd~~ Court

Balloston Glasgow G69 7EP

D.o.B.: 07.12.1972

Date:

Hospital no Unit no: 10638479K CHI No 0712726128

Use address label if available.

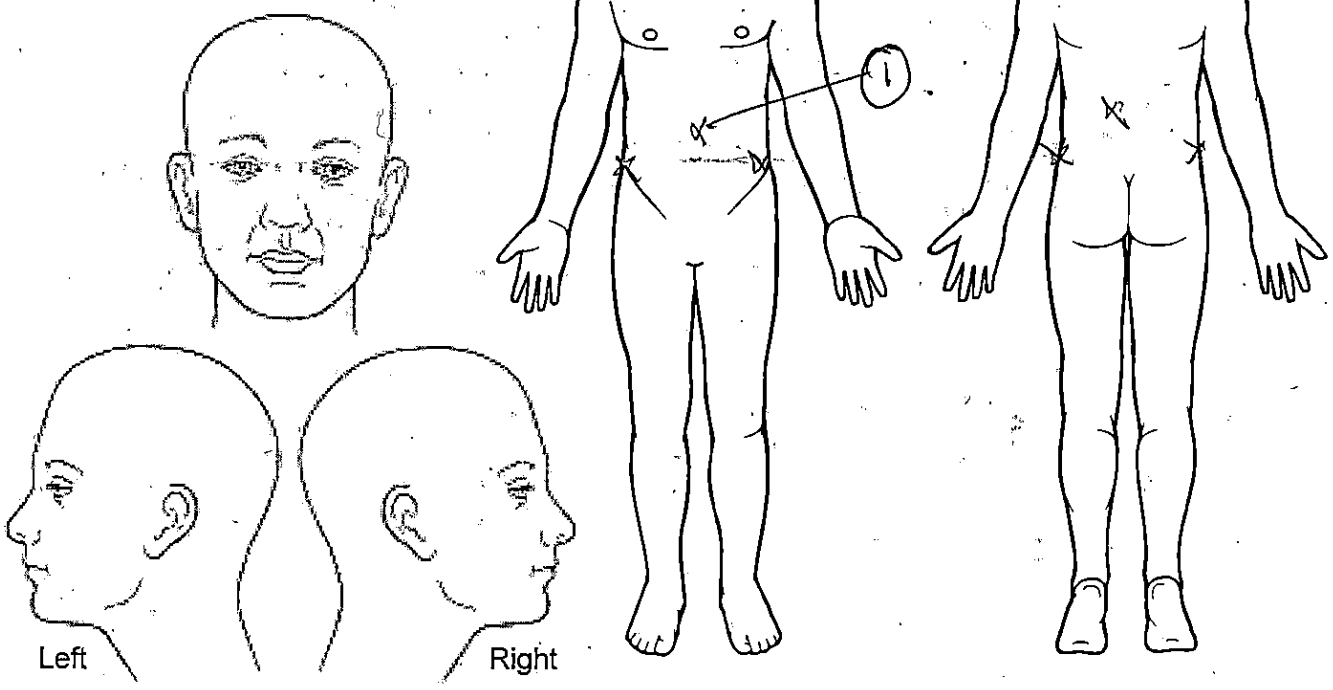
Please help us by filling in as much of the following questionnaire as you can.

Please bring the completed questionnaire with you when you come to hospital for your Pain Clinic appointment. Don't worry if you find some questions difficult, we will go over all the questions with you on your first visit to the clinic.

1. Where is your pain?

We need to know where you have pain. On the drawings opposite, please shade in the areas where you feel pain.

Put an **X** on the area that hurts the most.



CONFIDENTIALITY AND USE OF PATIENT'S INFORMATION

For the purpose of your present and future medical treatment, details of your medical care will be recorded. Some use may be made of this information for research purposes and to indicate the kind of future health services which patients may require; some will be processed on a computer. At all times great care is taken to ensure that high standards of confidentiality are maintained in respect of all information held. The "Data Protection Act 1998" gives you the right of access to any personal information which the Division may hold about you either in manual records or on its computers. If you wish to apply for access to your data, or if you would like more information about your rights under the Act, you should, in the first instance, contact the Health Records Officer at the hospital.

Please answer the following questions (Please use block capitals)

2. When did you start having problems with pain? If there was an accident or injury please describe it.

1995 then discoverd Gallstones in 1996
removed appendix Before discovering Gallstones
then 2 weeks later removed Gallbladder

3. Pain is often very difficult to describe to others. Below is a list of words that people sometimes use when talking about their pain. Please circle any words that you feel describe your pain. You can add other words if you wish.

cutting	pounding	tingling	tiring	deep
beating	squeezing	throbbing	horrible	stabbing
burning	pulling	sickening	biting	screaming
scraping	aching	uncomfortable	cold	tugging
pricking	cruel	warm	miserable	stretching
pinching	unbearable	sad	itching	terrible
stinging	cool	sore	flashing	pressing
fearful	sharp	jumping	tight	pins and needles
hot	spreading	punishing	searing	lonely bad

4. When do you have your pain?

every day

5. Is there anything that makes your pain worse?

eating

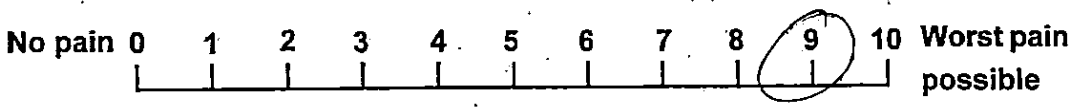
6. Is there anything that helps your pain?

rolling around the bed or. Sometimes the floor walking/pacing.

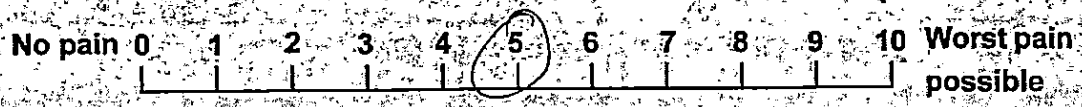
7. Please rate your pain by circling a number on the scales below. This will give us an idea of your pain level on average, at its worst and at its best.

The number 0 represents no pain at all, the number 10 represents the worst pain you could possibly have.

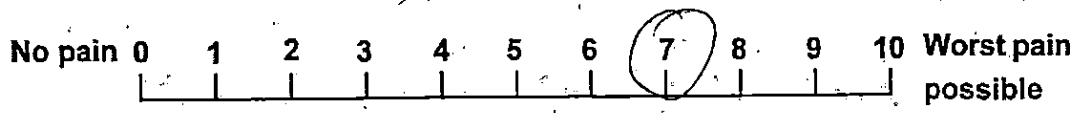
Please rate your pain **at its worst** in the past week...



Please rate your pain **at its best** in the past week...

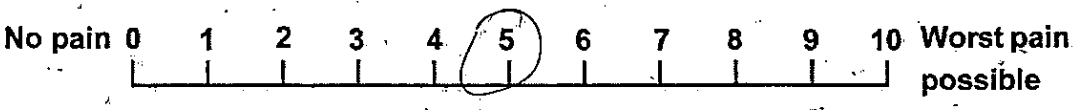


Please rate your pain **on the average** for the past week...



Continues opposite

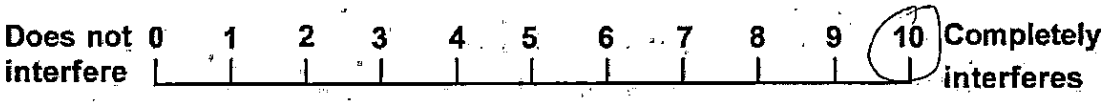
Please rate the pain you have **right now...**



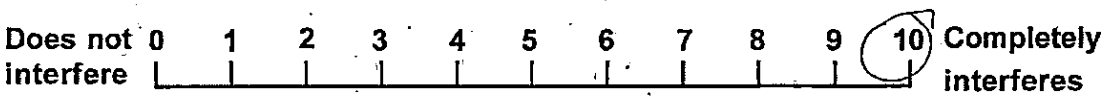
8. **Pain can sometimes interfere with our mood, our sleep, and the ability to do what we want to do.**

Please rate how much your pain interferes with the following areas of your life, by circling a number between 0 and 10 on the scales below (0 = no interference, 10 = complete interference).

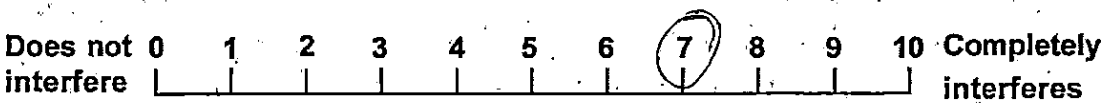
How much does your pain interfere with **your general activity?**



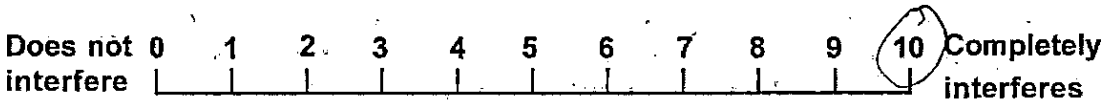
How much does your pain interfere with **your mood?**



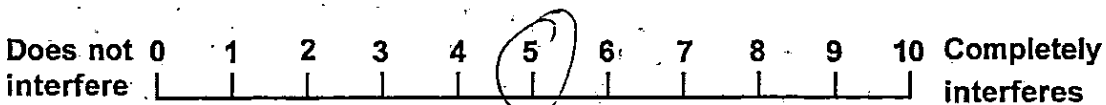
How much does your pain interfere with **your walking ability?**



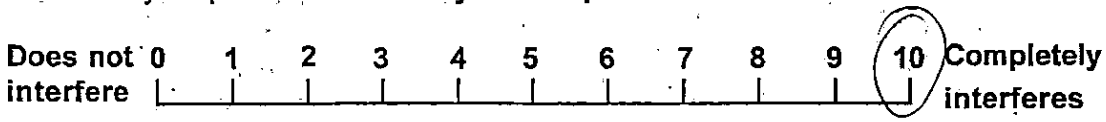
How much does your pain interfere with **your normal work?**



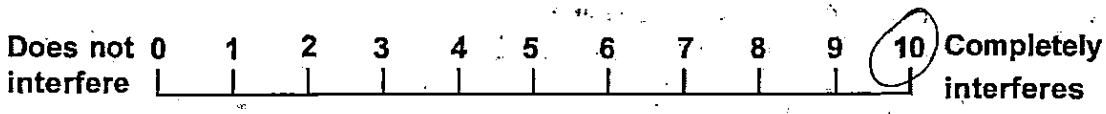
How much does your pain interfere with **your relationships with other people?**



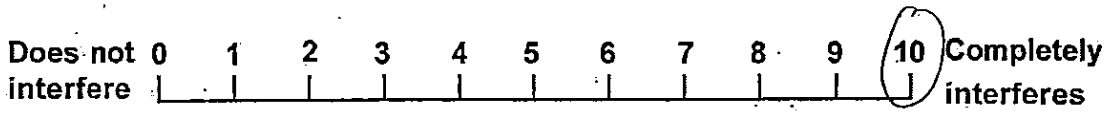
How much does your pain interfere **with your sleep?**



How much does your pain interfere with **your enjoyment of life?**



Are there any **activities** (for example hobbies, socialising) you would like to do, which **your pain stops you from doing?**



Medicines

9. Please list all medicines you are taking just now, including doses. If you have a list of medications from your GP please bring that with you when you attend the Pain Clinic.

Name of medication	Dose	Times taken	Does it help?
OMEPRAZOLE	40mg	1	Yes
Fluexitine	40mg	1	NOT SO much
GABAPENTINE	600mg	3	Sometimes
Fentenyl Patch	75mg	every 72 hours	Sometimes
Ohdracodine	60mg	4	NO WHEN PAIN IS AT WORST
Granisetron	1mg	When required	Yes
Maxalon	10mg	11	NO
Tamazepam	10mg	1 at night	Sometimes

10. Please list any other medicines you have taken <u>in the past</u> for your pain.

Name of medication	Did it help?	Why did you stop taking it?
Tramadol	Sometimes	advised to try other
Pethidine	Yes	advised to try other
Another Kind of Patch	NO	Didnt work
Oramorph	NO	Went into Spazims

11. Are there any medicines that you are allergic to? Yes ☑ No ☐

If 'Yes' please list these: Voltarol really upsets my stomach

12. Have you tried any other types of treatment (apart from conventional medicines) for your pain?

Name of treatment	Was it helpful?
tens Machine	No
homeopathic	NO
healers	NO
Accupuncter	NO

Finally, what do you hope to get from your visit to the Pain Clinic, and what would you like us to do to help you? Get my pain Under Control a better quality of life and get over this depression. To have a normal life with my daughter.

