ELECTRONIC PATIENT RECORDS

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

Including:

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

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: 0712726128 SULLIVAN Deborah F 07/12/1972	Ward: 65
Unit number:	Discharge destination:
CHI number:	Estimated Discharge Date (1) 03/07/23
Apply address/ugh...	Estimated Discharge Date (2) / /
	Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		R-L	
Relative/carer informed		✓		
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓		R-L	
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed		✓		
Compliance aids e.g. Dossette Box (involve pharmacist)		✓		
Medication received		✓		
Medication explained to patient and/or relative/carer		✓		
Own medication returned to patient	✓		R-L	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓		
Patients clothing available for day of discharge		✓		
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓		R-L	
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓		
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow		✓		
If unknown at time of discharge state reason		✓		
Additional information / leaflets / factsheets		✓		
Time of Discharge: 08:00				
Nurse's signature: R-Livingstone	**Designation:** STN		**Date:** 03/07/23	

NK. BN.

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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

	Date	Ward	Time
Admitted	2/7/13	ed	08:20
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and Size: S = sluggish, F = fixed, - = no reaction, C = eyes closed

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

Glasgow Coma Scale

Affix Patient ID

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

Pain Score

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

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

17/ Debs, Sullivan

NEWS 2 Key | 1 | 2 | 3

| | | |

My Admission Record

NHS Greater Glasgow and Clyde

Nai
Adc 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Dol Glasgow, Lanarkshire
CHI. G34 9JE
Affix patient ID label

Hospital: QA Ward: 66
Date of Admission: 22-2-23 Time: 2345
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐
Preferred Name:
Age: 50 Telephone Number: 07713718
Consultant: Quinn . 392

Communication

What is your first language? Engish
Do you require an interpreter? Yes ☐ No ☐
If yes, provide details of arrangements made
Do you use British Sign Language (BSL)? Yes ☐ No ☐
Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who

Preferred first contact	Preferred second contact
Name: DONNA SULLIVAN	Name:
Relationship: SISTER	Relationship:
Address:	Address:
Telephone: 07743956178	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Epigastric pain + vomiting. AMU ITT.

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Penicillin - Rash

Relevant past medical history

Fibromyalgia
PTSD
Pancreatitis
HTN . T2DM

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place . . .
Yes ☐ No ☐ If yes, Who asked for a copy?
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☐

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If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☑
- Obtain Rectal swab marked 'for CPE' ☑
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 5 years ago

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): F. CDW Signature:

Designation: SW Date: 22/2/23

My Assessment Record

Name 0712726128
SULLIVAN
Deborah F
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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____		N/A	

Name
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3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☑ Both ☐
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?			
Do you wear a prosthesis?			

Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			

Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?	✓		

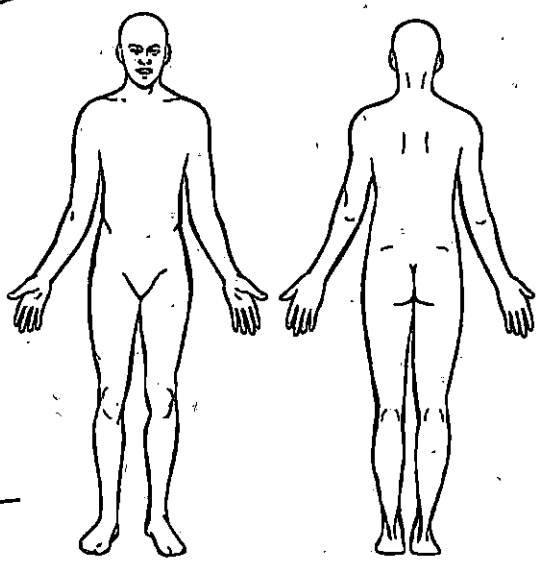
Can you describe where and what the pain is like?

Fibromyalgia - aching pain to knees + hips

Have you had treatment / intervention for the pain?

Pregabalin 300mg BD

Mark current pain on body chart



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

Can you describe any chronic pain that you have?

Fibromyalgia - Aching Pain to knees + hips

What makes the pain better?

Pregabalin 300mg BD

Name:
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Deborah
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CHI:
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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

No

What do you like to eat and drink?

Tea with extra milk
No sugar

What do you not like to eat and drink?

Not bothered

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral-Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 21/2/23

How often in a day/week do you have a bowel movement? Per day 1 Per week

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

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

What products do you normally use for this continence issue?

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

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

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems			New boil under right eye. Noticed by patient yesterday Pre admissio
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

Na
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8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	Uses Crutch with episodes of Fibromyalgia
Unsteady when walking			
Do you use a mobility aid	Yes ☑ occasionally	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☑	

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		
Do you do or use anything to help you sleep?	✓		Diazepam 2mg

Name: _____
Addre: 
0712726128
SULLIVAN F
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G34 9JE

11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify _____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		N/A

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☑ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

Nan
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Deborah 07/12/1972
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CHI:
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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting better

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

Informal Support

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

Daughter

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

Yes ☐ No ☑

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☐ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☐

Are you:

Employed ☐ Unemployed ☐

Self-employed ☐ Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
23/1/23 00[20]	Patient admitted to ward 66 with Epigastric pain and associated vomiting. Vomited on admission - Pain Score 8/10 NEWS 2 due to Saturations 94% on air and therefore 94 independent to the toilet + IV fluids	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	insert AW early review	FEDDY SN
23/2/23	Seen by FY2	
0430	? pancreatitis	
	? gastritis	
	Plan - IV Fluids	
	- Analgesia	LMCLEAN SN
	- Rpt bloods AM -	
0435	Pt cannula very	
	positional and slow	
	have asked FY1 to	
	resite cannula for	LMCLEAN SN
	IV Fluids	
ur	R/v by Miss Quinn	
	? Incisional hernia	
	Fast for CT + CCD.	
(1)	Independent & personal care.	
(2)	Catheter.	
(3)	IV fluids continue	
(4)	Currently off ward. for CT.	
(5)	News = 1.	
(6)	Analgesics as per Hepma	
	Anti emetics as per Hepma	

Name
Addre 0712726128
SULLIVAN
Deborah
F
07/12/1972
DoB:
CHI:
Affix patient ID label

Clinical Notes (cont.)

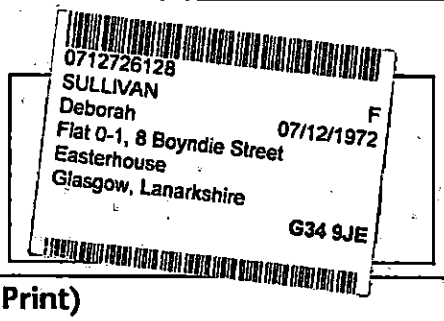
Date and Time	Notes	Print Name, Signature and Designation
24-2-23 0230	Observations as charted. news1 as Sats 95% on air. IV fluids running as right. Early from MV for ? OGD. All care as planned. Settled night offy no complaints	JCraig SN
0955	pt R/V on Surgical w/R plan - OGD ☑ → ↑ PPI - IVF - fast	AR SN ACOLVIN
17.30	R/V on Surgical w/R plan - ogd shows inflamation + delayed emptying - continue ppi + Sucralfate - post clinic o/p miss craig - home tonight with ldt.	AR SN ACOLVIN
18⁰⁰	Deborah settled throughout day. Attended OGD as above. No post procedure issues. Has now eaten + passed urine. NEWS (3) at present - O2 removed + 96% on air, tachy @ 119. For recheck obs. Aim (11) later pt happy w plan + d/c from ward 66 Venflon removed Spoke to mr anderson	

12 side.

Emergency Department Nursing Documentation

Presenting Complaint - Epigastric pain

Date: 22/2/23 Time: 1630



NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☑
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	**YES**
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details) N/A	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	**4**	**YES**
Acute change or fluctuating	**0**	**NO**

4AT score

/12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

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

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	**NO**

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
1635	Moved to cubicle awaiting review Had IV morphine and anti-emetic	CM COF
1935	IVF inserted. 5mg morphine IV given with good effect.	
20.20	Night shift taken over Pts care. NEWS 0, B/P normal.	

Nursing Notes		
Date and Time		Print Name and Signature

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Glasgow, Lanarkshire
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Unit No.:

NHS
Greater Glasgow and Clyde

Date:		23/2/23											
Time of Result:		11.17											
WCC	4-11	8.3											
Hb	M - 13-18 F - 11.5-16.5	132											
Plat	150-400	297											
Amylase	<100	87											
CRP	<10	4											
Na+	135-145	134											
K+	3-5-50	3.9											
Cl-	98-108	97											
Bic	21-28												
Urea	2.5-7.5	5.6											
Creat.	57-113	43											
EGFR	60>	>60											
Glucose	3.5-5.5												
Bilirubin	3-22	9											
ALT	<50	30											
AST	<40	22											
G-GT	<55												
Alk. Phos.	40 -150	78											
Albumin	32-45	38											
Mg^+													
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												

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☐

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
	In regards to pulse - happy for pt to be d/c. pt will collect IDL tomm AC SD ACorun happy on d/c. ——→	

83949 GCC0072

Fl

0712726128
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Easterhouse
Glasgow, Lanarkshire
G34 9JE

Affix patient data label

Hospital: GRI

Ward: E6

Date: 22/2/13

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____

NHS Greater Glasgow and Clyde

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00					IVF	500			500								CV
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00					IVF	500											
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 24/2/2023

Attach A

0712726128 F
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Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire G34 9JE

Ward: G6

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name M. DOS. NUM Designation MESW
2. Signed _____ Name A CORVIN Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

Def Better.

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	07 00	08 00	10 50	14 00	18 00															
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N															
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N															
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	S	Y	Y	Y															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		S	I	I	I															
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	S	Y	Y	Y															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	S	L	B	L															
		Chair Assist to walk or stand (W/ST)		S	-	-	-															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	L	L	I	I	I															
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y	Y	Y	Y	N															
		Drink taken?	N	S	N	N	N															
		Food, snack, or supplement taken?	N	S	N	N	N															
		Has oral hygiene been carried out as per care plan?	N	S	I	I	I															
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y															
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N															
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	MM	MM	N	N	N															
		Care provider / role	MM	MM	N	N	N															

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 23/2/23

0712726128
SULLIVAN F
Deborah 07/12/1972
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Easterhouse
Glasgow, Lanarkshire
G34 9JE

Att

Ward:

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name F-CDN Designation SN
2. Signed _____ Name [illegible] Designation RN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00/02	04/22	08/06	12/30	16/20	20/00													
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N													
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	N	Y	Y	N	N													
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	I	I	I	I	N													
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	/	—	—	/	/													
K	4	**KEEP MOVING** Has the patient moved or walked?	E	I	I	I	Y	Y													
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	/	B		B	B													
		Chair Assist to walk or stand (W/ST)	/	/	—	CH	/	/													
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I													
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N													
		Drink taken?	N	Y	Y	Y	N	Y													
		Food, snack, or supplement taken?	N	N	N	N	N	Y													
		Has oral hygiene been carried out as per care plan?	I	I	I	I	NT	NT													
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y													
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	N	N	NT	NT													
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	NA	NA	NA	NA	NA													
		Care provider / role																			

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 66	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
23/2/23	0030	N	N	N	N	N	N	4 hrly	
24/2/23	0825	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Intervel...onal Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: ~~23/2/23~~ ward 66 Date: 23/2/23 Time: 01.00	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	NA				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	✓				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

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Person Specific (Inpati… …dling Assessment Form

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

Person's Name:		Person is totally independent (tick here and go to date box)	✓

1. General Information

Body Build			
Weight		Height	
96.35	Kg	5ft 9	
31.46	BMI	175	cm

Problems with comprehension, …ation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes [ ] No [ ]

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	23/2/23		
Assessor's signature:			
Proposed Review date:	2/3/23		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes / No		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	175 cm	☐	☑	
Admission Weight	90.35 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date	23/1/23							
Time	0100							
Ward	66							
Oedema/ Ascities present Y/N								
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	90.35							
BMI	31.46							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	2/3/23							
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0712726128
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Easterhouse
Glasgow, Lanarkshire —
G34 9JE

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y ☐ N ☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP Initials ONLY:	Dr/ANP Initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
C = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Affix Patient ID

Glasgow Coma Scale

| | | |

(12 Deborah Sullivan

NEWS 2 Key | 1 | 2 | 3

| | | |

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

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

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

Hospital GGH

Date: 15/03/22 Time:

Triage Nurse

Patient Preferred Name:

Transport SAS/Self:

2. Presenting Complaint

See ARI

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☐

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

4. Communication

I.D. band on? Y / N

Relatives present? Y / N

Relatives / NOK informed? Y / N

Interpreter required? Y / N

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

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

NA

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Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: 0712726128 SULLIVAN Deborah F
Addre: Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE
DOB: 07/12/1972
CHI N:

Named Nurse/Team Leader: _____

Assessment Completed by: Name (PLEASE PRINT) _____

Patient Preparation

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

Urinalysis

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

Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:

☐ IV Fluids

☐ IV Drugs

☐ Suspected haemorrhage

☐ Diagnostic tests

Insertion Date: ___/___/___

Insertion Time: ____:____

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

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

Clinical Indication for Insertion:

Insertion Date: ___/___/___

Insertion Time: ____:____

Signature: _____

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

9. General Safety Precautions to be Undertaken by All Patients

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

Date: 15/05/22
Time: 20:10

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

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

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Ad 0712726128
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DC Flat 0-1, 8 Boyndie Street
Easterhouse
CH Glasgow, Lanarkshire
G34 9JE
F
07/12/1972

10. Risk Assessment

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

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

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

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

12. Pressure Area Assessment

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

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

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

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

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

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

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

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

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F 07/12/1972

15/03/22
- 2000.
- tx to bay (8). - bloods + ECG for CTB & LP & News - 0
No concerns at this time
- ek
carers visiting sat

2300 awake. Seen, evening meds given & News recorded etc. + area
- ek
carers visiting

9am - Patient accepted breakfast this morning. Observations stable. Medications as per HEPMA. No new concerns. Sweating

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Communication with Relatives	Signatures	Time
Next of Kin: Tel:		

Nursing Notes		
Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name:

Address:

DOB:

CHI Number:

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

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 46 Date: 6/3/22 Time: 13:00	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:	Ward: Date: Time:
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓				
2. Check walking aid (if required) is in reach and in use.	N/A				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	N/A				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Patient Details	Complete for all patients identified at risk of falling.	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING						
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)						
Assess if a low bed is required (Patient care plan 9)						
SAFETY						
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)						
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)						
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.						
HEALTH						
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)						
Document continence problems and link to care rounding (Patient care plan 6)						
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)						
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.						
COMMUNICATION						
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)						
Update the ward team of the patient's mobility status. (Patient care plan 8)						
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)						
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)						
Signature of nurse completing interventional plan / or update						

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

Feb 17 mi • 294647c Version 1_0 • GGC0233

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patie

0712726128
SULLIVAN
Deborah
07/12/1972
F

Name: _____
DOB: _____
Ward: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section ... insertion.

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

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

PVC inserted: Day 0	Date: ___/___/___ Hospital: _____ Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

no IV access

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

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

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

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score	
IV site appears healthy	[illegible] observe cannula
One of the following is evident : slight pain or redness near site	1 - Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2 - Early stage phlebitis : Remove if [illegible] cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3 - Phlebitis/thrombophlebitis : Remove if [illegible] cannula
As above including: palpable venous cord	4 - Seek further advice
As above including: pyrexia	5 - [illegible]

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

Care Rounds Checklist

Date: 16/3/22

Attach 0712726128 SULLIVAN Deborah F 07/12/1972

Ward:

NHS Greater Glasgow and Clyde

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

1. Signed EBawle Name EBAWLE Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	08																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:	N/INT																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/																	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R																	
		Chair Assist to walk or stand (W/ST)	/																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	(I)																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N																	
		Drink taken?	Y																	
		Food, snack, or supplement taken?	Y																	
		Has oral hygiene been carried out as per care plan?	N																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N																	
		Care provider / role	BN																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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Glasgow, Lanarkshire
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F
07/12/1972

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

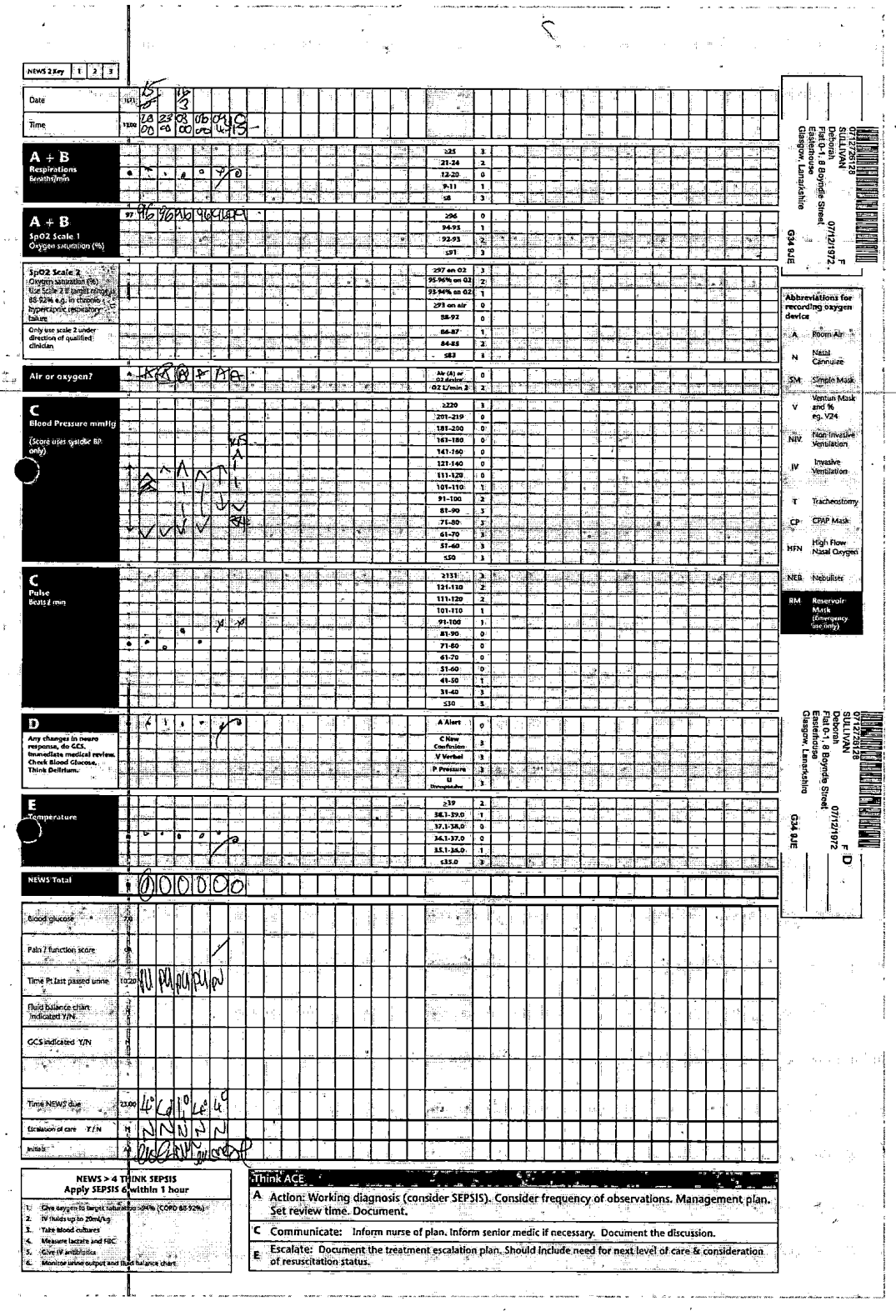
Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |


NEWS 2 Key 1 2 3
Date
Time
A + B
Respirations
Breaths/min
A + B
SpO2 Scale 1
Oxygen saturation (%)
SpO2 Scale 2
Oxygen saturation (%)
Use Scale 2 if target range is 88-92% e.g. in chronic hypercapnic respiratory failure
Only use scale 2 under direction of qualified clinician
Air or oxygen?
C
Blood Pressure mmHg
(Score uses systolic BP only)
C
Pulse
Beats / min
D
Any changes in neuro response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.
E
Temperature
NEWS Total
Blood glucose
Pain ? function score
Time Pt last passed urine
Fluid balance chart indicated Y/N
GCS indicated Y/N
Time NEWS due
Escalation of care Y/N
Initials
NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour
1. Give oxygen to target saturation 94% (COPD 88-92%)
2. IV fluids up to 20ml/kg
3. Take blood cultures
4. Measure lactate and FBC
5. Give IV antibiotics
6. Monitor urine output and fluid balance chart
Think ACE
A Action: Working diagnosis (consider SEPSIS). Consider frequency of observations. Management plan. Set review time. Document.
C Communicate: Inform nurse of plan. Inform senior medic if necessary. Document the discussion.
E Escalate: Document the treatment escalation plan. Should include need for next level of care & consideration of resuscitation status.
Abbreviations for recording oxygen device
A Room Air
N Nasal Cannulae
SM Simple Mask
V Venturi Mask and % eg. V24
NIV Non Invasive Ventilation
IV Invasive Ventilation
T Tracheostomy
CP CPAP Mask
HFN High Flow Nasal Oxygen
NEB Nebuliser
RM Reservoir Mask (Emergency use only)
0712728128
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Glasgow, Lanarkshire
G34 9JE
07/12/1972
F
D

My Admission Record

NHS Greater Glasgow and Clyde

N 0712726123
A SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
D Glasgow, Lanarkshire
C G34 9JE
A

Hospital: GRI Ward: 65
Date of Admission: 11/2/22 Time: 21:00
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 49 Telephone Number:
Consultant: Prof G McKay

Lumra positive
Lode positive

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☐
Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact	**Preferred second contact**
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Telephone:	Telephone:
Is this person aware of your admission? Yes ☐ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☐ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Abdo pain

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Penicillin

Relevant past medical history

Chronic Panc Fibromyalgia
Cholesytectomy
GORD
HTN T2DM

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place.
Yes ☐ No ☐ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

N [redacted]
A 0712726128
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D Glasgow, Lanarkshire
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C
A [redacted]

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☑	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

Nan 0712726128
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Easterhouse
Glasgow, Lanarkshire
Do! G34 9JE
CH
Affix patient ID label

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 10 years ago

Never smoked ☐

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): MKSINGH Signature: MKSingh

Designation: Staff Nurse Date: 11/2/22

My Assessment Record

Na
Ad 0712726128
SULLIVAN F
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Easterhouse
Do Glasgow, Lanarkshire
CH G34 9JE
Affi

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

Name:
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CHI Glasgow, Lanarkshire
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3. Senses

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

Can you describe where and what the pain is like?

N/A

Have you had treatment / intervention for the pain?

N/A

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

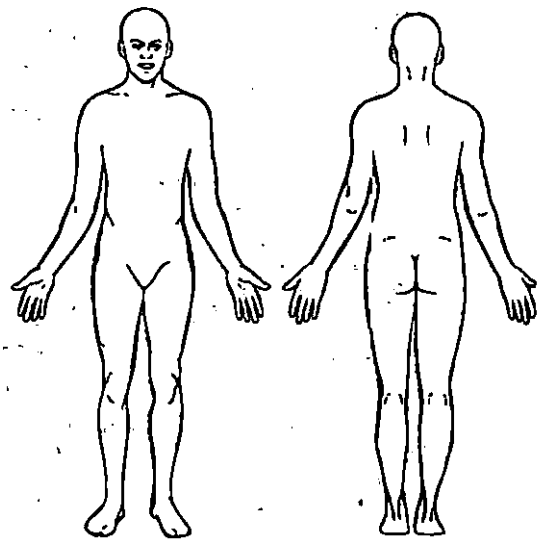
Can you describe any chronic pain that you have?

N/A

What makes the pain better?

N/A

Mark current pain on body chart



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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Nil

What do you like to eat and drink?

Anything

What do you not like to eat and drink?

Not fussy

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent	N/A	

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

What products do you normally use for this continence issue?

N/A

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

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

What products do you normally use for this continence issue?

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

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

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DoB: 07/12/1972
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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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Glasgow, Lanarkshire
DoB: ___
CHI: ___ G34 9JE
Affix patient ID

8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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Affix p

11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify_____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

RC

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

No

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

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting better + going home

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

Informal Support

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

family

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☑

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

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☑ Not appropriate at this time ☑
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☐
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☑
If yes when was patient referred ___/___/___

Name: [redacted]
Addr 0712726128 F
SULLIVAN 07/12/1972
Deborah
Flat 0-1, 8 Boyndie Street
DoB: Easterhouse
CHI: Glasgow, Lanarkshire G34 9JE
Affix [redacted]

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
11/2/22	Patient admitted to ward 65	
21.00	via A+E presenting with	
	Abdo pain. News ① PHR	
	Currently fasting. Awaiting	
	senior RIV	[illegible]
	Reviewed by registrar	
	Imp ? Gastroenteritis	→ Cont

Name [redacted] 0712726128
Addr SULLIVAN
Deborah F
Flat 0-1, 8 Boyndie Street 07/12/1972
Easterhouse
DoB Glasgow, Lanarkshire
CHI G34 9JE
Affix patient [redacted]

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
11/2/22	Plan - IV fluids	
2300	IV PPI	
	Rpt FBC	
	OP OGD	[redacted]
23/2/22	Settled night so far	
04.00	News ① 4HR	
	Medication given as per kepma	
	tolerated fluid	
	Passing urine spontaneously	
	Independently mobile	
	IVF running	
	All care given as per	
	care plans. Patient asleep	MRS MKH
	at time of writing	[redacted]
12/2/22 12:10	Patient independent with	
	ADL's. Mobilising to toilet	
	to void urine. Medication	
	given as per Hepma. Tolerating	
	diet + fluids as able.	
	Continues to be barrier	
	nursed due to cord.	
	Analgesia given PRN.	
	HR - Stop IV fluids	
	+ IV PPI. Continue analgesia	K. FEARON SCN
13/2/22	Settled night so far	
02:50	News ① 4HR BMs Stable & Mmm	
	Medication given as per kepma	[redacted] Cam

Name: Deborah Sullivan
Address:
DoB:
CHI: 07 12 72 6128
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
13/2/22 02:50 (Cont)	tolerated fluid + diet before bed. Passing urine spontaneously independently mobile Oramorph as charted All care given as per care plan Patient asleep at time of writing.	MKSINGH SN
12:00	HIR G. Madeley. Plan: 1) Regular antiemetic 2) (R) ace tolerating. F+D. Observations + BM stable Medications given as per Kapma Ind dependent with ADL Pt reported that vomited after bfast. Analgesics given as charted. Settled at present.	M. CRUZ ANDALUZ
17:00	Pt vomited after dinner Buccal Prochlorperazine given as charted with good effect.	M. CRUZ ANDALUZ
19:00	HIR Surgical reg Home tomorrow.	M. CRUZ ANDALUZ
14/02/22 03:55	Settled night so far Nausea (1) ↑ HR. Medication given as per kapma. Analgesia given as charted Tolerated fluid + diet before bed Passing urine spontaneously. All care given as per care plans. Patient sleeping at time of writing.	MKSINGH SN

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Deborah Sullivan

Date & Time		Signature, Print Name & Designation
14/2 12^{00}	Reviewed by Mr Mackay for home today as pain settled. Venflon removed, patient had own transport organised. IDL to be posted.	D Mackay

83949 GCC0072

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature
11/2/22 MW	No issues News ① THR	
11/2/22 MW	2, 3. Communication and senses No concerns can communicate needs	
11/2/22 MW	4. Cognitive status Alert + orientated	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
11/2/22 MW	Getting better and going home	
11/2/22 MW	5. Hydration and Nutrition Fasting currently thawed normally tolerates normal diet	
12/2/22 MW	6. Elimination Independent	

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
11/2/22 MES	Independent with ADLs		11/2/22 MES	Call buzzer in reach and working	
			11/2/22 MES	10. Sleep and Rest	
				Promote quite + peaceful environment	
11/2/22 MES	8. Mobility				
	Independently Mobile		11/2/22 MES	12. Privacy, dignity and sexuality	
				Ensure privacy + dignity at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mi • 285668 Version 1_0 • GGC0127

0712726128

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

Name: SULLIVAN Deborah F

DOB: 07/12/1972

Ward:

Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

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

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

PVC inserted: Day 0	Date: 12/12/22 Hospital: GRI Area: ED ☐ Theatre ☑ ITU/HDU ☐ Ward ☐ ____ Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☑ L Arm ☐ L Foot ☐ Other:
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☑ No ☐ If No, state reason: Verbally

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 13/2/23	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	MC
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

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

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

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

Fluid Balance Chart

0712726128
SULLIVAN
Deborah
F
07/12/1972

Hospital: GRI
Ward: 65
Date: 12/02/22

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00					NORM	100			100								
02:00																	
03:00																	
04:00																	
05:00																	
06:00				IVK	IVF	500			600								
07:00																	
08:00																	
09:00																	
10:00																	
11:00	WATER	200							800								
12:00									1000								
13:00	COFFEE	200															
14:00																	
15:00	ADDED	200							1200	PU							
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

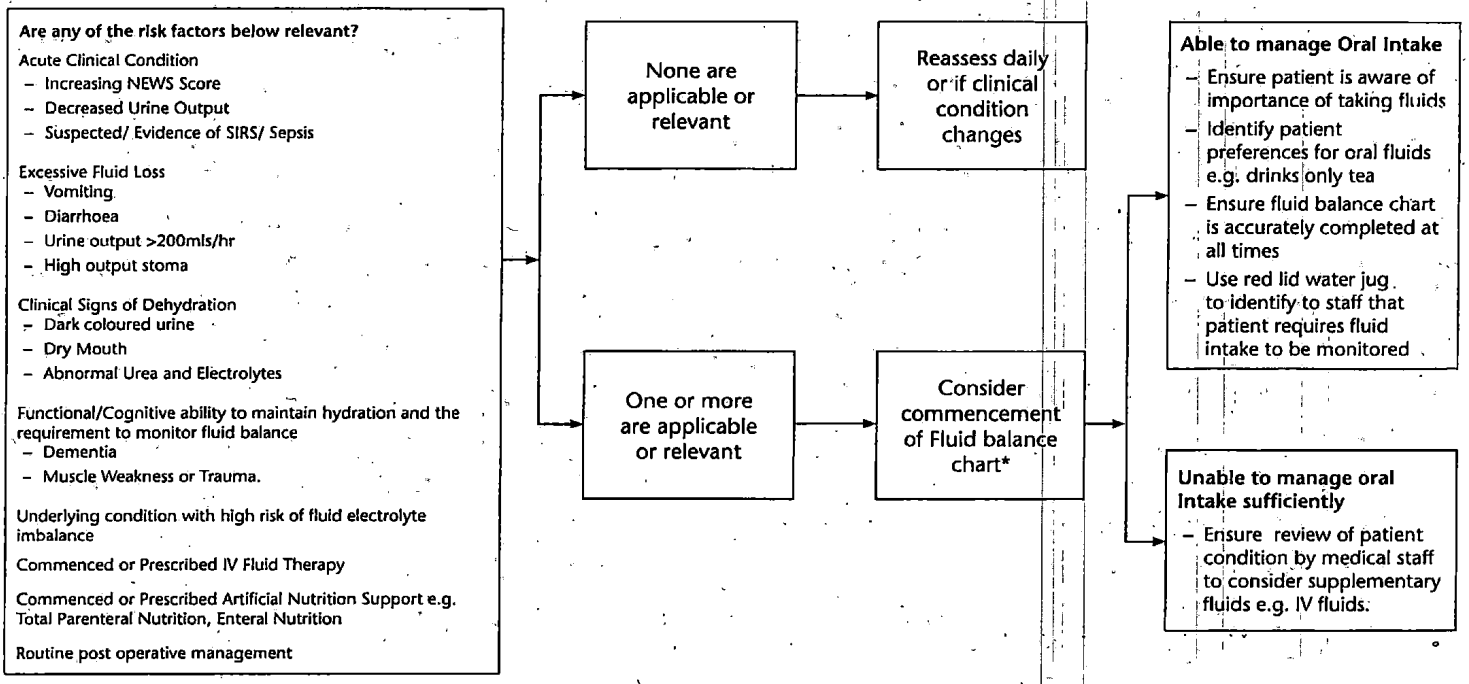
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 11.2.22

Attach Addressograph Label

Deborah Sullivan
07/12/1972
Ward: 65 07127D6128

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name MR SINGH Designation SW
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	0206 2000																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	N																
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.			N																
S	3	**SKIN INSPECTION** Pressure areas checked:		S	I																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		S	I																
K	4	**KEEP MOVING** Has the patient moved or walked?		S	I																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	I																
		Chair Assist to walk or stand (W/ST)			I																
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	I																
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		S	N																
		Drink taken?			Y																
		Food, snack, or supplement taken?		S	A																
		Has oral hygiene been carried out as per care plan?			I																
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		S	Y																
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		S	N																
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.			A																
			Care provider / role	SM	SM																

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

ml • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 13/02/22

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

1. Signed [signature] Name M KSINGH Designation S/N
2. Signed [signature] Name H CHADHA Designation SN
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

Deborah Sullivan

Ward: GS

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	08:00	10:00	14:00	18:00	23:00
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	N	–	I	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	–	I	I	I	–
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I	–	I	I	I	–
		Chair Assist to walk or stand (W/ST)	I	–	I	I	I	–
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N	N
		Drink taken?	S	N	N	N	N	Y
		Food, snack, or supplement taken?	S	N	N	N	Y	Y
		Has oral hygiene been carried out as per care plan?	S	I	I	I	I	I
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA
		Care provider / role	MS	SB HCA	MK S	MC SW	MC SW	SW

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 12/02/22

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

1. Signed MSingh Name MKSINGH Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addres
0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS Greater Glasgow and Clyde

Ward: 65

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	08:00	08:00	08:00	12:00	18:00	22:00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	S	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	S	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	S	S	I	I	I	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	S				I
K	4	**KEEP MOVING** Has the patient moved or walked?	S	S	Y	Y	I	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	S				I
		Chair Assist to walk or stand (W/ST)	S	S	W	W	W	I
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	S	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	S	N	N	N	N
		Drink taken?	S	S	Y	Y	Y	Y
		Food, snack, or supplement taken?	S	S	Y	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	S	S	I	S	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA
		Care provider / role	AE RN	AE RN	AE RN	AE RN	MK RN	SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GCC0098

Care Rounds Checklist

Date: 11/2/22

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

Ward: 65

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name M K SINGH Designation SIN
2. Signed _____ Name KIRSTY FRASER Designation SIN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	22																	
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N																	
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		N																	
S	3	SKIN INSPECTION Pressure areas checked:		N																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		INT																	
K	4	KEEP MOVING Has the patient moved or walked?		Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B																	
		Chair Assist to walk or stand (W/ST)		–																	
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I																	
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N																	
		Drink taken?		N																	
		Food, snack, or supplement taken?		N																	
		Has oral hygiene been carried out as per care plan?		I																	
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y																	
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT																	
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA																	
			Care provider / role	MS SN																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde.