Deborah Sullivan 7/12/72 10638479K

Problem 1. Epigastric pain → back – 3 years ago
2. Reflux
3. Nausea / vomiting
4. Lack of appetite
5. Depression

Rx fentanyl patch 75mg
Gabapentin 600mg TID
Tramadol 100mg 4x daily instat release
Altacite plus
Metoclopramide
Losec
Fluoxetine 40mg

PMH Nissan fundoplication 3 years ago
Lap cholecystectomy 1998
? pancreatitis – had pseudocyst required drainage

Plan 1. Suggest fentanyl duragesic patch – ? will stick better
2. Awaiting clinical psychology appt. – check WL
3. Trial of imipramine 10mg + increase
4. Discontinue prozac

Dr

STOBHILL HOSPITAL — OUTPATIENT CHART

SURNAME	FORENAME	UNIT NUMBER	PATIENT'S OCCUPATION	MARITAL STATUS M S W

DATE OF BIRTH	AGE	SEX	WARD/DEPT	RELIGION	MAIDEN NAME

ADDRESS	G.P.'S NAME & ADDRESS
TEL. NO.	TEL. NO.

DATE	SPECIALITY	CONSULTANT
	Pain	

Internal Ref

03 DEC 2008

Wt 74kg

Height = 171cm

BMI 25 Amcd

01.07.09 Miss Sullivan attended the Psychology clinic today and met with myself. She reported marked anxiety, low mood and inactivity. E. Toland, Dr Emma Toland, Clinical Psychologist.

17.07.09 Miss Sullivan returned to the Psychology clinic and continued the assessment. E. Toland, Dr Emma Toland, Clinical Psychologist.

21/8/09

21.08.09 Miss Sullivan attended Psychology. She explained that her pain has worsened over the past week since she was told by Mr Smith that her hernia will be operated on mid-September. We spoke about the anxiety involved in going to hospital and used pyramid diagrams to map the time it will take in hospital compared to all of the days she has spent sick. E. Toland, Dr Emma Toland, Clinical Psychologist.

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

OLOGY DEPARTMENT ULTRASOUND REPORT

DATE: 17/12/10
CONSULTANT: Dr Kumar
TIME OF APPT:

TAS/TVS/TAS & TVS

FULL BLADDER AT APPT TIME: YES/NO

SOURCE OF REFERRAL WARD/GOPD/SPECIAL CLINIC (Specify) .....

PARITY ..1.. CYCLE ..... LMP ..... CONTRACEPTION ..Nil — No partner

REASON FOR SCAN ..... Periods stopped 2 yrs ago — Well till with gall stones 12m — Now heavy ++ clots

See IP letter ..... Started 4/52 ago — Stopped 12/7 ago.

Chronic pain PREVIOUS SCAN: YES/NO SPECIFY ..... Allergic to Penicillin

Upper/lower Abs

REPORT Smear up to date

UTERUS - LENGTH A/V WIDTH ..... DEPTH ..... MORPHOLOGY ..N..

ENDOMETRIAL THICKNESS 2.9 mm ..... MAXIMUM FIBROID SIZE .....

OVARIES -	RIGHT	LEFT
SIZE	Normal	Normal — Appear active
MORPHOLOGY		
CYSTS		
PAPILA/SEPTAE		

FREE FLUID (NIL)/TRACE/SIGNIFICANT/GROSS ASCITES
TURBID - YES/NO

KIDNEYS RIGHT ..... LEFT .....

LIVER ..... GALLBLADDER ..... OMENTUM .....

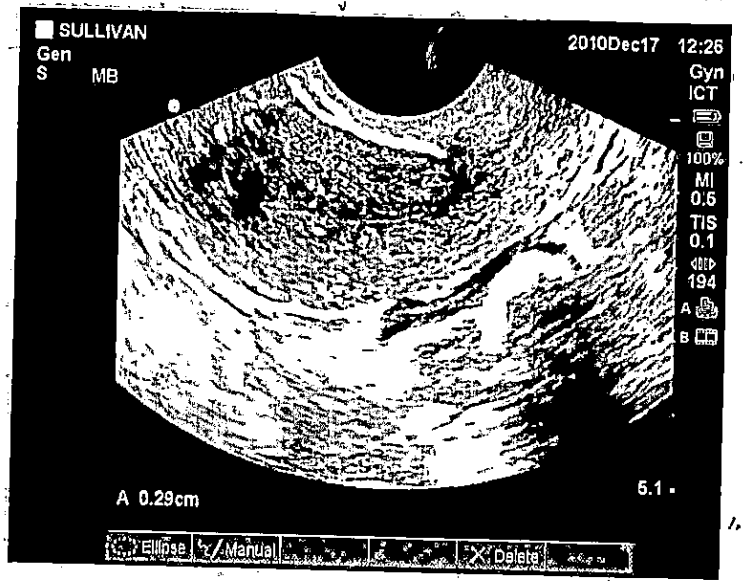
COMMENTS ..... Pipelle taken → Scanty tissue

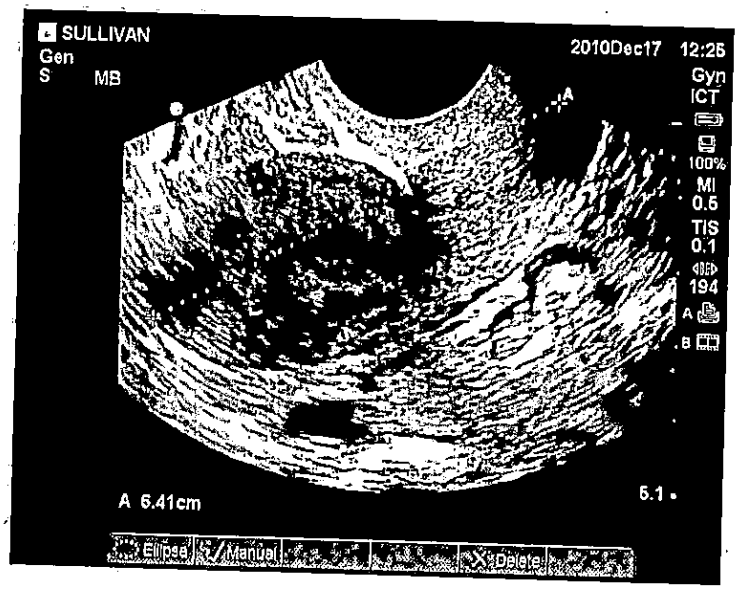
..... Monitor next few cycles — If heavy 2 ITS

..... Check Hgb

REPEAT APPOINTMENT YES/NO

DISPOSAL ..... SIGNATURE .....


SULLIVAN
Gen
S MB
2010Dec17 12:26
Gyn
ICT
100%
MI
0.5
TIS
0.1
194
A
B
A 0.29cm
5.1
Ellipse
Manual
Delete


SULLIVAN
Gen
S MB
2010Dec17 12:25
Gyn
ICT
100%
MI
0.5
TIS
0.1
194
A
B
A 6.41cm
5.1
Ellipse
Manual
Delete

PATHOLOGY DEPT - GLASGOW ROYAL INFIRMARY

Lab No.:R,10.0025146

CHI No. 0712726128

Name:SULLIVAN DEBORAH

DOB/Age:07.12.72

Post code:G69 7EP

Hosp.No(orPath.Comp.Ref.ZP): 10638479K

Consultant:/: ~~SMITHJ: MR.J.SMITH~~ Dr CHITNAKUMAR Location:STOBHILL ~~[redacted]~~ CLINIC F.

CLINICAL HISTORY:
Bleeding after 2 years. Amenorrhoea.

Endometrial Pipelle

Micro: Microscopy shows weakly proliferative endometrium.

There is no evidence of endometritis, hyperplasia or malignancy.

SMCC

Dr J Tolhurst

JTolh

Rep .Path.Dr Jenny Tolhurst
Cons.Path.Dr Jenny Tolhurst

Date collected 17.12.10
Date received 17.12.10
Date reported

PRESCRIPTION FORM

Hospital Name: Stobhill

PATIENT DETAILS

Name: [redacted]
10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Hos

DOE

Date of Admission: __/__/__

Height: 5' 11"

Weight: 13st.

Surface area:

Date of writing discharge prescription: __/__/__

Consultant Name: Ms CRAIG

Ward: 7A

Date and time this form prepared: __/__/__ Time:

Sheet No 1

2nd Prescription in use

DRUG SENSIT

VOLTEROL.

Family will bring in own meds

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐

Assessed by:

OTHER CHARTS

Insulin ☐

PCA and other infusions ☐

Anticoagulants: Heparin ☐ Oral ☐

Topical: ☐

TPN: ☐

Enteral Nutrition: ☐

Oxygen Therapy: ☐

Other:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
17/10/08	PETHIDINE	100mg	O		David Russell		
17/10/08	TEMAZEPAM	10mg	O		David Russell	CWL.	2210

1/ Meds clarified: pls sign.
2/ ? ↑ dihydro to 60mg qds while review awaited
3/ On OCP: ↑ ceftrone to 40mg ?
* cons/senior review *
4/ ? prn anti-emetics: cyclizine/ metoclopramide

ADMINIS RATION

PATIENT'S NAME:

Parenteral Drugs: Regular Prescription

DATE

MONTH

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

A DRUG FENTANYL PATCH

DOSE 75mcg/hr | ROUTE PATCH | DATE 17/11/08 | STOPPED DATE: 19/11/08 | INITIALS: DK

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY 2 hours

FOR DOCTORS USE ONLY

B DRUG CLEXANE

DOSE 20mg | ROUTE SC | DATE 17/11/08 | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR David Russell

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

PATIENT'S NAME: Debbie Sullivan

Oral and Other Drugs: Regular Prescriptions

ADMINISTRATION

DATE → 14 15
MONTH → 11. 11

J DRUG SENNA.

DOSE 2.5ml | ROUTE PO | DATE 13/11/18 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400 CW
Other time

K DRUG LACTULOSE

DOSE 15ml | ROUTE PO | DATE 13/11/18 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM

FOR DOCTORS USE ONLY

Other time
0700-0900 RB
1200-1400
1600-1800
2200-2400 CW
Other time

L DRUG PARACETAMOL

DOSE 500mg | ROUTE PO | DATE 13/11/18 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

Other time
0700-0900 X RB
1200-1400 X
1600-1800
2200-2400 CW
Other time

M DRUG OMEPRAZOLE

DOSE 40mg | ROUTE PO | DATE 13/11/18 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM

FOR DOCTORS USE ONLY

Other time
0700-0900
1200-1400
1600-1800
2200-2400 CW
Other time

Oral and Other Drugs: Regular Prescriptions

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

DATE → 17 18
MONTH → 11

N

DRUG: MOVICOL lemon lime
DOSE: 13.8g | ROUTE: PO | DATE: 17/11/18 | STOPPED DATE:
SIGNATURE OF DOCTOR: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	
0700-0900	✓ (3)
1200-1400	
1600-1800	✓
2200-2400	✓ (3)
Other time	

FOR DOCTORS USE ONLY

P

DRUG: DIAMORPHINE
DOSE: 30mg | ROUTE: PO | DATE: 17/11/18 | STOPPED DATE:
SIGNATURE OF DOCTOR: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	
0700-0900	✓
1200-1400	✓ (3)
1600-1800	
2200-2400	✓ (3)
Other time	

FOR DOCTORS USE ONLY

R

DRUG: FLUOXETINE
DOSE: 40mg | ROUTE: PO | DATE: 17/11/18 | STOPPED DATE:
SIGNATURE OF DOCTOR: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CM

Other time	
0700-0900	✓ (4)
1200-1400	
1600-1800	
2200-2400	
Other time	

FOR DOCTORS USE ONLY

S

DRUG: GRANISETRON
DOSE: 1mg | ROUTE: PO | DATE: 17/11/18 | STOPPED DATE:
SIGNATURE OF DOCTOR: | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CM

Other time	
0700-0900	✓ (4)
1200-1400	
1600-1800	
2200-2400	✓ (4)
Other time	

FOR DOCTORS USE ONLY

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

PATIENT'S NAME: DEBORAH SULLIVAN.

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE 17 18
MONTH 11 11

T DRUG GABAPENTIN

DOSE 600mg | ROUTE PO | DATE 17/11/1 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM

Other time
0700-0900 ✓ PB
1200-1400 ✓
1600-1800
2200-2400 ✓ CW
Other time

FOR DOCTORS USE ONLY

V DRUG Senna

DOSE 2t | ROUTE PO | DATE 18/11/08 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM

Other time
0700-0900
1200-1400
1600-1800
2200-2400 ✓
Other time

FOR DOCTORS USE ONLY

W DRUG Paracetamol

DOSE 1g | ROUTE PO | DATE 18/11/08 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900 ✓
1200-1400 ✓
1600-1800 ✓
2200-2400 ✓
Other time 5:30 CS

FOR DOCTORS USE ONLY

X DRUG Cilest

DOSE 1 tab | ROUTE PO | DATE 18/11/08. | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY CM
OCP: obtain pt's own

Other time
0700-0900 ✓
1200-1400
1600-1800
2200-2400
Other time

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME:

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE

MONTH

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

LL DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

← FOR DOCTORS USE ONLY →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

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

PATIENT'S NAME:

All Routes: As Required Prescriptions

ADMINISTRATION

MM	DRUG: Temazepam			STOPPED DATE:	INITIALS:
DOSE: 10mg	ROUTE: PO	INDICATION: insomnia			
SIGNATURE OF DOCTOR	MAX.FREQUENCY: Nocte			DATE: 15/11/06	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

NN	DRUG			STOPPED DATE:	INITIALS:
DOSE	ROUTE	INDICATION			
SIGNATURE OF DOCTOR	MAX.FREQUENCY			DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

PP	DRUG			STOPPED DATE:	INITIALS:
DOSE	ROUTE	INDICATION			
SIGNATURE OF DOCTOR	MAX.FREQUENCY			DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

RR	DRUG			STOPPED DATE:	INITIALS:
DOSE	ROUTE	INDICATION			
SIGNATURE OF DOCTOR	MAX.FREQUENCY			DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					

DATE	
TIME	
DOSE	
GIVEN BY	

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

SS	DRUG		STOPPED DATE: INITIALS:
DOSE	ROUTE	INDICATION	
SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																												
TIME																												
DOSE																												
GIVEN BY																												

TT	DRUG		STOPPED DATE: INITIALS:
DOSE	ROUTE	INDICATION	
SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																												
TIME																												
DOSE																												
GIVEN BY																												

VV	DRUG		STOPPED DATE: INITIALS:
DOSE	ROUTE	INDICATION	
SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																												
TIME																												
DOSE																												
GIVEN BY																												

WW	DRUG		STOPPED DATE: INITIALS:
DOSE	ROUTE	INDICATION	
SIGNATURE OF DOCTOR	MAX.FREQUENCY	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE																												
TIME																												
DOSE																												
GIVEN BY																												

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

Nurse/Midwife Administration by Protocol – Authorised Nurses/Midwives Only

(Maximum number of doses as per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:

Milligram = **mg**		Gram = **g**	
Millilitre = **ml**		Microgram:	**to be written in full.**
		Units:	**to be written in full.**

Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.

5. Method of administration should be abbreviated as follows:

Intravenous = **IV**		Oral = **O**	
Subcutaneous = **SC**		Per rectum = **PR**	
Inhalations = **INH**		Topical = **TOP**	
Sublingual = **SL**		Nasogastric = **NG**	
Intramuscular = **IM**		Vaginal = **PV**	
Intradermal = **ID**			

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

Codes for Non-Administration of Drugs

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

Ver 7, 07/2005

Stobhi[illegible]

10638479K
SULLIVAN
DEBORAH
6 MUIRHEAD COURT 07/12/1972 F
BAILLIESTON
GLASGOW
CHI-0712726128 G69 7EP

NHS
Greater Glasgow and Clyde

) BE FILED UNTIL DISCHARGE

Na[illegible] Unit No.:

Date:	17/11	18/11										
Time of Result:												
WCC 4-11	9.189	8.41										
Hb M - 13-18 F - 11.5-16.5	12.6	11.9										
Plat 150-400	304	237										
Hct 0-37-0-47												
Na 135-145	(134)	139										
K 3-5-50	4.3	4.2										
Cl 97-107	103	109										
Bic 23-30	[illegible]											
Urea 2-5-8.0	2.8	2.2										
Creat. 40-130	58	59										
Amylase .....<100	91											
CRP .....<10	3.8	4.6										
ESR .....AGE 12												
Adj. Ca ...2-2-2-6	2.37											
Phosphate 0-7-1-4	1.12											
Tot. Prot. ..62-82	71	61										
Albumin 36-55	38	32										
Alk. Phos. 80-280	(40)	38										
Gamma GT ..<50	50	42										
Bil 3-22	3	8										
AST 12-48	23	25										
ALT 3-55	19	20										
LD 200-520												
Glucose ..3-0-5-5												
PT 9-12												
APTT 25-37												
TT 11-15												
FIB 200-400												
INR												
APTT RATIO												
Drain Amylase												
H^+ 36-43												
PO_2 .....10.5-13.5												
PO_2 .....4.6-6.0												
HCO_3 20-28												

MIS 109801/Stob

Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	Deborah Sullivan
Address	
	10638 97916
Hospital No.	
DOB	

Admitted Date 17/11/08 Ward 7A

Transferred Date _____ Ward _____

Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

DATE	17/11	17/11	18/11	18/11													TEMP X
Time	5:30pm	22:00	04:00	19:00													
BP ^ v and Pulse •																	
Pulse	56	60	80	83													
Resp. Rate	16	16	16	18													
Inspiration O_2%	RA	(A)	(A)	(A)													
SpO_2%	93%	97	97	97													
Pain Score (0-10)	3	8	7	10													
Sedation Score	0	0	0	0													
Nausea Score	0	0	0	5													
Blood Glucose	X																
RSOM	Blood tracs obtained 17th Oct																
MSSM																	
HCG	NEG																

MEWS																	
	Resp. Rate	0		0	0												
	Pulse	0		0	0												
	Systolic BP	0		0	0												
	GCS / AVPU	0		0	0												
	Urine Output	0		0	0												
	Temp.	0		0	0												
	SpO_2%	0		0	0												
	TOTAL	0		0	0												

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

DATE																		TEMP X
Time																		
BP ^ v and Pulse •	240																	40°C
	230																	
	220																	39°C
	210																	
	200																	38°C
	190																	
	180																	37°C
	170																	
	160																	36°C
	150																	
	140																	35°C
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
	50																	
	40																	
Resp. Rate																		
Inspiration O_2%																		
SpO_2%																		
Pain Score																		
Sedation Score																		
Nausea Score																		
Blood Glucose																		

MEWS																	
	Resp. Rate																
	Pulse																
	Systolic BP																
	GCS / AVPU																
	Urine Output																
	Temp.																
	SpO_2%																
	TOTAL																

Calling Criteria

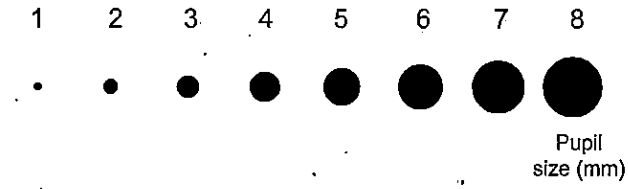
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

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

Glasgow Coma Scale



DATE																				
me																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
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		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

THIS DOCUMENT MUST BE RETAINED

STOBHILL HOSPITAL

NHS Greater Glasgow and Clyde

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6hr = 22 Drops/min.
4hr = 30 Drops/min. 8hr = 15 Drops/min.

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

SURNAME	FORENAME	Unit No.
Deborah Sullivan	1063864	19K

DATE 17/11/08

No. 0181327

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	Serial No. / Batch No.	Given by
(N) SALINE	500	21 55	4°	01 55		081 29T 35 03/11	B
5% DEXTROSE	500	01 55	4°	6am		08D 15E 1H 03/11	B
(N) SALINE	500	6am	4°			08D 15C 1H 03/11	B

MIS 147933

NHS
Greater Glasgow and Clyde

Pressu w Hospitals nt Documentation Form

10638479K
SULLIVAN
DEBORAH
CHI-0712726128

Patient Name: _____

Case Record Number: _____ Ward: 7A

Waterlow Risk Assessment		Initials	AP													
		Date	17/11													
		No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average 0 Above average 1 Obese 2 Below average 3		0													
Continence:	Completely catheterised 0 Occasionally incontinent 1 Cath. Incontinence of faeces 2 Doubly incontinent 3		0													
Skin type-visual risk areas:	Healthy 0 Tissue paper/dry 1 Oedematous clammy (temp↑) 1 Discoloured 2 Broken spot 3		0													
Mobility:	Fully 0 Restless/fidgety 1 Apathetic 2 Restricted 3 Inert/traction 4 Chairbound 5		0													
Age/Sex:	Male/Female ½ 14-49 1 50-64 2 65-74 3 75-80 4 80+ 5		1 1													
Appetite:	Average 0 Poor 1 NG Tube/fluids only 2 nbm – Anorexic 3		0													
Special risks – tissue malnutrition:	eg Terminal cachexia 8 Cardiac failure 5 Peripheral vascular disease 5 Anaemia 2 Smoking 1		1													
Neurological deficit:	Motor-sensory paraplegia 4-6 eg diabetes, MS, CVA															
Major surgery/trauma:	Orthopaedic Below waist, Spinal 5 On table > 2 hours 5															
Medication:	Cytotoxics, High dose steroids 4 Anti-inflammatory															
TOTAL SCORE			3													

Score: <10 = low risk; 10-14 = at risk; 15 – 19 = high risk 20+ = very high risk

DAILY PRESSURE AREA SKIN ASSESSMENT CHART

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

Grade one = blanching hyperaemia
Grade two = non blanching hyperaemia/superficial break
Grade three = through to subcutaneous tissue
Grade four = through to underlying muscle
Grade five = through to bone or presence of necrotic tissue

Date Skin Assessment	Skin Broken		Site of Damage	Grade of Damage	Signature
	Yes	No			

ENSURE ALL ACTION IS DOCUMENTED IN THE NURSING CARE PLAN

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

10638479K
SULLIVAN
DEBORAH
CHI-0712726128

NUTRITIONAL SCREENING TOOL

NHS Greater Glasgow and Clyde

Weight (kgs): 13st

Height (metres): 5'11"

B.M.I: .....

Please circle only one score in each section		RESCORE			
Date	17/11				
BODY WEIGHT					
• Normal (no recent weight changes)	0	0	0	0	0
• Recent unintentional weight loss (<6 kgs)	3	3	3	3	3
• Underweight / weight loss > 6 kgs	5	5	5	5	5
APPETITE					
• Good - finishing three meals per day	0	0	0	0	0
• Reduced - leaving quarter meals and fluids	2	2	2	2	2
• Poor - leaving half meals and fluids	3	3	3	3	3
• Little or no appetite, refusing or unable to eat/drink	5	5	5	5	5
ABILITY TO EAT AND DRINK					
• No difficulties, eating and drinking independently	0	0	0	0	0
• Requires assistance with eating and drinking	2	2	2	2	2
• Difficulty swallowing and/or chewing	5	5	5	5	5
SKIN CONDITION					
• Healthy	0	0	0	0	0
• Some red pressure areas	2	2	2	2	2
• Superficial breaks in pressure areas	4	4	4	4	4
• Multiple deep pressure sores	5	5	5	5	5
GUT FUNCTION					
• Normal	0	0	0	0	0
• Persistent nausea	2	2	2	2	2
• Nausea + / or occasional vomiting + / or some diarrhoea / constipation	3	3	3	3	3
• Diarrhoea > 3 per day / unable to keep food or fluids down	5	5	5	5	5
MEDICAL CONDITION					
• No impairment to food intake	0	0	0	0	0
• Minor surgery / mild infection	2	2	2	2	2
• Major surgery (Esp. G.I. Tract) / G.I. disease / CVA / Chronic illness	4	4	4	4	4
• Severe infection / Sepsis / Cancer / Burns > 15% / Multiple injuries	5	5	5	5	5
TOTAL (REFER TO ACTION PLAN)	10				

IF YOU FEEL THAT YOUR PATIENT REQUIRES DIETETIC INTERVENTION DESPITE THE SCORE, PLEASE CONTACT THE DIETITIAN TO DISCUSS.

ACTION PLAN

LOW RISK 0 – 5

Encourage normal diet.
Check weight weekly.
Re-assess if condition changes.

MEDIUM RISK 6 – 9

Commence 3 Day Food Record Chart.
Check weight twice weekly.

Re-assess after 3 days.

Beatson Oncology Centre:
Refer to Medium Risk Flow Chart

Intake / weight increasing → *Continue to encourage oral diet*

Intake / weight not increasing → *Refer to dietitian*

HIGH RISK 10+

Refer to Dietitian and Medical Staff

Beatson Oncology Centre:
Refer to High Risk Flow Chart

*during latter stages of palliative treatment weighing of patients to assess nutritional status may not be appropriate as weight loss may be as a result of the under lying disease

Date	Weight	Score	Date seen by Dietitian	Refer to Dietetic Care Plan
17/11/08	13st.	10		

PATIENT: MOVING AND HANDLING CARE PLAN

Patient's Details:	Deborah Sullivan 1063879K	Named Nurse:	LORNA	If Patient is totally independent, tick here and go to date box.	✓

BODY BUILD				Problems with comprehension, behaviour, co-operation (specify):
Obese		Tall		
Above average		Medium	✓	
Average	✓	Short		
Below Average		Weight	Kg	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
RISK OF FALLS				
High		Low	✓	

Into Bath or shower.

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT		BED BATH	
Ambulift		Parker		People 1		2		Additional Information:			
Shower Chair		Variable Height									
Other (specify)		Fixed Height									
		Shower									

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	
People 1	2	3		People 1	2		Additional Information:							
				Walking Aid (specify)										

Toiletting

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	
People 1	2	3		People 1	2		Additional Information:							
				Walking Aid (specify)										

Walking.

NO WALKING		MANUAL SUPPORT		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	
		People 1	2	Distance Walked/Additional Information:							
		Walking Aid (specify)									

Move up/down bed.

HOIST (specify)				HANDLING AIDS		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	
People 1	2	3		Sliding aid (fabric)		Additional Information:							
				Rope ladder									
				Hand blocks									

Sit up over side of bed.

ROPE LADDER		SWIVEL CUSHION		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	

Move on/off bed pan.

HOIST		ROLL PATIENT		PATIENT BRIDGES		MONKEY POLE		N/A	

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID		SLIDING AID - FABRIC		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT	

Other Instructions.