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 65	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
11/2/22	21:00	N	N	N	N	N	N	4 hrly	MLG
12/2/22	05:00	N	N	N	N	N	N	4 hrly	MLG
13/2/22	02:50	N	N	N	N	N	N	4 hrly	MLG
14/2/22	03:55	N	N	N	N	N	N	4 hrly	MLG
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

Patient Details

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 65 Date: 11/2/22 Time: 21:06	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Completed				
2. Check walking aid (if required) is in reach and in use.					
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Call bell in reach required				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Available				
5. If glasses are worn, check they are available and in use.	Reading only				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	[signature] 18/2/22									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Feb 17 mi • 294647c Version 1_0 • GGC0233

Person Specific (Inpatient) Moving and Handling Assessment Form

Person's Name:		Named Nurse:		Person is totally independent (tick here and go to date box)	✓

1. General Information

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Aleni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	11/2/22		
Assessor's signature:	[signature]		
Proposed Review date:	18/2/22		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Patient Label

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	_____ cm	☐	☐	
Admission Weight	_____ Kg	☐	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

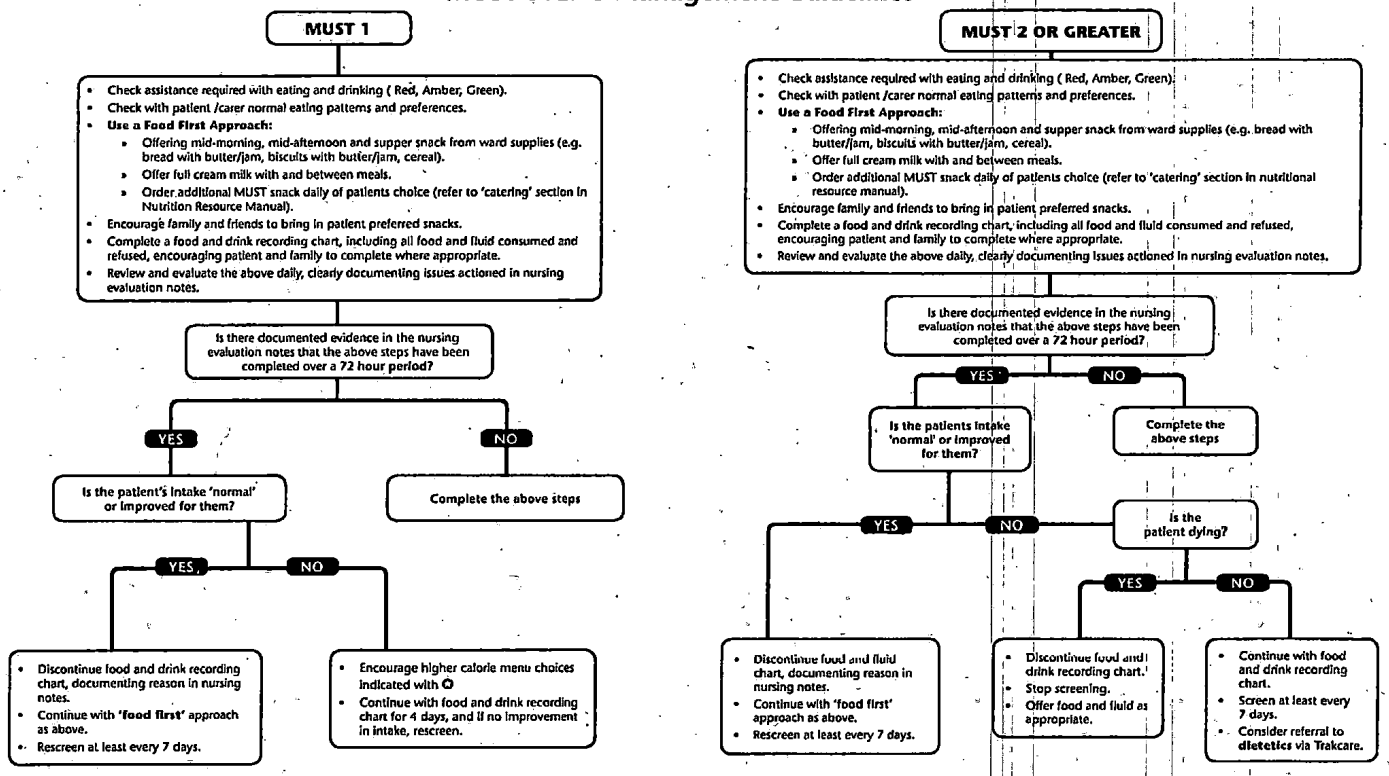
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date								
Time								
Ward								
Oedema/ Ascities present Y/N								
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes								
Weight (kgs)								
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2								
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2								
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0								
Step 4 Overall Risk of Malnutrition TOTAL								
Rescreen on								
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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NHS
Greater Glasgow and Clyde

Name: DEBORAH SULLIVAN Unit No.:

Date:		11/2	12/2	13/2									
Time of Result:													
WCC	4-11	N/A	7.4	6.3									
Hb	M - 13-18 F - 11.5-16.5	N/A	128	126									
Plat	150-400	N/A	340	307									
Amylase	<100	75											
CRP	<10	7	14	14									
Na+	135-145	141	139	138									
K+	3-5-50	2.5	4.6	4.2									
Cl-	98-108	100	102	100									
Bic	21-28												
Urea	2.5-7.5	6.1	5.6	4.6									
Creat.	57-113	59	67	53									
EGFR	60>	>60	>60	>60									
Glucose	3.5-5.5												
Bilirubin	3-22	6	5	6									
ALT	<50	67	48	41									
AST	<40	41	35	26									
G-GT	<55												
Alk. Phos.	40 -150	78	73	75									
Albumin	32-45	42	39	37									
Mg^+													
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												
HCG		<3											
TFTs		(N)											

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

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

Name:

Unit No.:

NHS
Greater Glasgow and Clyde

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											
K+	3-5-50											
Cl-	98-108											
Bic	21-28											
Urea	2.5-7.5											
Creat.	57-113											
EGFR	60>											
Glucose	3.5-5.5											
Bilirubin	3-22											
ALT	<50											
AST	<40											
G-GT	<55											
Alk. Phos.	40 -150											
Albumin	32-45											
Mg^+												
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											

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

NB: You are required to isolate until your admission.

Name:	Notes: List of Respiratory Symptoms that may indicate a virus	
CHI NO:	Congestion in the nasal sinuses or lungs, Rhinorrhoea (Runny nose)	
Date:	Sore throat, Coughing & Sneezing.	
Consultant:	Admission Area:	Admission Date:

COVID-19 Screening Questions	Yes	No
Do you or any member of your household/family have a confirmed diagnosis of COVID-19 diagnosed in the last 14 days?		
NB: Any person who has previously tested positive for SARS-CoV-2 by PCR should be exempt from being re-tested within a period of 90 days from their initial symptom onset, or the first positive test, if asymptomatic, unless they develop new possible COVID-19 symptoms. This is because fragments of inactive virus can be persistently detected by PCR in respiratory tract samples for some time following infection.		
Do you or any member of your household/family have suspected COVID-19 and are waiting for a COVID-19 test result?		
Have you travelled internationally in the last 10 days to a country that is on the Government red list?		
Have you had contact with someone with a confirmed diagnosis of COVID-19, or been in isolation with a suspected case in the last 10 days?		
Do you have any of the following symptoms; High temperature or fever? New, continuous cough? A loss or alteration to taste or smell?		

If the service user answers 'Yes' to any of the COVID-19 screening questions above, place on the respiratory pathway.

If service user answers 'No' to all of the COVID-19 screening questions above, proceed to general respiratory screening questions below.

General respiratory screening questions	Yes	No
Do you have any new or worsening respiratory symptoms not already mentioned which suggest you may have a respiratory virus? ([1] See note above)		
Have you been had a laboratory test with a confirmed respiratory virus/infection such as Influenza in the last 14 days?		

If the service user answers 'Yes' to any of the COVID-19 or the respiratory symptoms questions, place on the respiratory pathway.

I understand and agree that I will isolate until my admission date:	
Patients Signature	HCSW Signature

(18)

Emergency Department Nursing Documentation

0712726128
SULLIVAN F
Deborah 07/12/1972

NHS Greater Glasgow and Clyde

Presenting Complaint -

Date: 11/02/22 Time: 13.20.

Assessment Complete by: Name NURSE (Please Print) Adele, Aurora.

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☑
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - 11/02/2022 Time - 13.20 Signature AF	

4AT

AMT	Correct
Age	✓
Date of Birth	✓
Place	✓
Current year	✓

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score 0 /12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

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

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Glasgow, Lanarkshire
G34 9JE

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
	Notes: medical notes, GP letter, PRF	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
11/02/22	Pt presented to A&E with Abdo pain	
13.29.	Heametemesis T2DM.	AJ Murphy
	Bloods and IV access obtained	
	covid swab. 4mg ondansetron	
	5mg IV morphine given as	
	prescribed, awaiting urine	
	sample. ECG. fluids running as	AJ Murphy.
	per fluid chart	AJ Murphy.
15.42.	Pt attending xray	AJ Murphy.

Nursing Notes		
Date and Time		Print Name and Signature

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
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Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

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

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed .....

Medical: .....

Date: .....

Glasgow Coma Scale

Pupil Reaction and size: s = sluggish; + = reaction; - = no reaction; C = eyes closed

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

Date: 11/12
Time: 1340 1340

Eyes closed by swelling = NT — E: Spontaneously 4; To sound 3; To pressure 2; None 1; Non testable NT
Endotracheal tube or tracheostomy = NT — V: Orientated 5; Confused 4; Words 3; Sounds 2; None 1; Non testable NT
Always record the best response — M: Obeys command 6; Localising pressure 5; Normal flexion 4; Abnormal flexion 3; Extension 2; None 1; Non testable NT

TOTAL: 15 15
Right size: 4
Right reaction: +
Left size: 4
Left reaction: +

Record right (R) and left (L) separately if there is a difference between the two sides — A R M S: Normal power; MRC weakness; Severe weakness; Spastic flexion; Extension; No response
Record right (R) and left (L) separately if there is a difference between the two sides — L E G S: Normal power; MRC weakness; Severe weakness; Spastic flexion; Extension; No response

Pain Score

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

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

Pain Function Score

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

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(18) Deborah Sullivan

NEWS 2 Key | 1 | 2 | 3

| | | |

Emergency Department Nursing Documentation

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NHS Greater Glasgow and Clyde

Presenting Complaint -

Date: 17/9/21 Time: 1023

Assessment Complete by: Name NURSE (Please Prin

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT	
AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer
2) Mobility	Does the person require assistance?	Y/N			
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/N

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

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
Cannula		☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature

Nursing Notes		
Date and Time		Print Name and Signature

My Admission Record

NHS Greater Glasgow and Clyde

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Hospital: GRI Ward: 66
Date of Admission: 17/8/21 Time: 2215
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 48 Telephone Number:
Consultant: Mr Steele

L-ve PCR ☑

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☐
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☐
Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Donna Sullivan	Name:
Relationship: Sister	Relationship:
Address:	Address:
Telephone: 07743956178	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Abdo Pain

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Morphine. Penicillin

Relevant past medical history

Chronic pain
Cholecystectomy
GORD
HTN
T2DM
Fibromyalgia.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☐ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☐
3. Been told that you have CPE?	☐	☐
4. Been in close contact with a person with CPE?	☐	☐

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☑	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☐	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

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

Never smoked ☑

Do you use eCigarettes? Yes ☐ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): NCALLOTT Signature: NCR

Designation: SCN Date: 17/8/21

My Assessment Record

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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

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3. Senses

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

Can you describe where and what the pain is like?

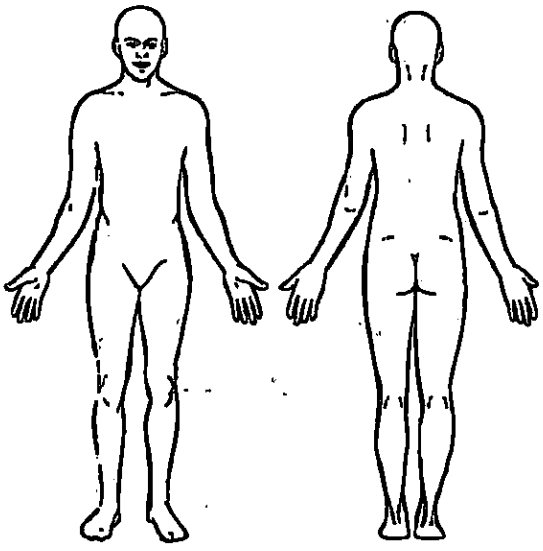
Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NONE

What do you like to eat and drink?

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids		✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 16/8/21

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

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

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

What products do you normally use for this continence issue?

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

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

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?	✓	
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

RC

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

NO

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

Healthcare Chaplain informed Yes ☐ N/A ☐

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	(NO)

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
	Notes: medical notes, GP letter, PRF	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature
28/6/21	PANCREATITIS - NOT VOMITTING.	
21 36	into CDR cubicle - ECG☑ IV access + bloods☑	
	Await R/V - urine sample requested ☐ —— Mulcahonna (RN).	
22 20.	Commenced on IV fluids + IV morphine + IV ondansetron — Mulcahonna (RN).	
2247	Cord swab has been obtained	
	and sent for analysis / —— K Keen (RN)	
2258	Further 5mg morphine given	
	for pain as per prescription.	(RN)
	Obs repeated, NEWS 0/4 -	Keen

Nursing Notes		
Date and Time		Print Name and Signature

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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	Date	Ward	Time
Admitted	28.6.21	RAE	21 37
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

| | | |

CPR

DEBORAH SULLIVAN.

07127261128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 0JE
F
07/12/1972

NEWS 2 Key | 1 | 2 | 3

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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Easterhouse
Glasgow, Lanarkshire
G34 9JE

	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Sp02 Scale 2 Target 88-92%
Signature:
Print Name:
Dr/ANP initials ONLY:
Date:

Patient on home oxygen Y☐ N☐

If yes, add details of oxygen therapy

Document all actions and interventions

NEWS 0	NEWS 1-4	NEWS 5-6 or 3 in one parameter	NEWS 7 or more
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
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NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the nursing notes

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Pupil Reaction and Size

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

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

Glasgow Coma Scale

Date:
Time:
11/1
11/2

MOTOR: Spontaneously 4; To sound 3; To pressure 2; None 1; Not tested NT
VERBAL: Orientated 5; Confused 4; Words 3; Sounds 2; None 1; Not tested NT
EYES: Open normally 4; Responds to voice 3; Responds to pain 2; None 1; Not tested NT

Eyes closed by swelling = NT
Endotracheal tube or tracheostomy = NT
Always record the best response

TOTAL 15
Right size: 3
Right reaction: +
Left size: 4
Left reaction: +

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

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

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Pain Score

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

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

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

mi • 316654 v5.1 • GGC0264

NEWS 2 Key | 1 | 2 | 3

| | | |

My Admission Record

NHS Greater Glasgow and Clyde

N
A 0712726128
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2 Deborah 07/12/1972
D
C

Hospital: GRI Ward: 66
Date of Admission: 6/12/21 Time: 20.50
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 48 Telephone Number: 07713718392
Consultant: Coats

Urine: protein, nitrates + glucose

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	Preferred second contact
Name: Donna Sullivan Relationship: Sister Address: Telephone: 07743956178 Is this person aware of your admission? Yes ☑ No ☐ Can we share information with this person? Yes ☑ No ☐	Name: Relationship: Address: Telephone: Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Chest pain / collapse

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☐ Pen allergy - Rash.

Relevant past medical history

Fibromyalgia, cholecystectomy, pancreatitis, fundoplication TYZO, Hypertension

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

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Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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07/12/197
Affix patient ID label

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 3 years.

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☑

If declined - Why: _____

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

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

Drugs

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

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

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): CHELSEA MCCABE Signature: C-McCabe

Designation: Student Nurse. Date: 6/2/21

My Assessment Record

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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____			

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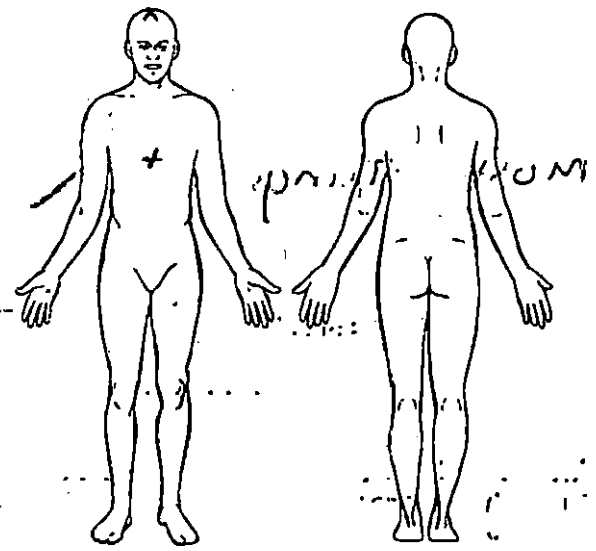
3. Senses

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

Can you describe where and what the pain is like?

very tight twisting pain migrain.

Mark current pain on body chart



Have you had treatment / intervention for the pain?

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

Can you describe any chronic pain that you have?

What makes the pain better?

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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NONE

What do you like to eat and drink?

Most things.

What do you not like to eat and drink?

Spicy food

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

Name:

0712726128
SULLIVAN
2 Deborah 07/12/197

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

What products do you normally use for this continence issue?

1

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 6/2/21

How often in a day/week do you have a bowel movement? Per day 1 Per week

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

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

What products do you normally use for this continence issue?

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

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

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

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

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

9. Maintaining a Safe Environment

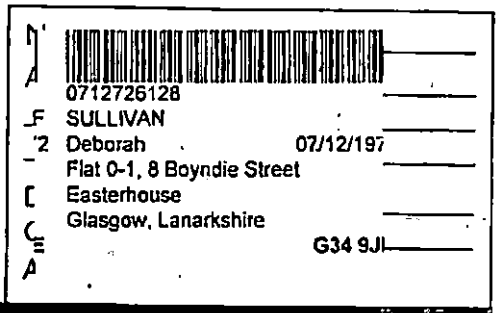
N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

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

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

10. Sleep and Rest

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



11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?	✓	
Do you support anyone (e.g. partner, children, relatives, animals)?	✓	
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

N/A

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

N/A

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

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting better

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

Informal Support

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

N/A

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Deborah
07/12/197

Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑

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

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☑ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?
Yes ☐ No ☑

Are you:

Employed	☐	Unemployed	☑
Self-employed	☐	Retired	☐
Full time education	☐		

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☑ Not appropriate to ask at this time ☐

If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☑ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☑ Not applicable ☐ Not appropriate to ask at this time ☐

If yes when was patient referred ___/___/___

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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
6/2/21	Admitted to ward 66 with	Student nurse
21.30	Chest pain + collapse. NEWS = 0	
	Awaiting Senior review.	C McCabe
07.02.21	> Patient settled and sleeping	
02.50	at present, no new concerns	
	Independant For all care	
	D+F as able, ? parenthesis	SW

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
07-02-21 02-50	Plan: > Antisickness if required > Analgesia > IV Fluids > monitor overnight	SN
10[40]	s/s nr Pain.	
	for CT Scan	
	Observations and GCS stable	
	Medication as Kardex	
	s/c morphine administered	
	Passive mvt as tol by hands, maint mvt of.	
	IVF continue at present	
	Allow F+D	
	Served and indicating	
(14)	Cannot tolerate F+D	
07-02 1500	Care as planned. Obs as Charted. Meds as Kardex- PRN morphine as prescribed. IV fluids continue @ present. NO Concerns	Lobo. LDublinSN
1800	For (H) await family collecting.	LDublin SN
1830	Pt had fall in bathroom alone. FY1 reviewed. Datix ☑ Web-647354 Not going home. X-ray required. (R) shoulder	Lobo. LDublinSN

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
08/2/2021	Deborah has requested Paracetamol	
0130	a few times overnight. Settled for short	
	spells. Omeprazole & Oramorph given	
	as required. Deborah has managed to	
	go to bathroom and back to bed	
	safely. All observations satisfactory.	
	Continue to monitor. Medication as	
	per Kardex.	N Bodiwala.
8/2/21	Deborah independently	
1250.	mobile + self-caring	
	with all personal care	
	needs. managing D+F	
	well. BM-9.5.	
	Observations as charted	
	NEWS(1) tachycardic @	
	110bpm. All medication	
	administered as per	
	Kardex - uncomplaining	
	of any pain or nausea	
	4° Active Care continues	
1	pressure Areas intact	
	bloods noted. CRP 11,	
	WCC 8.4.	
	Mobile up to bathroom	
	to pass urine - nil reports	
	of bowel movements	
	today. r/v via an arm ward	

N
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— Deborah 07/12/1972
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Easterhouse
D Glasgow, Lanarkshire
C G34 9JE
Affix patient ID label

11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify_____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☑ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

Name
Addre
0712726128 F
SULLIVAN
Deborah 07/12/1972
DoB: Flat 0-1, 8 Boyndie Street
Easterhouse
CHI: Glasgow, Lanarkshire
G34 9JE
Affix pa

13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Keep myself updated and informed.

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☑

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

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☑ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☑

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑ Not applicable ☐

Do you have any money worries?
Yes ☐ No ☑ Not appropriate to ask at this time ☐
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☑ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☑ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

Name:
Ad
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DoB
CHI:
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Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
29/6/21 0050	Deborah admitted to ward 66 with upper epigastric pain nausea vomiting radiating through to back. On UFIs at present. Known Type 2 Dm BM 6.9 on admission normally mobilises with Crutch however does not have Some	

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
cont.	therefore falls risk. mobilising with supervision. AIW medical review from surgeons on ward round reports pain score of 8/10 obs stable news 0	N Warner SN
28/6/21	R/V by Registrar treat as acute flare of chronic. Investigations Plan - IUF FBC Amylase. Anti emetics W/h empty/glucozade PPI	GRN.
29/6/21 0410	Deborah settled @ present obs stable - apyrexial BM 6.9. awaiting blood results RSO - for g/LC SIR Registrar - ? acute flare of chronic pancreatitis analgesia/antiemetics PPI - IUF	CJ

Name: _____

Addr [barcode] 0712726128

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DoB: Deborah 07/12/1972

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	Allow FTO as Tolerated	
	with empagliflozin /	
	gliclazide	
	+ Ghule + Sole - carry	
	pink canula (Chart)	Lille
10.00	Patient R/V by Mr MacKay;	SH
	- IVF.	
	- Analgesia.	
	- Antiemetics.	
	- WH glucazide. (Informed Medical	
	staff patient had self administered	KRoberts(cs)
	already)	Klaus
1635 -	Patient R/V by Mr Mackay	
	Bloods NAD.	
	Patient unable to tolerate food	
	today - RPT CT. as IP.	
30/6/21	Pt mobile + self-caring.	
01:00	Obs stable NEWS=0. BM-6.6mmol	
	fluid + diet tolerated before	
	sleeping.	
	Meds given as per kardex.	SMcCallum(SN)
	PRN analgesia taken.	
	Settled + sleeping at present.	KBoyle SEN
	Awaiting CT scan.	KIRSTY CROWE
30/6/21 WR	G Mackay	
	(P) CTAP.	(cont)
1340	All care provided as per care	

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CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
30/6/21	plan. Independent with personal	
1340	hygeine this morning. Medication	
(cont	given as per kardex. Observations	
	to charted News ① HR 92. Voiding	
	urine. Fluid and diet taken as	
	able. Awaiting CTAP. NO issues.	
	Settled at present.	L Lindsay
WR	G Mackay	
	Ⓟ Can F+O tonight -> if manages	
	am: Ⓗ mane	L Lindsay
1.7.21	Independently mobile &	
0045a	self caring	
	All meals as per kardex	
	NEWS = 0. BM 12.4	
	DTF taken as tolerated	
	Voiding urine spontaneously,	
	no reports of bowel	
	movements	
	Settled eslept for long	
	spells overnight ? Home	SmcCulloch(SN)
	tomorrow	
WR	Dolan	
	Ⓟ Home today	
	NO FH.	
1230	Patient discharged from ward 65.	
	PVC removed. Wasering advice	
	given well on leaving.	L Lindsay SN

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

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium.

This should be done on admission; at each transition of care; if SQID positive; or if any clinical concerns.

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4AT	Ward 66 Date & Time 0030 25/6/21	Ward ____ Date & Time	Ward ____ Date & Time	Ward ____ Date & Time	Ward ____ Date & Time
(1) Alertness This includes patients who may be markedly drowsy (e.g. difficult to rouse and/or sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. **Ask the patient to state their name and address to assist rating**					
Normal (fully alert, but not agitated, throughout the assessment)	(0)	0	0	0	0
Mild sleepiness for <10 seconds after waking, then normal	0	0	0	0	0
Clearly abnormal	4	4	4	4	4
(2) AMT4 Ask the patient their **Age, Date of Birth, Place** (name of hospital) **Current Year**					
No mistakes	(0)	0	0	0	0
1 mistake	1	1	1	1	1
2 or more mistakes	2	2	2	2	2
(3) Attention Ask the patient **"Please tell me the months of the year in backward order, starting at December".** To assist, one prompt of **"What is the month before December"** is permitted.					
Achieves 7 months or more correctly	(0)	0	0	0	0
Starts but scores < 7 months or refuses to start	1	1	1	1	1
Untestable (cannot participate because too drowsy or inattentive)	2	2	2	2	2
(4) Acute change or fluctuating course Evidence of significant change of fluctuation in: alertness, cognition, other mental function (e.g. hallucinations, paranoia) over the past 2 weeks and still present in preceding 24 hrs.					
No	(0)	0	0	0	0
Yes	4	4	4	4	4
4AT TOTAL SCORE	04				
Print initials of assessor	NW				

Score >4 This is a possible DELIRIUM +/- COGNITIVE IMPAIRMENT, start 'T' and 'I' of TIME and escalate to medical staff to confirm diagnosis	**Score 1-3** This is a possible COGNITIVE IMPAIRMENT, and requires further assessment	**Score 0** DELIRIUM or SEVERE COGNITIVE impairment unlikely

All patients scoring 0-3 are still at high risk of delirium. Use the Triggers listed overleaf to plan care and reassess daily by asking 'Is the patient more confused or drowsy?' This is the single question in delirium (SQID)

Affix ID Label

NHS Greater Glasgow and Clyde

TIME checklist to guide Delirium risk reduction, Identification and Management

The TIME checklist is a joint medical and nursing responsibility.

	Triggers, Investigate, Manage and Engage	Date	Date	Date	Date	Date
Triggers	**Think possible triggers for delirium**	Tick box	Tick box	Tick box	Tick box	Tick box
	Is the patient in pain? Start pain chart, review analgesia and consider need for an aperient					
	Is the patient constipated or at risk of constipation? Commence bowel chart and review daily to assess for constipation, especially if on analgesia. Consider rectal examination					
	Is the patient in urinary retention? Palpate bladder/scan					
	Is the patients oral intake sufficient to prevent dehydration? Encourage hourly fluids, start fluid balance chart					
	Could any drugs trigger delirium? Doctor to review medication					
	Blood sugar, high or low?					
	Is there a history of alcohol intake/drug abuse? Intoxication or withdrawal, start GMAWS/drug misuse guidelines					
	Does the patient have sensory impairment? Ensure patient is wearing their glasses/hearing aid(s)					
	Is the patient immobile? Promote early mobilisation in order to prevent delirium					
	Document 4AT score					
	Does the patient have Delirium? (Yes; No/Unsure) Please Circle	Y N U	Y N U	Y N U	Y N U	Y N U
Investigate	**Investigate**					
	Record NEWS					
	Screen for infection					
	Take bloods and ensure ECG/appropriate imaging					
Manage	**Management: Diagnose causes & initiate treatment**					
	Document diagnosis of delirium					
	Document potential causes of delirium					
	Document treatment plan					
Engage	**Engage and Explore**					
	If appropriate, explain diagnosis of delirium to patient/ family/ carers and provide delirium leaflet					
	Engage with patient/ family/ carers. Complete "What matters to me"/"Getting to know me" document					
	Does the patient have capacity to consent to care? (Yes/No/Ongoing Assessment)	Y N O	Y N O	Y N O	Y N O	Y N O
	If no, complete AWI document					
	Print initials of assessor					

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Care Plan

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Care discussed with patient ☒ Yes ☐ No ☐ Unable	If unable, give reason:		
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:		

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
29/6/21 NW	No issues noted as per		29/6/21	Keeping myself informed	
	Icarcleno				
			29/6/21	5. Hydration and Nutrition	
				Fasting for nerves	
29/6/21	2, 3. Communication and senses				
	Can communicate needs				
	clearly				
			29/6/21	6. Elimination	
29/6/21	4. Cognitive status			Independant no issues	
	Alert and Orentated				
	LIAT = 0				

p1/2 PTO

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Care Plan

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Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
29/6/21	Independant		29/6/21	3° ACR Buzzer to hand and explained	
			29/6/21	10. Sleep and Rest	
				Promote peaceful environment	
29/6/21	8. Mobility				
	Independant		29/6/21	12. Privacy, dignity and sexuality	
	with Crutch uses long			Maintain at all times	
	Distances				
	Refer to Physio for crutch/				
	Assessment				
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Unit No.:

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Date:		28/6	29/6	30/6									
Time of Result:													
WCC	4-11	8.5	7.9	8.3									
Hb	M - 13-18 F - 11.5-16.5	139	127	126									
Plat	150-400	342	287	274									
Amylase	<100	(133)	70										
CRP	<10	9	4	11									
Na+	135-145	140	139	137									
K+	3-5-50	4.1	4.1	3.9									
Cl-	98-108	104	105	102									
Bic	21-28	26											
Urea	2.5-7.5	3.8	4.0	3.8									
Creat.	57-113	56	66	60									
EGFR	60>	>60	>60	>60									
Glucose	3.5-5.5	6.5											
Bilirubin	3-22	5	5	7									
ALT	<50	30	34	40									
AST	<40	18	29	29									
G-GT	<55												
Alk. Phos.	40 -150	75	68	74									
Albumin	32-45	40	37	37									
Mg^+													
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												

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

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Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

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Glasgow, Lanarkshire
G34 9JE

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria – complete this section at time of insertion.

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

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

PVC Inserted: Day 0	Date: 29/6/21 Hospital: GRI Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☑ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☑ If No, state reason: verbal

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 30/6/21	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	[illegible]
Day 1 Check 2 Night 30/6/21	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	KM ST/N
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

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

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

*Date PVC Removed: [illegible] 01/07/21

*Reason For Removal: [illegible] discharged HHusIP

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

Care Rounds Checklist

Date: 1·7·21

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

1. Signed [signature] Name SMcCulloch Designation SN
2. Signed Messenger Name Kirsty Messenger Designation ST/N
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach Addressograph Label

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Glasgow, Lanarkshire G34 9JE

Ward: 65

NHS Greater Glasgow and Clyde

'Must dos' for me ... is anything they want specifically done today:

			Times	00 00	03 50	8 00																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	S	N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		S	S	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:		S	S	I																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		S	S	—																	
K	4	**KEEP MOVING** Has the patient moved or walked?		S	S	Y																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	S	—																	
		Chair Assist to walk or stand (W/ST)		S	S	—																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	S	I																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		S	S	N																	
		Drink taken?		S	S	Y																	
		Food, snack, or supplement taken?		S	S	Y																	
		Has oral hygiene been carried out as per care plan?		S	S	Y																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y	Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		S	S	NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA																	
			Care provider / role	KW SN	KW ST/N	[illegible]																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 30/6/21

Attac 0712726128
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Easterhouse
Glasgow, Lanarkshire
Ward: 65 G34 9JE

NHS Greater Glasgow and Clyde

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

1. Signed KOBoyle Name KIRSTY OBOYLE Designation STN
2. Signed SLindsay Name SLindsay Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	22 30	06 30	09 50	10 15	13 40	17 30	21 15											
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N											
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	Y											
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I	I	I											
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	-	-	-	-	-	-											
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I	I	I	I	I											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	-	-	-	-	-	-	-											
		Chair Assist to walk or stand (W/ST)	-	-	-	-	-	-	-											
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I	I											
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	N	N	N	N	N	N											
		Drink taken?	S	Y	Y	Y	Y	Y	Y											
		Food, snack, or supplement taken?	S	Y	N	N	N	Y	N											
		Has oral hygiene been carried out as per care plan?	S	I	I	I	I	I	I											
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	Y	Y	Y	Y	Y	Y											
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT	N	NT	NT	NT	NT											
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	N/A	N	NA	NA	NA	NA											
		Care provider / role	HCA	HCA	RN	RN	RN	RN	HCA											

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GCC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRH Ward: 66	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
29/6/21	00:20	N	N	N	N	N	N	4 hrly	NWaqed
30/6/21	01:00	N	N	N	N	N	N	4 hrly	RO'B
1/7/21	00:40	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Interve onal Plan

NHS Greater Glasgow and Clyde

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

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

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

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 29/6/21	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used:	Specify: • Mattress: SFM • Cushion: NA • Detail additional pressure redistributing equipment:	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used:	• Skin care to be carried out 4 hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? Verbal YES ☐ NO ☑	N Warren Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: G6 Date: 29/6/21 Time: 20:20	Ward: Date: Time: --:--	Ward: Date: Time: :	Ward: Date: Time: --:--	Ward: Date: Time: --:--
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Independant with Crutch				
2. Check walking aid (if required) is in reach and in use.	Not with patient				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓ in reach/ explained				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓ safe				
5. If glasses are worn, check they are available and in use.	✓ worn				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

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Deborah
F
07/12/1972

FALLS INTERVENTI(CHECKLIST

NHS
Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: 66 Date: 29/6/21 Time: 00:25	Ward: Date: Time: --:--	Ward: Date: Time: --:--	Ward: Date: Time: --:--	Ward: Date: Time: --:--
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	Referred				
Assess if a low bed is required (Patient care plan 9)	NA				
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	NOT REQ				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	2-HOURLY				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	NO				
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	✓ Completed				
Document continence problems and link to care rounding (Patient care plan 6)	N/A				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	NA				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	Reviewed.				
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	verbal				
Update the ward team of the patient's mobility status. (Patient care plan 8)	✓				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	✓				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	NA				
Signature of nurse completing interventional plan / or update	N Warren				

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

Person Specific (Inpatient) Moving and Handling Assessment Form

Person Name:	0712726128 SULLIVAN Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	F 07/12/1972	Named Nurse:	NWarren	Person is totally independent (tick here and go to date box)	

1. G — Problems with comprehension, behaviour, co-operation (specify):

V — kg — BMI — cm

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes ✓ No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ✓ 2 >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 ✓ 2 >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 ✓ 2 >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 ✓ 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 ✓ 2 >3	Additional Information / Equipment (eg sling fitting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alan)			

9. Walking

No Walking	Walking Aid ✓	Assistance	Supervision ✓	Independent
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walker)	
	Uses crutch for long distances.			