Date Assessed:	17/11/08					
Assessor's Signature:	LP					
Proposed Review Dates:						

nto Bath or shower.

HANDLING AID	WHICH BATH	ASSISTANCE	SUPERVISION	INDEPENDENT	BED BATH
Ambulift	Parker	People 1	2	Additional Information:	
Shower Chair	Variable Height				
Other (specify)	Fixed Height				
	Shower				

ransfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

oiletting

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Walking

VALKING	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
	People 1 2	Distance Walked/Additional Information:			
	Walking Aid (specify)				

Move up/down bed.

HOIST (specify)	HANDLING AIDS	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	Sliding aid (fabric)	Additional Information:			
	Rope ladder				
	Hand blocks				

it up over side of bed.

ROPE LADDER	SWIVEL CUSHION	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Move on/off bed pan.

HOIST	ROLL PATIENT	PATIENT BRIDGES	MONKEY POLE	N/A

ransfer to/from trolley (or bed etc).

SLIDING AID - RIGID	SLIDING AID - FABRIC	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

her Instructions.

Date Assessed:						
Assessor's Signature:						
Proposed Review Dates:						

Acute Services Division

Hospital / Department STOBHILL 7A

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: Deborah Smillie

Ward: 7A

CHI number: 0712726128 Unit/Hospital number 1063846791K

Contents

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

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

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 17/11/18	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s)		8 (1) AP						
SCORE 2 - 8 = LOW, 9 - 12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE		AP						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

Action code	NURSING INTERVENTIONS	DATE 17/11/08	DATE	DATE	DATE	DATE	DATE	DATE
	LOW, MODERATE AND HIGH RISK							
1	Prevention and general safety precautions discussed with patient and family.	✓						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE	dp						

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

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

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

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

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

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

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

Name: Rebecca Sullivan Ward: 7A Date: 17/11/08 Case Record No.: 10638479K

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
17/11	AP	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		2.NUTRITION		
17/11	B	Fasting 6am		
17/11	AP	Normal Diet		
		Special Diet / Modified Diet		
		3.ELIMINATION		
17/11	AP	Independent		
		Commode		
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
17/11	AP	Fully Independent/fully mobile Low falls risk		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
	AP	Waterlow daily (if score is over 10+)		
17/	AP	TPR x 4 daily		
	AP	BP x 4 daily		
/11	AP	Pain Score		
	AP	Fluid Balance		
17/11	B	MEWS Score <0		

00629

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
17/11	AP	IV Infusion 4°		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
17/11	AP	IV access: ∞ IV cannulae AP - blue ○ hand ∞ others		
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
17/11	AP	RSOV/MSSV/HCG	P3	AP C8
		9.SLEEP		
17/11	PS	promote restful sleep		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
17/11	AP	Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: Yes ☐ N/A ☐
Signature of nurse: **Date:** 17/11/08

Registration

Ms Deborah Sullivan
1 Camp Road 6 Muirhead court
CARROWHILL
GLASGOW
G69 6QR G69 7EP.
Telephone: 771 6310
Contact: ?
ContactRelship: ?
Email: ?
CHI Number: 0712726128
NHS Number: 604/72/263
Patient ID: B
Occupation:
Registered GP: Dr JJ Langan
Registered: 27/05/2002
Confirmed: 31/05/2002
BMI: 0.0
Height: 0 m
Weight: 0 kg
Parity: 0
Gravida: 0

Service Code: Permanent
DoB: 07/12/1972
Age: 35
Road: 0 Water: 0 FootPath: 0
Marital Status: Unknown
Records Received: 14/08/2002
BP: 130/84

Repeat Medication

Drug/Preparation	Quantity/Dose/Frequency	Start	Last	Interval Pres.	Review
Senna TABS 7.5MG	100 2 Tabs As directed	07/11/2008	07/11/2008	0	52
Lactulose Oral SOLN 3.35G/5ML	500 15 ml Twice daily	07/11/2008	07/11/2008	17	52
Paracetamol TABS 500MG	224 2 Tabs 4 times daily	02/09/2008	29/10/2008	84	52
Omeprazole CAPS 40MG	28 1 Cap In the morning	05/02/2008	29/10/2008	84	52
Movicol Lemon & Lime 13.8g SACH	60 1 sachet Twice daily	05/02/2008	10/09/2008	84	52 ?

Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
12/10/2006	None	High	Anxiety with depression	
18/01/2005	None	High	Never smoked tobacco	
05/11/2004	None	High	Hiatus hernia NOS	
Freetext: moderately large				
26/10/2004	None	High	Nissen fundoplication using abdominal approach	
17/03/2004	None	High	Dislocation or subluxation of shoulder	
Freetext: Left shoulder				
30/08/2002	None	High	Overdose of drug	
Freetext: Kapake and Tramadol with Diazepam				
27/08/2002	None	High	[D]Abdominal pain	
Freetext: Vomiting				
02/07/2002	None	High	Chronic pancreatitis	
02/07/2002	None	High	Constipation	
01/10/2001	None	High	Chronic pancreatitis	
01/07/2001	None	High	[X]Rape	
01/07/2001	None	High	Anxiety states	Chronic

01/07/2001	None	High	Sexual assault	
23/04/1999	None	High	Diaphragmatic hernia	
23/04/1999	None	High	Reflux oesophagitis	
27/03/1999	None	High	[D]Abdominal pain	Recurrent
14/11/1996	None	High	[SO]Sphincter of Oddi	
Freetext: Dysfuntion				
10/10/1996	None	High	Endoscopic retrograde cholangiopancreatography	
Freetext: Major papilla was located in the second part of the duodenum				
23/04/1996	None	High	Acute cholecystitis	
23/04/1996	None	High	Cholelithiasis	
23/04/1996	None	High	Excision of gall bladder	
01/06/1995	None	High	Urinary tract infection, site not specified	
01/02/1995	None	High	[D]Nausea and vomiting	

Screening

05/10/2005	**Cervical Screening$$**	Cervical smear: negative	
Repeat after an Interval - 36 Months		Do not send recall letter	Do not send result letter

Priority Clinical / User Marker

Date Recorded	Start Date	Priority	Description	Modifier
12/10/2006	None	High	Anxiety with depression	
18/01/2005	None	High	Never smoked tobacco	
05/11/2004	None	High	Hiatus hernia NOS	
Freetext: moderately large				
26/10/2004	None	High	Nissen fundoplication using abdominal approach	
17/03/2004	None	High	Dislocation or subluxation of shoulder	
Freetext: Left shoulder				
30/08/2002	None	High	Overdose of drug	
Freetext: Kapake and Tramadol with Diazepam				
27/08/2002	None	High	[D]Abdominal pain	
Freetext: Vomiting				
02/07/2002	None	High	Chronic pancreatitis	
02/07/2002	None	High	Constipation	
01/10/2001	None	High	Chronic pancreatitis	
01/07/2001	None	High	[X]Rape	
01/07/2001	None	High	Anxiety states	Chronic
01/07/2001	None	High	Sexual assault	
23/04/1999	None	High	Diaphragmatic hernia	

23/04/1999	None	High	Reflux oesophagitis	
27/03/1999	None	High	[D]Abdominal pain	Recurrent
14/11/1996	None	High	[SO]Sphincter of Oddi	
Freetext:	Dysfuntion			
10/10/1996	None	High	Endoscopic retrograde cholangiopancreatography	
Freetext:	Major papilla was located in the second part of the duodenum			
23/04/1996	None	High	Acute cholecystitis	
23/04/1996	None	High	Cholelithiasis	
23/04/1996	None	High	Excision of gall bladder	
01/06/1995	None	High	Urinary tract infection, site not specified	
01/02/1995	None	High	[D]Nausea and vomiting	

Acute Prescriptions

Drug/Preparation	Quantity/Dose/Frequency	Date
Dihydrocodeine Tartrate TABS 30MG	100 tabs 1 or 2 Tabs up to qds prn	11/11/2008
Gabapentin CAPS 300MG	112 caps 2 Caps 3 times daily	11/11/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning	07/11/2008
	make appt for next supply	
Granisetron TABS 1MG	20 1 Tab Twice daily	07/11/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	07/11/2008
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs up to qds prn	30/10/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	23/10/2008
Gabapentin CAPS 300MG	112 2 Caps 3 times daily	23/10/2008
Temazepam TABS 10MG	28 1 Tab At night	23/10/2008
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs up to qds prn	16/10/2008
Granisetron TABS 1MG	20 1 Tab Twice daily	16/10/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	06/10/2008
Dihydrocodeine Tartrate TABS 30MG	100 1 or 2 Tabs up to qds prn	06/10/2008
Temazepam TABS 10MG	14 1 Tab At night	06/10/2008
Gabapentin CAPS 300MG	112 2 Caps 3 times daily	26/09/2008
Temazepam TABS 10MG	14 1 Tab At night	22/09/2008
Fentanyl 75 Micrograms/Hour PATCH	5 Apply every 72 hours	22/09/2008
Fentanyl Matrix 50 Micrograms/Hour PATCH	5 Apply every 72 hours	10/09/2008

Gabapentin CAPS 300MG	112 2 Caps 3 times daily	02/09/2008
Temazepam TABS 10MG	14 1 Tab At night	02/09/2008
Gabapentin CAPS 300MG	56 1 Cap As directed	27/08/2008
Fentanyl Matrix 50 Micrograms/Hour PATCH	5 Apply every 72 hours	25/08/2008
Fluoxetine CAPS 20MG	60 2 Caps Daily	18/08/2008
Gabapentin CAPS 300MG	56 1 Cap Twice daily	18/08/2008
Cyclizine TABS 50MG	84 1 Tab 3 times daily	18/08/2008
Temazepam TABS 10MG	14 1 Tab At night	18/08/2008
Fentanyl Matrix 25 Micrograms/Hour PATCH	5 Apply every 72 hours	18/08/2008
Cilest TABS	6OP 1 Tab As directed	17/07/2008
Co-Amoxiclav 250mg/125mg TABS	21 1 Tab 3 times daily	27/06/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning	27/06/2008
	make appt for next supply	
Clarithromycin TABS 500MG	14 1 Tab Twice daily	13/06/2008
Prochlorperazine Maleate TABS 5MG	84 1 Tab 3 times daily	01/05/2008
Pethidine TABS 50MG	112dips weekly 1 Tab 4 times daily	01/05/2008
Pethidine TABS 50MG	50 1 Tab 4 times daily	18/04/2008
Pethidine TABS 50MG	16 1 or 2 Tabs 4 times daily	04/04/2008
Diprobase Pump Dispenser CREAM	500ML Apply As directed	04/04/2008
Pethidine TABS 50MG	16 1 or 2 Tabs 4 times daily	02/04/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	26/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	19/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	11/03/2008
Fluoxetine CAPS 20MG	112 2 Caps In the morning	05/03/2008
	make appt for next supply	
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	05/03/2008
Senna TABS 7.5MG	60 2 Tabs At night	05/03/2008
Cefalexin CAPS 250MG	20 1 Cap 4 times daily	05/03/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	27/02/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	20/02/2008
Pethidine TABS 50MG	25 1 or 2 Tabs 4 times daily	18/02/2008
Pethidine TABS 50MG	50 1 or 2 Tabs 4 times daily	12/02/2008
Clarithromycin TABS 500MG	14 1 Tab Twice daily	18/01/2008

Pain Clinic Only

	03/12/08	– Booked - Dr Rae
	22/10/08	– Could Not Attend - CR
	15/3/06	– DNA – CR
*	16/11/05	– Attended - Dr Rae
	14/9/05	– DNA – CR
	27/10/04	– Ptn Cancelled – CR
	27/7/03	– DNA – CR
	10/6/03	– Ptn cancelled – CR
	04/09/01	– DNA – Dr Baoler
	10/07/01	– Cancelled on Day – MB

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Ward: 7A Date: 30/9/08 Case Record No.:

CARE PLAN

Date Comm.	Signature	1.BASIC CARE AND PERSONAL HYGIENE	Date Disc.	Signature
30/9/08	RM	Independent		
		Bed bath		
		Assisted wash		
		Oral hygiene		
		Pressure care		
		2.NUTRITION		
30/9/08	RM	Fasting		
		Normal Diet		
		Special Diet / Modified Diet		
		3.ELIMINATION		
30/9/08	RM	Independent		
		Commode		
		Bedpan/urinal		
		Urinary Catheter | Size: | Batch No:		
		Type of Material: | H_2O in Balloon:		
		Type of Stoma Appliance:		
		4.MOBILITY		
30/9/08	RM	Fully Independent/fully mobile		
		Minimal assistance (give details)		
		Dependent (See movement and handling sheet - keep with patient)		
		5.OBSERVATIONS		
30/9/08	RM	Waterlow daily (if score is over 10+)		
↓	↓	TPR		
		BP		
		Pain Score		
		Fluid Balance		

CARE PLAN

Date Comm.	Signature	6.TECHNICAL CARE	Date Disc.	Signature
		IV Infusion		
		Monitor		
		Catheter		
		Oxygen Therapy		
		Nebulisers		
30/9/08	RM.	IV access: ∞ IV cannulae R. foe arm ∞ others		
		7.WOUND CARE		
		8.SPECIMENS/INVESTIGATIONS		
30/9/08	RM	RSV D		
		9.SLEEP		
		Provide Natural Sleep.		
		10.SPECIAL NEEDS		
		Assess for dysphagia (refer to speech and language therapist)		
		Source/protective isolation (refer to infection Control)		
		Blind/visually impaired		
		Deaf/hard of hearing		
		Anti-embolic stockings		
		Nurse escort when out of ward		
		11.OTHER RELEVANT INFORMATION		
		12.FAMILY/SIGNIFICANT OTHER		

Initial Care Plan seen and agreed by patient: Yes ☑ N/A ☐

Signature of nurse: **Date:** 30/09/08

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

NUTRITIONAL SCREENING TOOL

NHS Greater Glasgow and Clyde

Weight (kgs): .....

Height (metres): .....

B.M.I: .....

Please circle only one score in each section		RESCORE			
Date	30/9				
BODY WEIGHT					
● Normal (no recent weight changes)	(0)	0	0	0	0
● Recent unintentional weight loss (<6 kgs)	3	3	3	3	3
● Underweight / weight loss > 6 kgs	5	5	5	5	5
APPETITE					
● Good - finishing three meals per day	0	0	0	0	0
● Reduced - leaving quarter meals and fluids	(2)	2	2	2	2
● Poor - leaving half meals and fluids	3	3	3	3	3
● Little or no appetite, refusing or unable to eat/drink	5	5	5	5	5
ABILITY TO EAT AND DRINK					
● No difficulties, eating and drinking independently	(0)	0	0	0	0
● Requires assistance with eating and drinking	2	2	2	2	2
● Difficulty swallowing and/or chewing	5	5	5	5	5
SKIN CONDITION					
● Healthy	(0)	0	0	0	0
● Some red pressure areas	2	2	2	2	2
● Superficial breaks in pressure areas	4	4	4	4	4
● Multiple deep pressure sores	5	5	5	5	5
GUT FUNCTION					
● Normal	0	0	0	0	0
● Persistent nausea	(2)	2	2	2	2
● Nausea + / or occasional vomiting + / or some diarrhoea / constipation	3	3	3	3	3
● Diarrhoea > 3 per day / unable to keep food or fluids down	5	5	5	5	5
MEDICAL CONDITION					
● No impairment to food intake	(0)	0	0	0	0
● Minor surgery / mild infection	2	2	2	2	2
● Major surgery (Esp. G.I. Tract) / G.I. disease / CVA / Chronic illness	4	4	4	4	4
● Severe infection / Sepsis / Cancer / Burns > 15% / Multiple injuries	5	5	5	5	5
TOTAL (REFER TO ACTION PLAN)	4				

IF YOU FEEL THAT YOUR PATIENT REQUIRES DIETETIC INTERVENTION DESPITE THE SCORE, PLEASE CONTACT THE DIETITIAN TO DISCUSS.

ACTION PLAN

LOW RISK 0 – 5

Encourage normal diet.
Check weight weekly.
Re-assess if condition changes.

MEDIUM RISK 6 – 9

Commence 3 Day Food Record Chart.
Check weight twice weekly.

Re-assess after 3 days.

Beatson Oncology Centre:
Refer to Medium Risk Flow Chart

Intake / weight increasing → *Continue to encourage oral diet*

Intake / weight not increasing → *Refer to dietitian*

HIGH RISK 10+

Refer to Dietitian and Medical Staff

Beatson Oncology Centre:
Refer to High Risk Flow Chart

*during latter stages of palliative treatment weighing of patients to assess nutritional status may not be appropriate as weight loss may be as a result of the under lying disease

Date	Weight	Score	Date seen by Dietitian	Refer to Dietetic Care Plan

10638479K F
SULLIVAN
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
Patier CHI-0712726128

North Glasgow Hospitals

ɔre Risk Assessment Documentation Form

NHS Greater Glasgow and Clyde

Case Record Number: _____ Ward: 7a

Waterlow Risk Assessment			Initials	RM												
			Date	30/9												
			No.	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Body weight for height:	Average	0		0													
	Above average	1															
	Obese	2															
	Below average	3															
Continence:	Completely catheterised	0		0													
	Occasionally incontinent	1															
	Cath. Incontinence of faeces	2															
	Doubly incontinent	3															
Skin type-visual risk areas:	Healthy	0		0													
	Tissue paper/dry	1															
	Oedematous clammy (temp↑)	1															
	Discoloured	2															
	Broken spot	3															
Mobility:	Fully	0		0													
	Restless/fidgety	1															
	Apathetic	2															
	Restricted	3															
	Inert/traction	4															
	Chairbound	5															
Age/Sex:	Male/Female	½		2													
	14-49	1		1													
	50-64	2															
	65-74	3															
	75-80	4															
	80+	5															
Appetite:	Average	0		1													
	Poor	1															
	NG Tube/fluids only	2															
	nbm – Anorexic	3															
Special risks – tissue malnutrition:	eg Terminal cachexia	8		8													
	Cardiac failure	5															
	Peripheral vascular disease	5															
	Anaemia	2															
	Smoking	1		1													
Neurological deficit:	Motor-sensory paraplegia eg diabetes, MS, CVA	4-6		0													
Major surgery/trauma:	Orthopaedic Below waist, Spinal	5		0													
	On table > 2 hours	5															
Medication:	Cytotoxics, High dose steroids Anti-inflammatory	4		0													
TOTAL SCORE				5													

Score: <10 = low risk; 10-14 = at risk; 15 – 19 = high risk 20+ = very high risk

DAILY PRESSURE AREA SKIN ASSESSMENT CHART

CLASSIFICATION OF PRESSURE DAMAGE (TORRANCE)

Grade one = blanching hyperaemia
Grade two = non blanching hyperaemia/superficial break
Grade three = through to subcutaneous tissue
Grade four = through to underlying muscle
Grade five = through to bone or presence of necrotic tissue

Date Skin Assessment	Skin Broken		Site of Damage	Grade of Damage	Signature
	Yes	No			

ENSURE ALL ACTION IS DOCUMENTED IN THE NURSING CARE PLAN

Designed & Produced by Department of Medical Illustration MID Job No. 99/1694

Acute Services Division

Hospital / Department | STOBHILL

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

10638479K
Patient name: SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
Ward: BAILLIESTON
GLASGOW G69 7EP
CHI number: CHI-0712726128 Unit/Hospital number

Contents

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

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

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

Continuing Care Wards: Mobile and 'at risk' patients should have risk assessment and care plan reviewed monthly.

Cannard Falls Risk Assessment

(Must be completed within 24 hours)

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						DATE 30/9	DATE	DATE	DATE	DATE	DATE	DATE
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	60-70 1	71-80 2	81+ 1			0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		1						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed bound 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s)		(1)						
SCORE 2–8 = LOW, 9–12 = MEDIUM, 13+ = HIGH RISK				NURSE SIGNATURE		RM						

** If you are in any doubt about whether a person's medicine belongs to one of the types listed ask the person or carer or please phone the number on the medicine container and ask the community or hospital pharmacist.

* Please see back page for clarification

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	DATE 30/9/04	DATE	DATE	DATE	DATE	DATE	DATE
Action code	**LOW, MODERATE AND HIGH RISK**							
1	Prevention and general safety precautions discussed with patient and family.	✓						
	MODERATE AND HIGH RISK							
2	Move to more observable area of ward to optimise supervision.							
3	Refer to Physiotherapist.							
4	Refer to Occupational Therapist.							
5	Patient requires footwear or podiatry referral. (Date referred:)							
6	Commence continence assessment							
7	Monitor lying and standing BP and pulse.							
8	Request medication review.							
9	Select suitable seating (refer to policy).							
10	Non-slip mat on chair/floor following advice of OT.							
11	Bed rails/bumpers to be used (refer to policy).							
12	Falls map in use for seven days.							
13	Bed/chair monitor in use.							
14	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.							
15	Patient to be nursed on mattress on the floor (refer to policy.)							
16	Patient requires one to one nursing care.							
17	Other interventions.							
	HIGH RISK ONLY (Score of 13 or over)							
18	Provide hip protectors to patients being discharged to care homes/longterm NHS facilities							
	SIGNATURE	R Mitchell						

Review Cannard score weekly / monthly as per policy.

Enter action code(s) selected in action taken section on Falls Risk Assessment.

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

BLOOD PRESSURE TABLETS include Captopril, atenolol and many others.

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

SLEEPING TABLETS include medicines such as Diazepam, Temazepam, Nitrazepam, Chlordiazepoxide and Zopiclone (Zimovane).

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

ESTRICTED 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.

IG AND HANDLING CARE PLAN

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Patient's Detai

Named Nurse:

If Patient is totally independent, tick here and go to date box. √

BODY BUILD			
Obese		Tall	
Above average		Medium	
Average		Short	
Below Average		Weight	Kg
RISK OF FALLS			
High		Low	

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Into Bath or shower.

HANDLING AID		WHICH BATH		ASSISTANCE		SUPERVISION		INDEPENDENT		BED BATH
Ambulift		Parker		People 1		2		Additional Information:		
Shower Chair		Variable Height								
Other (specify)		Fixed Height								
		Shower								

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
People 1		2	3	People 1		2	Additional Information:						
				Walking Aid (specify)									

Toiletting

HOIST (specify)				MANUAL SUPPORT			ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
People 1		2	3	People 1		2	Additional Information:						
				Walking Aid (specify)									

Walking.

NO WALKING		MANUAL SUPPORT		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
		People 1	2	Distance Walked/Additional Information:						
		Walking Aid (specify)								

Move up/down bed.

HOIST (specify)				HANDLING AIDS		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT
People 1	2	3		Sliding aid (fabric)		Additional Information:						
				Rope ladder								
				Hand blocks								

Sit up over side of bed.

ROPE LADDER		SWIVEL CUSHION		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT

Move on/off bed pan.

HOIST		ROLL PATIENT		PATIENT BRIDGES		MONKEY POLE		N/A

Transfer to/from trolley (or bed etc).

SLIDING AID - RIGID		SLIDING AID - FABRIC		ASSISTANCE		INSTRUCTION		SUPERVISION		INDEPENDENT

Other Instructions.

Date Assessed:	30/9/08					
Assessor's Signature:	K Mylne					
Proposed Review Dates:	2/10/08					

Into Bath or shower.

HANDLING AID	WHICH BATH	ASSISTANCE	SUPERVISION	INDEPENDENT	BED BATH
Ambulift	Parker	People 1	2	Additional Information:	
Shower Chair	Variable Height				
Other (specify)	Fixed Height				
	Shower				

Transfers (including to/from: bed; wheelchair; commode; toilet).

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Toileting

HOIST (specify)	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	People 1 2	Additional Information:			
	Walking Aid (specify)				

Walking

D WALKING	MANUAL SUPPORT	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
	People 1 2	Distance Walked/Additional Information:			
	Walking Aid (specify)				

Move up/down bed.

HOIST (specify)	HANDLING AIDS	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT
People 1 2 3	Sliding aid (fabric)	Additional Information:			
	Rope ladder				
	Hand blocks				

Sit up over side of bed.

ROPE LADDER	SWIVEL CUSHION	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Move on/off bed pan.

HOIST	ROLL PATIENT	PATIENT BRIDGES	MONKEY POLE	N/A

Transfer to/from trolley (or bed etc).

SLIDING AID RIGID	SLIDING AID FABRIC	ASSISTANCE	INSTRUCTION	SUPERVISION	INDEPENDENT

Other Instructions.

Date Assessed:						
Assessor's Signature:						
Proposed Review Dates:						

NHS Greater Glasgow and Clyde

North Glasgow Hospit

Stobhill Hospital

SULLIVAN, Deboran

6 Muirhead Court, Baillieston, Glasgow, Lanarkshire, G69 7EP

Referrer: DR DT HANSELL - STOB WARD 5 OUTPATIENT

Diagnostic Imaging Report

DoB: **07/12/1972**

Chi No: **0712726128**

CRIS No: **5387096**

Hosp No: **10638479K**

VERIFIED Verified By: DR TH BRYANT 11/09/08 1149.

Clinical History :

Previous fundoplication plus cholecystectomy for gallstones. Currently epigastric and RUQ pain plus vomiting. Triangle LFT's. Ultrasound for visualisation of ducts/gallbladder bed, ? retained or recurrent ductal stone/dilatation.

MRCP :

Standard MRCP has been performed.

There is no evidence of filling defect within the common bile duct to indicate a retained calculus. The common bile duct appears normal in calibre measuring 4.5mms. Pancreatic duct also appears unremarkable. No other lesion is identified within the liver or upper abdomen.