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	29/6/21		
Assessor's signature:	NWarren		
Proposed Review date:	6/7/21		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ☐ No ☐		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

	Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
		People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Aleni) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ >3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 29/6/21 Time 0025 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	5ft 9 cm	☐	☑	
Admission Weight	97·15 Kg	☐	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

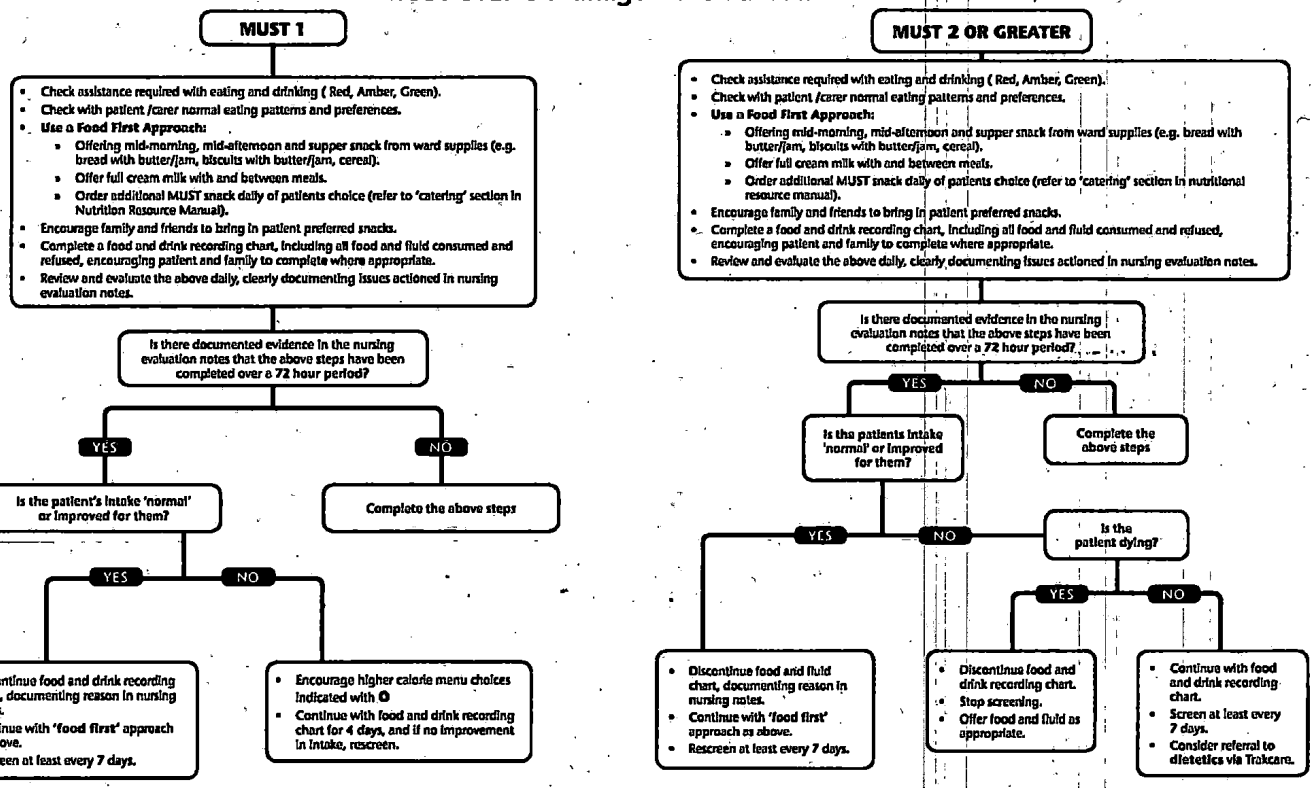
Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	29/6/21							
Time	0025							
Ward	66							
Oedema/ Ascities present Y/~~N~~	NO							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	97·15							
BMI	31·7							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	6/7/21							
Signature	NW							

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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CPR

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 28 / 6 / 21 Time: 21:33

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

Label

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) KIRSTY / MAGDALENA

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☑
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/(N)	SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
Mental Health Triage Assessment	Y/(N)	If NOT WHY? - (details) Not clinically indicated.	(NO)
GMAWS	Y/(N)	Date - 28/6/21 Time - 21:34 Signature - MWOWOWNA (RN)	

4AT

AMT -	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

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

Care Rounds Checklist

Date: 17/8/21

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F el
07/12/1972

NHS Greater Glasgow and Clyde

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

1. Signed NR Name MCALLISTER Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	21:30																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N																		
S	3	**SKIN INSPECTION** Pressure areas checked:	N																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT																		
K	4	**KEEP MOVING** Has the patient moved or walked?	Y																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B																		
		Chair Assist to walk or stand (W/ST)	I																		
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N																		
		Drink taken?	Y																		
		Food, snack, or supplement taken?	Y																		
		Has oral hygiene been carried out as per care plan?	Y																		
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA																		
		Care provider / role	NR																		

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 18/8/21

0712728128
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NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name [illegible] Designation SN
2. Signed [signature] Name [illegible] Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	2206	1800																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	N	N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		S	N	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:		S	Y	I																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		S	INT	-																	
K	4	**KEEP MOVING** Has the patient moved or walked?		S	Y	I																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	B	-																	
		Chair Assist to walk or stand (W/ST)		S	-	-																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		S	I	I																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		S	N	N																	
		Drink taken?		S	Y	Y																	
		Food, snack, or supplement taken?		S	Y	Y																	
		Has oral hygiene been carried out as per care plan?		S	-	I																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		S	Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		S	N	N																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		S	N	N																	
			Care provider / role	[illegible]	[illegible]	[illegible]																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

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

Write or affix patient label

Name: _____ CHI: _____

DOB: _____ Address: _____

Ward: _____ Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

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

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

PVC inserted: Day 0	Date: 18/8/2 Hospital: Gren Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ ____ Unknown ☐ ____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: ____
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: ____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 18/8/2	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☐	J
Day 1 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: ____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: ____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2, Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: ____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: ____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: ____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

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

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

*Date PVC Removed: __/__/__

*Reason For Removal: ____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

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Glasgow, Lanarkshire
G34 9JE

Unit No.:

NHS
Greater Glasgow and Clyde

Date:		17.08											
Time of Result:		18.13											
WCC	4-11	6.8											
Hb	M - 13-18 F - 11.5-16.5	147											
Plat	150-400	340											
Amylase	<100	63											
CRP	<10	(11)											
Na+	135-145	138											
K+	3-5-50	4.9											
Cl-	98-108	102											
Bic	21-28	23											
Urea	2.5-7.5	5.9											
Creat.	57-113	50											
EGFR	60>	>60											
Glucose	3.5-5.5	(6.3)											
Bilirubin	3-22	6											
ALT	<50	33											
AST	<40	34											
G-GT	<55												
Alk. Phos.	40 -150	83											
Albumin	32-45	42											
Mg^+													
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												

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

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NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

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Glasgow, Lanarkshire
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	Date	Ward	Time
Admitted			
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed:.....

Medical:.....

Date:.....

Pupil Reaction and size
a = sluggish
b = fixed
c = no reaction
c = eyes closed
Pupil Size (mm) 1 2 3 4 5 6 7 8

Glasgow Coma Scale

Date																								
Time																								
EYES Eyes closed by swelling = NT	Spontaneously	4																						
	To sound	3																						
	To pressure	2																						
	None	1																						
VERBAL Endotracheal tube or tracheostomy = NT	Able to converse	5																						
	Disoriented	4																						
	Confused	3																						
	Words	2																						
	Sounds	1																						
	None	NT																						
MOTOR Always record the best response	Obeys command	6																						
	Localising pressure	5																						
	Normal flexion	4																						
	Abnormal flexion	3																						
	Extension	2																						
	None	1																						
	Main motor	NT																						
TOTAL		15																						
Pupil size – Right:		4																						
Right reaction:		3																						
Left size:		4																						
Left reaction:		3																						
Record right (R) and left (L) separately if there is a difference between the two sides	Normal power	6																						
	MRC weakness	5																						
	Severe weakness	4																						
	Specific flexion	3																						
	Extension	2																						
	No response	1																						
Record right (R) and left (L) separately if there is a difference between the two sides	Normal power	6																						
	MRC weakness	5																						
	Severe weakness	4																						
	Specific flexion	3																						
	Extension	2																						
	No response	1																						

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

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

Pain Function Score

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

Affix Patient ID

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NEWS 2 Key | 1 | 2 | 3

Date	1/11																						
Time	11.08	11		12		8	56		00		20												

A ↔ B Respirations (rate/min)

≥25	3
21–24	2
12–20	0
9–11	1
≤8	3

A ↔ B SpO2 Scale 1 Oxygen saturation (Sp2)

≥96	0
94–95	1
92–93	2
≤91	3

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

Only use scale 2 under direction of qualified clinician.

≥97 on O2	3
95-96% on O2	2
93-94% on O2	1
≥93 on air	0
88-92	0
86-87	1
84-85	2
≤83	3

Air or oxygen?

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

C Blood Pressure (mmHg) e.g. non-specific BP

≥220	3
201–219	0
181–200	0
161–180	0
141–160	0
121–140	0
111–120	0
101–110	1
91–100	2
81–90	3
71–80	3
61–70	3
51–60	3
≤50	3

C Pulse (beats / min)

≥131	3
121–130	2
111–120	2
101–110	1
91–100	1
81–90	0
71–80	0
61–70	0
51–60	0
41–50	1
31–40	1
≤30	3

D Any changes to acute response, do GCS. Immediate medical review. Check Blood Glucose. Think Delirium.

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

E Temperature

≥39	2
38.1–39.0	1
37.1–38.0	0
36.1–37.0	0
35.1–36.0	1
≤35.0	3

NEWS total 0 2 1 0 0 0

Blood glucose	7.0																						
Pain / function score	0A																						
Time Pt last passed urine	10.20																						
Fluid balance chart indicated Y/N	N																						
GCS indicated Y/N	N																						
Time NEWS due	23.08																						
Escalation of care Y/N	N																						
Initials	AS																						

NEWS > 4 THINK SEPSIS
Apply SEPSIS 6 within 1 hour

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

Think ACE

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

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

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

Abbreviations for recording oxygen device

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

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07/12/1972
F

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07/12/1972
F

My Admission Record

NHS Greater Glasgow and Clyde

N
A 0712726128 F
— SULLIVAN 07/12/1972
— Deborah
D Flat 0-1, 8 Boyndie Street
C Easterhouse
Glasgow, Lanarkshire G34 9JE
Aff

Hospital: GRI Ward: 66
Date of Admission: 29/6/21 Time: 0030
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 48 Telephone Number:
Consultant: G. McKay

L ✓
PGRL ✓
U&E

Communication

(E) -gluc
(L) -ve
PCR ✓

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Donna Sullivan.	Name:
Relationship: Sister	Relationship:
Address: 8 Millenium Gardens Glasgow G34 9HH	Address:
Telephone: 07743956178	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

epigastric pain, nausea + vomiting

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☐ Penicillin

Relevant past medical history

FH, Diabetes Type 2 (tablet Controlled), pancreatitis 2nd to GS, migranes, acid reflux, chronic symptoms of Sreat.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☒ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name-
Adc
0712726128
SULLIVAN
Deborah
F
07/12/1972
DoB
CHI:
Affix

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name:_____ Relationship:_____ Contact Tel Number_____

Name:_____ Relationship:_____ Contact Tel Number_____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES Inform the IPCT** ☐

Name:
Ac
— 0712726128
— SULLIVAN F
— Deborah 07/12/1972
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Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☑

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): Nicola Warren Signature: NWarren

Designation: SIN. Date: 29/6/21

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

N...
A [redacted]
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Af ...

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day	✓	✓
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

New frequency

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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– Deborah
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Af ... label

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? 29/6/21

How often in a day/week do you have a bowel movement? Per day 1-2 Per week 6-7

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

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

What products do you normally use for this continence issue?

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

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

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?		✓	
Are your dentures a good fit?		✓	
Do you have any other dental work that we need to be aware of?		✓	

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

Na
Ad 0712726128
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8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent			uses crutch for long distances.
Unsteady when walking	–	✓	
Do you use a mobility aid	Yes ☑	No ☐	
Do you have your mobility aid with you?	Yes ☐	No ☑	

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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13. Person Centred Care

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

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

getting better

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

Informal Support

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

N/K

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☑
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☑
If yes when was patient referred ___/___/___

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
7/8/21 2240	Patient ~~Admitted~~	
	onto ward	
	AP known	
	Chronic Panc.	
	NEWS stable	
	FAST await RIV	[illegible]

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Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
18/8/21 0315	Patient Seen by Surgeons allow FTD Analgesia & Antiemetics —	
18/8/21 1030	Patient independent with personal hygiene. FTD as able: Obs as charted - NEWS=0. PVC removed R/V by mr Steele; (H) today % Gastro R/V	
11th	plc have in access removed	

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
17/8/21 NLR	SIC ADLS		17/8/21 NLR	care Buzzer sensor	
				10. Sleep and Rest	
17/8/21 NLR	8. Mobility SIC indep			12. Privacy, dignity and sexuality	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient Unable	☐ Yes	☑ No	☐
If unable, give reason:			
Care discussed with family Unable	☐ Yes	☑ No	☐
If unable, give reason:			

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
17/8/21 NLR	News chart.		17/8/21 NLR	Getting Better	
			17/8/21 NLR	5. Hydration and Nutrition Fluid.	
17/8/21 NLR	2, 3. Communication and senses Speaks English				
			17/8/21 NLR	6. Elimination PU	
17/8/21 NLR	4. Cognitive status A+O.				

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 17/8/21 Time 2230 of initial height and weight on admission to hospital SG 9.94kg		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	NA cm	☐	☐	
Admission Weight	[illegible] kg	☐	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

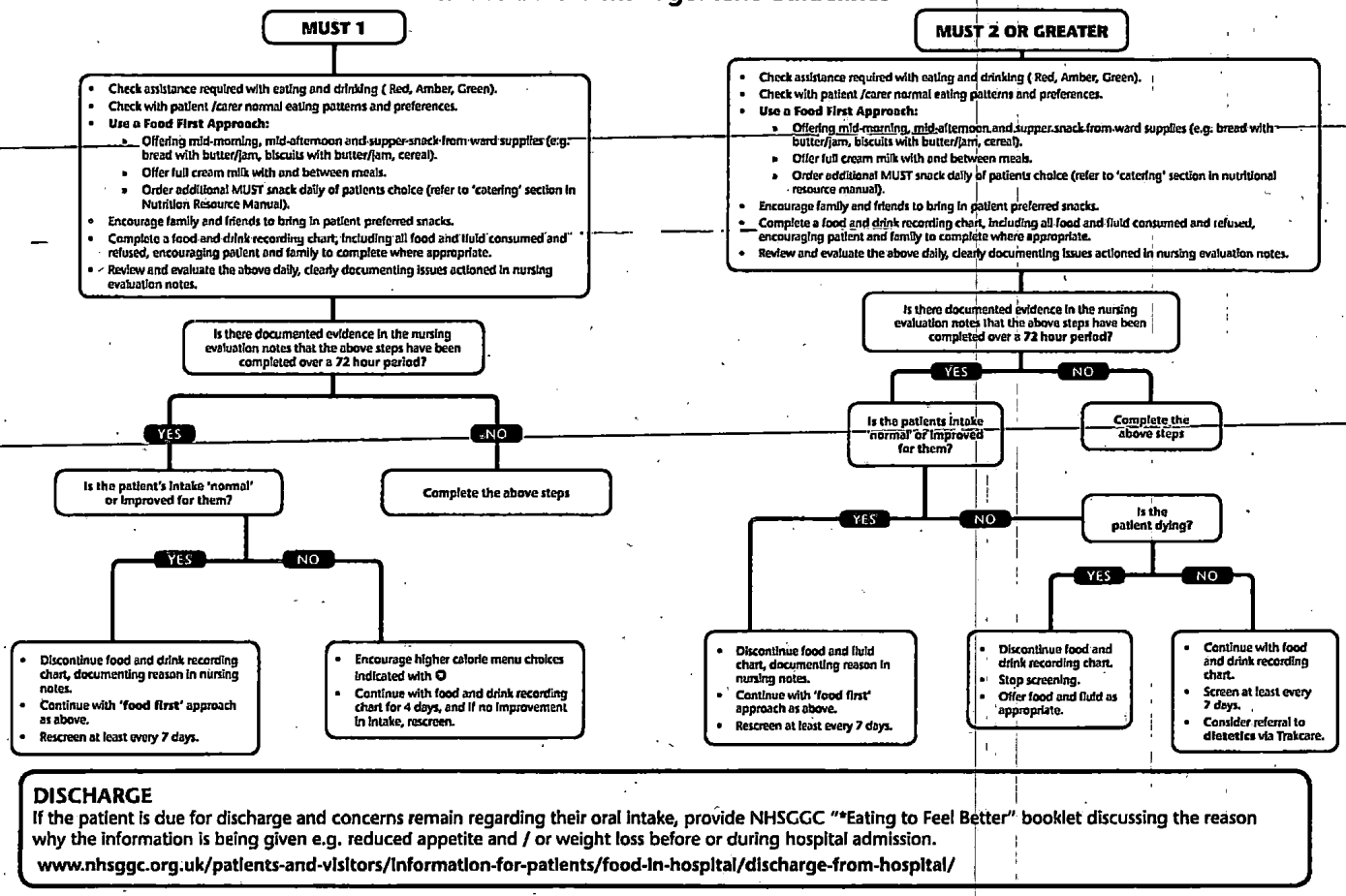
Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date								
Time								
Ward								
Oedema/ Ascities present Y/N								
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes								
Weight (kgs)								
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2								
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2								
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0								
Step 4 Overall Risk of Malnutrition TOTAL								
Rescreen on								
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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ific (Inpatient) Moving and Handling Assessment Form

	Named Nurse:		Person is totally independent (tick here and go to date box)	

smine Johal

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Aten)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	17/8/21		
Assessor's signature:	AOR		
Proposed Review date:			

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes / No		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist / Standaid	Walking Aid	Assistance	Supervision / Independent
Model	Aid Type	People: 1 / 2 / ≥3	Additional Information / Equipment:
Sling type			
Sling Size			

3. Toileting

Hoist / Standaid	Walking Aid	Assistance	Supervision / Independent
See No 2 Sit to Stand Transfers for details	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information:

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision / N/A
See No 2 Sit to Stand Transfers for details	Roll patient Monkey pole Person bridges	People: 1 / 2 / ≥3	Additional Information:

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision / Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets Monkey pole Rope ladder	People: 1 / 2 / ≥3	Additional Information:

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision / Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board Other (Please specify)	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sliding sheets):

7. Sit up over side of bed

Bed Rest	Assistance	Supervision / Independent
	People: 1 / 2 / ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision / Independent
Shower Variable / Fixed height bath Bed bath	Shower chair Shower trolley Bathing hoist (eg Akas)	People: 1 / 2 / ≥3	Additional Information / Equipment (eg sling fitting hoist after risk assess):

9. Walking

No Walking	Walking Aid	Assistance	Supervision / Independent
	see 'sit to stand transfers'	People: 1 / 2 / ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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Created on 17 Aug 2021 17:19 by Jai

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS Action the following safety precautions on admission to your ward. Update weekly or on change of condition.	Ward: 66 Date: 17/8/21 Time: 22.00	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	SC				
2. Check walking aid (if required) is in reach and in use.	none				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	BUZZER Given				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	n.s.a.w				
5. If glasses are worn, check they are available and in use.	none				
6. If hearing aid/s are worn, check they are working and in use.	none				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____	Ward: Date: Time: ____:____
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLA

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 66	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
17/8/21	2000	N	N	N	N	N	N	4 hrly	
18/8/21	0800	N	N	N	N	N	N	4 hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Interve onal Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Affix patient ID label

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? Wed am.

How often in a day/week do you have a bowel movement? Per day 1 Per week

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

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

What products do you normally use for this continence issue?

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

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

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

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

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify_____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		✓

12. Emotional and Spiritual Care

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

Candle

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

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

Healthcare Chaplain informed Yes ☐ N/A ☐

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

managing pain /treatment plan.

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

Informal Support

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

Sister + Daughter

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

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

Yes ☐ No ☑

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

Has the carer been advised of the Carers Information Line?

Yes ☐ No ☑ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?

Yes ☐ No ☑

Are you:

Employed ☐ Unemployed ☑

Self-employed ☐ Retired ☐

Full time education ☐

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

Yes ☐ No ☐ Not applicable ☐

Do you have any money worries?

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

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

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

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

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

If yes when was patient referred ___ /___/___

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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓			
Generic Pain Scale Assessment Chart		✓			
Abbey Pain Scale (if unable to self report pain)		✓			
4AT and TIME for Detection, Management and Prevention of Delirium		✓			
Getting to Know Me – Relatives to complete		✓			
What Matters to Me		✓			
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓			
Malnutrition Universal Screening Tool (MUST)	✓		✓		11/6/20
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		11/6/20
Adult Wound Assessment and Management Chart		✓			
Moving and Handling Assessment		✓	✓		
Falls Risk Assessment	✓		✓		11/6/20
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
11/6/20	Patient admitted to ward 67 with	
01:45.	(R) upper abdo pain.	
	Patient alert and oriented on	
	ward. fully independent with	
	mobility and personal care.	
	News as per documented (1) slightly	
	tachy.	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
01:45	Plan - CXR, AXR, bloods, analgesia,	
	PPI, Urinalysis ☐	
	No other new issues at time	
	of documentation.	
08:00	W/R Mr Jamieson	
	Commence metoclopramide ✓	
	Diabetic nurse review ☐	
11:15.	NEWS = 2 due SpO2 = 95% RA, HR = 100	
	Medications given as charted.	
	Nicotine patch applied.	
	Independent with ADL.	
	Passing urine spontaneously. Bowels functioning.	
	Attended CAXR. Pain free at present.	
11:40	Diabetic referral done.	
	Settled day.	
	Fully mobile.	
	No vomiting.	
	Analgaesia as charted	
12/6/20 NS	Patient transferred to ward 64. NAD	
	on arrival. NEWS = 0 due to tachycardia.	
	for diabetic review.	
	Patient independent + mobile.	
	Passing urine freely. Reports feeling	
	constipated. Prn lactulose given pm.	
	Analgesia given overnight + as charted.	
	Appears to have slept well.	
12/6/20	Settled morning + day. NEWS = 2 due to	

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

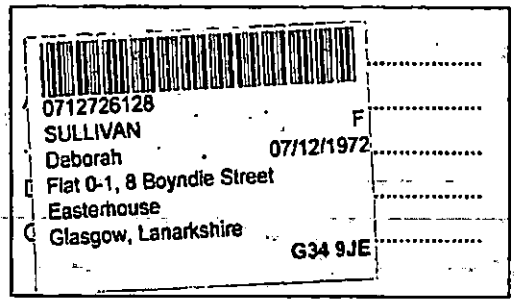
Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	HR= 109 and SPO= 96%. Medication	
	given as per kardex. Diabetic	
	review ☑. Patient for home.	
	Awaiting meds ☑ IDL ☑.	
	No issues or concerns. ——	[illegible] STN

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

This form should be stored at the front of the patient's nursing notes during the period of admission and then filed on discharge.



Hospital:	Ward:

Support and Care Arrangements	No Carer identified ✓ If NO following section N/A	

IDENTIFYING	Yes ✓	No ✓
Have support and care arrangements been confirmed with relative / carer? N.B. record details below including details of any existing support plans		
INVOLVING	Yes ✓	No ✓
Have progress and on-going support needs been discussed with relative / carer?		
Have the carer's views / opinions / requests on discharge plan been noted?		
Has the carer given consent to share their views with the patient?		
SUPPORTING	Yes ✓	No ✓
Has the carer been advised of what support is available to them?		
Has the "Are you looking after someone?" flyer been given to the carer?		
Have you referred to a support service?		
Has the offer of support been declined by the carer?		

Record Name of who discussed with; details of discussion; action agreed.

Date	Record of Communication	Print and Sign Name	Staff Code

Staff Codes: **N** – Nursing. **M** – Medical. **P** – Physiotherapist. **OT** – Occupational Therapist. **SW** – Social Worker. **SLT** – Speech and Language Therapist. **D** – Dietician. **O** – Other.

Carers Information Line: 0141 353 6504
NHSGGC Support & Information Services: 0141 452 2387

Record Name of who discussed with; details of discussion; action agreed.			
Date	Record of Communication	Print and Sign Name	Staff Code

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Unit No.:

NHS
Greater Glasgow and Clyde

Date:		11/6/20	11/6
Time of Result:		0056	1200
WCC	4-11	7.5	7.8
Hb	M - 13-18 F - 11.5-16.5	130	125
Plat	150-400	289	259
Amylase	<100	73	
CRP	<10	3	3
Na+	135-145	140	139
K+	3-5-50	4.5	4.1
Cl-	98-108	104	104
Bic	21-28		
Urea	2.5-7.5	(2.4)	2.5
Creat.	57-113	63	51
EGFR	60>	>60	>60
Glucose	3.5-5.5		
Bilirubin	3-22	6	3
ALT	<50	32	32
AST	<40	25	27
G-GT	<55		
Alk. Phos.	40 -150	73	68
Albumin	32-45	34	34
Mg+			
Ca	2.1-2.6		
Adj Ca	2.1-2.6		
PO4	0.7-1.4		
PT	9-12	11/0.9	
APTT	25-37	29/0.9	
TCT	11-15	11/0.8	
lactate		1.5	

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

NEWS – National Early Warning Score

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	Date	Ward
Admitted		
Transferred		
Transferred		

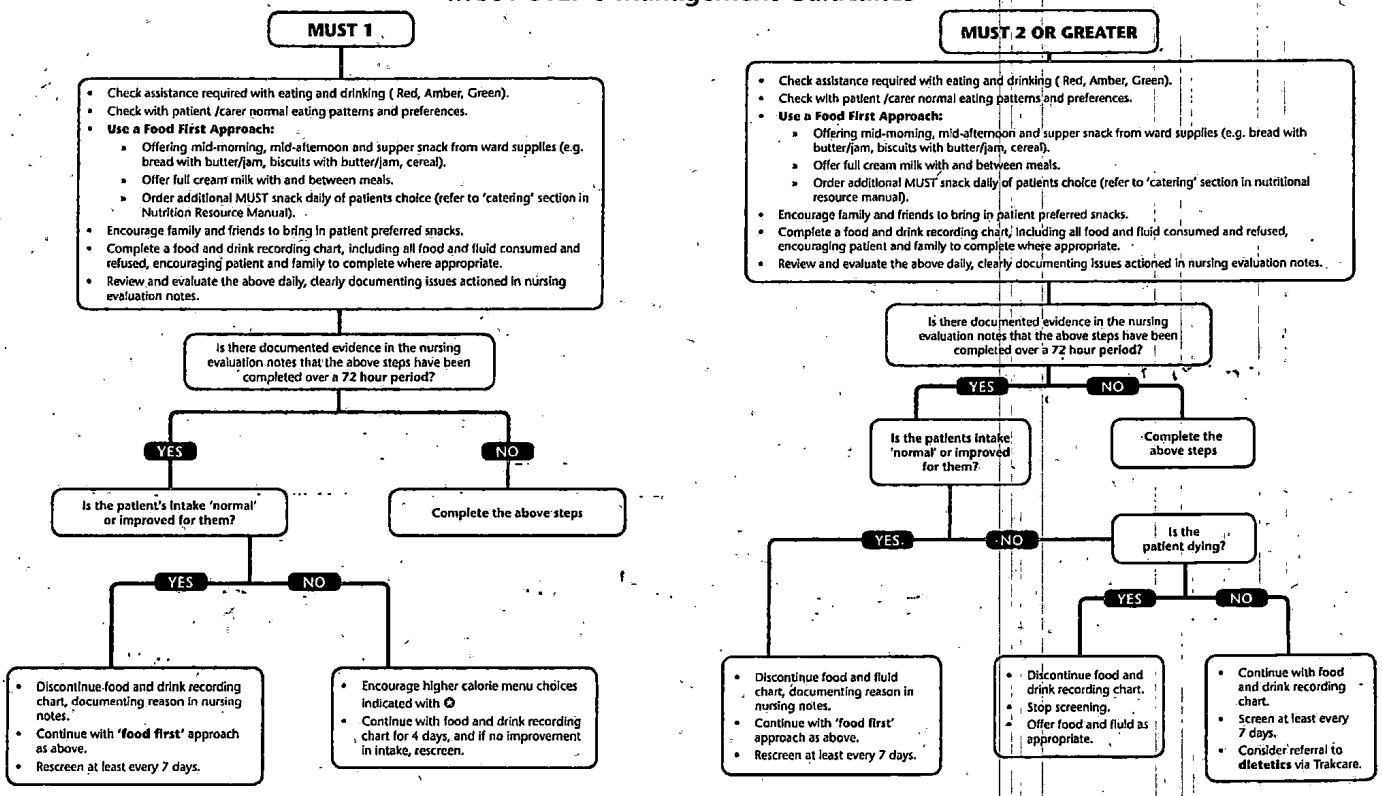
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

See NEWS Actions Reference Tool for local escalation policy

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

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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Care Plan

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Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:				
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:				
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
6/2/21 C.McCabe	NO issues				
				5. Hydration and Nutrition	
			C.McGibe 6/2/21	Normal diet & fluids	
	2, 3. Communication and senses				
C.McCabe 6/2/21	Speakes English NO Communication issues				
				6. Elimination	
	4. Cognitive status		C.McCabe 6/2/21	Independent to toilet	
C.McCabe 6/2/21	NO issues				

p1/2 PTO

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Care Plan

NHS
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Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
6/2/21 C.McCabe	Independent with personal hygiene.		6/2/21 C.McCabe	Nurse buzzer at hand	
				10. Sleep and Rest	
			6/2/21 C.McCabe	Requires Sleeping tablet to Sleep.	
	8. Mobility				
6/2/21 C.McCabe	Independent NO mobility aid.			12. Privacy, dignity and sexuality	
			6/2/21 C.McCabe	Ensured at all times.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

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Easterhouse Address: _____
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Insertion criteria: Please complete this section at time of insertion.

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

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

PVC inserted: Day 0	Date: 06/08/21 Hospital: GRI Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐
Insertion site:	R Hand ☐ R Arm ☑ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other:
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason:

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 7/2/21	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☐	M
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP:	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

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

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

*Date PVC Removed: ___/___/___

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

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Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

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Label

Presenting Complaint -

Date: 06/02/21 Time: 1750

Assessment Complete by: Name NURSE (Pleas Kirsty / Holly

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☑
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☑ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis							
Leucocytes	☐	Nitrites	☐	Protein	☐	Blood	☐
Ketones	☐	Glucose	☐	PH		S.G.	
MSSU / CSU	☐	Toxiclogy	☐				
HCG	☐	+VE	☐	-VE	☐	Strip No -	

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - 6/2/21 Time - 1750 Signature - Kher	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	**F**unctional impairment (new or worsening) eg difficulty with self care		
R	**R**esident in a care home?		
A	**A**ltered mental state such as acute confusion or dementia use the 4AT		
I	**I**mmobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	**L**ikely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer
1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA					
2) Mobility	Does the person require assistance?	Y/(N)			
3) Continence	Incontinent of urine ? seizure	Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?	Y/(N)
4) Nutrition	NDtF	Y/(N)	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS	Y/(N)

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
10/2/21	1745	RL												
6/2/21	1945	RL												

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At risk of falls?
(clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*

YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
6/2/21 1800	Pt nursed in cubicle (15). Has been seen by Orth Dr. ECG has been obtained + r/v'd. IV access gained & Bloods have been obtained. Patient is connected to cardiac monitor due to tachycardia IV morphine 10mg administered, 4mg IV ondansetron & fluids running. Pt is ? pancreatitis/	KIRSTY KEENAN RGN
6/2/21	Pts pain is now 10/10 again -10mg IV morphine given for pain.	

Nursing Notes		
Date and Time		Print Name and Signature

(15) Deborah Sullivan

NEWS 2 Key | 1 | 2 | 3

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

| | | |

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0712726129
SULLIVAN, Deborah F.
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
Affix 07/12/1972

	Date	Ward	Time
Admitted	6/2/25	ED.	1745
Transferred			
Transferred			
Transferred			
Transferred			

Sp02 Scale 1 Target >96%	Sp02 Scale 2 Target 88-92%	Patient on home oxygen Y☐ N☐
Signature:	Signature:	If yes, add details of oxygen therapy
Print Name:	Print Name:	
Dr/ANP initials ONLY:	Dr/ANP initials ONLY:	
Date:	Date:	

Document all actions and interventions

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

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

Discontinuation of NEWS

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

Signed.....

Medical: .....

Date: .....

Glasgow Coma Scale

Date:
Time:
Eyes closed by swelling = NT
Endotracheal tube or tracheostomy = NT
Always record the best response
TOTAL
Right size:
Right reaction:
Left size:
Left reaction:
Record right (R) and left (L) separately if there is a difference between the two sides
Record right (R) and left (L) separately if there is a difference between the two sides

Pupil Reaction and size
s = sluggish
+ = reaction
- = no reaction
c = eyes closed
Pupil Size (mm)

Affix Patient ID

Pain Score

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

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

Pain Function Score

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

MI • 316654 v5.1 • CGC0264

My Admission Record

NHS Greater Glasgow and Clyde

Na
Ad 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Do Easterhouse
Cl Glasgow, Lanarkshire
Affi G34 9JE

Hospital: GRI Ward: C07
Date of Admission: 11/6/20 Time: 00:45
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 47 Telephone Number:
Consultant: Mr Jamieson.

5ft 9. 98.3kg.

illness treated.

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Donna Sullivan.	Name:
Relationship: Sister	Relationship:
Address: 1 Corsehill Park Easterhouse	Address:
Telephone: 07743956178	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Abdo pain (R)

Explained to the patient? Yes ☑ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☑ No ☐

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

No known allergies ☐ ** Penicillin **

Relevant past medical history

Appendicectomy, bilateral chalazia, tonsillectomy, HTN, T2DM, PTSD - Night terrors, Nissan fundiplication.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Nan
Add
0712726128
SULLIVAN F
Deborah 07/12/1972
DoI
CHI
Affi

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☑
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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

Lifestyle

Smoking

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

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐ vape.

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): LESLEY BLANKIN. Signature: [signature]

Designation: Student Nurse. Date: 11/6/20

My Assessment Record

N
A 0712726128
SULLIVAN F
Deborah 07/12/1972
D
C

Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____		✓	

Name:
0712726128
SULLIVAN F
Deborah 07/12/1972

3. Senses

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

Can you describe where and what the pain is like?

middle
Stabbing pain through to back / shoulder.

Have you had treatment / intervention for the pain?

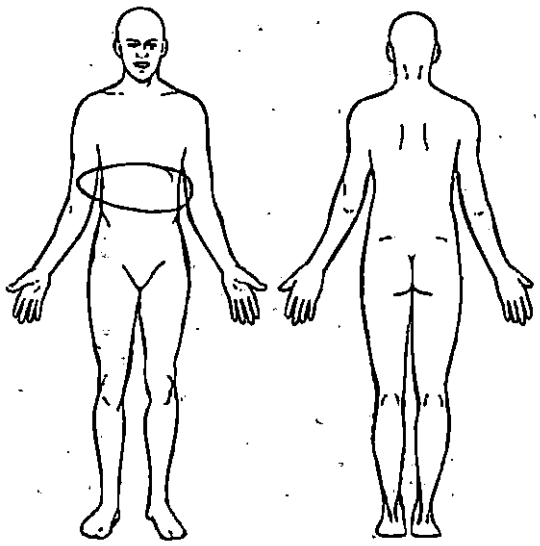
Oramorph.

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



0712726128
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Easterhouse
Glasgow, Lanarkshire
G34 9JE

4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NO

What do you like to eat and drink?

anything

What do you not like to eat and drink?

—

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

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Date & Time		Signature, Print Name & Designation
	round; aiming (H) today -	
	fall yesterday noted.	
	CTAP - nil acute.	
	die at clinic appointment	
	with Mr Forshaw today @	
	1:30pm for d/c prior.	
	d/c letter to be posted out	CR SN
	in due course.	Cleaman

83949 GGC0072

Care Rounds Checklist

Date: _____

Attach Addr

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

Ward: 46

NHS Greater Glasgow and Clyde

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

1. Signed NBukhawb Name Nur Bukhawb Designation SN
2. Signed CP Name CPENMAN Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	8	8	8	10	12
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	1	1	1	1	1
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	✓	✓	✓	✓	✓
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	B	BR	B	BR
		Chair Assist to walk or stand (W/ST)	—	-	✓	W/ST	✓
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	1	1	1	1	1
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N
		Drink taken?	MG	S	Y	N	Y
		Food, snack, or supplement taken?	S	S	N	N	Y
		Has oral hygiene been carried out as per care plan?	1	1	1	1	1
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N/A	N/A	N/A	N/A	N/A
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N	N	N	N
		Care provider / role	NB	NB	CP	CP	CP

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 07.02.21

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

1. Signed [signature] Name CHILL Designation SN
2. Signed [signature] Name [illegible] Designation SN
3. Signed _____ Name _____ Designation _____

Attach Add

07,12726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Ward: 66

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00	05	08 30	14 30	20 30
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	Y	Y	N	N	Y
S	3	SKIN INSPECTION Pressure areas checked:	I	I	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	–	–	–	–
K	4	KEEP MOVING Has the patient moved or walked?	I	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	–	–	–	–	R
		Chair Assist to walk or stand (W/ST)	–	–	–	–	–
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	N	N	N	N	N
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	N	N	N
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	N	NA
		Care provider / role	CM SN	CM SN	SN	SN	RB

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 6/2/21

Attach Ad

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

Ward: 66

NHS Greater Glasgow and Clyde

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

1. Signed C.McCabe Name Chelsea McCabe Designation Student Nurse
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	20/45																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y																		
S	3	**SKIN INSPECTION** Pressure areas checked:	I																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	Int																		
K	4	**KEEP MOVING** Has the patient moved or walked?	I																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I																		
		Chair Assist to walk or stand (W/ST)	I																		
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N																		
		Drink taken?	N																		
		Food, snack, or supplement taken?	N																		
		Has oral hygiene been carried out as per care plan?	N/A																		
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N/A																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A																		
		Care provider / role	CMcC/ STN																		

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Fluid Balance Chart

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

Hospital: Gre
Ward: 66
Date: 7-2-21

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00										A/L							
01:00																	
02:00	water	200							200								
03:00										150						150 ++	
04:00																	
05:00	water	200							400								
06:00																	
07:00	milk	150							550	200						350 ++	
08:00																	
09:00					IVF	500			1050	220						570 ++	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00	sips																
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00										200						770 ++	NB
23:00																	
								*Total Intake	[redacted]						*Total Output	[redacted]	

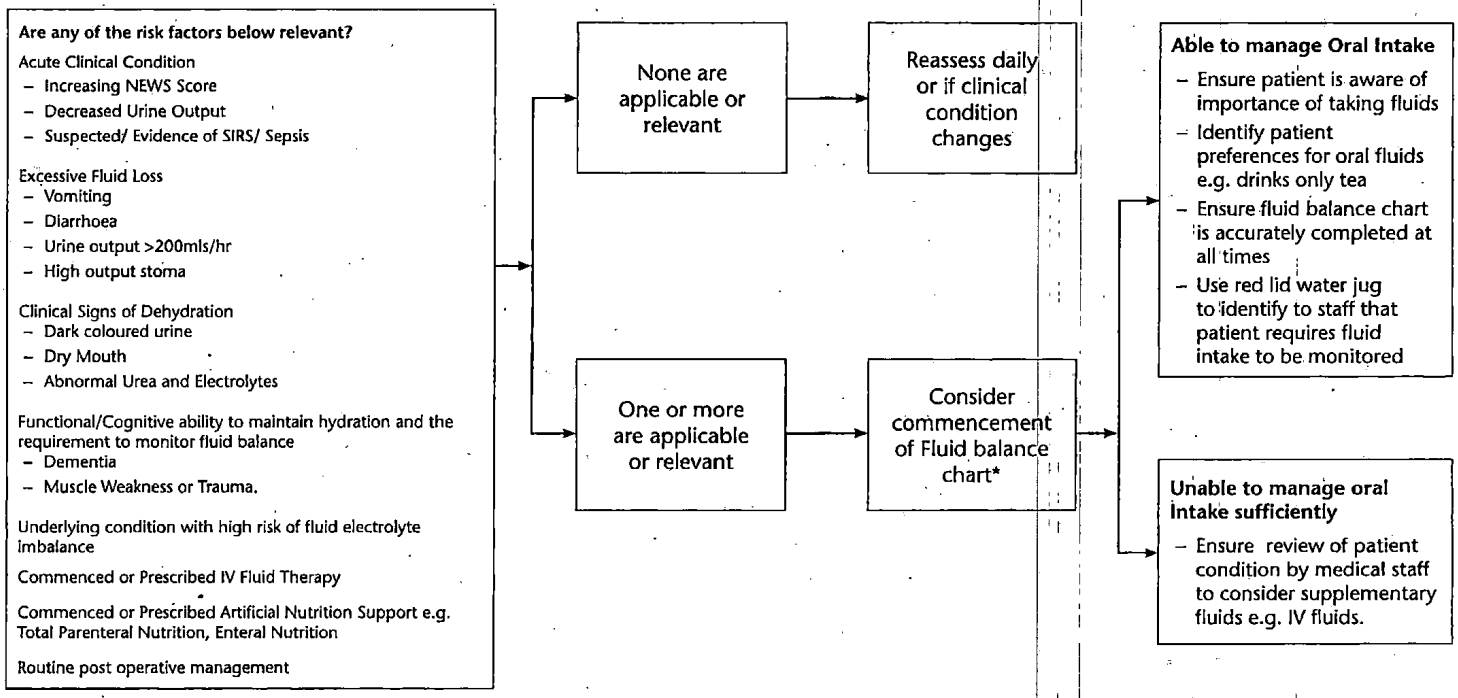
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN Deborah F 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 66	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

3

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
06/2/21	2045	N	N	N	N	N	N	4 hrly	C. McCabe
07/02/21	02:10	N	N	N	N	N	N	4 hrly	
7/2/21	01:40	N	N	N	N	N	N	4 hrly	NB
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

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

Prevention of Pressure Ulcer Intervational Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

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Glasgow, Lanarkshire
G34 9JE

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 66 Date: 6/2/21 Time: 20:45	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Y				
2. Check walking aid (if required) is in reach and in use.	N/A				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Y				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Y				
5. If glasses are worn, check they are available and in use.	N/A				
6. If hearing aid/s are worn, check they are working and in use.	N/A				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf).

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?	✓									
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?	✓									
5. Based on your clinical judgement, is this patient at high risk of falling?	✓									
Signature of nurse completing assessment / update	E-McCabe 13/2/21									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: 66 Date: 6/2/21 Time: 21:30	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)	✓				
Assess if a low bed is required (Patient care plan 9)	✓				
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)	N/A				
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)	✓				
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.	N/A				
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)	N/A				
Document continence problems and link to care rounding (Patient care plan 6)	N/A				
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)	N/A				
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.	N/A				
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)	✓				
Update the ward team of the patient's mobility status. (Patient care plan 8)	✓				
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)	✓				
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)	✓				
Signature of nurse completing interventional plan / or update	13/2/21 C. McCabe				

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PI

0712726128
SULLIVAN
Deborah [illegible] F
07/12/1972

Pers[illegible]t) Moving and Handling Assessment Form

Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow: Lanarkshire
G34 9JE

Person's Name:	[illegible]amed urse: Chelsea McCabe	Person is totally independent (tick here and go to date box)	

1. Gener[illegible]

Body Build		
Weight	Height	
Kg	cm	
BMI		

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes [ ] No [ ]

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	
	Monkey pole [ ]			
	Independent bridging [ ]			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	
	Monkey pole [ ]			
	Rope ladder [ ]			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) [ ]			

7. Sit up over side of bed

	Bed Rest	Assistance	Supervision	Independent
		People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley [ ]			
Bed bath	Bathing hoist (eg Alerit) [ ]			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	6/2/21		
Assessor's signature:	C. McCabe		
Proposed Review date:	13/2/21		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes / No		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alerti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 6/2/21 Time 21.30 of initial height and weight on admission to hospital 175.26	Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height 5.9 cm	☐	☑	
Admission Weight 15.6 Kg 99.06	☐	☑	

*Obtain accurate height/weight and rescreen as soon as possible

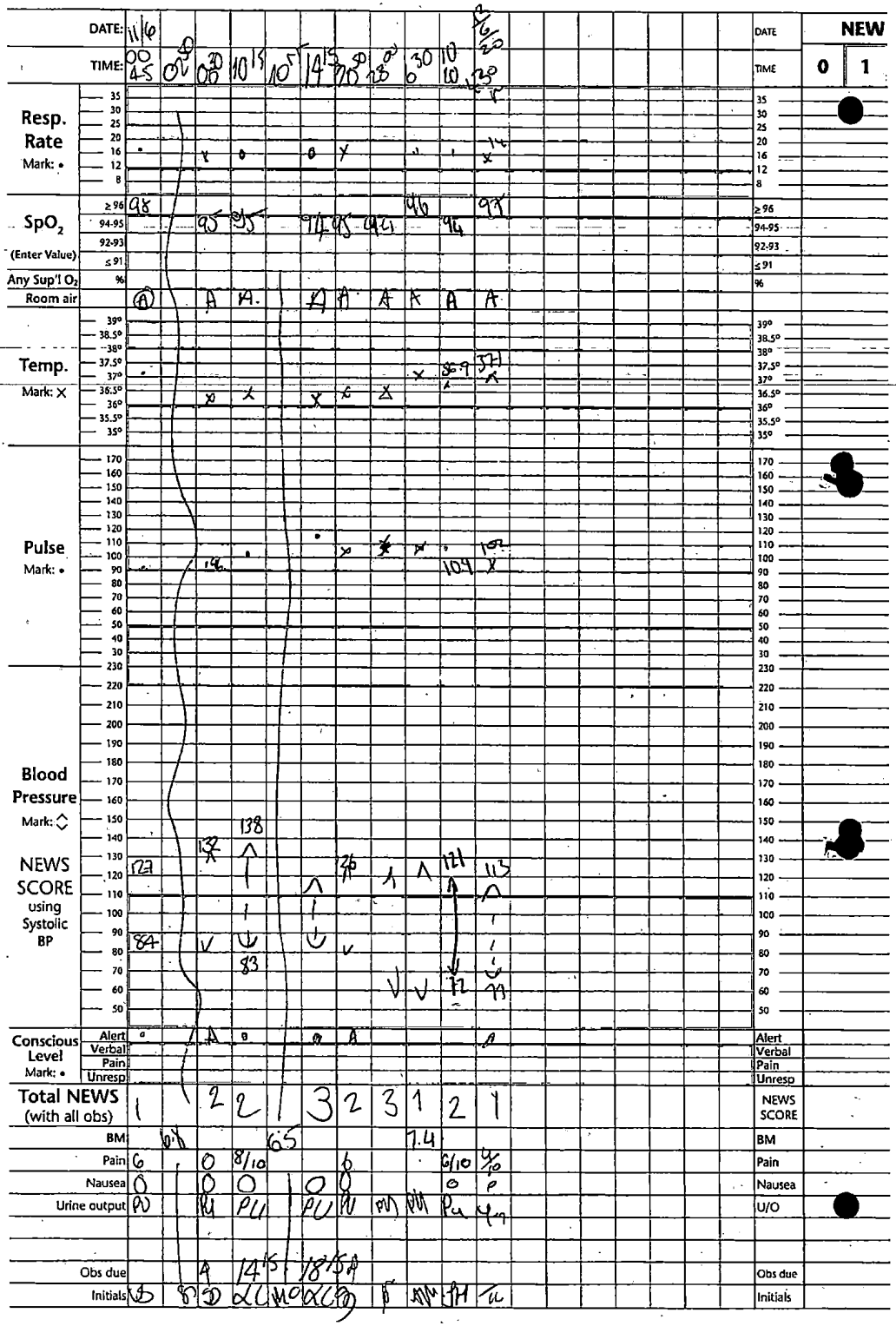
Patients reported normal weight _____ Unable to Recall ☐

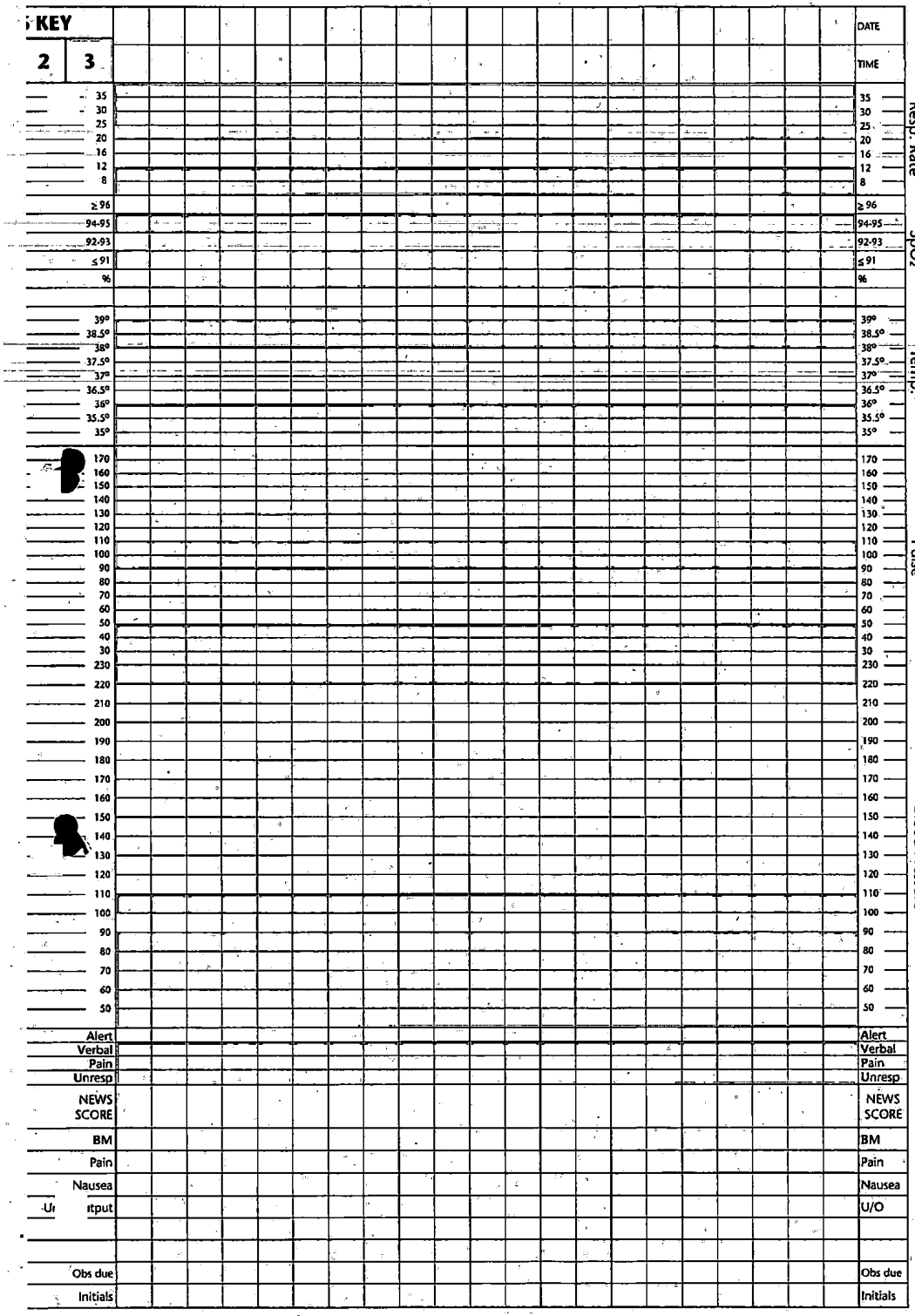
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☑ Don't Know ☐

Date	6/2/21							
Time	21.40							
Ward	66							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes								
Weight (kgs)	99.06							
BMI	32.2							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	13/2/21							
Signature	C. McCab							

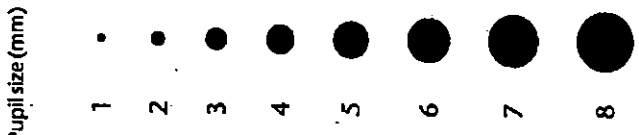
Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf


DATE
TIME
NEW
0
1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ^
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
35
30
25
20
16
12
8
≥ 96
94-95
92-93
≤ 91
%
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale



Neurological Observations

| | | |

NO ACCESS.

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

Name: _____
DOB: _____
Ward: _____

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Easterhouse
Glasgow, Lanarkshire
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07/12/1972
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NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this sect

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

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

PVC inserted: Day 0	Date: ___/___/___ Hospital: _____ Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

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

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

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

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

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

NO

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRH Ward: G7	Points to consider: • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
11/6/20	01:00	2	2	2	2	2	2	4 hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Interve...onal Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 67 Date: 11/6/20 Time: 21:00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	indept				
2. Check walking aid (if required) is in reach and in use.	NA				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	in reach				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓				
5. If glasses are worn, check they are available and in use.	in use				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

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

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Person Specific (Inpatient) Moving and Handling Assessment Form

Person's Name:		Named Nurse:		Person is totally independent (tick here and go to date box)	✓

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1. General Information

Body Build		Problems with comprehensi	Handling constraints, e.g. dis
Weight	Height		
98.3 Kg	175 cm		
31 BMI			
Risk of Falls: Yes	No		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateni)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	11/6/20		
Assessor's signature:			
Proposed Review date:	18/6/20		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alerti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 11/6/20 Time 01:00 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	175 cm	☑	☐	
Admission Weight	98-3 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date	11/6/20							
Time	01:00							
Ward	67							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	98-3							
BMI	31							

Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	18/6/20							
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with **'food first'** approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ✪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patients intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to **dietetics** via Trakcare.

NO

Complete the above steps

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "**Eating to Feel Better**" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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Care Plan

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Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:	
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:	

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
				5. Hydration and Nutrition	
	2, 3. Communication and senses				
				6. Elimination	
	4. Cognitive status				

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
				10. Sleep and Rest	
	8. Mobility				
				12. Privacy, dignity and sexuality	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Care Rounds Checklist

Date: 13/6/20

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

1. Signed AMcGee Name AMGee Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addr
G1
64
Ward:

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NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	10	60	80															
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N															
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	S	N	N															
S	3	SKIN INSPECTION Pressure areas checked:	S	N	-															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	-	-															
K	4	KEEP MOVING Has the patient moved or walked?	S	Y	-															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	B	B															
		Chair Assist to walk or stand (W/ST)	S	W	-															
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	I															
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	S	N	N															
		Drink taken?	S	Y	Y															
		Food, snack, or supplement taken?	S	N	Y															
		Has oral hygiene been carried out as per care plan?	S	-	-															
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	Y	Y															
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	S	N	N															
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	S	N	N/A															
		Care provider / role	AMcG	AMcG	HCA															

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 1/1/2020

Attach Addressograph Label

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Easterhouse
Glasgow, Lanarkshire G34 9JE

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name Ashley Brown Designation SJN
2. Signed _____ Name _____ Designation SN
3. Signed _____ Name _____ Designation SW

'Must ... there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	08⁰⁰	08⁰⁰	10⁰⁰	12⁰⁰	16⁰⁰	20⁰⁰
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	W	N	N			N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	N	Y			Y
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	I	I			I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	✓	I			✓
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	I				I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	✓				✓
		Chair Assist to walk or stand (W/ST)	CH	✓	W/ST			✓
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I			I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N			N
		Drink taken?	N	Y	Y			Y
		Food, snack, or supplement taken?	N	N	Y			Y
		Has oral hygiene been carried out as per care plan?	I	I	I			I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y			Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	Y			N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N	N			N
		Care provider / role	SN	SN	SW			SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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My Admission Record

NHS Greater Glasgow and Clyde

Name: [redacted]
Address: 0712726128 F
SULLIVAN
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
DoB:
CHI:
Affix patient ID label

Hospital: GRI Ward: 65
Date of Admission: 1.4.20 Time: 1am
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: Debbie
Age: 47 Telephone Number:
Consultant: mr stevenson

RSOU +pro -Not sent

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Donna Sullivan	Name:
Relationship: Sister	Relationship:
Address:	Address:
Telephone: 07743956178	Telephone:
Is this person aware of your admission?	Is this person aware of your admission?
Yes ☐ No ☐	Yes ☐ No ☐
Can we share information with this person?	Can we share information with this person?
Yes ☑ No ☐	Yes ☐ No ☐

Presenting Complaint / Diagnosis

Central abdo pain

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Penicillin -rash

Relevant past medical history

Chronic pancreatitis
Gastritis
Hiatus hernia
Cholecystectomy
Laparoscopic fundoplication
Anxiety + depression
HTN
T2DM
GORD

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name
Addr 0712726128
SULLIVAN
Deborah
F
07/12/1972
DoB:
CHI:
Affix patient

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☐

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☑	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☐	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☐	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

Name: [redacted]
Addres: 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
Affix pa [redacted]

Lifestyle

Smoking

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

Never smoked ☑

Do you use eCigarettes? Yes ☑ No ☐ "Vape"

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): SMcCulloch Signature: [signature]

Designation: SN Date: 1-9-20

My Assessment Record

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1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems			
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension	✓	✓	
Do you have any other symptoms?			

2. Communication

	Yes ✓	**No** ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

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Affix p... ID label

3. Senses

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

Can you describe where and what the pain is like?

Sudden abdo pain

Have you had treatment / intervention for the pain?

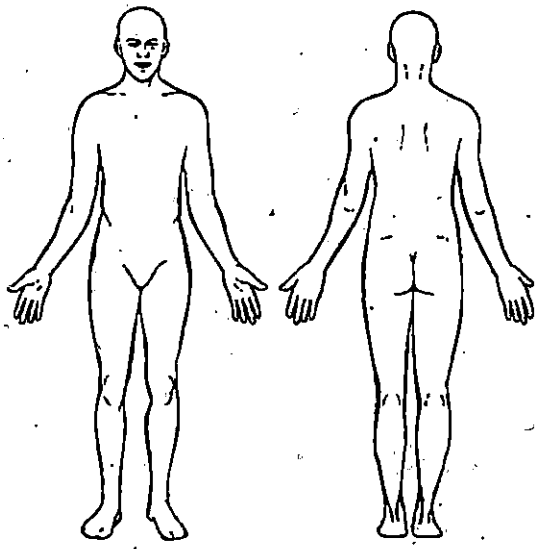
Analgesia

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



Name: _____
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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Nil

What do you like to eat and drink?

Nomal DIF

What do you not like to eat and drink?

Not jussy

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Address: Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE
DoB:
CHI:
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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? Today

How often in a day/week do you have a bowel movement? Per day 1 Per week

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

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

What products do you normally use for this continence issue?

Lasaldo

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

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

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify _____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

Nil

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

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

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

"Finding out whats wrong"

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

Informal Support

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

Family

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

Name: See NOK

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☑

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

Name: _ 0712726128
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Deborah 07/12/1972
DoB: __
CHI: __
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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☑
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☑ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

Name: _____
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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓			
Generic Pain Scale Assessment Chart		✓			
Abbey Pain Scale (if unable to self report pain)		✓			
4AT and TIME for Detection, Management and Prevention of Delirium		✓			
Getting to Know Me – Relatives to complete		✓			
What Matters to Me		✓			
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓			
Malnutrition Universal Screening Tool (MUST)	✓				1.4.20 sm
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				1.4.20sm
Adult Wound Assessment and Management Chart		✓			
Moving and Handling Assessment		✓			
Falls Risk Assessment	✓				1.4.20 sm
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
1.4.20 -	Patient admitted to ward	
1am	65 with central abdo pain	
	NEWS = 1 on admission	
	due to HR 98bpm, RSOB	
	+ pro, not sent. BM 5.5.	
	Fasting awaiting senior	SmCCu Jackson
	review	

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
1/4/20 0315	S/O ST7 Vela	
	- Await cannulas ✓	
	- For AXR ✓	
	- F+D -	
	- check serum HCG	
	- ? adhesional pain, ? non-specific abdominal pain	K Connelly R Connelly
1/4/20 am	REVIEWED BY MR DICKSON	
	PR CT JAN	
	BLOOD RESULTS	
	? HOME TODAY	
11⁰⁰	Independent with hygiene	
	taking PO, up to toilet	
	4hrly Obs - News (3)	
	Pr tachy/hypotensive -	
	asymptomatic with same	
	Await time for CT ✓	
17.10	RETURNED PR CT JAN - LAST	
	REVIEW REVIEW	
eve	REVIEWED BY MR STEVENS	
	PLAN HOME	
	O/P F/U	
	MEDICATION	
18.10	PATIENT SEEN PR HOME - IDL TO BE	
	SENT OUT - F/U AS AN OUTPATIENT	

Name: _
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

0712726128
SULLIVAN F
Deborah 07/12/1972

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:	
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:	

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
1-4-20 sm	known HTN - Tzom				
	As per NEWS chart				
			1-4-20 sm	5. Hydration and Nutrition	
				Normal DTE.	
1-4-20 sm	2, 3. Communication and senses				
	Communicates clearly.				
	Wears glasses for reading				
			1-4-20 sm	6. Elimination	
1-4-20 sm	4. Cognitive status			PIV freely	
	Alert + orientated			Takes laxatives for bowels	

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Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
1-4-20 sm	Independently mobile States skin intact		1-4-20 sm	Call buzzer to hand	
			1-4-20 sm	10. Sleep and Rest	
				Encourage sleep/rest	
1-4-20 sm	8. Mobility				
	Independently mobile		1-4-20 sm	12. Privacy, dignity and sexuality	
				Promote privacy/dignity	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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0712726128
SULLIVAN
Deborah F
Flat 0-1, 8 Boyndie Street 07/12/1972
Easterhouse
Name Glasgow, Lanarkshire Unit No.:
G34 9JE

NHS
Greater Glasgow and Clyde

Date:		31/05	1/6	1/6/20									
Time of Result:													
WCC	4-11	12.7	13.5	13.5									
Hb	M - 13-18 F - 11.5-16.5	146	135	135									
Plat	150-400	346	311	311									
Amylase	<100	84	33	111									
CRP	<10	4	1	6									
Na+	135-145	140	141	137									
K+	3-5-50	4.6	3.9	4.1									
Cl-	98-108	101	104	100									
Bic	21-28	24											
Urea	2.5-7.5	3-8	4.5	4.8									
Creat.	57-113	46	53	50									
EGFR	60>	>60	NA	160									
Glucose	3.5-5.5												
Bilirubin	3-22	5	13	5									
ALT	<50	29	24	24									
AST	<40	26	23	16									
G-GT	<55												
Alk. Phos.	40 -150	87	72	79									
Albumin	32-45	41	40	37									
Mg^+													
Ca	2.1-2.6												
Adj Ca	2.1-2.6												
PO4	0.7-1.4												
PT	9-12	11/0.9											
APTT	25-37	33/1.0											
TCT	11-15	11/0.9											

Microb

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Easterhouse
Name: Glasgow, Lanarkshire CHI:
G34 9JE

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
0712726128
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Flat 0-1, 8 Boyndie Street
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DoB

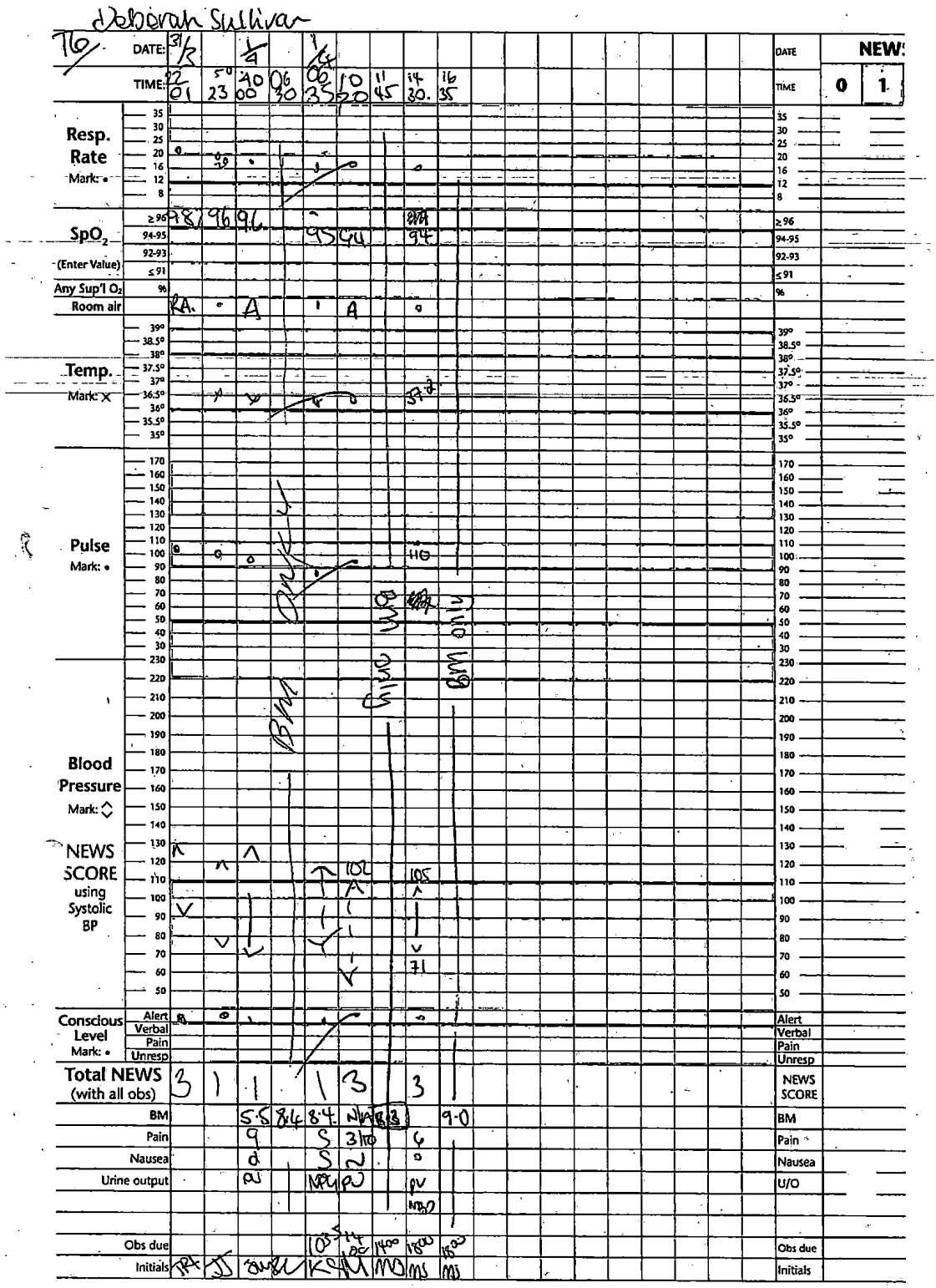
	Date	Ward
Admitted -		
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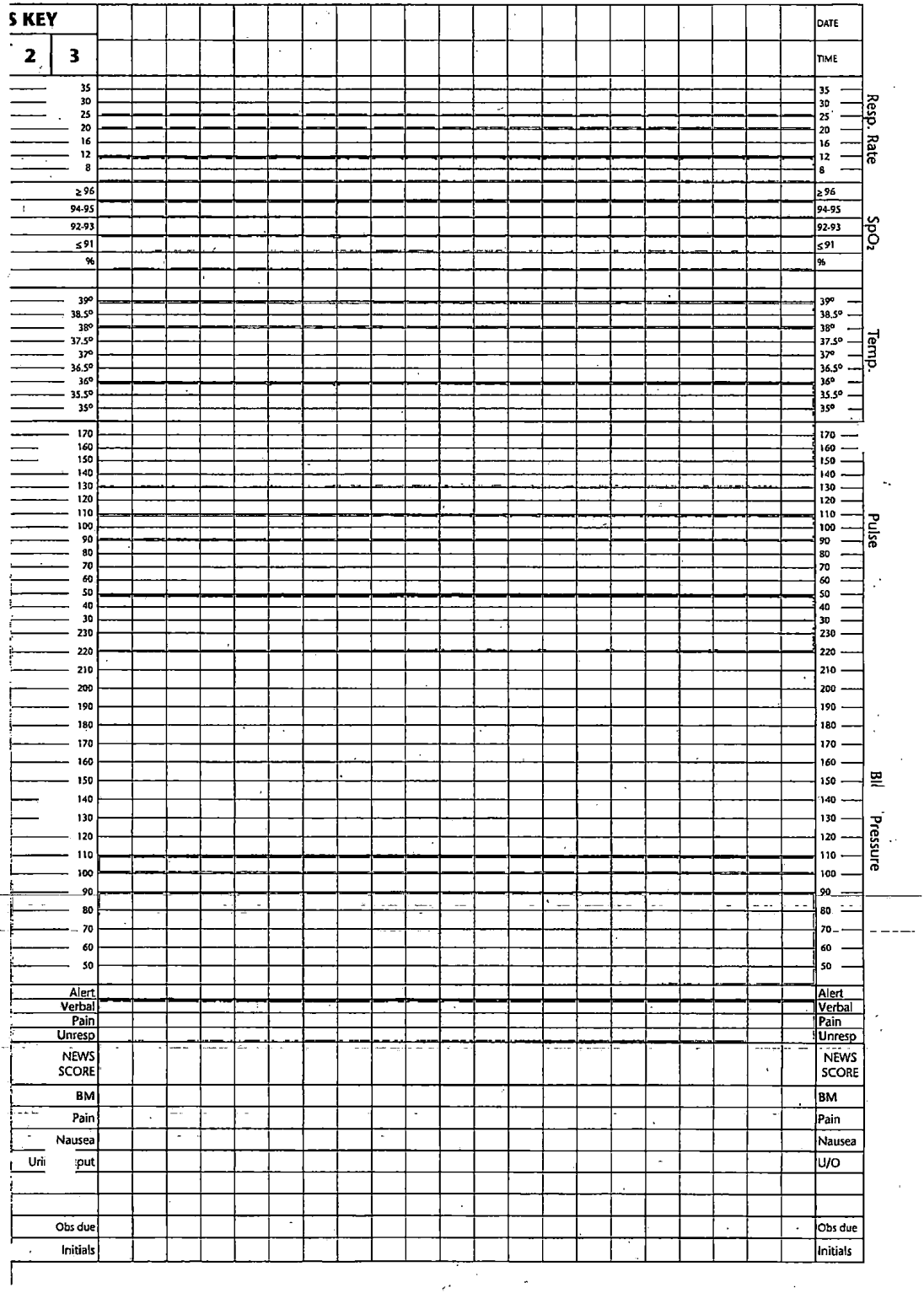
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

See NEWS Actions Reference Tool for local escalation policy

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


Deborah Sullivan
TO
DATE:
TIME:
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS
0
1


S KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Bl Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



AFFIX PATIENT ID

Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

0712726128
SULLIVAN
Deborah
F
07/12/1972

CHI: _____
Address: _____
Hospital: GRI

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

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

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

PVC inserted: Day 0	Date: 01/04/10 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☑ 65 Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
Colour of cannula:	Blue ☑ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☑ If No, state reason: PATIENT ASLEEP

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

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

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

*Date PVC Removed: 01/04/10

*Reason For Removal: ASKED

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

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

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

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

Diagnostics ☑ **Resuscitation/Chest Pain** ☐ **IV Drugs** ☐ **Fluids** ☐ **Transfusion** ☐

PVC inserted: Day 0	Date: 1/4/20 Hospital: _____ Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☑ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: Inserted in ATS

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

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

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

***Date PVC Removed:** 1/4/20

***Reason For Removal:** Dislodged.

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

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

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

YES

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

NO

Care Rounds Checklist

Date: 1420

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

1. Signed _____ Name SMcCulloch Designation SN
2. Signed _____ Name Williams Designation SIN
3. Signed _____ Name _____ Designation _____

Attach Addr

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

Ward: 65

NHS Greater Glasgow and Clyde

'Must dos' for the: Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	86	08 30	12 50																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N																	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	N	N																	
S	3	**SKIN INSPECTION** Pressure areas checked:	1	1	1																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	1	-	-																	
K	4	**KEEP MOVING** Has the patient moved or walked?	1	1	1																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	1	-	-																	
		Chair Assist to walk or stand (W/ST)		-	-																	
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	1	1	1																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y	4	4																	
		Drink taken?	2	N	N																	
		Food, snack, or supplement taken?	2	4	4																	
		Has oral hygiene been carried out as per care plan?	1	1	1																	
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	4	4																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	NA	NA																	
		Care provider / role	SN SIN	SN	SN																	

Care Rounds Variance Sheet

Attach Add

0712726128
SULLIVAN
Deborah
Flat 0-1, 6 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972

Ward:

NHS
Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah [illegible] 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 65	**Points to consider:** • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
1/4/20	1 00	N	N	N	N	N	N	4 hrly	[signature]
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	
/ /	:							__hrly	

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

Prevention of Pressure Ulcer Interve...ional Plan

NHS Greater Glasgow and Clyde

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

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

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

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

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

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

CURRENT PRECAUTIONS
TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 65 Date: 14-20 Time: 01:00	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Independent				
2. Check walking aid (if required) is in reach and in use.	Independent				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	To reach				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Yes				
5. If glasses are worn, check they are available and in use. ,	Yes				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	[signature] 14:20									

Highlight risk of fall at the ward safety brief.