Ref. Src: Stobhill Hospital, 133 Balornock Road, Glasgow, , G21 3UW

Exams: MRCP

Exam Date: 10/09/08 Event: E-11217819

08965

Acute Services Division

Part 2 Discharge Letter / Transfer Plan

NHS Greater Glasgow and Clyde

- ☐ Glasgow Royal Infirmary 0141 211 4000
- ☑ Stobhill Hospital 0141 201 3000
- ☐ Western Infirmary 0141 211 2000
- ☐ Southern General Hospital 0141 201 1100
- ☐ Victoria Infirmary 0141 201 6000
- ☐ Mansionhouse Unit 0141 201 6101
- ☐ Gartnavel General Hospital 0141 211 3000
- ☐ Blawarthill Hospital 0141 211 9000
- ☐ Drumchapel Hospital 0141 211 6000
- ☐ Lightburn Hospital 0141 211 1500
- ☐ Vale of Leven Hospital 01389 754 121
- ☐ Royal Alexandra Hospital 887 9111
- ☐ Inverclyde Royal Hospital 01475 633777
- ☐ Other:

Name: DEBORAH SULLIVAN

Address: 6 MUIRHEAD COURT

BAILLIESTON

Discharge Address:

CHI number: 0712726128

Unit number: 1063847K D.O.B. 07/12/72

Telephone: 771 6317

Next of kin: CATHLEEN

Relationship: MOTHER

Address:

Telephone: 771-3743

Ward: 6

Telephone: 0141/ 201 / 4100

Admission date: 30/ 9 / 08

Final discharge/transfer date: / /

Named Nurse:

Consultant: MS CRAIG

G.P.: DR J LANGAN

Address: BAILLIESTON N.C.

20 MUIRSIDE RD

BAILLIESTON

Telephone:

Post Discharge Services Arranged (e.g. District Nurse, CPN, Day Hospital, Home Care)
State package requested and time of first visit.

Service:	Service:
Contact number:	Contact number:
Service details:	Service details:

Additional/Transfer Information (including equipment/adaptions)

Patient Assessment/Comments

Mobility:

Personal hygiene/Dressing:

Continence: Catheter in situ: Yes ☐ No ☐
Type: Size:
Date of change:

Continence details:

Dietary requirements:

Communication / Swallowing:

ntal state:

Skin condition/Waterlow Score:

Wound care/Stoma care:

Special Instructions for Patient (e.g. Exercise , Diet, Wounds, Others)

Others/Follow-up arrangements

Progress discussed with patient: Yes ☐ No ☐
Progress discussed with relative/carer: Yes ☐ No ☐

This information has been fully discussed with Patient/Carer.

Date and signature of Nurse:

Date and signature of Patient/Carer:

Diagnosis:

TOP COPY

TOP COPY TO - Patient; OTHER COPIES TO - G.P.; District Nurse; Case Notes.

NHS
Greater Glasgow and Clyde

STOBHILL HOSPITAL

DAY SURGERY ENDOSCOPY

Unit No	10638479K
Name	SULLIVAN F
	DEBORAH 07/12/1972
Addres	6 MUIRHEAD COURT
	BAILLIESTON
	GLASGOW G69 7EP
	CHI-0712726128
DOB	

DATE _____

CONSULTANT Mr Smith

A. ASSESSMENT

1. CURRENT MEDICATION Losec, Tramadol, Maxalon
   Fluoxetine
2. MEDICAL PROBLEMS IBS, Pancreatitis, cholecystectomy
3. PAST HISTORY OF HEPATITIS OR JAUNDICE No ☐ Yes ☐
4. DISCHARGE ARRANGEMENTS - Escort No ☐ Yes ☐ Who Ward 6
   Overnight No ☐ Yes ☐ Who _____

PATIENTS DECLARATION

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

Patients signature ✓

B. PREPARATION

~~Tests~~ Consent

1. LAST ATE OR DRANK	Time 12 Midnight				
2. IDENTITY BAND	✓				
3. CASENOTES/ADMISSION PACK					
4. DENTURE/CROWNS/CAPS/BRIDGE	NO ✓				
5. BOWEL PREPARATION (If required)	N/A				
6. UNDERWEAR JEWELLERY REMOVED	pants on				
7. ALLERGIES	Voltarol				
8. BASELINE OBSERVATIONS	Pulse	77	Blood Pressure	141	80

PROBLEMS/NEEDS

Allergic* Voltarol*

Temp 39.4

COMMENTS

Signature _____

ONCE ONLY PRESCRIPTIONS

Date	Time	Drug	Dose	Route	Signature	Given by	Time given
3/10/08	1607	MIDAZOLAM	8	IV			

ENDOSCOPY

PROCEDURE Gastroscopy + Biopsy + CLOTEST

SEDATION No ☐ Yes ☑

THROAT SPRAY No ☑ Yes ☐ Time _____

PATIENT POSITION Left Lateral ☑

DIATHERMY Yes ☐ No ☐

SPECIMENS

PATH ☑ BACT ☐ CLO ☑

NAMED NURSES

SR Oliver

COMMENTS

RECOVERY

POST ENDOSCOPY OBSERVATIONS

TIME	1620	1640	1710														
PULSE	80	83	87														
BLOOD PRESSURE	123/86	131/84	129/74														
SA O2	98	96	95														
RESPIRATORY RATE	~~22~~																
OXYGEN	2L																
SEDATION SCORE	1	1															
VENFLON	✓	✓															
NURSES INITIALS	JE	KT															

SEDATION SCORE

A = ASLEEP
0 = ALERT
1 = RESPONDS TO VERBAL COMMAND
2 = RESPONDS TO PAINFUL STIMULI
3 = UNRESPONSIVE

MULTIDISCIPLINAR

DATE / TIME

DISCHARGE	YES	NO
1. STABLE VITAL SIGNS	☐	☐
2. CANNULAE REMOVED	☐	☐
3. ABLE TO DRESS, SIT AND WALK UNAIDED	☐	☐
4. TOLERATING FOOD AND FLUIDS	☐	☐
5. INSTRUCTIONS GIVEN SEDATION	☐	☐
6. GP LETTER GIVEN BEFORE DISCHARGE	☐	☐
7. FOLLOW UP APPOINTMENT	☐	☐

DISCHARGE AT _____ TO _____ CARE

NURSE'S SIGNATURE _____

CONSENT FORM

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Special requirements (e.g. other language / Communication method) .....

Proposed operation, investigation or other treatment.
(BLOCK CAPITALS)
GASTROSCOPY + BIOPSY
.....
.....

I have explained the procedure named on this form to the patient in the terms which, in my judgement, are suited to their understanding. In particular, I have fully explained: the intended benefits; appropriate alternatives which are available (including no treatment); any sign if cant risks which may result from the procedure; and any extra procedures which may become necessary during the procedure (please specify major procedure above).

An information leaflet/tape has been provided .....

..... (Title)

Signature of Practitioner .....

Name / Designation (Print) .....

Date 3 / 10 / 07

STATEMENT TO BE COMPLETED BY PATIENT/PARENT*
(* parental responsibility for a minor without capacity)

You should read this form and the notes below carefully. If there is anything you do not understand ask the Practitioner for an explanation. If the information is correct and you understand the procedure, you should sign the form. You have the right to change your mind at any time, including after you have signed this form.

I understand

- the procedure, important risks and appropriate alternatives which have been explained to me by the practitioner named on this form.
- that a practitioner other than the practitioner who has been providing treatment so far might carry out the procedure.
- that any procedure in addition to that named on this form will only be carried out if it is necessary and is reasonable in the circumstances, in relation to the medical treatment proposed, to safeguard or promote physical or mental health.

I have been told about additional procedures which may become necessary during treatment. I have listed below **any procedures which I do NOT wish to be carried out without further discussion.**

I agree -

- to the administration of an anaesthetic or to sedation if required.
- to the procedure named on this form
- that the examination for the purposes of teaching will not be undertaken without my consent
- to the emergency administration of blood or blood products

Please sign here if you refuse to consent to the emergency administration of blood or blood products.

Signature ..... Date ...../...../.....

Additionally you have to agree or disagree the following:-	Agree	Disagree
that information and/or images kept in records may be used anonymously for education, audit, and research with appropriate ethical approval, to improve the quality of patient care.	☐	☐
that surplus tissue not essential for my diagnosis or future treatment may be used for medical education and ethically approved medical research.	☐	☐

PATIENT AGREEMENT FOR TREATMENT

Signature: ..... Date ...../...../.....

Name (Print): .....

CONFIRMATION OF CONSENT
(to be completed when patient is admitted for procedure if form signed in advance)

I confirm that I have no further questions and wish the procedure to go ahead.

Signature: ..... Print name.....

Date ...../...../.....

Stol

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

NHS Greater Glasgow and Clyde

TO BE FILED UNTIL DISCHARGE

Na Unit No.:

Date:	30/9	1/10	2/10	3/10								
Time of Result:	1553	07:00										
WCC 4-11	9·54		6·45	7·0								
Hb M - 13-18 F - 11.5-16.5	13·0		11·3	11·3								
Plat 150-400	309		249	248								
Hct 0-37-0-47												
Na 135-145	139		139	142								
K 3-5-50	4·8		4·1	4·7								
Cl 97-107	102		107	108								
Bic 23-30												
Urea 2-5-8.0	3·7		2·1	2·8								
Creat. 40-130	63		60	62								
Amylase .....<100	86	75										
CRP .....<10	6·5	5·7	4·3	3·1								
ESR .....AGE 12												
Adj. Ca ...2-2-2-6	2·48											
Phosphate 0-7-1-4	1·23											
Tot. Prot. ..62-82	73	63	62	64								
Albumin 36-55	36	31	30	32								
Alk. Phos. 80-280	(55)	52	50	47								
Gamma GT ..<50	(113)	106	127	127								
Bil 3-22	5	9	5	4								
AST 12-48	29	32	30	23								
ALT 3-55	31	35	37	27								
LD 200-520												
Glucose ..3-0-5-5	5·2											
PT 9-12	12	12		11								
APTT 25-37	33	31		31								
TT 11-15	12	13		13								
FIB 200-400	(408)	360		344								
INR												
APTT RATIO		(conar)										
Drain Amylase												
H^+ 36-43		(45·3)										
PO_2 .....10.5-13.5		11·6										
PCO_2 .....4.6-6.0		6·4										
HCO_3 20-28		25·9										

lactate 0·8

MIS 109801/Stob

THIS DOCUMENT MUST BE RETAINED

STOBHILL HOSPITAL

NHS Greater Glasgow and Clyde

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6hr = 22 Drops/min.
4hr = 30 Drops/min. 8hr = 15 Drops/min.

INTENSIVE I.V. THERAPY PRESCRIPTION SHEET

SURNAME	FORENAME	Unit No.
SULLIVAN	DEBORAH	

DATE 2/10/08

No. 0181327

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	Serial No. / Batch No.	Given by
Dextrose 5%	500	8.40	6°	15.00	[signature]	08A 04E 1A 12/10	GG
0.9% NaCl	500	15.20	6°		Sharon Downie	08F2 5T3H	PB GG
5% Dextrose + 20mmol KCl	500	22.30	6°		Sharon Downie	08F 17E 1A	JW
(N) Saline	500	04.30	6°	1410	[signature]	08F 25T 3M	JW
5% Dextrose	500	1410	6°		[signature]	08A04 E1A 12/10.	LB / PB
N-Saline	500	22.30	6°		[signature]	08F 25T 3M	JW
5% DEXTROSE + 20 mmol KCl	500	04.10	6°	1040 am	[signature]	08F 17E 1A	JW

STOBHILL HOSPITAL – ACUTE PAIN SERVICE - Page Sister: 1184

OBSERVATION CHART FOR THE ADMINISTRATION OF

SUBCUTANEOUS ANALGESIA

Deborah Sulivan.