McGavin
Baillieston Health Centre
20 Muirside Road
Glasgow
G69 7AD

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----	Ward: Date: Time: ----:----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

0712726128
SULLIVAN
Deborah
07/12/1972

Pers[illegible]nt) Moving and Handling Assessment Form

Person's Name:		Named Nurse:		Person is totally independent (tick here and go to date box)	✓

1. General Information

Body Build		
Weight	Height	
Kg	cm	Problems with comprehension, behaviour, co-operation (specify):
BMI		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alent)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	1.4.20		
Assessor's signature:	[signature]		
Proposed Review date:	Ongoing		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alent)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 14-20 Time 1am of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	175 cm	☑	☐	
Admission Weight	99 Kg	☐	☐	

*Obtain accurate height/weight and rescreen as soon as possible

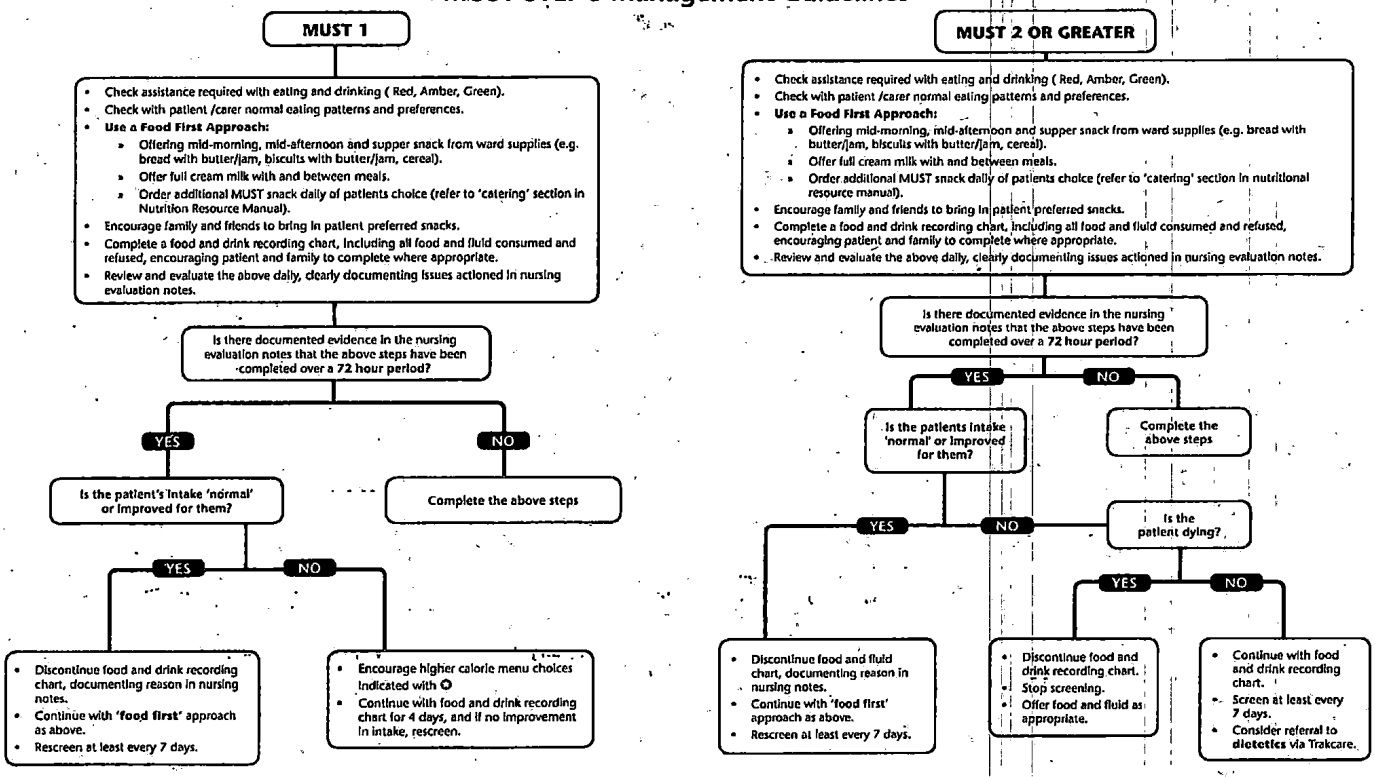
Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☐ Don't Know ☐

Date	1-4-20							
Time	1am							
Ward	65							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	99							
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	7-4-20							
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)	
Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	**LOW RISK** - Repeat screening every 7 days
1	**MEDIUM RISK** - Follow the flowchart for MUST 1 overleaf
2 or greater	**HIGH RISK** - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

mi • 285884 v3.0 • GGC0250

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 31/03/30 Time: 0240

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Flat 0-1, 8 Boyndie Street
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G34 9JE

label

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Noah

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☑
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools
(Please tick/circle when completed)

SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

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

Patient Addressograph Label

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☑	☐	
	Cannula	☐	☐	
	Notes: medical notes, GP letter, PRF	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes		
Date and Time		Print Name and Signature
31/3/20	Pt c/o abdo pain has hx pancreatitis gallbladder removed 20 years ago. Pt into room gown awaiting assesment. Bloods ☑	

Nursing Notes		
Date and Time		Print Name and Signature

My Admission Record

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
Affix patient ID label

Hospital: GRI Ward: 65
Date of Admission: 24/02/20 Time: 0220
Information obtained from: Name:
Patient ☐ Relative ☐ Other ☐ _____
Preferred Name: Debbie.
Age: 47. Telephone Number: 07713718392.
Consultant: G. Mackay.

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☐
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☐
Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: Donna Sullivan	Name:
Relationship: Sister	Relationship:
Address: 1 Corsehill Path. Glasgow. G34	Address:
Telephone: 07743 956178	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Epigastric pain ?pancreatitis

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Penicillin

Relevant past medical history

Gastritis
Lap chole (26yrs ago)
PTSD
depression
Sexual assault in childhood
hx Fibromyalgia
Prev. drug O/D.
T2dm.

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Name:
0712726128
SULLIVAN
Deborah
F
07/12/1972

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES Inform the IPCT** ☐

Name:
A 0712726128 F
SULLIVAN 07/12/1972
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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 1 year ago

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐ Vape.

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): SSLOAN Signature: _____

Designation: SN Date: 24/02/20.

My Assessment Record

Name: _____

Address:



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D Deborah 07/12/1972
Cl Flat 0-1, 8 Boyndie Street
Easterhouse
Af Glasgow, Lanarkshire G34 9JE

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

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3. Senses

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

Can you describe where and what the pain is like?

Gripping pain

Have you had treatment / intervention for the pain?

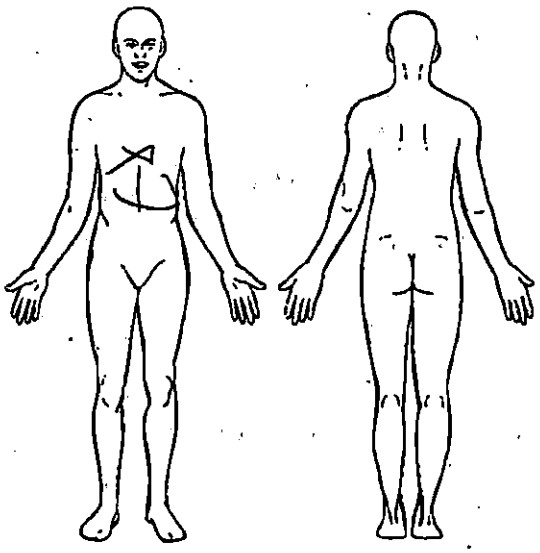
Otamorph
Co-codomol.

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

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



Name: _____

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4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

Nil

What do you like to eat and drink?

not fussy

What do you not like to eat and drink?

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Easterhouse
DoB Glasgow, Lanarkshire
CHI G34 9JE
Affix patient ID label

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move? today.

How often in a day/week do you have a bowel movement? Per day 1 Per week 7.

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

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

What products do you normally use for this continence issue?

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

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

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Affix patient ID label

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

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

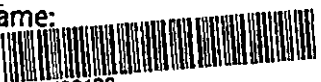
Pressure ulcer identified on admission: Yes ☐ No ☐

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

Name:
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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐

Other please specify _____ ☐

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)?		✓
Do they need support from someone else whilst you are in hospital?		✓
Would someone else be able to provide this support when you are in hospital? If yes, who?		✓

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☑ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		✓

12. Emotional and Spiritual Care

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

n/a.

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

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

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

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

Informal Support

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

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

Name: .....

Contact Details: .....

.....

.....

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

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

Yes ☐ No ☐

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

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑

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

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☑ Not appropriate at this time ☐

Carers Information Line: 0141 353 6504

Carers Information Leaflet provided?
Yes ☐ No ☑

Are you:

Employed	☐	Unemployed	☑
Self-employed	☐	Retired	☐
Full time education	☐		

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑

If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☑ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☑ Not applicable ☐ Not appropriate to ask at this time ☐
If yes when was patient referred ___/___/___

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F
07/12/1972

Risk Assessments/Other Documentation

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

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
24/02/2020 0300	Pt. admitted to wd. 65 with epigastric pain ? Pancreatitis Observations Stable, News ② due to HR-100 + BP-105/61. Pt. currently fasting awaiting Surgical R/V. Settled at present. no issues	SSLOAN (SN)

Nar
Adc 0712726128
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Easterhouse
Dol Glasgow, Lanarkshire
CHI G34 9JE
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
24/2/20	R/V by Dreyer	
3:55.	Imp: ? gastritis.	
	No acute surgical issue	
	Plan: 1) R/V in am	
	2) (R) tomorrow.	
	Settled night. No complaints.	Capt / SD M. CUSACK ANCSW
24/2/20	AM WR GMackay – eat and drink	
	?home later.	PHNGU Shuttle
1100	Independent with personal hygiene.	
	Mobile independently around room.	
	Voiding urine, no reports of bowels. Tolerating diet and	
	fluids. Medication taken as	
	per kardex.	PHNGU Shuttle

Na
Ad 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
Dol G34 9J
CHI
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

NHS
Greater Glasgow and Clyde

Name: Deborah Sullivan Unit No.: 0712726128

Date:		24/2	24/2										
Time of Result:		01:00	1212										
WCC	4-11	10.3	10.0										
Hb	M - 13-18 F - 11.5-16.5	122	121										
Plat	150-400	266	278										
Amylase	<100	76	70										
CRP	<10	2	2										
Na+	135-145	141	142										
K+	3-5-50	3.9	3.8										
Cl-	98-108	100	107										
Bic	21-28	25											
Urea	2.5-7.5	4.6	5.8										
Creat.	57-113	52	49										
EGFR	60>	>60	>60										
Glucose	3.5-5.5	8.0											
Bilirubin	3-22	4	4										
ALT	<50	27	26										
AST	<40	18	16										
G-GT	<55												
Alk. Phos.	40 -150	73	70										
Albumin	32-45	36	35										
Mg^+													
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												
HCG		<3											

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

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Glasgow, Lanarkshire G34 9JE

CHI No.
DoB

	Date	Ward
Admitted		
Transferred		
Transferred		

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

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

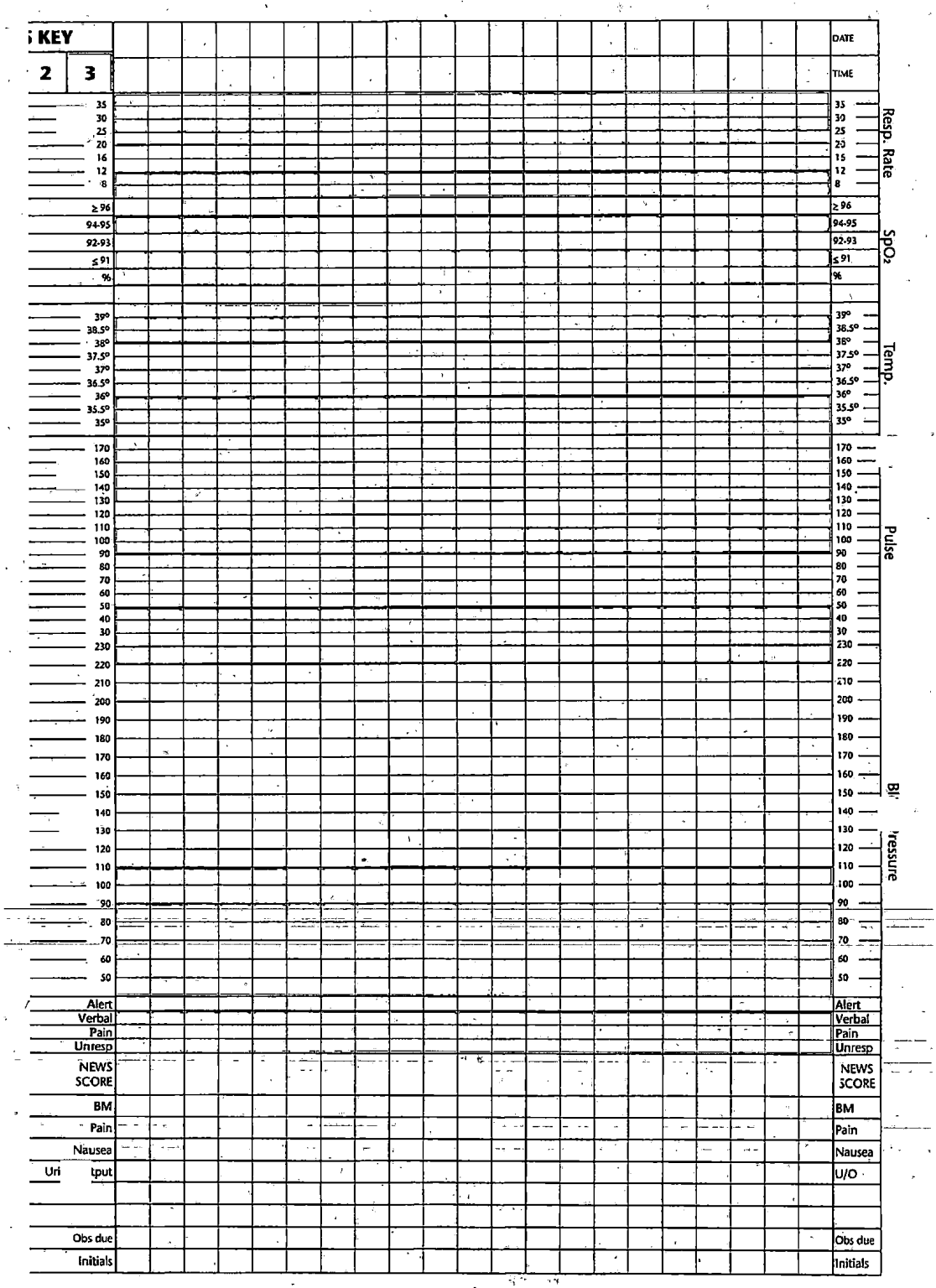
See NEWS Actions Reference Tool for local escalation policy

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

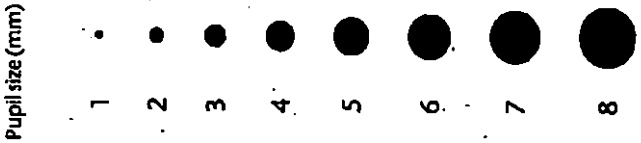
Deborah Sullivan

(18)

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO₂
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale



Neurological Observations

| | | |

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or ah

Name: SULLIVAN Deborah F

DOB: 07/12/1972

Ward: Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE

0712726128

NO access

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

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

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

PVC inserted: Day 0	Date: ___/___/___ Hospital: _____ Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

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

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

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

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

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

DRIFT

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

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

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

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

Are all of the following IVOST criteria met?

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

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

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

YES

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

NO

Care Rounds Checklist

Date: 24/02/2020.

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W

NHS Greater Glasgow and Clyde

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

1. Signed _____ Name CSLOAN Designation SN.
2. Signed _____ Name HNIGD Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	02 30	06 00	10 00	12 45	14 40														
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N														
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	Y														
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	–	I	I	I	–														
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I	I	I														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	–	I	I	I	R														
		Chair Assist to walk or stand (W/ST)	–	I	I	I	–														
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I														
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N														
		Drink taken?	Y	Y	Y	Y	Y														
		Food, snack, or supplement taken?	N	N	N	Y	N														
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I														
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y														
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT														
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA														
		Care provider / role	SN	HCA	SN	HCA	SN														

Care Rounds Variance Sheet

Attach Addressograph Label
Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 65.	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1	Pressure Damage NO	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
24/02/20	02:30	N	N	N	N	N	N	4 hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

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

Prevention of Pressure Ulcer Interve ional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

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

	Ward: 65 Date: 24/02/20 Time: 02:40	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Independent.				
2. Check walking aid (if required) is in reach and in use.	N/A				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	In situ.				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Yes.				
5. If glasses are worn, check they are available and in use.	Yes with pt.				
6. If hearing aid/s are worn, check they are working and in use.	N/A.				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	[signature] 30/02/20									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTIO... CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Person Specific (In[illegible] Handling Assessment Form

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

Person's Name:		Person is totally independent (tick here and go to date box)	✓

1. General Information

Body Build		
Weight	Height	
97 Kg	175 cm	
31 BMI		

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes [ ] No [ ]

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	
	Monkey pole [ ]			
	Independent bridging [ ]			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information:	
	Monkey pole [ ]			
	Rope ladder [ ]			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) [ ]			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower [ ]	Shower chair [ ]	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath [ ]	Shower trolley [ ]			
Bed bath [ ]	Bathing hoist (eg Ateni) [ ]			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 [ ] 2 [ ] ≥3 [ ]	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	24/02/2020		
Assessor's signature:	[signature]		
Proposed Review date:	30/02/2020.		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ☐ No ☐		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

	Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
		People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Alerti) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 24/02/20 Time 0240 of initial height and weight on admission to hospital 99.		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	175 cm	☐	☑	
Admission Weight	97. Kg	☑	☑	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

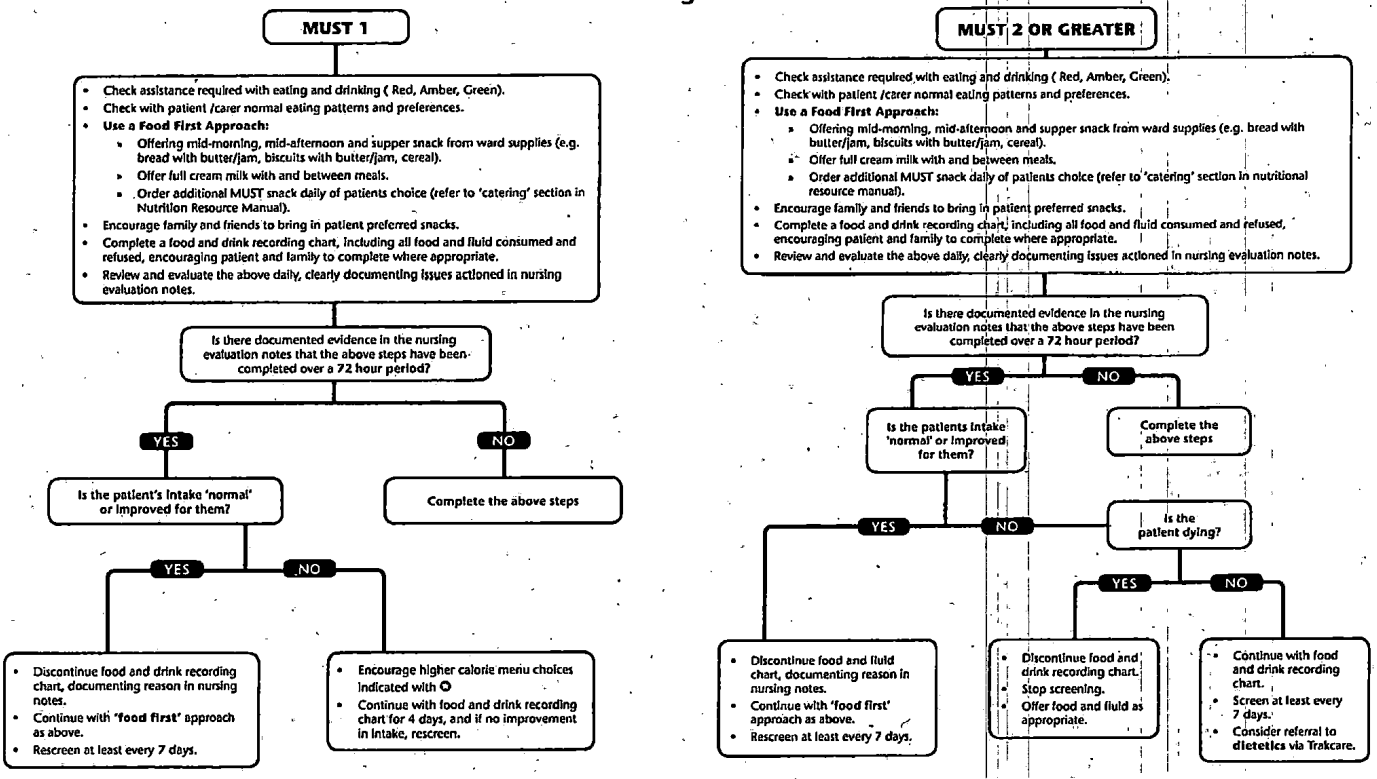
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☑ Don't Know ☐

Date	24/2/20							
Time	0240							
Ward	65							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH.							
Weight (kgs)	97kg.							
BMI	31.							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	30/02/20							
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines



DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient ☐ Yes ☐ No ☐ Unable	If unable, give reason:		
Care discussed with family ☐ Yes ☐ No ☐ Unable	If unable, give reason:		

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
24/02/20 DS.	NEWS ② HR- 90; BP- 105/61.		24/02/20 DS.	Likes to be called Debbie	
			24/02/20 DS.	5. Hydration and Nutrition	
				Normal O+F.	
24/02/20 DS.	2, 3. Communication and senses				
	Can communicate needs freely. Wears glasses for reading				
			24/02/20 DS.	6. Elimination	
24/02/20 DS	4. Cognitive status			No issues.	
	Alert + Orientated				

p1/2 PTO

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
24/02/20 SS.	Ind. with ADL		24/02/20 SS	Buzzer in situ.	
				10. Sleep and Rest	
24/02/20 SS.	8. Mobility				
	Ind. mobile.			12. Privacy, dignity and sexuality	
			24/02/20 SS.	Maintain @ all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Emergency Department Nursing Documentation

Presenting Complaint - Abdo Pain

Date: 23/2/2020 Time: 2325

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Label

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please ...) ISAY

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☑	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/(N)	SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)	YES
Mental Health Triage Assessment	Y/(N)	If NOT WHY? - (details)	(NO)
GMAWS	Y/(N)	Date - 23/2/2020 Time - 2325 Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

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

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		
Are any of the above criteria met? If YES to any of the above move to step 2			

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/(N)	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/(N)				
3) Continence		Y/(N)	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/(N)
4) Nutrition		Y/(N)	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/(N)

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

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At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	(NO)

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
	Notes: medical notes, GP letter, PRF	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
13/6/2020	Taken to cub 17. Repped for exam.	S/N.
2310	Vs/bs requested.	
0145	Analgesia given. Referred surgeons. Pt slightly more hypotensive. Medic aware.	S/N

Nursing Notes			
Date and Time		Print Name and Signature	

My Admission Record

NHS Greater Glasgow and Clyde

Na
Ad 0712726128
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Do Glasgow, Lanarkshire
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Affi

Hospital: GRI Ward: 65/67.
Date of Admission: 22/1/20 Time: 0445.
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 47 Telephone Number: 07713718392
Consultant: D. Mafi

urine; NAD.

Communication

What is your first language? English
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	Preferred second contact
Name: Dayna Sullivan.	Name:
Relationship: Sister.	Relationship:
Address:	Address:
Telephone: 07743956178.	Telephone:
Is this person aware of your admission? Yes ☐ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☐ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

Gastritis epigastric pain + nausea.

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐
Do you understand the reason for your admission? Yes ☐ No ☐

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

No known allergies ☐ Penicillin

Relevant past medical history

Fundoplication
Pancreatitis (chronic)
Lap chole
Fibromyalgia
HTN.
recurrent epigastric pain
Delayed gastric emptying
NIDDM
PTSD
Appendicectomy
Haemolaemesis 2010; no point of bleeding

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

Name: [redacted]
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CHI:
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Affix pa[redacted]

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

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

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☑	☐	☐
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 1yr.

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

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

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

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

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

Drugs

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

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

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

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

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

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

Name (Please PRINT): K.STEWART Signature: KS

Designation: S/N Date: 22/1/20

My Assessment Record

Name: 0712726128
Addre: SULLIVAN F
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Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
DoB: G34 9JE
CHI:
Affix patient ID label

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?			
Do you have a Learning Disability?			
Do you have support from a Learning Disability Team? Contact details: _____			

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3. Senses

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

Can you describe where and what the pain is like?

Epigastric

Have you had treatment / intervention for the pain?

Morphine

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

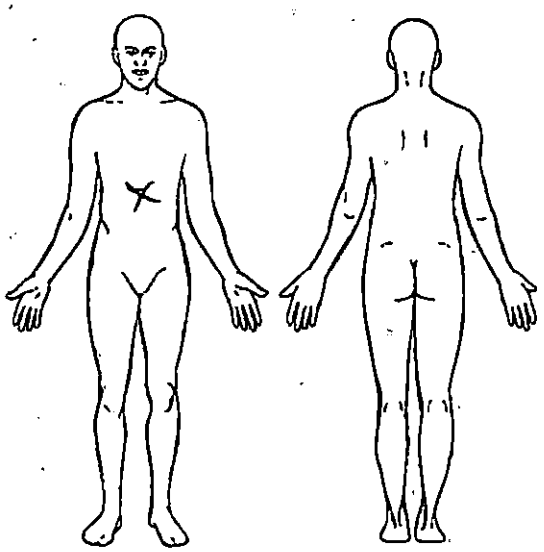
Can you describe any chronic pain that you have?

FM, chronic pancreatitis

What makes the pain better?

Regular analgesia.

Mark current pain on body chart



Name: 
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Affix pa

4. Cognitive Status THINK DELIRIUM

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

N.B. Think Delirium

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

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

and follow the guidance

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

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

No

What do you like to eat and drink?

Not fussy

What do you not like to eat and drink?

Not fussy

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

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Cl
Affix patient

Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Pass urine with no problems	✓	✓	
Frequently pass urine during the day			
Frequently pass urine overnight			
Sense of urgency when need to pass urine			
Urine retention			

Bladder (cont)	Admission *Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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

What products do you normally use for this continence issue?

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

Date urinary catheter last changed ___/___/___

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

Bowels

When did your bowels last move?

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

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

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular		✓	-recently loose - uses laxatives due to analgesia
Constipated			
Diarrhoea / loose stools	✓		
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

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

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

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CHI: _
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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?			

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

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

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

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

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

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		

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8. Mobility

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

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

9. Maintaining a Safe Environment

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

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

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

10. Sleep and Rest

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

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify_____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?	✓	
Do you support anyone (e.g. partner, children, relatives, animals)?	✓	
Do they need support from someone else whilst you are in hospital?	✓	
Would someone else be able to provide this support when you are in hospital? If yes, who? Sister	✓	

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

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

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☑

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

Getting better

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

Family

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends? (please tick) Yes ☐ No ☐

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☑
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☑
If yes when was patient referred ___/___/___

Name: [redacted]
0712726128
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Deborah F
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Easterhouse
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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)					
Generic Pain Scale Assessment Chart					
Abbey Pain Scale (if unable to self report pain)					
4AT and TIME for Detection, Management and Prevention of Delirium					
Getting to Know Me – Relatives to complete					
What Matters to Me					
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)					
Malnutrition Universal Screening Tool (MUST)	✓		✓		
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		
Adult Wound Assessment and Management Chart					
Moving and Handling Assessment					
Falls Risk Assessment	✓		✓		
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
22/1/20	Admitted to W67 with epigastric	
06⁰⁰	pain. Obs stable O/A NF	
	commenced PV freely, bowels	
	currently loose. Analgesia required	
S/E:	Analgesia + antiemetics	
	IVF + IVPPI	K STEWART JW
	OGD if not improving	

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A 0712726128
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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
22/01/20 ve	REVIEWED BY MR MAFI	
	MUST ANY USE	
	FOR IVF/WIDS	
	CONTINUE IV LOCT	
	ALLOW FREE MVIDS	
12.30	MODERATE WIN BEFORE HYGIENE	
	ALLOW FREE MVIDS	
	HAS BLOOD CULT - ASKED TO USE 1 HYGIENE	
	MODERATELY POSITIVE	
	NEWS-4 BP 97/69 SPO2 95% on	
	OR. PULSE - 98bpm	
	MVIDS CONTINUE	
	ORAL MEDICATION GIVEN PR FOR	
	MUST REVIEW BLOODS	
Dr	REVIEWED BY MR MAFI	
	MVID + DICT	
	ALLOW HOME	
	INCREASE ESOMEPRAZOLE	
	DOSE - 40mg BD	
18.55	PATIENT RE DISCHARGE HOME	
	VENFLON REMOVED	
	PATIENT HAS MEDICINE BOX - ALREADY ON	
	ESOMEPRAZOLE 40mg BD -	
	ALLOW HOME	
	NO FOLLOW UP	

Name: _____

Address: _____

_____

_____

DoB: _____

CHI: _____

Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

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Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient, Unable ☐ Yes ☐ No ☐		If unable, give reason:			
Care discussed with family Unable ☐ Yes ☐ No ☐		If unable, give reason:			
Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
[illegible] 22/11/20	No issues No hx Obs stable.				
				5. Hydration and Nutrition	
				MUST=0 BMI=31	
	2, 3. Communication and senses			No specific requirements	
	Wears reading glasses.				
				6. Elimination	
	4. Cognitive status			PU freely Bowels loose Continent	
	A+O				

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
KS 22/1/20	Independant			Call bell to hand.	
				10. Sleep and Rest	
				Poor sleeper due to PTSD	
				Uses temazepam	
	8. Mobility				
	Independent			12. Privacy, dignity and sexuality	
				Maintain + respect	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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Glasgow

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Deborah 07/12/1972
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Easterhouse
Glasgow, Lanarkshire
G34 9JE,

NHS
Greater Glasgow and Clyde

Name: Unit No.:

Date:		22/1	22/										
Time of Result:		00 37	14 00										
WCC	4-11	12.4	12.8										
Hb	M - 13-18 F - 11.5-16.5	157	125										
Plat	150-400	382	281										
Amylase	<100	N/A	63										
CRP	<10	5.	4										
Na+	135-145	139	140										
K+	3-5-50	N/A	4.3										
Cl-	98-108	105	105										
Bic	21-28												
Urea	2.5-7.5	4.4	4.5										
Creat.	57-113	43	55										
EGFR	60>	>60	760										
Glucose	3.5-5.5												
Bilirubin	3-22	4	8										
ALT	<50	42	33										
AST	<40	N/A	20										
G-GT	<55												
Alk. Phos.	40 -150	94	76										
Albumin	32-45	44	34										
Mg^+													
Ca	2.1-2.6	2.76											
Adj Ca	2.1-2.6	2.69											
PO4	0.7-1.4												
PT	9-12												
APTT	25-37												
TCT	11-15												
TROP		<4											

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	0712726128 F SULLIVAN Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE
CHI No.	
DoB	

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

Deborah Sullivan 5ft 9 97kg.

17 DATE: 24/01 24/01 22/01 22/11 23/11

2020 TIME: 21 09 23 30 00 00 06 45 10:20 12:00 16:00

DATE NEWS

TIME 0 1

Resp. Rate Mark: •

35 30 25 20 16 12 8

SpO_2 (Enter Value)

≥96 94-95 92-93 ≤91 %

96% 97% 95 95 95

Any Sup'l O_2 Room air

A A A A A O A

Temp. Mark: X

39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°

36°C 36.3

Pulse Mark: •

170 160 150 140 130 120 110 100 90 80 70 60 50 40 30

99

Blood Pressure Mark: ◇

NEWS SCORE using Systolic BP

230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50

107 108 97 64 79

Consciousness Level Mark: •

Alert Verbal Pain Unresp

A A A A

Total NEWS (with all obs)

2 3 1 4 4

NEWS SCORE

BM 18.6 16.3

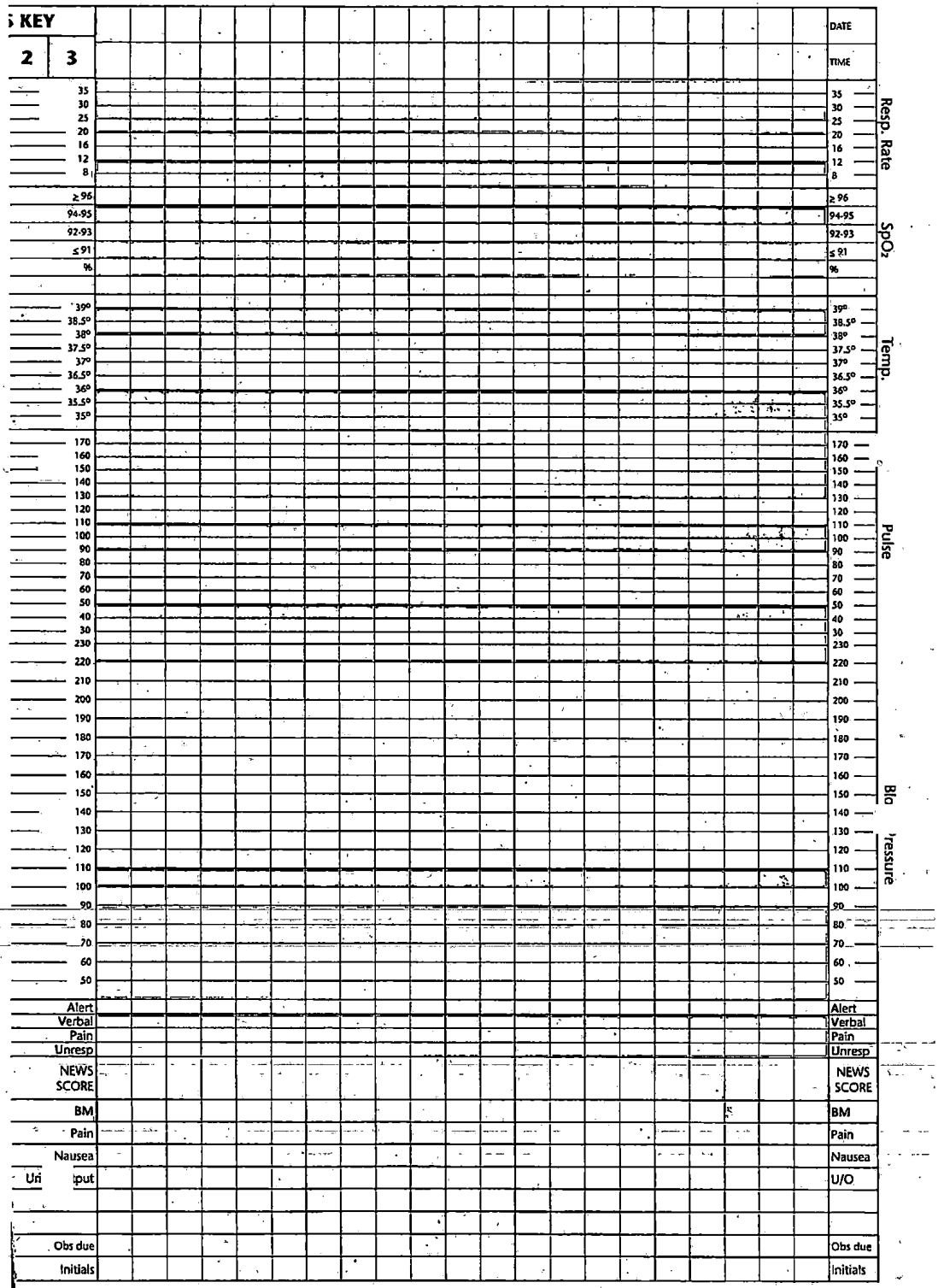
Pain 5 10 8

Nausea No No

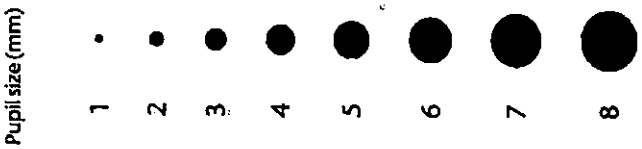
Urine output 116 PU

Obs due 1400 2000

Initials MA MS CO A PR


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine Output
U/O
Obs due
Initials

Glasgow Coma Scale



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Deborah 07/12/1972
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G34 9JE

Neurological Observations

Date:																														
Time:																														
COMA SCALE	E Eyes open	Spontaneously	4																											Eyes closed by swelling = C
		To speech	3																											
		To pain	2																											
		None	1																											
	V Best Verbal response	Orientated	5																											Endotracheal tube or tracheostomy = T
		Confused	4																											
		Inappropriate words	3																											
		Incomprehensible sounds	2																											
		None	1																											
	M Best motor response	Obeys	6																											Usually record the best arm response
		Localises	5																											
		Flexion - withdrawal	4																											
		Flexion - abnormal	3																											
		Extension to pain	2																											
		None	1																											
	TOTAL SCORE																													
PUPILS	R	Size																												
		Reaction																												+ reacts – no reaction c. eyes closed
	L	Size																												
		Reaction																												
LIMB MOVEMENT	ARMS	Normal power																												Record right (R) and left (L) separately If there is a difference between the two sides
		Mild weakness																												
		Severe weakness																												
		Spastic flexion																												
		Extension																												
		No response																												
	LEGS	Normal power																												
		Mild weakness																												
		Severe weakness																												
		Spastic flexion																												
		Extension																												
		No response																												

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Adult In. 0712726128 V... C... F
SULLIVAN 07/12/1972
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire G34 9JE

Write or affix patient label

Name: _____ CHI: _____

DOB: _____ Address: _____

Ward: _____ Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☑ Fluids ☑ Transfusion ☐

PVC inserted: Day 0	Date: 22/1/19 Hospital: _____ Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: Unknown

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 22/1/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☑ No ☐ N/A ☐	TR
Day 1 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 22/01/20

*Reason For Removal: DISCHARGE HOME

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Fluid Balance Chart

N: 0712728128
D: SULLIVAN, Deborah — F: 07/12/1972
Cl:
Ah

Hospital: GRI
Ward: 67
Date: 22/01/20

Reason for Fluid Balance Chart: IVF
Is patient fluid restricted? Yes ☐ No ☑
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00					IVF	500											
01:00																	
02:00					IVF	500											
03:00																	
04:00	water	100															
05:00																	
06:00																	
07:00					IVI	100			1400	300							JC
08:00	water	150															
09:00																	
10:00																	
11:00																	
12:00	Water	100				500			2100	200							HC
13:00																	
14:00																	
15:00																	
16:00	Water	500							2600	PU							
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
							*Total Intake		[redacted]					*Total Output		[redacted]	

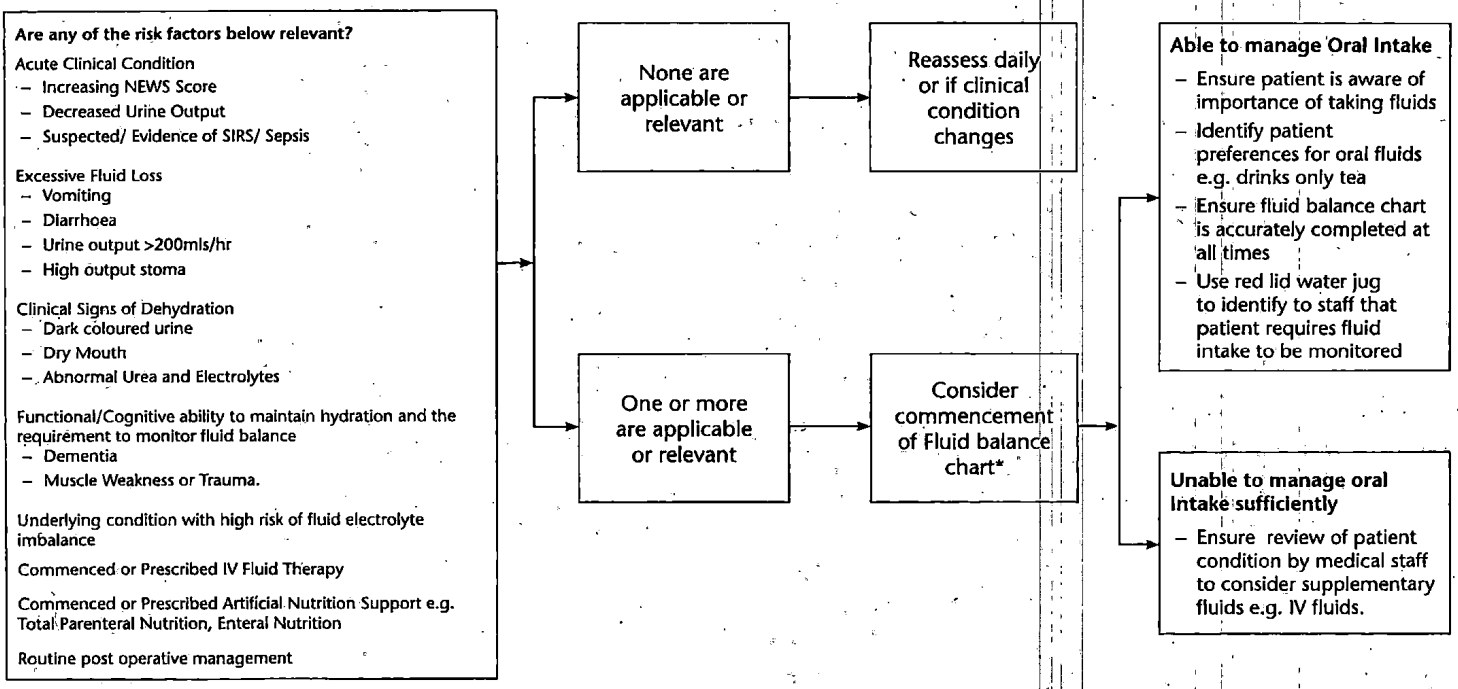
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 22/1/20

Attach A
0712726128 [illegible]
SULLIVAN F.
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow. Lanarkshire
Ward: G34 9JE

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next workshift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed KS Name KSTEWART Designation SIN.
2. Signed [illegible] Name [illegible] Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	0500	0800	1020	1200	1600
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N
S	3	SKIN INSPECTION Pressure areas checked:	I	I	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	✓	–	–	–	INT
K	4	KEEP MOVING Has the patient moved or walked?	I	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	✓	✓	–	–	✓
		Chair Assist to walk or stand (W/ST)	✓	✓	✓	✓	✓
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	Y	N	N	N	NA
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	NT	NT
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA
		Care provider / role	HCA	[illegible]	[illegible]	[illegible]	HCA SN

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse [illegible] Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 67	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1 Pressure Damage	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise?
3	Continence	Does the person have continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
22/1/20	04:50	N	N	N	N	N	N	4hrly	[signature]
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interven...nal Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition.

	Ward: 67. Date: 22/1/20 Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Independent				
2. Check walking aid (if required) is in reach and in use.	Not requ.				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	To hand.				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Safe.				
5. If glasses are worn, check they are available and in use.					
6. If hearing aid/s are worn, check they are working and in use.					

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	KS									

Highlight risk of fall at the ward safety brief.

Patient Details	FALLS INTERVENTION CHECKLIST	NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team
EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

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patient) Moving and Handling Assessment Form

Pers
Nam

Named Nurse:

Person is totally independent (tick here and go to date box) ✓

1.

Weight	Height
Kg	cm
BMI	

Risk of Falls: Yes | No

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist | Standaid | Walking Aid | Assistance | Supervision | Independent

Model		Aid Type	People: 1 / 2 / ≥3
Sling type			
Sling Size			

Additional Information / Equipment:

3. Toileting

Hoist | Standaid | Walking Aid | Assistance | Supervision | Independent

See No 2 Sit to Stand Transfers for details

see 'sit to stand transfers'

People: 1 / 2 / ≥3

Additional Information:

4. Move on / off bed pan

Hoist | Manoeuvre | Assistance | Supervision | N/A

See No 2 Sit to Stand Transfers for details

Roll patient
Monkey pole
Independent bridging

People: 1 / 2 / ≥3

Additional Information:

5. Move up / down bed

Hoist | Handling Aids | Assistance | Supervision | Independent

See No 2 Sit to Stand Transfers for details

Sliding sheets
Monkey pole
Rope ladder

People: 1 / 2 / ≥3

Additional Information:

6. Lateral Transfer to / from trolley / bed

Hoist | Handling Aids | Assistance | Supervision | Independent

See No 2 Sit to Stand Transfers for details

Rigid Transfer Board
Other (Please specify)

People: 1 / 2 / ≥3

Additional Information / Equipment (eg sliding sheets):

7. Sit up over side of bed

Bed Rest | Assistance | Supervision | Independent

People: 1 / 2 / ≥3

Additional Information / Equipment (eg rope ladder, swivel cushion):

8. Into Bath or Shower

Equipment | Handling Aid | Assistance | Supervision | Independent

Shower
Variable / Fixed height bath
Bed bath

Shower chair
Shower trolley
Bathing hoist (eg Alerto)

People: 1 / 2 / ≥3

Additional Information / Equipment (eg sling lifting hoist after risk assess):

9. Walking

No Walking | Walking Aid | Assistance | Supervision | Independent

see 'sit to stand transfers'

People: 1 / 2 / ≥3

Additional Information / Equipment (eg hoist with walking sling, dist. Walked)

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	22/1/20		
Assessor's signature:			
Proposed Review date:	29/1/20		

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alenti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	176 cm	☐	☑	
Admission Weight	97 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☑

Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☑ Don't Know ☐

Date	22/1							
Time	0800							
Ward	65							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	97							
BMI	31							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	29/1							
Signature	KS							

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with **'food first'** approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ✪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patients intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with **'food first'** approach as above.
- Rescreen at least every 7 days.

NO

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to **dietetics** via Trakcare.

NO

Complete the above steps

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "**"Eating to Feel Better"** booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

NU • 285884 v3.0 • GGC0250

Emergency Department Nursing Documentation

Presenting Complaint -

Date: ____/____/____ Time: _____

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Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☐	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☐
GGC RED BAG - with patient	☐		
12 Lead ECG	☐	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☐ No ☐		Xrays / CT Scan Performed:	☐
IV Access: Yes ☐ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☐ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis				
Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	YES
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score

/12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) **Pressure Damage** Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	**Date**	**Location of Redness/Ulcers**	**Grade of Ulcer**	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

Patient Addressograph Label

At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*	
YES	NO

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
23∆0 21/01/20	patient nas abdo pain Bloods obtained. IV Morphine & IVF's commenced.	SW

Nursing Notes		
Date and Time		Print Name and Signature

My Admission Record

NHS Greater Glasgow and Clyde

Nar
Adc 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Dol Easterhouse
Glasgow, Lanarkshire
CHI G34 9JE
Affix patient ID label

Hospital: GRI Ward: 67/65
Date of Admission: 4/12/19 Time: 2100
Information obtained from: Name: HN16UD
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: DEBBIE
Age: 46 Telephone Number: 07713718392 Urine ☐
Consultant: M QUINN

Communication

What is your first language? ENGLISH
Do you require an interpreter? Yes ☐ No ☑
If yes, provide details of arrangements made _____
Do you use British Sign Language (BSL)? Yes ☐ No ☑
Do you need someone to help you to communicate? Yes ☐ No ☑ If yes, who _____

Preferred first contact	**Preferred second contact**
Name: DONNA SULLIVAN	Name:
Relationship: SISTER	Relationship:
Address:	Address:
Telephone: 07743 956178	Telephone:
Is this person aware of your admission? Yes ☑ No ☐	Is this person aware of your admission? Yes ☐ No ☐
Can we share information with this person? Yes ☑ No ☐	Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

RUQ/epigastric pain 5/12 - CT ☐ WCC 13.5

Explained to the patient? Yes ☐ No ☐ Not Applicable ☑
Do you understand the reason for your admission? Yes ☑ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ penicillin - rash

Relevant past medical history

chronic pancreatitis, cholecystectomy, re-do nissens fundoplication, gastric dysmotility + oesophageal spasm, delayed gastric emptying, haematemesis, NIDDM, PTSD, appendicectomy, fibromyalgia
2020 (no point of bleeding)

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place
Yes ☐ No ☑ If yes, Who asked for a copy? _____
Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Nan
Add 0712726128
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Dol Easterhouse
CH Glasgow, Lanarkshire
Affix patient... G34 9JE

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☑
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 10 months

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☑

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

How often do you have more than 6 units of alcohol on one occasion:

Never ☑ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): HN160 Signature: [signature]

Designation: SN Date: 4/12/19

My Assessment Record

Nam
Addr
0712726128
SULLIVAN F
? Deborah 07/12/1972
DoB: Flat 0-1, 8 Boyndie Street
CHI: Easterhouse
Glasgow, Lanarkshire
Affix G34 9JE

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____			

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3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☑ Both ☐
Do you have your glasses with you?	✓		
Do you wear contact lenses?		✓	
Do you have your lenses with you?			
Do you wear a prosthesis?			

Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?			
Do you use a hearing aid?			
Do you have your hearing aid(s) with you?			

Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?	✓		

Can you describe where and what the pain is like?

Stabbing pain

Have you had treatment / intervention for the pain?

morphine.

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

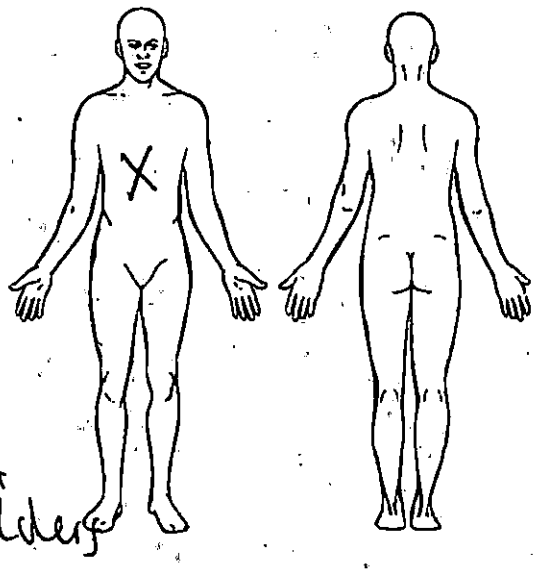
Can you describe any chronic pain that you have?

fibromyalgia – knees, wrist hands, shoulders

What makes the pain better?

pregabalin

Mark current pain on body chart



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Affix patient ID label

4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

NO

What do you like to eat and drink?

varied diet

What do you not like to eat and drink?

not fussy

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state		
Thickened Fluid Please state		
Oral Nutritional supplements Preferred flavour		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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07/12/1972
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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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07/12/1972
Place patient ID label

N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☑ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? 4/12/19

How often in a day/week do you have a bowel movement? Per day 1 Per week

Do you use any medication e.g. laxative to help your bowels move? Yes ☑ No ☐

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	lactulose + laxido
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	Yes ✓	No ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?			
Have you brought any of your stoma products with you?			

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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems			
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)	dry mouth	dry mouth	

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?			
Are your dentures a good fit?			
Do you have any other dental work that we need to be aware of?	✓		fillings

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient


0712726128
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Glasgow, Lanarkshire
G34 9JE

8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☑	
Do you have your mobility aid with you?	Yes ☐	No ☑	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

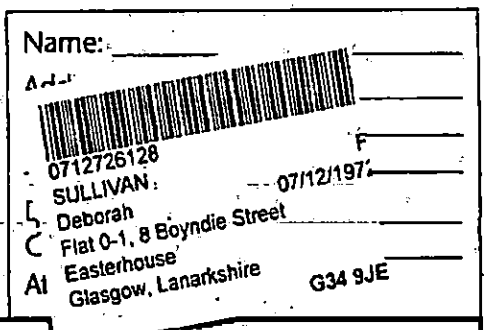
N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		temazepam
Do you do or use anything to help you sleep?	✓		



11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify _____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?		✓
Do you support anyone (e.g. partner, children, relatives, animals)? cat	✓	
Do they need support from someone else whilst you are in hospital?	✓	
Would someone else be able to provide this support when you are in hospital? If yes, who? daughter	✓	

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓
If yes, please provide details:		
If yes, has contact been made to cancel arrangements during admission?		

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

catholic

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

NO

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☑

Healthcare Chaplain informed Yes ☐ N/A ☑

Name: _____

0712726128 F

SULLIVAN 07/12/197

D Deborah

Flat 0-1, 8 Boyndie Street

Cl Easterhouse

Af Glasgow, Lanarkshire G34 9JE

13. Person Centred Care

What matters and is important to you whilst you are in hospital?

This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

getting better

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

N/A

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: .....

Contact Details: .....

.....

.....

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☐ No ☐

If yes, has the help or support listed above been confirmed with the patient's family/ friends? (please tick) Yes ☐ No ☐

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A 0712726128
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Deborah F
07/12/197
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Easterhouse
Glasgow, Lanarkshire
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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☐
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☐
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☑
If yes when was patient referred ___/___/___

Name:
0712726128
SULLIVAN F
Deborah 07/12/197
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓			
Generic Pain Scale Assessment Chart		✓			
Abbey Pain Scale (if unable to self report pain)		✓			
4AT and TIME for Detection, Management and Prevention of Delirium		✓			
Getting to Know Me – Relatives to complete		✓			
What Matters to Me		✓			
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓			
Malnutrition Universal Screening Tool (MUST)	✓		✓		4/12/19 [illegible]
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		4/12/19 [illegible]
Adult Wound Assessment and Management Chart		✓			
Moving and Handling Assessment	✓		✓		4/12/19 [illegible]
Falls Risk Assessment	✓		✓		4/12/19 [illegible]
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
4/12/19 2125	46 year old lady admitted with RUQ/epigastric pain. Reviewed by SHO ?acute pancreatitis. Plan: chase bloods, CXR/AXR, CTAP, IV PPI, clear fluids orally.	[illegible]

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
5/12	Continues to complain	
0430	of pain - oramorph	
	as per kardex	
	ondansetron for	
	nausea.	
	IV omeprazole as	
	prescribed.	
	Clear fluids only	
	2 For CT in am.	SN Lsong
0700	News 2 - pulse 98	
	Sats 95%.	SN Lsong
5/12/19 WR	AM	
	@ CTAP	LDunleavy
1140	Observations stable	
	Independently passing urine	
	Tolerating fluids	
	Medication and analgesia	
	as kardex	
	Passing wind freely	
	Awaiting CTAP.	
	IV lines continues.	
	Settled at present.	JLaverty
1715	w/e NS Qun.	
	CTAP nom.	
	@ DPI.	JLaverty
6/12/19 0510	Patient settled and slept ex	
	long spell overnight Analgesia	

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	given with good effect. Observations as charted NEWS 2 due to 2 litres of O2 therapy commenced on oxygen due to ABG. Medication administered as per Kardex patient has own medication for COPD this morning	Lamson Lamsa
n/k	Await CT	EGorrell
1050	Patient Independent with personal hygiene, Independent + mobile. Very clammy, patient states that she is sore. Temp ok. Oral ondansetron given. NEWS 3 tachy + O2 therapy (II). Meds as per kardex.	S/N LTurner LTURNER
n/k	Await CT	
	Ionide as prescribed	
	wean off O2	EGorrell
1900	Patient reported haematemasis - small amount of blood noticed on noted in x2 sick bowls. ?from coughing. Reviewed by FY1 who thinks the same. Monitor bloods	S/N LTurner LTURNER

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name:	Ward: 64
Unit number:	Discharge destination: Home
CHI number:	Estimated Discharge Date (1) / /
Apply addressograph label	Estimated Discharge Date (2) / /
	Final date of discharge : 12 / 12 / 19

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		DS	
Relative/carer informed	✓		DS	
Others informed: Care Home		---	---	
Transport arranged				
Own transport (preferred option)	✓		DS	
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)	✓		DS	
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed				
Equipment ordered (inc. walking aids) in place for discharge				
Part 2 Discharge letter - Required				
- Completed				
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow	✓		DS	
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge: 1715				
Nurse's signature:	Designation: SN		Date: 12/12/19	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✓ appropriate directorate

DEBORAH SULLIVAN
07127726128.

Date & Time		Signature, Print Name & Designation
07/12/19 0300	Orientated and alerted to ward.	
07/12/19	Medication as per kardex.	lesleytoungL
	Awaits CTAP.	LESLEY TOUNG S/N
07/12/19	Pt walk today : cadgeat	
1415	with washing dressing	
	managed OFF ✓ pa	
	spontaneously. nil from	
	bowels so far today	
	NEWS - ① TACHYCARDIC 105. Meds	
	as per Kdep. given via	
	dosset due to certain meds	
	that are unobtainable. Pt	
	awaits CTAP. no issues at present	eKelly SN
1930	Pt Coughs up small amount	
	of blood. States that may be	
	from cut in throat? FYI	
	to view - well at present.	
	obs - ok. Cleane N/N this evening	eKelly SN.
08/12/19	Independant and self caring.	
0240.	Medication as charted/ PRN	
	analgesia overnight. Attended	
	xray awaiting results.	LESLEY TOUNG S/N
	No further vomiting.	lesleytoungL
8:12:19	All care given as per care plan	
1905	medication administered as per kardex	
	Observations obtained NEWS = 2. sats 94%	
	on air and ~~temp~~ pulse 101 bpm.	
	Awaiting results from todays CT abdo scan.	
	Recieved an enema this morning No bowel	

83949 CGC0072

Date & Time		Signature, Print Name & Designation
Cont 6.12.19 1905	movement yet.	
	Passing urine freely	
	Patient was sick very small amounts of	
	blood twice. PO ondansetron administered	
	which settled her nausea.	
1910	No further issues ———	M. Stenhouse SRN
	Creon at lunch time was withheld	
	as she had not eaten and was being	
	sick ———	M Stenhouse SRN
07/12/19	Independant and self caring.	
0510	Medication as charted. PRN	
	analgesia required overnight.	
	No further vomiting. Did	
	not want another enema prior	
	to settling, took laxative,	Linkstaff
	orally. Scan — NAD.	RESPITOR SRN
9/12/19	DS reviewed ward. For	
1330	OGD ? tomorrow. All	
	care carried out as per care	
	plan. Taking diet and fluids	
	passing urine, NAD PR	
	Hourly, PW2 bpm	
	SpO 95% air.	
	OGD instructions given as	
	received.	MCHALL
	BM stable as charted	MCHALL SRN
09/12/19	Pt well this evening, slept for	
0700	long spells. remained OTF. pu	
	Spontaneously no bowel movements	
	this evening. NEWS: 0 meds	
	as per Kardex. Awaits: OGD: fasted	
	from 0600. Well at present.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

DEBORAH SULLIVAN
07127726128

Date & Time		Signature, Print Name & Designation
10/12/19	Patient currently attending OGD.	
09:50	Consent and checklist complete.	
	TED stockings in place. All meds given	
	as per kardex pre theatre.	RDOCHERTY. RDoherty SN
10:00	Deborah returned from theatre.	
	News as charted. OGD Normal	RDOCHERTY
	diet and fluids resumed. NAD. Ind.	RDoherty SN
12:30	Pain relief and anti sickness	
	given as per kardex. Deborah did	
	not tolerate lunch due to nausea.	
	Observations as charted. vomited small amounts.	RDOCHERTY RDoherty SN
17:08	Patient tolerated dinner, keeping	
	fluids down. Independent, PU.	
	Obs as charted. Medications as	RDOCHERTY
	per kardex.	RDoherty SN
11/12/19	Deborah settled, analgesia given,	
	obs stable, OGD NAD await review	
	in am nil vomit o/n	NWarren SJ
09:00	Seen on ward round, oromorph	
	stopped, for home when well. All	RDOCHERTY
	medications given as per kardex. News as charted.	RDoherty SN
16:20	Patient taken for CT scan. Pink	
	cannula inserted, Dr unable to insert	
	green due to difficult access.	RDoherty SN
18:15	Returned to ward after CT.	
	Dr reports CT NAD. Patient tolerating	
	normal diet and fluids. BM stable,	
	News as charted, medications	
	given as per kardex.	RDoherty SN

83949 GGC0072

Date & Time		Signature, Print Name & Designation
12/12/19 0515	Deborah, given all meds as per Kardex, obs stable, aim home in am, no issues overnight	NWarren
12/12/19	pt for discharge. - PVCs removed - Transport time w/ family - Awaiting d/c meds & letter - Follow up - Respiratory clinic - appt to follow. - NEWS = 0	CERTIFIED ES RN

Care Rounds Checklist

Date: 12/12/19

Attach Addressograph Label

Deborah Sullivan

Ward: 64

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed _____ Name _____ Designation _____
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.																		
S	3	**SKIN INSPECTION** Pressure areas checked:																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)																		
K	4	**KEEP MOVING** Has the patient moved or walked?																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B																		
		Chair Assist to walk or stand (W/ST)																		
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?																		
		Drink taken?																		
		Food, snack, or supplement taken?																		
		Has oral hygiene been carried out as per care plan?																		
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.																		
		Care provider / role																		

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance		Sign & Print Name

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Care Rounds Checklist

Date: 10/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed [signature] Name Charles K Designation SN
2. Signed [signature] Name [illegible] Designation SN
3. Signed [signature] Name Nicole Warren Designation SN

Attach Addre

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Ward: 64

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00 04	06 10	08	12 60	17 60	20 30	22 30
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N	Y	Y	Y	Y	N
S	3	**SKIN INSPECTION** Pressure areas checked:	S	I	I	I	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	—	—	—	—	Int	I
K	4	**KEEP MOVING** Has the patient moved or walked?	S	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	R	R	B	B	B
		Chair Assist to walk or stand (W/ST)	S	—	—	—	—	Ind	—
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	I	I	I	Ind	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N	N	N	N	N	N
		Drink taken?	S	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?		N	N	N	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	S	N	N	I	I	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	N	Y	Y	N	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	N	N	NA	NA	NA	NA
		Care provider / role	N	N	N SD	N SD	N SD	N SD	N SD

Care Rounds Variance Sheet

Attach Addressograph Label	
Ward:	

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance		Sign & Print Name

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Fluid Balance Chart

Name: Deborah Sullivan
DoB: 7/12/72
Chi number: 0712726128
Affix patient data label

Hospital: GRI
Ward: 64
Date: 12/12/09

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
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18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake						*Total Output			

*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Fluid Balance Chart

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital: GRI
Ward: G4
Date: 11/12/19

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
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16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
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Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Fluid Balance Chart

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital: QRC
Ward: 64
Date: 10/12/19

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs
+/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00	Sips																
07:00																	
08:00																	
09:00	Sips																
10:00	Sips																
11:00	Water	100mls							200								
12:00	Water	100mls							300								
13:00	Water	100mls							400								
14:00	Water	100mls							500								
15:00																	
16:00																	
17:00	Juice	200mls															
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

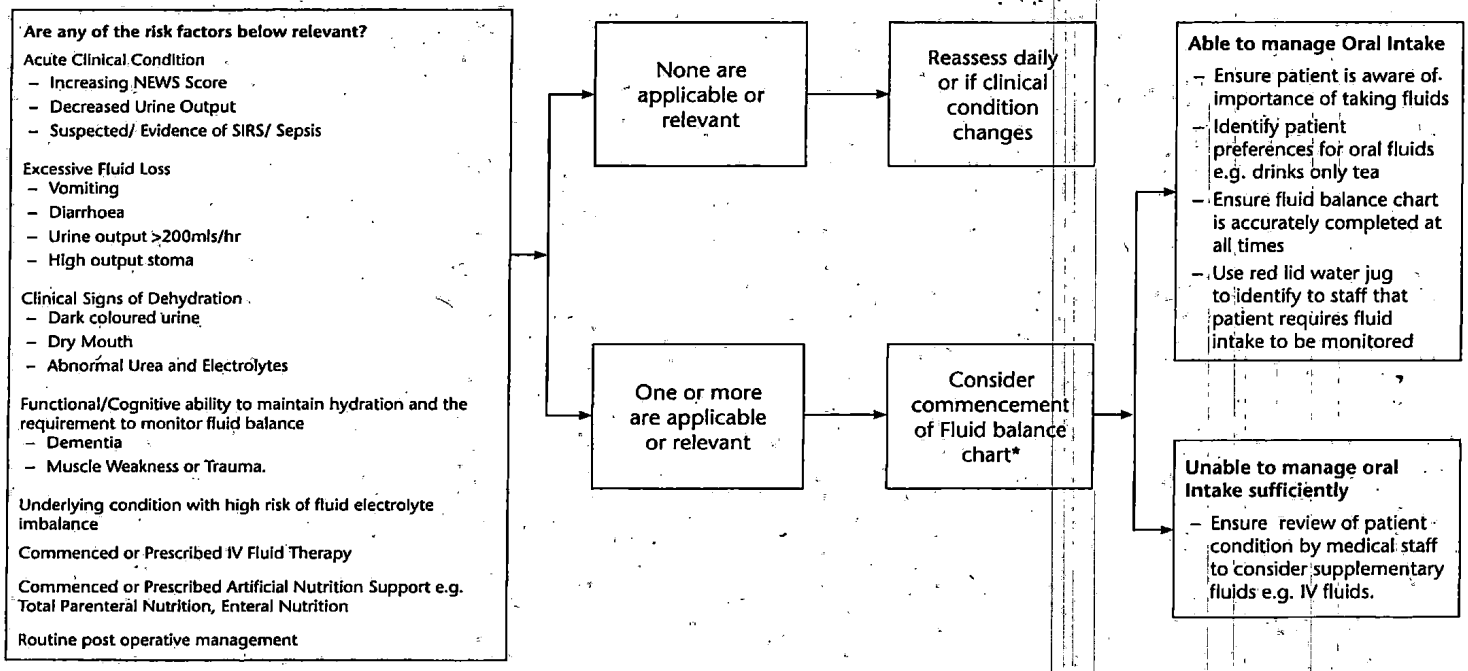
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Patient Address Label

Cumulative Fluid Balance chart

NHS Greater Glasgow and Clyde

N.B. Columns NOT shaded are considered mandatory for all patients on a Fluid Balance chart. Shaded columns are completed dependant on the patient's clinical need and plan of care.