NHS Greater Glasgow and Clyde

Date	Time	Sedation Score	Resp. Rate	Pain Score	Dose of Analgesia administered	Pain Score (After 1 hr)	Comments	Sign
30/9/08	1840	0	16	10	10mgs		sleeping	JH
30/9/8	2230	0	16	10	10ns	Asleep		C
1/10/8	0250	0	16	8	10mg			BP
1/10	0640	0	16	10	10ns			C
1/10	0859	0	20	8	10mgs			CMACD
1/10	2245	0	16	10	10mg	ASLEEP		[illegible]
2/10	01.40	0	16	8	10m	ASLEEP		[illegible]
2/10	06.00	0	18	10	10m	ASLEEP		[illegible]
2/10	9.40	0	17	8	10mg			[illegible]
4/10	09.45	0	16	8	10mg			[illegible]

PAIN SCORE

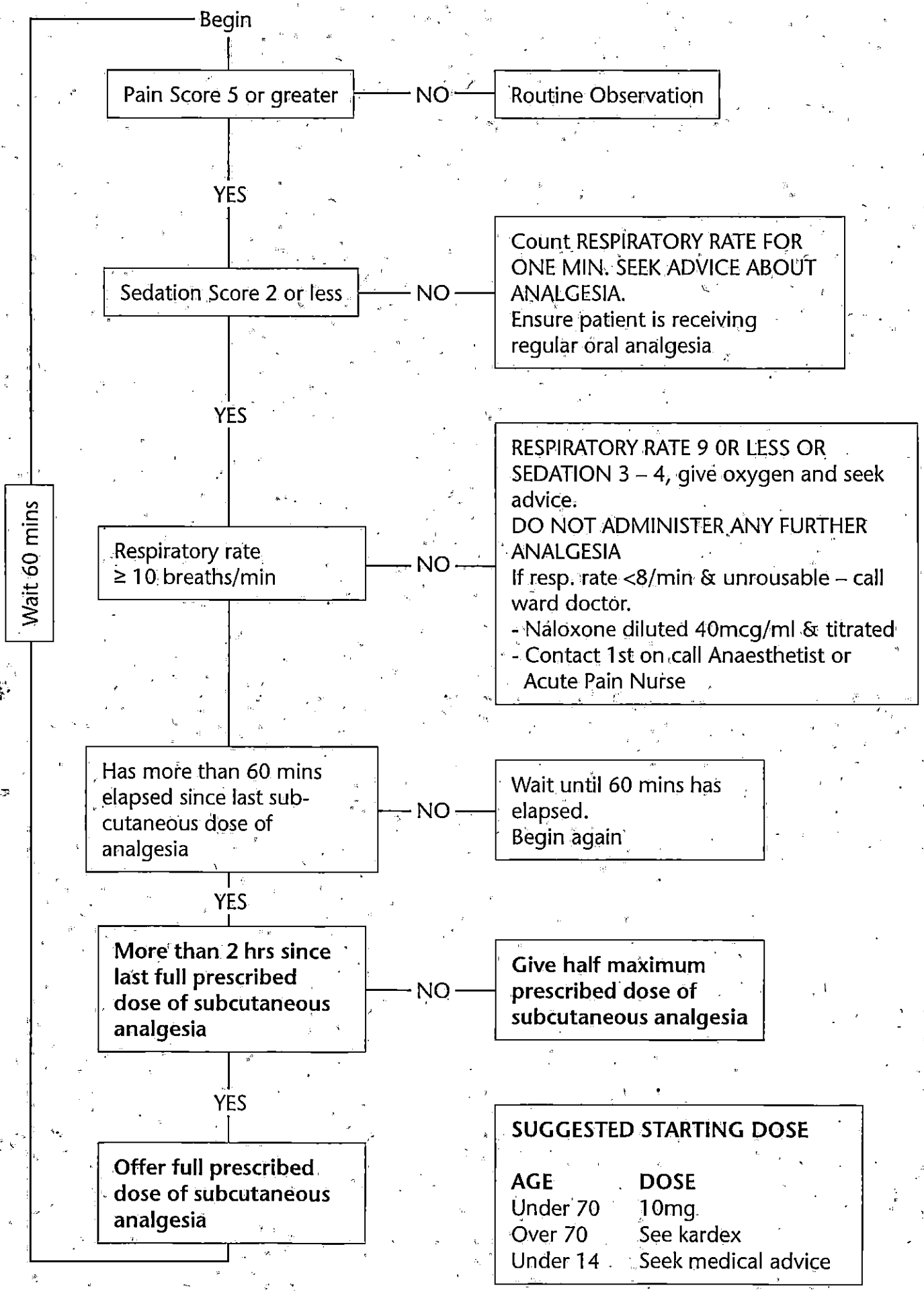
0 5 10

No pain Worse Pain Ever

SEDATION SCORE

0 = Awake
1 = Alert
2 = Responds to verbal command
3 = Responds to painful stimuli
4 = Unresponsive and unrousable
5 = Normal sleep

STOBHILL HOSPITAL
SUBCUTANEOUS ANALGESIA PROTOCOL ALGORITHM



Patient Observation Chart

NHS Greater Glasgow and Clyde

Name	
Address	10638479K SULLIVAN F DEBORAH 07/12/1972 6 MUIRHEAD COURT BAILLIESTON GLASGOW G69 7EP
Hospital	CHI-0712726128
DOB	

Admitted Date 30/9/08 Ward 7a.
Transferred Date _____ Ward _____
Transferred Date _____ Ward _____

Patient Observation Chart Guidelines

Not all patients will require every part of this observation chart to be completed. Clinical judgement should be used to dictate the type and frequency of vital sign monitoring required.

The following patients are considered to be at high risk of developing a critical illness therefore it would be considered good practice to commence MEWS at the earliest opportunity.

- All emergency admissions
- Unstable patients
- Patients whose condition is causing concern
- Patients requiring frequent or increasing frequency of observations
- Patients who have stepped down from a higher level of care
- Patients with a chronic health problem
- Patients who are failing to progress
- Post-operative patients

There are also patients in whom the use of MEWS may be inappropriate:

- Day case patients
- Patients requiring no observations
- Patients who are terminally ill
- Planned discharges.

This is not an exhaustive list. Although the majority of patients may benefit from utilisation of the scoring system, a nurse's own clinical judgement dictates whether he/she feels the patient reqiures scoring. For guidance on the use of MEWS, refer to the Nurse in Charge.

Pain Score

Remember to check scores after pain relief.
Patient asked to report pain at rest and on movement.
0 = No pain at rest or on movement
1 = No pain at rest, slight pain on movement
2 = Intermittent pain at rest, moderate on movement
3 = Continuous pain at rest severe on movement
Review 5 mins after I/V, 1 hour after I/M, S/C or oral analgesia.
Sustained pain score of 2 or pain score of 3 requires intervention.

Sedation Score

0 = Awake, alert, orientated
1 = Mild, aroused by verbal stimulus
2 = Moderate, aroused by physical stimulus
3 = Severe, no response
S = Normal sleep, easy to rouse
Score 2 or 3 requires immediate intervention

Nausea Score

0 = No nausea
1 = Mild (No treatment wanted)
2 = Moderate (Treatment required)
3 = Severe (Clinical problem persists despite treatment)
Review 1 hour after treatment. Inform doctor if additional treatment required.

DATE	9/10		1/10	1/10	1/10	2/10	2/10	3/10									TEMP X
Time	1820	2200	0007	1110	1745	0900	1700	1000									
BP ^																	40°C
BP v																	39°C
and																	38°C
Pulse •																	37°C
																	36°C
																	35°C
Pulse.	94	88	98	77	91	84	87	89									
Resp. Rate	16	16	16	16	16	16	16	16									
Inspiration O_2%	A	A	A	A	A	A	A	A									
SpO_2%	98	96	98	94	97	97	97	95									
Pain Score	10	8	7	7	8	8	7	6									
Sedation Score	0	0	0	0	0	0	0	0									
Nausea Score	0	1	2	0	0	0	0	2									
Blood Glucose	X		X														
RSAU LH	AB																
MSSU																	
TTG D	neg																

MEWS																	
	Resp. Rate	0	0	0	0	0	0										
	Pulse	0	0	0	0	0	0										
	Systolic BP	0	0	0	0	0	0										
	GCS / AVPU	0	0	0	0	0	0										
	Urine Output	0	0	0	0	0	0										
	Temp.	0	0	0	0	1	0										
	SpO_2%	0	0	0	0	0	0										
	TOTAL	0	0	0	1	1	0										

Modified Early Warning Score (MEWS)

Score	3	2	1	0	1	2	3
Resp. Rate		≤8	9-10	11-20	21-25	26-30	≥31
Pulse		≤40	41-50	51-100	101-110	111-130	≥131
Systolic BP	≤84	85-89	90-100	101-199		>200	
GCS / AVPU	≤8	9-13	14 New agitation or confusion	15 / Alert	Voice	Pain	Unresponsive
Urine	<10mls/hr for 2 hrs	<30mls/hr for 2 hrs					
Temp. (°C)		≤35.0	35.1-35.9	36.0-37.4	37.5-38.5	≥38.6	
SpO_2%	≤87	88-91	92-94	95-100			

DATE																		TEMP X
Time																		
BP ^ v and Pulse •	240																	40°C
	230																	
	220																	39°C
	210																	
	200																	38°C
	190																	
	180																	37°C
	170																	
	160																	36°C
	150																	
	140																	35°C
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
	50																	
	40																	
Resp. Rate																		
Inspiration O_2%																		
SpO_2%																		
Pain Score																		
Sedation Score																		
Nausea Score																		
Blood Glucose																		

MEWS																		
	Resp. Rate																	
	Pulse																	
	Systolic BP																	
	GCS / AVPU																	
	Urine Output																	
	Temp.																	
	SpO_2%																	
	TOTAL																	

Calling Criteria

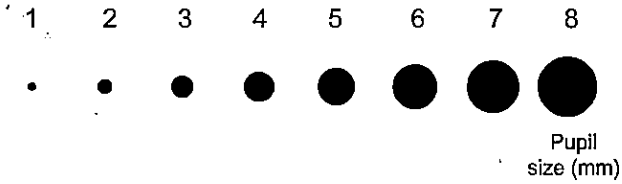
Score is 1-3	Increase frequency of patient observations, monitor trends and inform Nurse in Charge.
Score is 3 in one category	Contact Senior Nurse and increase frequency of patient observations.
Score is 4 and above or increasing by 2 or more Patient's GCS falls by 2 or more Any patient whose condition is causing concern	Contact Senior Nurse and increase frequency of patient observations Contact Critical Care Outreach Team.

The Senior Nurse will direct patient care and contact the appropriate medical staff when necessary.

Neurological Observation Chart

DATE																				
Time																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		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
		R Reaction																		
		L Size																		
		L Reaction																		
LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Glasgow Coma Scale



DATE																				
me																				
COMA SCALE	E Eyes open	Spontaneously	4																	Eyes closed by dwelling = C
		To speech	3																	
		To pain	2																	
		None	1																	
	V Best verbal response	Orientated	5																	Endotracheal tube or tracheostomy = T
		Confused	4																	
		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																	
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		Extension to pain	2																	
		None	1																	
		TOTAL SCORE																		
PUPILS		R Size																		= reacts —no reaction c. eyes closed
		R Reaction																		
		L Size																		
		L Reaction																		
LIMB MOVEMENT	ARMS	Normal power																		Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness																		
		Severe weakness																		
		Spastic flexion																		
		Extension																		
		No response																		
	LEGS	Normal power																		
		Mild weakness																		
		Severe weakness																		
		Extension																		
		No response																		

Medical Illustration Services, MIS 111948 - Reorder CEDAR 35497

THIS DOCUMENT MUST BE RETAINED

STOBHILL HOSPITAL

NHS Greater Glasgow and Clyde

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

PRESCRIPTION SHEET

Approximate Rate for 500ml.
1 hr = 120 Drops/min. 6hr = 22 Drops/min.
4hr = 30 Drops/min. 8hr = 15 Drops/min.

FORENAME	Unit No.

DATE

No. 0181327

FLUID / ADDITIVE DRUG	VOL. / DOSE	Commence	Duration	Finish	SIGNATURE	Serial No. / Batch No.	Given by
5% Dextrose	500	18.40	1h	19.40		08A 04E1A 12/10	RM
0.9% Saline + 20mmol KC	500	19.40	2h	21.45		08A 02E1A 03/2011	CP/RM
5% Dextrose	500	21.45	4h	01.45		08A0 4E1A 12/10	BP
5% Dextrose	500	01.45	4h	05.45		08A0 4E1A 12/10	BP
HARTMANN'S	500	05.45	4h	10.45		08E1 6T3J exp 4/11	C
5% Dextrose 20mmol KCl	500	10.45	4h	16.30		08F1 7E1A 05/11	C
Hartmann's	500	16.30	6h			08J1 0T3H 06/11	C
5% Dextrose	500	23.45	6h			08E 28E IR	
HARTMANN'S	500	03.50	4	8.15.		08G 10T 3N	

STOBHILL HOSPITAL
24 HOUR FLUID CHART

NHS Greater Glasgow and Clyde

DATE: 4/10/08

SURNAME	CHRISTIAN / FORENAME	UNIT NO.
Sullivan	Deborah	

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
Porridge, Tea	300		8am.					
Water	100		9am.	UTT.				
			10 am.					
			11 am.					
			12 noon					
			1pm.					
			2pm.					
			3pm.					
			4pm.					
			5pm.					
			6pm.					
			7pm.					
			8pm.					
			9pm.					
			10pm.					
			11pm.					
			12 mid.					
			1am.					
			2am.					
			3am.					
			4 am.					
			5 am.					
			6am.					
			7 am.					
TOTALS								
TOTAL INTAKE						TOTAL OUTPUT		

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum : Urea, Sodium, Potassium, Chloride, Bicarbonate, Creatinine	
Urine : Urea, Chloride	

129198/2

STOBHILL HOSPITAL
24 HOUR FLUID CHART

NHS Greater Glasgow and Clyde

DATE: 3/10/08

SURNAME	CHRISTIAN / FORENAME	UNIT NO.
Sullivan	Deborah	

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
			8am.					
			9am.					
			10 am.					
			11 am.					
			12 noon					
			1pm.					
N-Saline		500	2pm.					
			3pm.					
			4pm.					
			5pm.					
			6pm.					
			7pm.					
			8pm.	LTT				
Tea	150		9pm.					
Rantac Water	150	500	10pm.	LTT				
			11pm.					
			12 mid.					
			1am.					
Water	100		2am.	LTT				
			3am.					
N-Saline		500	4 am.					
Nil			5 am.					
			6am.	LTT				
			7 am.					
TOTALS	400	1500						

TOTAL INTAKE 1900 | LTT TOTAL OUTPUT

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum: Urea, Sodium, Potassium, Chloride, Bicarbonate, Creatinine	
Urine: Urea, Chloride	