DAILY SUMMARY OF FLUID BALANCE										BALANCE	
Date	INTAKE				OUTPUT						
	Oral	Enteral	IV/Other	Total Intake	Urine	Gastric	Bowel	Other	Total Output	Daily Fluid Balance (+ / -)	Cummulative Fluid Balance (+/-)
09/12	2050			2050	U.TT				U.TT		

Patient Address Label

Cumulative Fluid Balance chart

NHS
Greater Glasgow and Clyde

N.B. Columns NOT shaded are considered mandatory for all patients on a Fluid Balance chart. Shaded columns are completed dependant on the patient's clinical need and plan of care.

DAILY SUMMARY OF FLUID BALANCE										BALANCE	
Date	INTAKE				OUTPUT						
	Oral	Enteral	IV/Other	Total Intake	Urine	Gastric	Bowel	Other	Total Output	Daily Fluid Balance (+ / -)	Cummulative Fluid Balance (+/-)

mi • 279972-4
GGC0020

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 F SULLIVAN 07/12/1972 Deborah reet Flat 0-1, 8 Boyndie Str Easterhouse Glasgow, Lanarkshire. G34 9JE	Hospital: GRI Ward: 67/65	Points to consider: • Use within 8 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1	Pressure Damage NO	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY pressure relieving care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	Mobility	Does the person require assistance to mobilise?
3	Continence	Does the person have continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY pressure relieving care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue with patient interventions depending on individual need and reassess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Care Prescribed	Signature
4/12/19	21:00	N	N	N	N	N	N	4 hrly	
5/12/19	11:00	N	N	N	N	N	N	4 hrly	
6/12/19	11:00	N	N	N	N	N	N	4 hrly	
07/12/19	08:00	N	N	N	N	N	N	4 hrly	
8/12/19	09:00	N	N	N	N	N	N	4 hrly	
9/12/19	08:00	N	N	N	N	N	N	4 hrly	
10/12/19	09:30	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Interventional Plan

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN Deborah F 07/12/1972 aph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan: 4/12/19	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used: N/A	Specify: • Mattress: SOFTFOAM • Cushion: N/A • Detail additional pressure redistributing equipment: N/A	• Reposition 4 hourly in bed and chair. • Overnight patient / carer has agreed to repositioning 4 hourly • Specify any manual handling equipment used: N/A	• Skin care to be carried out 4 hourly. • Specify products required for increased moisture / continence management: N/A	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☑ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition ____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out ____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued:

Fluid Balance Chart

Name: DEBORAH SULLIVAN
DoB:
CHI number:
Affix patient data label

Hospital: GRI
Ward: 64
Date: 9-12-19

Reason for Fluid Balance Chart
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours?
Fluid balance from previous 24hrs +/-

Does patient require thickened fluids?
Yes ☐ No ☐ Stage
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type circle how many daily 1 2 3
2. Type circle how many daily 1 2 3
Signature: Designation:

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Output							
	Oral Fluids		Enteral		IV / Other				Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	Running Total INPUT						Running Total OUTPUT	Initials
00:00																
01:00																
02:00																
03:00																
04:00																
05:00																
06:00																
07:00																
08:00	Tea	200														
09:00									UN							
10:00	Water	150														
11:00	Water	402														
12:00																
13:00	Lunch	150							UN							
14:00																
15:00	WATER	150														
16:00									UN							
17:00	DINNER	300														
18:00																
19:00	WATER	150														
20:00																
21:00																
22:00																
23:00																
							*Total Intake	2050						*Total Output	1475	

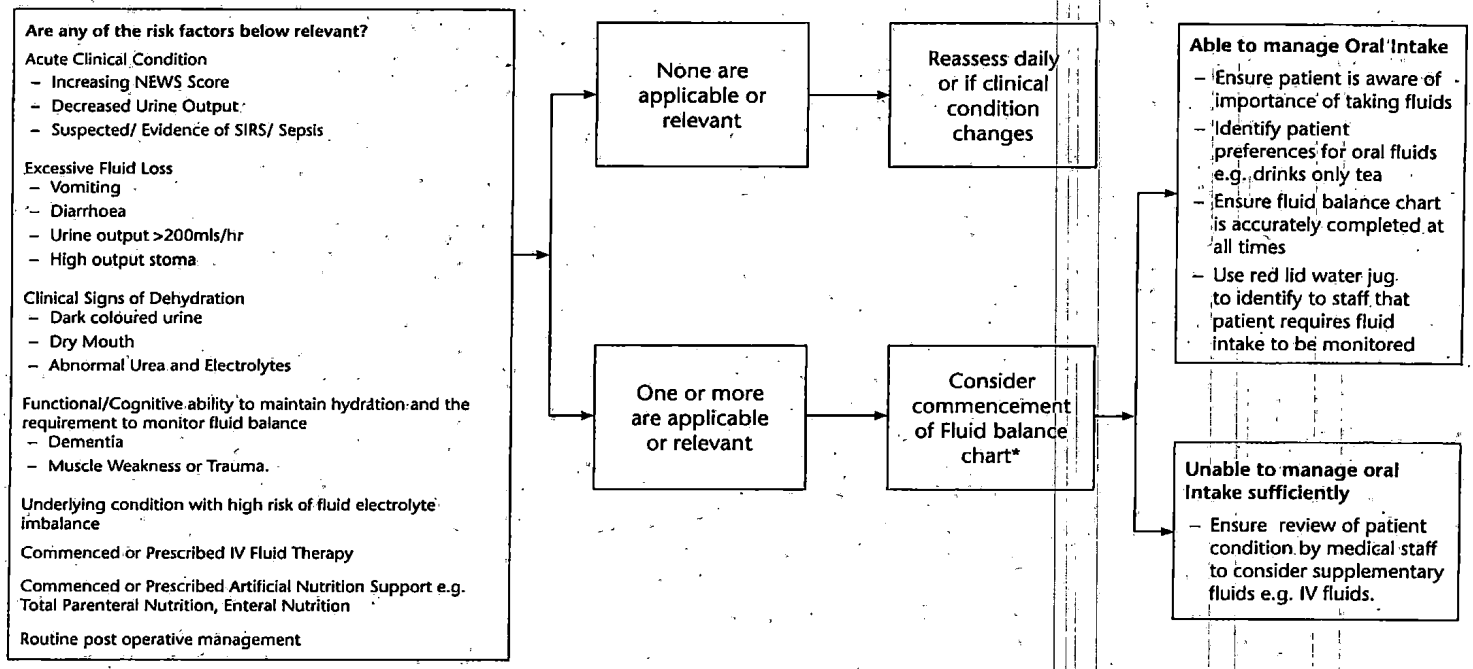
*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.



Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 9-12-19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed [illegible] Name [illegible] Designation S/N
2. Signed [illegible] Name [illegible] Designation SN
3. Signed [illegible] Name [illegible] Designation SN

Attach Addressograph Label

DEBORAH SULLIVAN

Ward: 64

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	02[00]	06[00]	08[15]	10[30]	14[15]	17[10]	20[30]	24[00]										
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N	N	N										
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N	N	N	N	N										
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I	I	I	I										
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	—	—	—	—	—	—	—	—										
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	I	I	I										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	B	B	B	—	—	B										
		Chair Assist to walk or stand (W/ST)	—	—	—	—	—	—	—	—										
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	INC	INC	I	I	I										
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N	N	N										
		Drink taken?	Y	Y	Y	Y	Y	Y	Y	Y										
		Food, snack, or supplement taken?	N	N	Y	Y	Y	Y	Y	N										
		Has oral hygiene been carried out as per care plan?	R	R	I	—	—	I	I	I										
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y	Y	Y										
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	NT	N	N	NT	N	NT										
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	N	NA										
		Care provider / role	HCA	HCA	HCA SN	HCA AW	HCA AW	HCA AW	HCA SN	HCA										

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Adult Peripheral Vascular Cann

Insertion and Maintenance Care Plan

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion cr ection at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☑ Transfusion ☐

PVC inserted: Day 0	Date: 8/12/19 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ DU Unknown ☐ _____
Insertion site: _____	R Hand ☐ R Arm ☑ R Foot ☐ _____ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☑ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: Unfed

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 9/12/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	AL
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 10/12/19

*Reason For Removal: dislodged

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → **Can I switch my patient from IV to oral antibiotics?**

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Na
Ad 0712726128
SULLIVAN
Deborah F
07/12/1972

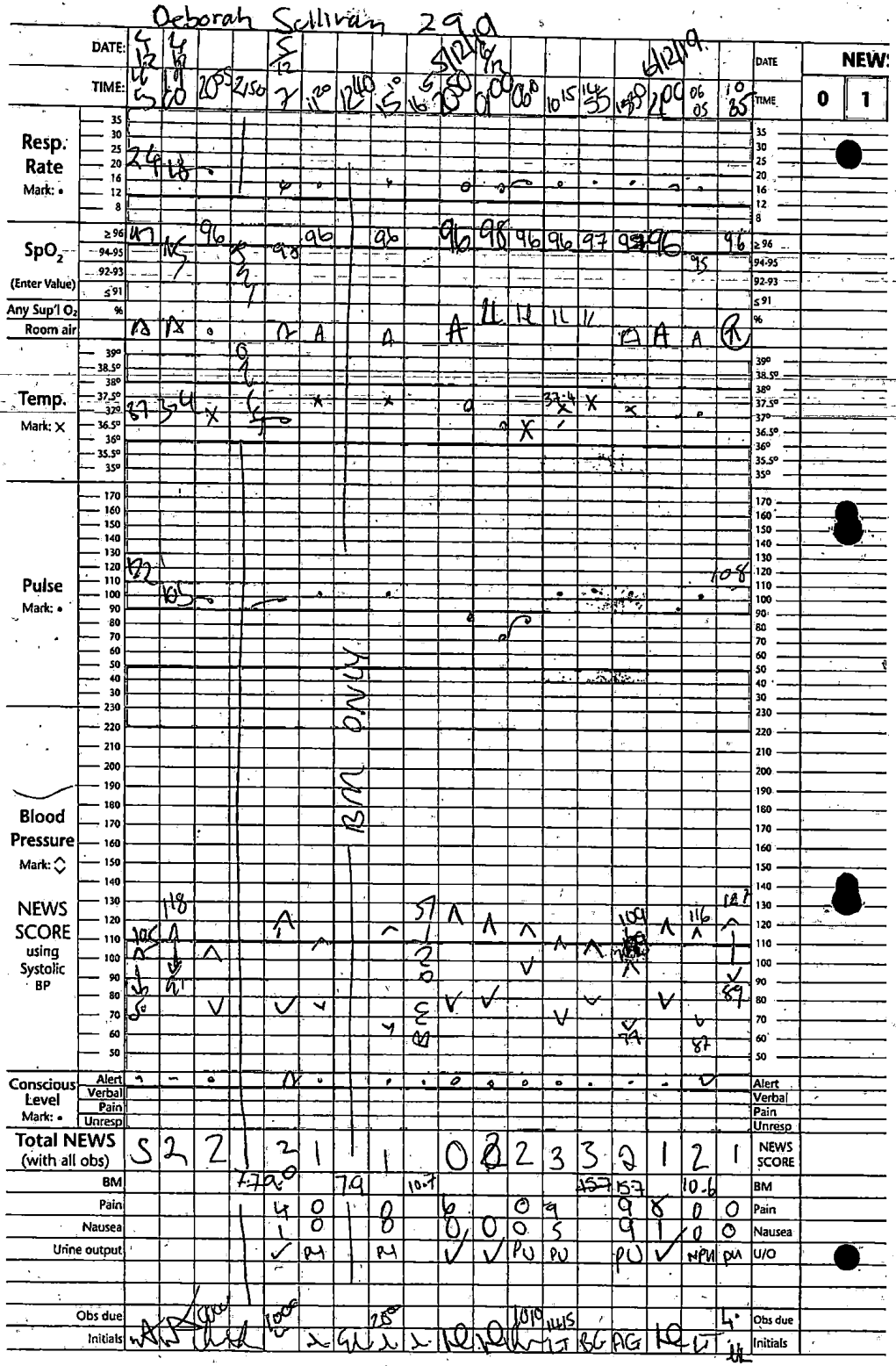
	Date	Ward
Admitted	4/12/19	65/67
Transferred		
Transferred		

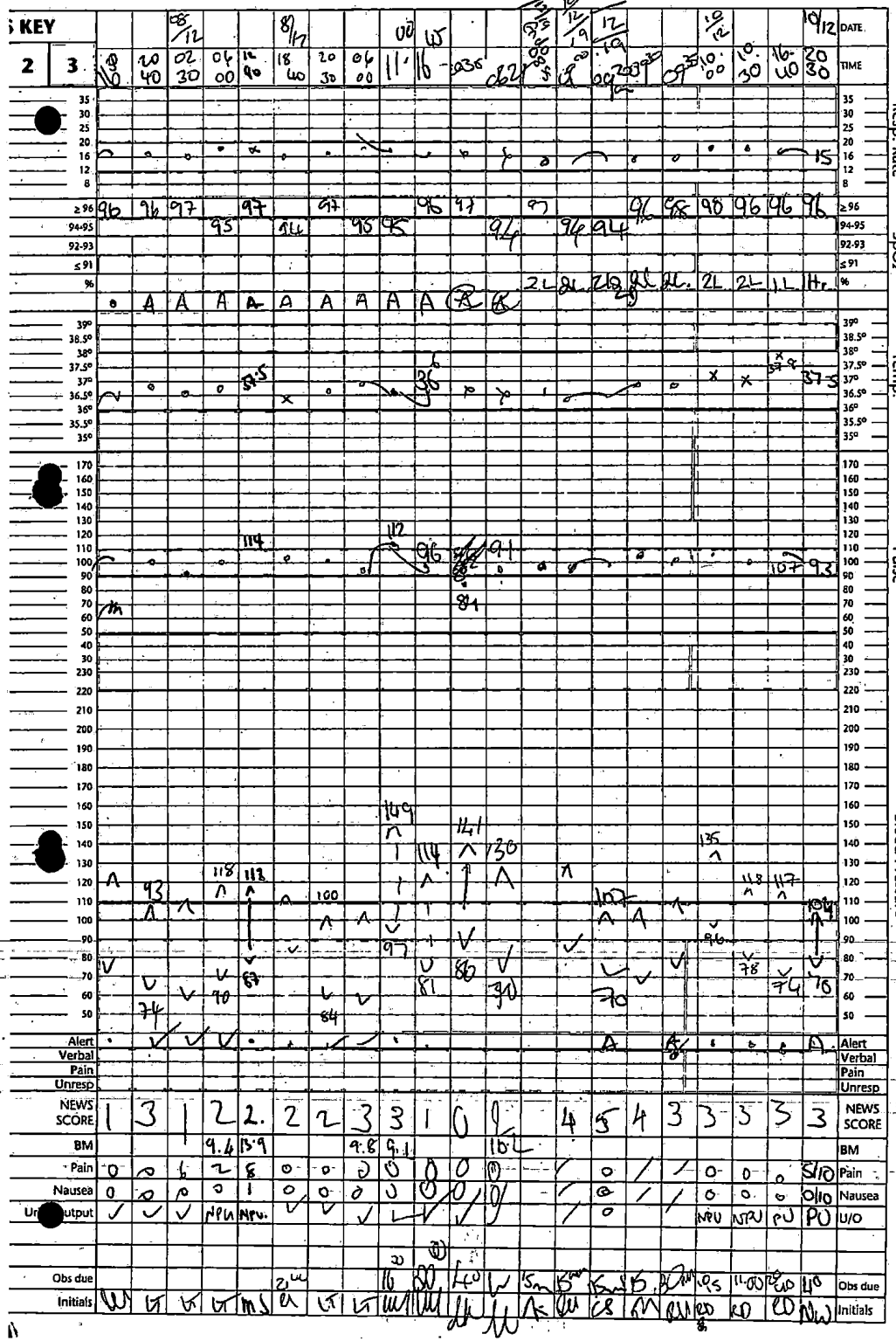
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

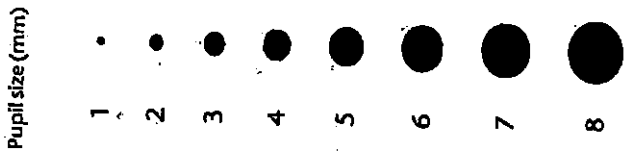
See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


Deborah Sullivan 29
DATE:
TIME:
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
NEWS SCORE using Systolic BP
Conscious Level
Alert
Verbal
Pain
Unresp
Mark: •
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS
0
1


KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale



AFFIX PATIENT ID

Neurological Observations

| | | |

Care Rounds Checklist

Date: 12/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, **based on the patient's most critical need** should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed N Warren Name Nicole Warren Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Addres

0712726128
SULLIVAN F
Laborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Ward: 64

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	0800	1000	1800	1400															
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N															
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	4	N	N															
S	3	**SKIN INSPECTION** Pressure areas checked:	S	4	Y	Y															
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	int	INT	INT															
K	4	**KEEP MOVING** Has the patient moved or walked?	S	4	Y	Y															
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	B	L	L															
		Chair Assist to walk or stand (W/ST)	S	Ind	–	–															
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	Ind	I	I															
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	N	N	N															
		Drink taken?	S	4	Y	Y															
		Food, snack, or supplement taken?	S	4	Y	Y															
		Has oral hygiene been carried out as per care plan?	S	4	I	I															
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	4	Y	Y															
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT	N	N															
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	MA	N	N															
		Care provider / role	NW SN	NW SN	OA	OA															

Care Rounds Checklist

Date: 11/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed N Warren Name Nicole Warren Designation SN
2. Signed [illegible] Name [illegible] Designation SN
3. Signed N Warren Name Nicole Warren Designation SN

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

Attach Addr

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Ward: 64

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

		Times	06 00	08 00	10 00	12 00	16 00																
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	S	N	O																
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	1	1	Y	Y	O																
S	3	SKIN INSPECTION Pressure areas checked:	1	1	I	1	O																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	1	1	-	—	/																
K	4	KEEP MOVING Has the patient moved or walked?	Y	Y	I	Y	O																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	B	B	-																
		Chair Assist to walk or stand (W/ST)	-	-	1	-	-																
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	1	1	I	1	O																
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	O																
		Drink taken?	S	1	Y	Y	-																
		Food, snack, or supplement taken?	S	1	Y	Y	-																
		Has oral hygiene been carried out as per care plan?	S	1	I	1	-																
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	O																
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	S	N	N	N	-																
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	MA	MA	MA	MA	-																
		Care provider / role	BP	BP	[illegible] SN	[illegible] SN	RN SN																

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance		Sign & Print Name

mi • 278936 v2.1 • GGC0098

0712726128
F SULLIVAN
07/12/1972 Deborah
reet Flat 0-1, 8 Boyndie St
Easterhouse
Glasgow, Lanarkshire
G34 9JE

FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: 67/65 Date: 4/12/19 Time: 21:00	Ward: 64 Date: 07/12/19 Time: 06:00	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓INDEP	IND			
2. Check walking aid (if required) is in reach and in use.	N/A	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓IN REACH	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓ SAFE	SAFE			
5. If glasses are worn, check they are available and in use.	✓WITH PATIENT	✓			
6. If hearing aid/s are worn, check they are working and in use.	N/A	N/A			

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓		✓						
2. Does the patient have cognitive impairment or a possible delirium?		✓		✓						
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓		✓						
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓		✓						
5. Based on your clinical judgement, is this patient at high risk of falling?		✓		✓						
Signature of nurse completing assessment / update	[illegible]		[illegible]							

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing Interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Person Specific (Inpatient) Moving and Handling Assessment Form

P N: 0712726128	Named Nurse:		Person is totally independent (tick here and go to date box) ✓

1 F SULLIVAN
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Easterhouse
Glasgow, Lanarkshire
G34 9JE

cm

BMI

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

Risk of Falls: Yes | No

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 ≥3	Additional Information / Equipment:	✓
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information:	✓

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 ≥3	Additional Information:	✓
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 ≥3	Additional Information:	✓
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 ≥3	Additional Information / Equipment (eg sliding sheets):	✓
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 ≥3	Additional Information / Equipment (eg rope ladder, swivel cushion):	✓

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 ≥3	Additional Information / Equipment (eg sling tilting hoist after risk assess):	✓
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Ateml)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 ≥3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	✓

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	4/12/19	11/12/19	
Assessor's signature:	[signature]	[signature]	
Proposed Review date:	11/12/19	19/12/19	

Continuation Sheet

1. General Information (Only complete this section if changed from over page)

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		
Risk of Falls: Yes ☐ No ☐		

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Model		Aid Type	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist ☐	Standaid ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	

4. Move on / off bed pan

Hoist ☐	Manoeuvre ☐	Assistance ☐	Supervision ☐	N/A ☐
See No 2 Sit to Stand Transfers for details	Roll patient ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Person bridges ☐			

5. Move up / down bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Sliding sheets ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information:	
	Monkey pole ☐			
	Rope ladder ☐			

6. Lateral Transfer to / from trolley / bed

Hoist ☐	Handling Aids ☐	Assistance ☐	Supervision ☐	Independent ☐
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify) ☐			

7. Sit up over side of bed

	Bed Rest ☐	Assistance ☐	Supervision ☐	Independent ☐
		People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment ☐	Handling Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
Shower ☐	Shower chair ☐	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath ☐	Shower trolley ☐			
Bed bath ☐	Bathing hoist (eg Ateni) ☐			

9. Walking

No Walking ☐	Walking Aid ☐	Assistance ☐	Supervision ☐	Independent ☐
	see 'sit to stand transfers'	People: 1 ☐ 2 ☐ ≥3 ☐	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	☐ / Forward slash	☐ X Where a forward slash exists, add a back slash to make a cross	☐ * Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 4/12/19 Time 2100 of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	175 cm	☐	☑	
Admission Weight	95.85 Kg	☑	☐	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☑

Any unplanned weight loss in the last 6 months Yes ☐ how much _____ No ☑ Don't Know ☐

Date	4/12/19							
Time	2100							
Ward	67							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	CH							
Weight (kgs)	95.85							
BMI	31.2							
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	11/12/19							
Signature								

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

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Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient ☑ Yes ☐ No ☐ Unable	If unable, give reason:		
Care discussed with family ☐ Yes ☑ No ☐ Unable	If unable, give reason:		

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature
4/12/19 h	No issues. Regular NEWS.	
	2, 3. Communication and senses	
4/12/19 h	Speaks english. Wears glasses for reading	
	4. Cognitive status	
4/12/19 h	Alert and orientated.	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
4/12/19 h	"I live at home alone with my cat. Ive been unemployed due to ill health for 15 years"	
	5. Hydration and Nutrition	
4/12/19 h	Normal diet and fluids. MUST=0	
	6. Elimination	
4/12/19 h	No issues PV. States bowels regular with use of laxatives.	

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Care Plan

NHS
Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
4/12/19 h	Independent.		4/12/19 h	Aware of own limitations Orientated to ward and call bell.	
				10. Sleep and Rest	
			4/12/19 h	Disturbed - takes temazepam.	
	8. Mobility				
4/12/19 h	Independent			12. Privacy, dignity and sexuality	
			4/12/19 h	Maintained at all times with use of curtains.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	
Address	0712726128 SULLIVAN Deborah F 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE
CHI No.	
DoB	

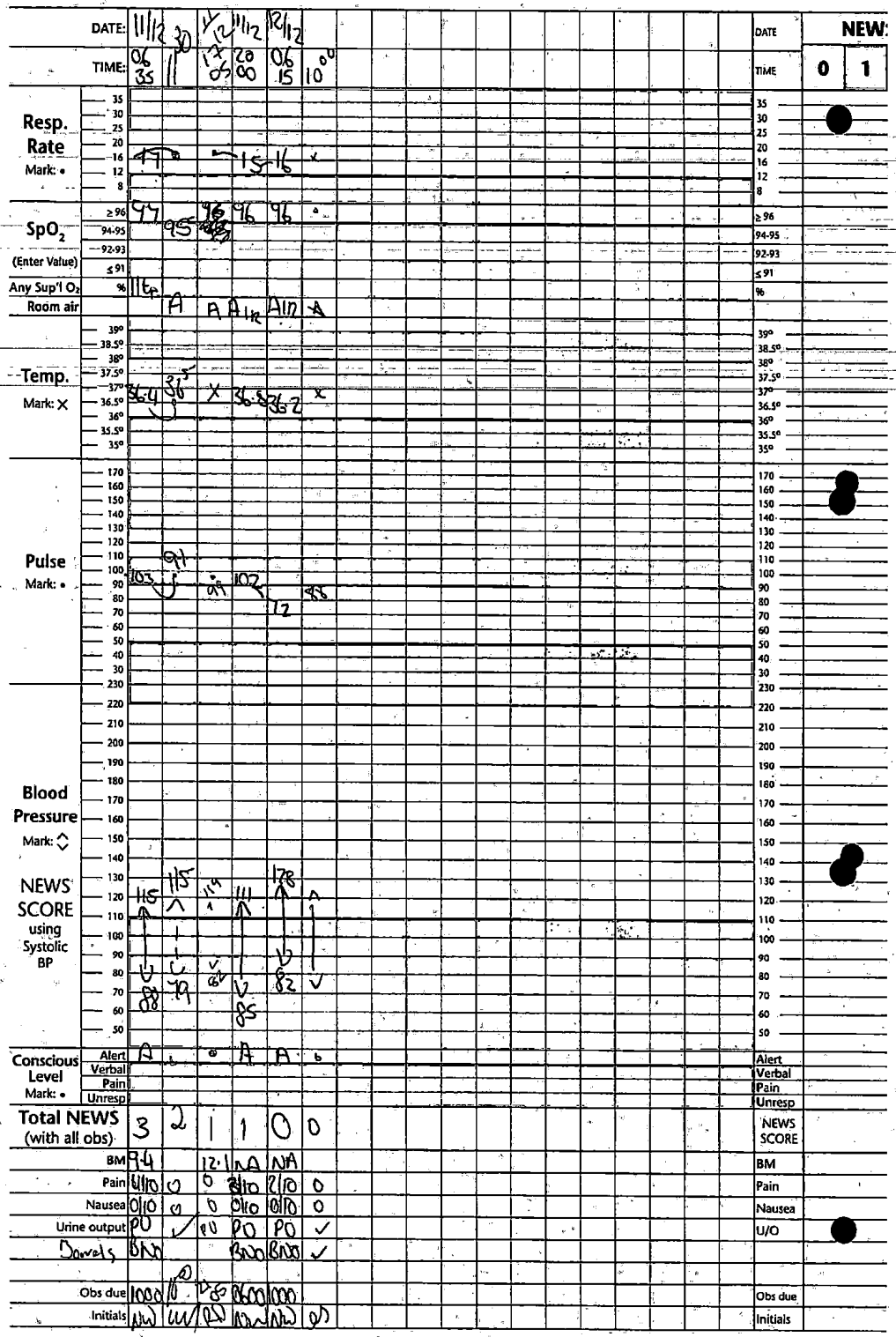
	Date	Ward
Admitted		
Transferred		
Transferred		

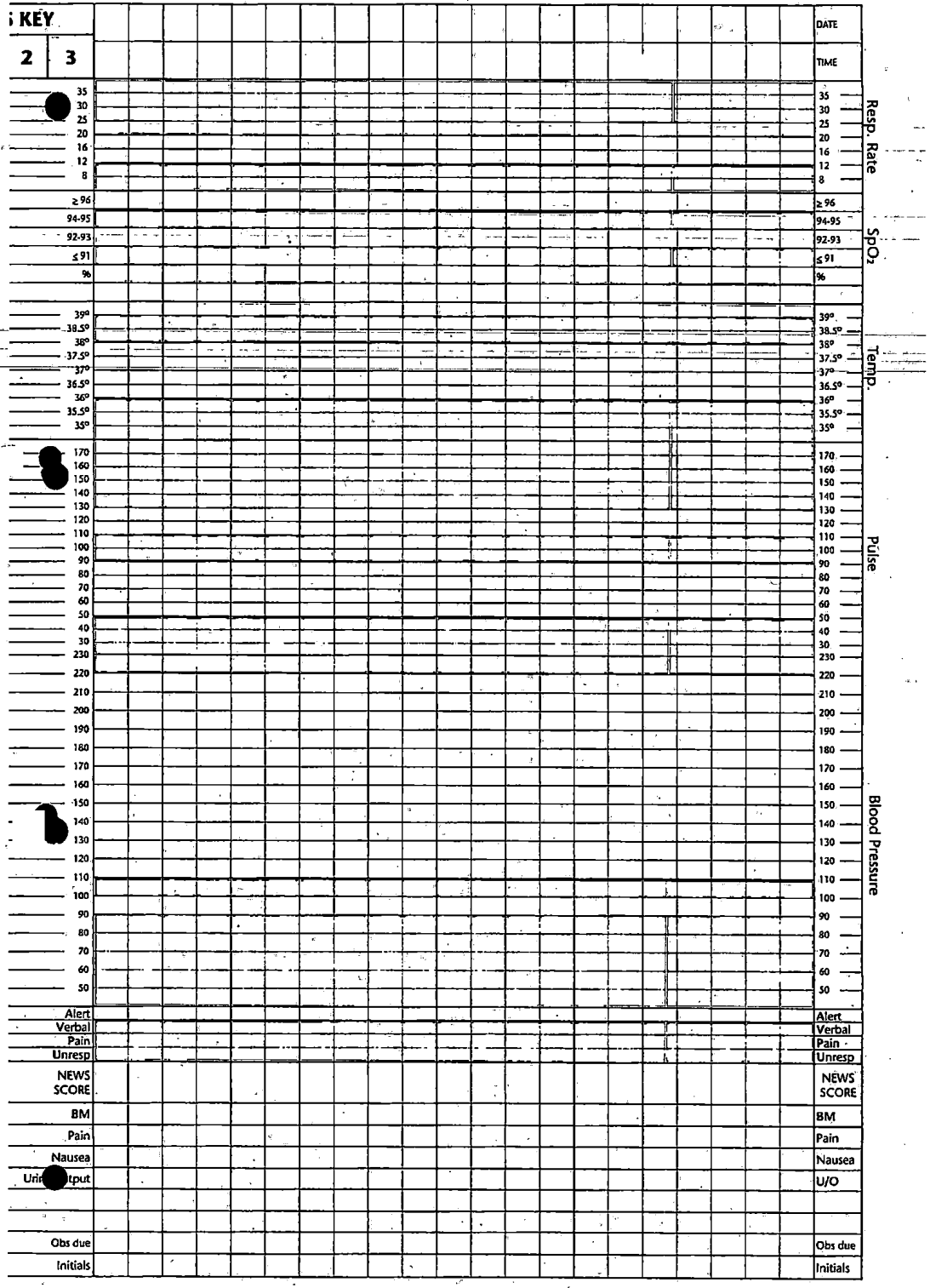
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.