129198/2

STOBHILL HOSPITAL
24 HOUR FLUID CHART

NHS Greater Glasgow and Clyde

DATE : 2nd Oct 08

SURNAME	CHRISTIAN / FORENAME	UNIT NO.
Sullivan	Deborah	

FLUID AND SUPPLEMENT	ORAL	I.V. OR OTHER	TIME	URINE	VOMIT	GASTRIC ASPIRATE	BOWEL	OTHER
porridge + Tea + Roll	300		8am.	UTT				
Haemaccel		500	9am.					
			10 am.					
FASTING			11 am.					
			12 noon	Nil				
			1pm.					
			2pm.					
Dextrose 5%		500	3pm.					
			4pm.					
Sulbex + tea	300		5pm.					
			6pm.					
			7pm.					
			8pm.					
			9pm.					
N-Saline		500	10pm.	UTT				
			11pm.					
			12 mid.					
			1am.					
			2am.					
			3am.	UTT				
Dextrose + KCL		500	4 am.					
			5 am.					
			6am.		50 (orange juice)			
			7 am.					
TOTALS								
TOTAL INTAKE							TOTAL OUTPUT	

INSTRUCTIONS

PARENTERAL

ORAL

Previous 24 hrs. Balance =

Biochemistry Results	Time
Serum : Urea, Sodium, Potassium, Chloride, Bicarbonate, Creatinine	
Urine : Urea, Chloride	

129198/2

PRESCRIPTION FORM

Hospital Name: Stobhill

PATIENT DETAILS

10638479K
SULLIVAN F
DEBORAH 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
GLASGOW G69 7EP
CHI-0712726128

Height:

Weight:

Surface area:

Date of writing discharge prescription: __/__/__

Date of Admission: 30/9/08

Consultant Name: Mr Craig

Ward: 7A

Date and time this form prepared: __/__/__ Time:

Sheet No: 1

2nd Prescription in use: Yes or NO

DRUG SENSITIVITIES

NKDA

DVT Risk on Admission (SIGN Guideline)

High ☐ Moderate ☐ Low ☐

Assessed by: Date: __/__/__

OTHER CHARTS IN USE

Insulin	☐	TPN:	☐
PCA and other infusions	☐	Enteral Nutrition:	☐
Anticoagulants: Heparin	☐	Oxygen Therapy:	☐
Oral	☐	Other:	
Topical:	☐		

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF DOCTOR	GIVEN BY	TIME GIVEN
30/9	CYCLIZINE	50mg	IV	1800	Fiona Ross MM	JHay	1815
30/9	~~MORPHINE~~ 1st Dose	~~5mg~~	~~IV~~				
31/10/08	TEMAZEPAM	10mg	O	23:20	~~Chris Stobo~~	[illegible]	23:20

PATIENT'S NAME: deborah sullivan

Parenteral Drugs: Regular Prescription

ADMINISTRATION

DATE → 30 1 2 3

MONTH → 9 10 10 10

A DRUG CLEXANE

DOSE 20 mg | ROUTE SC | DATE 30/9 | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

1600-1800: C MAK 6

Other time: 6

FOR DOCTORS USE ONLY

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR DOCTORS USE ONLY

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR DOCTORS USE ONLY

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

FOR DOCTORS USE ONLY

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME: deborah sullivan

Oral and Other Drugs: Regular Prescriptions

ADMINISTRATION

DATE: 30 | 1 | 2 | 3 | 4
MONTH: 9 | 10 | 10 | 10 | 10

J DRUG: Fluoxetine
DOSE: 40mg | ROUTE: O | DATE: 30/9 | STOPPED DATE:
SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

Other time
0700-0900 ✓
1200-1400
1600-1800
2200-2400
Other time

K DRUG: Omeprazole
DOSE: 40mg | ROUTE: O | DATE: 30/9 | STOPPED DATE:
SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

Other time
0700-0900 ✓
1200-1400
1600-1800
2200-2400
Other time

L DRUG: Gabapentin
DOSE: 600 mg | ROUTE: O | DATE: 30/9 | STOPPED DATE:
SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Please renew with GP - Jeffrey a prior to his bed rest
FOR DOCTORS USE ONLY

Other time
0700-0900 ✓
1200-1400 ✓
1600-1800
2200-2400 ✓
Other time

M DRUG: Ramadol
DOSE: 100mg | ROUTE: O | DATE: 30/9 | STOPPED DATE:
SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
FOR DOCTORS USE ONLY

Other time
0700-0900 ✓
1200-1400 ✓
1600-1800 ✓
2200-2400 ✓
Other time

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

Oral and Other Drugs: Regular Prescriptions

DATE → 30 1 2 3 4 | MONTH → 9 10 10 10 10

N

DRUG: Loraesdemol

DOSE: 1g | ROUTE: O | DATE: 30/9 | STOPPED DATE:

SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR DOCTORS USE ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

P

DRUG: Granisetron

DOSE: 1mg | ROUTE: PO | DATE: 30/9 | STOPPED DATE: 4/10/08

SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS: SMcL

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: see PP

FOR DOCTORS USE ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

R

DRUG: MOVICOL

DOSE: 1 sachet | ROUTE: O | DATE: 30/9 | STOPPED DATE:

SIGNATURE OF DOCTOR: David Russell | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR DOCTORS USE ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

S

DRUG: Metoclopramide

DOSE: 10mg | ROUTE: | DATE: 30/9/08 | STOPPED DATE:

SIGNATURE OF DOCTOR: | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

FOR DOCTORS USE ONLY

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

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

PATIENT'S NAME: deborah sullivan

Oral and Other Drugs: Regular Prescriptions

ADMINISTRATION

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

---

T DRUG: FENTANYL PATCH

DOSE: 75 micrograms | ROUTE: TRANS DERM | DATE: 3/10/18 | STOPPED DATE: 4/10/18

SIGNATURE OF DOCTOR: S. Downing | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

V DRUG: GRANISETRON

DOSE: 1mg | ROUTE: ORAL | DATE: 4/10/18 | STOPPED DATE:

SIGNATURE OF DOCTOR: S. Downing | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

W DRUG: FENTANYL PATCH

DOSE: 25 micrograms | ROUTE: TRANS DERM | DATE: 4/10/18 | STOPPED DATE:

SIGNATURE OF DOCTOR: S. Downing | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

X DRUG:

DOSE | ROUTE | DATE | STOPPED DATE:

SIGNATURE OF DOCTOR | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

PATIENT'S NAME: deborah sullivan

ADMINISTRATION

Oral and Other Drugs: Regular Prescriptions

DATE →

MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

SIGNATURE OF DOCTOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FOR DOCTORS USE ONLY

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

Oral and Other Drugs: Regular Prescriptions

DATE →
MONTH →

HH	DRUG				
DOSE	ROUTE	DATE	STOPPED	DATE:	
SIGNATURE OF DOCTOR				INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
FOR DOCTORS USE ONLY					

Other time	
0700-0900	
1200-1400	
1600-1800	
2200-2400	
Other time	

JJ	DRUG				
DOSE	ROUTE	DATE	STOPPED	DATE:	
SIGNATURE OF DOCTOR				INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
FOR DOCTORS USE ONLY					

Other time	
0700-0900	
1200-1400	
1600-1800	
2200-2400	
Other time	

KK	DRUG				
DOSE	ROUTE	DATE	STOPPED	DATE:	
SIGNATURE OF DOCTOR				INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
FOR DOCTORS USE ONLY					

Other time	
0700-0900	
1200-1400	
1600-1800	
2200-2400	
Other time	

LL	DRUG				
DOSE	ROUTE	DATE	STOPPED	DATE:	
SIGNATURE OF DOCTOR				INITIALS:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					
FOR DOCTORS USE ONLY					

Other time	
0700-0900	
1200-1400	
1600-1800	
2200-2400	
Other time	

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

PATIENT'S NAME: deborah sullivan

All Routes: As Required Prescriptions

ADMINISTRATION

MM DRUG: MORPHINE — STOPPED DATE: 4/10 — INITIALS:
DOSE: 10mg | ROUTE: S/C | INDICATION: PAIN IV
SIGNATURE OF DOCTOR: [signature] | MAX.FREQUENCY: As Per Protocol | DATE: 30/9
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	30/9	30/9	1/10	1/10	1/10	1/10	1/10	1/10	1/10	2/10	2/10	2/10	2/10	3/10	3/10	3/10	3/10	4/10	4/10								
TIME	18:40	22	02	06	08:50	12:10	18:10	22:40	01:40	06:00	9:40	14:05	22:50	4	11 am	15:35	21:35	01:40	09:45								
DOSE	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg								
GIVEN BY	JH	C	BP	C	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]								

slc slc slc 5/2

NN DRUG: CYCLIZINE — STOPPED DATE: — INITIALS:
DOSE: 50mg | ROUTE: IV | INDICATION: NTV
SIGNATURE OF DOCTOR: [signature] | MAX.FREQUENCY: TD | DATE: 30/9
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	1/10	1/10																									
TIME	01:10	05:45																									
DOSE	50 mg	50 mg																									
GIVEN BY	BP	[illegible]																									

PP DRUG: ONDANSETRON — STOPPED DATE: 1/10/09 — INITIALS: SLK
DOSE: 4mg | ROUTE: IV | INDICATION: NTV
SIGNATURE OF DOCTOR: [signature] | MAX.FREQUENCY: BD | DATE: 30/9
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: ~~IM~~ SEE (P)

DATE	30/9																										
TIME	23																										
DOSE	4 mg																										
GIVEN BY	C																										

1~

RR DRUG: Metoclopramide — STOPPED DATE: — INITIALS:
DOSE: | ROUTE: | INDICATION:
SIGNATURE OF DOCTOR: | MAX.FREQUENCY: | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE																											
TIME																											
DOSE																											
GIVEN BY																											

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

SS	DRUG: BUSCOPAN	STOPPED DATE:	
DOSE: 20mg	ROUTE: SC	INDICATION: Spasm, Pain	STOPPED INITIALS:
SIGNATURE OF DOCTOR:	MAX.FREQUENCY: Qhy	DATE: 4/10/18	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	
TIME	
DOSE	
GIVEN BY	

TT	DRUG:	STOPPED DATE:	
DOSE:	ROUTE:	INDICATION:	STOPPED INITIALS:
SIGNATURE OF DOCTOR:	MAX.FREQUENCY:	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	
TIME	
DOSE	
GIVEN BY	

VV	DRUG:	STOPPED DATE:	
DOSE:	ROUTE:	INDICATION:	STOPPED INITIALS:
SIGNATURE OF DOCTOR:	MAX.FREQUENCY:	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	
TIME	
DOSE	
GIVEN BY	

WW	DRUG:	STOPPED DATE:	
DOSE:	ROUTE:	INDICATION:	STOPPED INITIALS:
SIGNATURE OF DOCTOR:	MAX.FREQUENCY:	DATE:	
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			

DATE	
TIME	
DOSE	
GIVEN BY	

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

Nurse/Midwife Administration by Protocol — Authorised Nurses/Midwives Only

(Maximum number of doses per protocol)

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

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the nurse/midwife administration protocol No.(s) ..... with the following exceptions: _____

Signature: _____ Date: _____

DATE	DRUG	DOSE	ROUTE	TIME	SIGNATURE OF NURSE	GIVEN BY	TIME GIVEN

Notes for Users

FOR DOCTORS:

1. Sign your name clearly against each prescription.
2. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date appropriate boxes.
3. If an existing prescription is to be modified, delete existing prescription as described and re-write new instructions in a new section.
4. Use approved names in BLOCK LETTERS and use metric doses as follows:

   Milligram = **mg** Gram = **g**
   Millilitre = **ml** Microgram: **to be written in full.**
   Units: **to be written in full.**

   Fractions of a milligram should be written in micro grams. A zero should be written in front of a decimal point where there is no other figure, e.g. 0.5ml **not** .5ml.
5. Method of administration should be abbreviated as follows:

   Intravenous = **IV** Oral = **O**
   Subcutaneous = **SC** Per rectum = **PR**
   Inhalations = **INH** Topical = **TOP**
   Sublingual = **SL** Nasogastric = **NG**
   Intramuscular = **IM** Vaginal = **PV**
   Intradermal = **ID**

FOR NURSES:

1. The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.
2. Ensure entry is made on administration record each time drug is given. Initial in relevant date column and time row.
3. Check that all drugs prescribed at a certain time are administered.
4. If drug is not administered, enter reason in appropriate box using the undernoted coding system.

Codes for Non-Administration of Drugs

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

Ver 7, 07/2005

NHS
Greater Glasgow and Clyde

STOBHILL HOSPITAL

CASUALTY DEPARTMENT

0712726128
SULLIVAN. F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

NB: ONLY AN EMER[illegible] SCRIBED

PATIENT'S NAME [illegible] BIRTH

PATIENT'S ADDRESS

DIAGNOSIS

ISSUED BY (NURSE)

TREATMENT

8, Kerrs daily
BE

FOLLOW UP

DOCTOR'S SIGNATURE: [signature]

DATE: 23/5/2023

PATIENT'S SIGNATURE: [signature]

NOTE TO PATIENT: You have been issued with an emergency supply of drugs. Please take this letter to your own doctor who will record it in your records and give you a