DATE:
TIME:
11/12
06 35
11/12
20 00
12/12
06 15
10 00
DATE
TIME
NEW:
0 1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: X
Pulse
Mark: •
Blood Pressure
Mark: ^
NEWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
Bowels
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
Blood Pressure
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
U/O
Obs due
Initials

Glasgow Coma Scale



PATIENT ID

Neurological Observations

Date:																									
Time:																									
COMA SCALE	E Eyes open	Spontaneously	4																						Eyes closed by swelling = C
		To speech	3																						
		To pain	2																						
		None	1																						
	V Best Verbal response	Orientated	5																						Endotracheal tube or tracheostomy = T
		Confused	4																						
		Inappropriate words	3																						
		Incomprehensible sounds	2																						
		None	1																						
	M Best motor response	Obeys	6																						Usually record the best arm response
		Localises	5																						
		Flexion - withdrawal	4																						
		Flexion - abnormal	3																						
		Extension to pain	2																						
		None	1																						
TOTAL SCORE																									
PUPILS	R	Size																							
		Reaction																							+ reacts – no reaction c. eyes closed
	L	Size																							
		Reaction																							
LIMB MOVEMENT	ARMS	Normal power																							
		Mild weakness																							
		Severe weakness																							
		Spastic flexion																							
		Extension																							
		No response																							
	LEGS	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																							

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Adult Peripheral Vascular C

Insertion and Maintena
Care Plan

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CHI: _____
Address: _____
Hospital: GRI

NHS Greater Glasgow and Clyde

Insertion — **This section at time of insertion.**

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 11/12/19 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☑ 64 Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other:
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason:

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night 11/12/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☐ No ☑	Yes ☐ No ☐ N/A ☑	WW
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 16/12/19

*Reason For Removal: Best Discharge

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE** is available reliably (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

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NHS
Greater Glasgow and Clyde

Unit No.:

Date:		4/12/12	5/12	6/12	7/12	8/12	9/12	10/12					
Time of Result:		17.09	11.46	12.32									
WCC	4-11	13.5	10.0	9.9	9.4	9.0	7.6	8.3					
Hb	M - 13-18 F - 11.5-16.5	149	131	128	135	126	121	122					
Plat	150-400	322	294	251	283	261	265	298					
Amylase	<100	53	50	56									
CRP	<10	8	10	10	20	22	25	26					
Na+	135-145	138	138	137	138	138	138	140					
K+	3-5-50	3.9	3.7	4.7	4.3	4.2	4.0	4.4					
Cl-	98-108	102	102	104	99	101	102	103					
Bic	21-28												
Urea	2.5-7.5	4.8	4.6	3.7	2.7	2.7	1.9	2.3					
Creat.	57-113	52	50	53	64	58	52	56					
EGFR	60>	>60	>60	>60	>60	>60	>60	>60					
Glucose	3.5-5.5	8.9											
Bilirubin	3-22	8	10	9	9	7	7	7					
ALT	<50	37	42	37	61	46	36	34					
AST	<40	26	33	31	47	26	22	20					
G-GT	<55												
Alk. Phos.	40 -150	105	105	96	110	94	84	83					
Albumin	32-45	40	35	34	37	33	32	32					
Mg^+													
Ca	2.1-2.6												
Adj Ca	2.1-2.6												
PO4	0.7-1.4												
PT	9-12	12/1.0											
APTT	25-37	29/0.9											
TCT	11-15	21/0.9											

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin

Fluid Balance Chart

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Hospital: GRI
Ward: 64
Date: 8-12-19

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00	WATER	SD.								PU.							
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

*24 hr Fluid Balance +/-

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral Intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 5/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed L Johnson Name L JOHNSON Designation S/N
2. Signed [illegible] Name NURSE Designation SN
3. Signed _____ Name _____ Designation _____

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

A[illegible] 0712726128
F SULLIVAN
07/12/1972 Deborah
reet Flat 0-1, 8 Boyndie St
Easterhouse
W Glasgow, Lanarkshire
G34 9JE

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

		Times	00 00	06 50	11 30	15 00	20 50
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	2	2	2	2
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	2	4	4	4	4
S	3	**SKIN INSPECTION** Pressure areas checked:	S	1	1	1	1
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	-	-	-	-
K	4	**KEEP MOVING** Has the patient moved or walked?	S	1	1	1	1
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	-	-	-	-
		Chair Assist to walk or stand (W/ST)	S	-	-	-	-
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	1	1	1	1
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	2	2	2	2
		Drink taken?	S	4	4	4	4
		Food, snack, or supplement taken?	S	2	2	2	2
		Has oral hygiene been carried out as per care plan?	S	1	-	-	1
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	4	4	4	4
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	2	2	2	2	2
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	[illegible]	2/9	2/4	10
		Care provider / role	SB	[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 4/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr 4hr

1. Signed [signature] Name [illegible] Designation RN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Ad[illegible]
0712726128
F SULLIVAN
07/12/1972 Deborah
reet Flat 0-1, 8 Boyndie St
Easterhouse
Glasgow, Lanarkshire
Ward: 65 G34 9JE

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	2100																
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N																
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		Y																
S	3	SKIN INSPECTION Pressure areas checked:		H																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		I																
K	4	KEEP MOVING Has the patient moved or walked?		H																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		R																
		Chair Assist to walk or stand (W/ST)		I																
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		H																
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N																
		Drink taken?		N																
		Food, snack, or supplement taken?		N																
		Has oral hygiene been carried out as per care plan?		I																
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y																
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT																
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		N																
			Care provider / role	[illegible]																

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Fluid Balance Chart

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital: GRZ
Ward: GLP
Date: 07/12/19

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00										pu		BO					
07:00	200																
08:00	200																
09:00																	
10:00	water	200															
11:00																	
12:00	150																
13:00																	
14:00																	
15:00	200									pu							
16:00	tea	200															
17:00	milk	200															
18:00																	
19:00										pu							
20:00																	
21:00											200						
22:00	water	100															
23:00																	
								*Total Intake							*Total Output		

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Care Rounds Checklist

Date: 08/12/17

Attach Ac 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
Ward: G34 9J

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed LOUGH Name LOUGH Designation S/N
2. Signed M. Stenhouse Name MAIRI STENHOUSE Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	02 30	06	10 00	14 35	17 45	22 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	N	N	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	/	–	–	/	/
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	R	B	R	B	R
		Chair Assist to walk or stand (W/ST)	/	/	–	–	I	I
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N
		Drink taken?	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	N	N	Y	Y	Y	Y
		Has oral hygiene been carried out as per care plan?	I	I	I	N	I	I
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	NT	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N	N	N	NA	NA
		Care provider / role	LOU	LOU	MS	MS	AK	MS

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 07/12/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed A Kelly Name CHRIS KELLY Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

Attach Address
0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Ward: G4

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
No Thanks-

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	02	06	08	10	12	16	20														
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N	N	N	N														
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	S	N	N	N	N	N	N														
S	3	SKIN INSPECTION Pressure areas checked:	S	I	I	I	I	I	I														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	✓	✓	✓	✓	✓	✓														
K	4	KEEP MOVING Has the patient moved or walked?		Y	Y	Y	Y	Y	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	B	B	✓	—	✓	✓														
		Chair Assist to walk or stand (W/ST)		✓	✓	✓	—	✓	✓														
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	I	I	I	I	I														
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	S	N	N	N	N	N	N														
		Drink taken?		N	Y	Y	Y	Y	Y														
		Food, snack, or supplement taken?	S	N	Y	N	N	N	Y														
		Has oral hygiene been carried out as per care plan?		I	I	I	I	I	I														
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	S	Y	Y	Y	Y	Y	Y														
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	S	NT	N	N	N	N	NT														
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	S	NT	N	N	N	N	NT														
		Care provider / role			SN	SN	SN	SN	SN														

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Care Rounds Checklist

Date: 6.12.19.

Attach Addressograph Label

DEBORAH SULLIVAN

Ward: 65

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next ~~work~~ shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed [signature] Name GUNNER Designation S/N
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00 00	07 00	11 00	15 00	22. 00														
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N														
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	Y	Y	Y	N														
S	3	SKIN INSPECTION Pressure areas checked:	S	I	I	I	I														
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	/	/	/	/														
K	4	KEEP MOVING Has the patient moved or walked?	S	I	I	I	I														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	/	/	/	B														
		Chair Assist to walk or stand (W/ST)	S	/	/	/	/														
I	5	ELIMINATION Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	I	I	I														
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	S	N	N	N	N														
		Drink taken?	S	Y	Y	Y	Y														
		Food, snack, or supplement taken?	S	Y	N	N	N														
		Has oral hygiene been carried out as per care plan?	S	I	I	I	I														
	7	ENVIRONMENT Check: Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y														
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.	N	NT	NT	NT	NT														
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	/	NA	NA	NA	NA														
		Care provider / role	SG HCA	LT SN	LT SN	LT SN															

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

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Adult Peripheral Vascula

Insertion and Mainte
Care Plan

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

DOB 07/12/197_ CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 4/12/19 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ AAU Unknown ☐ _____
Insertion site:	R Hand ☐ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☑ L Foot ☐ Other: _____
Colour of cannula:	Blue ☑ Pink ☐ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: Unknown

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 5/12/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☐	N
Day 1 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day 6/12/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	LT
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day 07/12/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: __/__/__

*Reason For Removal: _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy.
Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Nai
Add
DO
CH

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

1. Triage (Consider Mental Health Triage Assessment - if applicable)

Hospital	Patient Preferred Name:
Date: Time:	
Triage Nurse	Transport SAS/Self:

2. Presenting Complaint

Category ☐ Gap Score ☐

3. Observations

Allergies (including food allergies):

No Known allergies ☐

Resp. Rate	Sp02	Temperature	Pulse	Blood Pressure
GCS	**NEWS Score**	**PEFR**	**Blood Glucose**	**Pain Score**
/15				/10

4. Communication

I.D. band on? (Y) / N
Relatives present? Y (N)
Relatives / NOK informed? Y (N)
Interpreter required? Y / (N)

5. 4AT and TIME for Detection, Management, and Prevention of Delirium

Complete for patients: age 65 and over; patients of any age with an existing cognitive impairment; previous delirium; current hip fracture; or severe illness. These patients are at high risk of delirium. This should be done on admission; at each transition of care; if SQiD positive; or if any clinical concerns.

mi • 287900 v3.0 • GGC0255

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name: SULLIVAN Deborah F
Addre: Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE
DOB: 07/12/1972
CHI Nu: 0712726128

Named Nurse/Team Leader: _____

Assessment Completed by: Name (PLEASE PRINT) _____

6. Patient Preparation

Prepare patient for examination	☐	IV Cannula (if required)		Y/N
Clothing bag labelled and stored	☐	Blood samples taken		
GGC RED BAG - with patient	☐	If Yes, list requests		Y/N
12 Lead ECG	☐	Cardiac Monitoring		Y/N
X rays performed	☐	Height:	Weight:	

Urinalysis

Leucocytes	Nitrites	Protein	pH
Blood	S.G.	Ketones	Glucose
MSSU/CSU Sent ☐			
HCG specimen if indicated	+ve ☐	-ve ☐	Strip Lot no:

. Peripheral Vascular Catheter (PVC) Bundle

Reason for PVC Insertion:

☐ IV Fluids

☐ IV Drugs

☐ Suspected haemorrhage

☐ Diagnostic tests

Insertion Date: ___/___/___

Insertion Time: ____:____

Hand hygiene performed immediately before PVC insertion.	☐
Skin antiseptic containing 70% isopropyl alcohol used to cleanse the skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐
Sterile, transparent, semi permeable dressing used to cover catheter site.	☐
Size/Colour:_____ Insertion site:_____	
Signature:_____	

8. Adult Urethral Urinary Catheter Insertion (Use maintenance care plan as appropriate)

Clinical Indication for Insertion:

Insertion Date: ___/___/___

Insertion Time: ____:____

Signature: _____

Hand hygiene performed immediately before insertion.	☐
Aseptic technique maintained throughout insertion procedure and connection to closed drainage.	☐
Urethral meatus cleansed with saline and lubricant used.	☐
Guage: _____ _____ mls in balloon	

9. General Safety Precautions to be Undertaken by All Patients

Falls Risk - if yes to any - FULL RISK ASSESSMENT

Action the following safety precautions on admission to your ward.
Update weekly or on change of condition

Date: 4/12

Time: 1615

1. Document mobility status in clinical record and complete a moving and handling assessment if appropriate	
2. Check walking aid (if required) is in reach and in use.	
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	
5. If glasses are worn, check they are available and in use	
6. If hearing aid/s are worn, check they are working and in use.	

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah
F
07/12/1972

10. Screening Tool (Requires escalation/specialist referral/separate Risk Assessments)

Child Protection concern	Y / N / NA	Learning Disabilities	Y / N / NA
Adult Support and Protection	Y / N / NA	Patient has appointed Welfare Guardian/Power of Attorney	Y / N / NA
>65 years: 4AT/TIME BUNDLE COMPLETE?	Y / N / NA	Patient has Adult with Incapacity Section 47 certificate in place	Y / N / NA
Mental Health Triage	Y / N / NA	Infection Risk	Y / N / NA
Has swallow test been carried out?	Y / N / NA	STOPPS completed? Y / N / NA Date 4/12 Time 1610 Sign	
Sepsis Risk: Systemic inflammatory response syndrome (SIRS) Criteria 2 or more → commence Sepsis Bundle	Y / N / NA	Anticipatory Care Planning? (If applicable, complete GAEL chart)	Y / N / NA
FRAILTY SCREENING	Y / N / NA	SUBSTANCE MISUSE FAST SCORE / GMAWS	Y / N / NA

11. Frailty Screening Tool

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self-care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

12. Pressure Area Assessment

1 Pressure Damage	Does the person have redness and/or existing damage? Yes / No If YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occuring and complete the pressure ulcer intervention plan (PUDRA Chart).

Date	Location of redness/ulcers	Grade of ulcer	Date	Location of redness/ulcers	Grade of ulcer

2 Mobility	Does the person require assistance to mobilise?	Yes / No
3 Continence	Does the person have continence issues with urine and/or faeces	Yes / No
4 Nutrition	Does the person appear malnourished and/or unable to eat or drink	Yes / No
5 Skin	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?	Yes / No
6 Judgement	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:	Yes / No

13. Record of Intentional Rounding – ask whenever patient is visited but no longer than every 2 hours

1. Think delirium: Is the patient more confused?
2. Comfort: Are you comfortable?
3. Pain: Do you have any pain?
4. Drink/Mouth Care: Would you like a drink?
5. Food: Are you hungry?
6. Continence: Do you need to go to the toilet?
7. Possessions: buzzer, tissues, glasses within reach, water available and relatives at bedside?
8. Is there anything else I can do for you?

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.
4/12/24	1015	LXT												

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

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Easterhouse
Glasgow, Lanarkshire
G34 9JE

Communication with Relatives	Signatures	Time
Next of Kin: Tel:		

Nursing Notes		
Date and Time		Print Name and Signature
4/12/19 1615	Mrs Sullivan admitted to [illegible] ward via GP - dyspnoea [illegible]	
1625	NC's x 2 - washed, SOB [illegible] - looks better	

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

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Address: Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
DOB:
CHI Nun

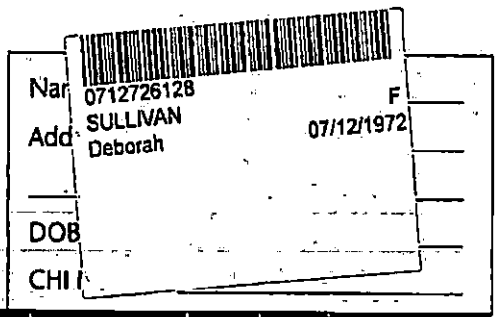
Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde



Nursing Notes

Date and Time		Print Name and Signature

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde



Pause for Transfer (Please tick when completed)		Tick when completed	N/A	Notes
	Relatives Informed	☐	☐	Information on discussion with relatives
	Cannula	☐	☐	
	Name Band	☐	☐	
	4AT	☐	☐	
	NEWS >7 Snr Dr.: _____ Page no.: _____	☐	Always	
Prescriptions signed	Infusions	☐	☐	
	Drugs	☐	☐	
	Fluids	☐	☐	
	GMAWS	☐	☐	
GGC RED BAG - with patient		☐	☐	Please note here if any other tasks required prior to transfer
	Belongings (including patients medication)	☐	Always	
	Bed requested, accepted and ward informed/SBAR completed	☐	Always	
	Notes: medical notes; GP letter, PRF	☐	Always	
Investigations	CXR reviewed	☐		
	ECG reviewed	☐	☐	Print name
	Bloods sent	☐	☐	
	Bloods reviewed	☐	☐	
	Patient on 02: cylinder checked	☐	☐	
	Patients requiring analgesia: sufficient	☐	☐	

Pause for Discharge (Please tick when completed)	Tick when completed	N/A	Notes
Advice leaflets given	☐	☐	Information on discussion with relatives
GGC RED BAG - with patient	☐	☐	
Belongings (including patients medication)	☐	Always	
New medications explained	☐	☐	
PVC removed	☐	☐	
Relatives aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/Support Services required and contacted	☐	☐	
SAS Transport required and ref. no.	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Created by AAU Team -GRI

Emergency Department Nursing Documentation

Presenting Complaint - abdo pain

Date: 27/9/19 Time: 2155

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G34 9JE

bel

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) DM JC

Patient Prep / Investigations (Please tick/circle when completed)		Communication (Please Circle Tick)	
Prepare patient for examination / Clothing bag labelled + stored	☑	NEWS Chart complete / NEWS SCORE - (Record pain, blood sugar and Neuro Obs on NEWS Chart)	☑
GGC RED BAG - with patient	☐		
12 Lead ECG	☑	ID Band	☐
Weight:	☐	Peak Flow	☐
Blood Samples Obtained: Yes ☑ No ☐		Xrays,/ CT Scan Performed:	☐
IV Access: Yes ☑ No ☐		Relatives / NOK informed (Carers)	☐
Blood Gas: VBG ☑ ABG ☐		Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Urinalysis

Leucocytes ☐	Nitrites ☐	Protein ☐	Blood ☐
Ketones ☐	Glucose ☐	PH	S.G.
MSSU / CSU ☐	Toxiclogy ☐		
HCG ☐	+VE ☐	-VE ☐	Strip No -

Screening Tools (Please tick/circle when completed)			
SEPSIS RISK? / SIRS Criteria 2 or more	Y/N	**SWALLOW TEST CARRIED OUT? (susp any neurological signs or symptoms)**	**YES**
Mental Health Triage Assessment	Y/N	If NOT WHY? - (details)	NO
GMAWS	Y/N	Date - Time - Signature -	

4AT

AMT	Correct
Age	
Date of Birth	
Place	
Current year	

No mistakes	= 0
1 mistake	= 1
> 1 mistake	= 2

Attention (months of year backwards)	
> = 7 correct	0
< 7 correct	1
Untestable	2

Alertness	
Normal	0
Mild sleepiness	0
Clearly abnormal	4

Mental status according to family/carer		
Acute change or fluctuating	4	YES
Acute change or fluctuating	0	NO

4AT score /12

STEP 1 Would this person benefit from Comprehensive Geriatric Assessment (CGA)?

All over 75s and care home residents over 65. For younger patients use clinical judgement and consult local guidelines.

		YES	NO
F	Functional impairment (new or worsening) eg difficulty with self care		
R	Resident in a care home?		
A	Altered mental state such as acute confusion or dementia use the 4AT		
I	Immobility/instability. New decline in mobility, difficulty mobilising without help or fall leading up to admission		
L	Likely to require support for discharge? (either new or increase in existing support)		

Are any of the above criteria met? If YES to any of the above move to step 2

STEP 2 Would this person be better managed by another specialty team at present?

Indicator for care by another acute specialty regardless of age.

	YES	NO
Clear need for other specialty input eg exacerbation of known long term condition such as COPD		
Need for HDU/ITU (including non-invasive ventilation)		
Suspected new stroke or TIA, consider thrombolysis and care in stroke unit		
Head injury with loss of consciousness		
Acute abdominal pain/surgical presentation		
Upper GI Bleed		
Chest pain with suspected acute coronary syndrome		
Trauma with suspected fracture		

Are any of the above criteria met?

If **YES** to any criteria in step 2:

- Prioritise move to non geriatric service as appropriate. If necessary consider geriatric advice on parent ward.

If **NO** to the list in step 2:

- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

1) Pressure Damage Does the person have redness and/or existing damage? If YES - continue with a minimum of 2 hourly Active Care + Complete PUDRA		Y/N	Date	Location of Redness/Ulcers	Grade of Ulcer	
2) Mobility	Does the person require assistance?	Y/N				
3) Continence		Y/N	**5) Skin**	Is skin compromised by other source, eg neurological deficit, medication, substance, diabetes, co-morbid?		Y/N
4) Nutrition		Y/N	**6) Judgment**	In your clinical judgment is this person at risk for developing pressure damage? IF YES - DETAILS		Y/N

Date	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.	Time	Init.

Patient Addressograph Label

At risk of falls?
(clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *At risk complete risk assessment*

YES	NO
	(NO)

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives Informed of Admission / Discharge		☐	☐	Information on discussion with relatives
Relatives/carer with patient on transfer to ward		☐	Always	
GGC RED BAG - with patient		☐	Always	
Name Band		☐	Always	
Nursing Screening Tools completed		☐	Always	
Bed requested, SBAR COMPLETE		☐	☐	
NEWS chart		☐	Always	
Prescriptions / Charts signed	Infusions	☐	☐	
	Cannula	☐	☐	
Notes: medical notes, GP letter, PRF		☐	☐	
Patients requiring analgesia: sufficient		☐	☐	
Belongings (including patients medication)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport required and ref. no.		☐	☐	
Print Name Sign -				

Nursing Notes

Date and Time		Print Name and Signature
27/9/19 1235	Abdo pain ? pancreatitis.	
	Reviewed by doctor.	
	Analgesia ✓	
	Anti emetic ✓	
	IVF ✓	
	Admit surgeon	[signature]

Nursing Notes		
Date and Time		Print Name and Signature

My Admission Record

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Dr. AL McGinley
Lochend Surgery
Easterhouse Health Centre
Auchinlea Road
Glasgow
G34 9HQ
(0141) 531 8150

Hospital: GRI Ward: 65
Date of Admission: 28/9/19 Time: 0040
Information obtained from: Name:

Patient ☑ Relative ☐ Other ☐ _____

Preferred Name:

Age: 46 Telephone Number: 07713718392

Consultant: MR Duxbury

Communication

What is your first language? English

Do you require an interpreter? Yes ☐ No ☐

If yes, provide details of arrangements made _____

Do you use British Sign Language (BSL)? Yes ☐ No ☐

Do you need someone to help you to communicate? Yes ☐ No ☐ If yes, who _____

urine Prot. Ketones

Preferred first contact	**Preferred second contact**
Name: Donna Sullivan	Name:
Relationship: Sister	Relationship:
Address:	Address:
Telephone: 07743956178	Telephone:
Is this person aware of your admission?	Is this person aware of your admission?
Yes ☐ No ☑ Pt will inform	Yes ☐ No ☐
Can we share information with this person?	Can we share information with this person?
Yes ☑ No ☐	Yes ☐ No ☐

Presenting Complaint / Diagnosis

@ abdo pain - epig pain → Back

nauses

Explained to the patient? Yes ☐ No ☐ Not Applicable ☐

Do you understand the reason for your admission? Yes ☐ No ☐

Allergies / Sensitivities (Record food allergies in the Hydration and Nutrition section)

No known allergies ☐ Penicillin

Relevant past medical history

Pancreatitis
Fundoplication x2
Cholecystectomy
appendisectomy
C-section
Delayed gastric emptying

On admission, is there a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place

Yes ☐ No ☑ If yes, Who asked for a copy? _____

Date they asked for a copy __/__/__ Date Obtained __/__/__

Power of Attorney / Guardianship / Adult with Incapacity

0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972

Affix patient ID label

Does someone have Power of Attorney (POA) for you?

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

If yes, is this for:- Finance ☐ Welfare ☐ Both ☐

Which are currently in action? Finance ☐ Welfare ☐ Both ☐ Nil ☐

Please obtain a copy and place in the patient's notes

Who asked for a copy?_____ Date they asked for a copy __/__/__ Date Obtained __/__/__

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

N.B. If you think the patient may lack capacity inform Medical Staff to assess and, if required, consider the need for an 'Adult with Incapacity' Section 47

Carbapenemase-producing enterobacteriaceae (CPE)

Have you ever:	Yes	No
1. Been an inpatient in a hospital outside Scotland?	☐	☑
2. Received holiday dialysis outside Scotland?	☐	☑
3. Been told that you have CPE?	☐	☑
4. Been in close contact with a person with CPE?	☐	☑

If the answer is yes to **ANY** of the questions in this section, you must

- Isolate the patient in a side room ☐
- Obtain Rectal swab marked 'for CPE' ☐
- If patient refuses rectal swab, obtain a stool specimen marked 'for CPE' ☐
- **and inform the IPCT** ☐

MRSA Screening

	Yes	No	Unsure
Will the patient be an inpatient for more than 23 hours	☐	☐	☑
If **YES** complete the following section			
1. Have you ever been told that you have MRSA?	☐	☑	☐
2. Have you been admitted from another hospital/ residential setting or care home?	☐	☑	
3. Do you have a wound / skin ulcer or invasive device which you had before admission?	☐	☑	☐

If **YES** to Q1, 2 or 3 above OR the patient is admitted to a 'high impact speciality' i.e. Orthopaedics, Vascular, Renal Unit, Critical Care – obtain MRSA swabs

Nasal ☐ Perineum ☐ Other ☐ Specify _____ Patient refused ☐

Creutzfeldt-Jakob Disease (CJD)

	Yes	No	Unsure
Have you ever been informed that you are at increased risk of CJD or vCJD?	☐	☑	☐

If **YES inform the IPCT** ☐

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07/12/1972

Affix patient ID label

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? Feb 2019

Never smoked ☐

Do you use eCigarettes? Yes ☑ No ☐

If a smoker, the NHSGGC Smokefree policy has been explained and Nicotine Replacement Therapy (NRT) has been offered

Yes - administered NRT ☐ Yes - patient declined NRT ☐

If declined - Why: _____

Do you want to talk to someone about your smoking? Yes ☐ No ☐

If yes, refer to Smokefree Services (Trakcare) Date referred: ___/___/___

Drugs

Do you use recreational or illicit drugs or are you receiving opiate replacement therapy (ORT / Methadone / Suboxone)? Yes ☐ No ☑

If yes, please specify and refer to the NHSGGC Guidelines for the Management of Drug Users in Glasgow and Clyde Acute Hospitals

_____

_____

Alcohol

Do you drink alcohol? Yes ☐ No ☑

How often do you have more than 6 units of alcohol on one occasion:

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

NB: If daily or almost daily commence the Glasgow Assessment and Management of Alcohol (GAMA), complete FAST Tool and take further action as per guidance.

Name (Please PRINT): GMITCHEL Signature: GMitchel

Designation: SN Date: 28/9/19

My Assessment Record

0712726128
SULLIVAN F
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Glasgow, Lanarkshire
G34 9JE

1. Breathing and Circulation

Breathing	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's breathing
No breathing problems	✓	✓	
Breathless at rest			
Breathless on exertion			
Productive / Non-productive cough			
Cyanosed			
Uses nebulisers			
Uses inhalers			
Oxygen therapy			
Do you have any other symptoms?			

Circulation	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's circulation
No circulatory problems	✓	✓	
Chest pain at rest			
Chest pain on exertion			
Angina			
Do you take medication for symptoms of angina?			
Hypertension			
Do you have any other symptoms?			

2. Communication

	Yes ✓	No ✓	Assessment of the patient's communication needs
Do you have any difficulties communicating your needs?		✓	
Do you have any difficulties with your speech?		✓	
Do you have a Learning Disability?		✓	
Do you have support from a Learning Disability Team? Contact details: _____		✓	

Name:
0712726128
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3. Senses

Vision	**Yes** ✓	**No** ✓	Assessment of the patient's vision
Do you have any problems with your vision?	✓		
Do you wear glasses?	✓		Distance ☐ Reading ☑ Both ☐
Do you have your glasses with you?		✓	
Do you wear contact lenses?		✓	
Do you have your lenses with you?	NA		
Do you wear a prosthesis?	NA		
Hearing	**Yes** ✓	**No** ✓	Assessment of the patient's hearing
Do you have any problems with your hearing?		✓	
Do you have any hearing loss?		✓	
Do you use a hearing aid?		✓	
Do you have your hearing aid(s) with you?		NA	
Pain	**Yes** ✓	**No** ✓	Assessment of the patient's pain
Do you have pain?	✓		8/10

Can you describe where and what the pain is like?

epig

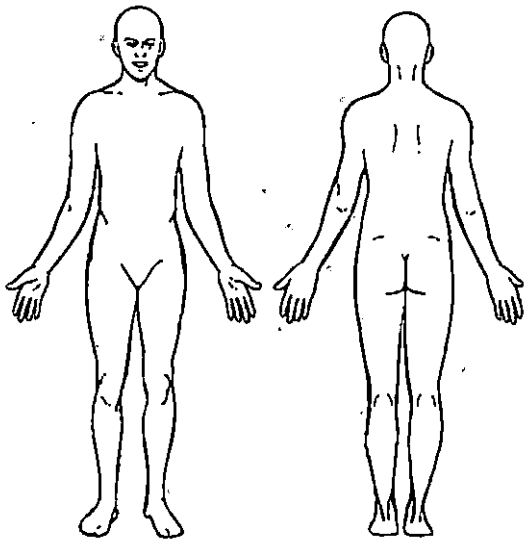
Have you had treatment / intervention for the pain?

N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

What makes the pain better?

Mark current pain on body chart



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Glasgow, Lanarkshire G34 9JE

4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	
Impaired conscious level			
Confused			
Dementia			
Stressed / Distressed			

N.B. Think Delirium

Complete 4AT for all patients 65 and over, AND for patients of any age with one or more of the following:

- existing cognitive impairment
- previous delirium
- current hip fracture
- severe illness

and follow the guidance

N.B. 'Getting to Know Me' and 'What Matters to Me' should be completed for all patients with dementia, cognitive impairment or complex needs

5. Hydration and Nutrition

Do you have any food allergies or food intolerances?

nil

What do you like to eat and drink?

likes most food

What do you not like to eat and drink?

nil

N.B. Malnutrition Universal Screening Tool (MUST) to be completed for all patients within 24 hours of admission

Diet and Fluids	Admission Presentation ✓	Normal for the patient ✓
Normal diet and fluids	✓	✓
Therapeutic diet		
Cultural, ethnic or religious diet		
Texture Modified Diet Please state _____		
Thickened Fluid Please state _____		
Oral Nutritional supplements Preferred flavour _____		
Enteral Nutrition		
Parenteral Nutrition		
Nil by Mouth		

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Assessment of the patient's hydration and nutrition needs

N.B. If the patient has any difficulty in the oropharyngeal stage of swallowing complete Screening Tool for Oropharnygeal Swallow Symptoms (STOPSS) within 4 hours of admission

Assistance with eating and drinking	Admission Presentation ✓	Normal for the patient ✓
Independent (Green)	✓	✓
Prompting / encouragement / opening packets/cutting up food (Amber)		
Full assistance with eating and drinking (Red)		

Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

6. Elimination

Bladder	Admission Presentation ✓	Normal for the patient ✓
Pass urine with no problems	✓	✓
Frequently pass urine during the day		
Frequently pass urine overnight		
Sense of urgency when need to pass urine		
Urine retention		

Assessment of the patient's elimination needs

Bladder (cont)	Admission Presentation ✓	Normal for the patient ✓
Haematuria		
Incontinent		

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N.B. If new incontinence report to medical staff to rule out infection or physiological cause

What products do you normally use for this continence issue?

No urinary catheter ☐ ✓ Urinary catheter in situ: Urethral ☐ Suprapubic ☐

Date urinary catheter last changed ___/___/___

N.B. If Urinary Urethral Catheter (UCC) in situ commence NHSGGC Adult UCC Insertion and Maintenance Care Plan

Bowels

When did your bowels last move? UBM – this evening

How often in a day/week do you have a bowel movement? Per day 1 Per week ☐

Do you use any medication e.g. laxative to help your bowels move? Yes ☐ ✓ No ☐

laxido / lactulose

Bowel Habit	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's elimination needs
Regular	✓	✓	
Constipated			
Diarrhoea / loose stools			
Blood in stools			
Incontinent			

What products do you normally use for this continence issue?

N.B. if concerned about bowel patterns (e.g. infrequent movement or frequent loose stools) consider using the Bristol Stool Chart

Stoma	**Yes** ✓	**No** ✓	Assessment of the patient's needs in relation to their stoma
Do you have a stoma?		✓	
Do you require assistance with your stoma care?	NA		
Have you brought any of your stoma products with you?	NA		

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7. Personal Hygiene, Oral Health, Skin Care and Wound Care

Personal Hygiene	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's personal hygiene needs
Independent	✓	✓	
Requires assistance with washing and dressing			

Oral Health	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's oral health needs
No problems	✓	✓	
Sore mouth / mucositis / ulcer			
Requires assistance with oral hygiene			
Other (eg dry lips, tongue coated?)			

Dental work	**Yes** ✓	**No** ✓	Description of any dental work
Do you wear dentures?		✓	
Do you have your dentures with you?	NA		
Are your dentures a good fit?	NA		
Do you have any other dental work that we need to be aware of?		✓	

Skin Care	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's skin care needs
No problems	✓	✓	
Skin broken			
Skin oedematous			
Skin discoloured / red			

N.B. Complete PUDRA for all patients within 8 hours of admission

Pressure ulcer identified on admission: Yes ☐ No ☑

Pressure Ulcer Grade: _____

Pressure Ulcer Site: _____ **Adult wound assessment and management chart required**

N.B If Grade 2 pressure damage on ankle or below refer to Podiarty via TrakCare

Wound Care	Yes ✓	No ✓
Do you have any wounds? **N.B. If yes, complete an assessment chart for wound management**		✓

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8. Mobility

Mobility	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's mobility needs
Fully mobile and independent	✓	✓	
Unsteady when walking			
Do you use a mobility aid	Yes ☐	No ☑	
Do you have your mobility aid with you?	Yes ☐ N/A	No ☐	

N.B. If not fully mobile and independent on admission complete moving and handling assessment within 24 hours of admission

9. Maintaining a Safe Environment

N.B. Complete a falls risk assessment for all patients within 24 hours of admission. If a falls risk is identified complete the falls intervention checklist and document all nursing actions in the care plan.

Safety	Yes ✓	No ✓	Assessment of the patient's ability to maintain a safe environment
Is the patient at risk of falling, rolling, slipping or sliding from the bed?		✓	
Would you like bedrails to be used while in hospital?		✓	

N.B. If yes, to either of the two questions above complete a bedrail risk assessment

10. Sleep and Rest

Sleep	Yes ✓	No ✓	Assessment of the patient's sleep and rest needs
Do you have any difficulties with sleeping?	✓		
Do you do or use anything to help you sleep?	✓		TOMAZEPAM

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11. Social Circumstances

Do you:

Live alone	☑	Live with family/ friend/ other	☐
Live in a nursing home	☐	Live in a care home	☐
Live in residential supported care	☐	Live in student accommodation	☐
Live in 'homeless' accommodation	☐	Have no fixed abode	☐
Other please specify_____	☐		

Dependants	**Yes** ✓	**No** ✓
Do you have any dependants?	M	✓
Do you support anyone (e.g. partner, children, relatives, animals)? daughter age 26	M	✓
Do they need support from someone else whilst you are in hospital?		M
Would someone else be able to provide this support when you are in hospital? If yes, who?		M

If no support available contact Duty Social Worker

Duty Social Worker Required ☐ Not required ☐ Referred ☐

Services	**Yes** ✓	**No** ✓
Do you have support from social work, social services or a care package?		✓

If yes, please provide details:

If yes, has contact been made to cancel arrangements during admission?

12. Emotional and Spiritual Care

Do you have a religion or beliefs that we can help you observe while you are in hospital?

Catholic

Is there anything else with regards to your values, religion or culture that we can support you with during your stay in hospital (e.g. prayer meditation)?

Would you like to talk to someone (e.g. Hospital Healthcare Chaplain) about you, your loved ones, your values and beliefs, or any worries you have? Yes ☐ No ☑

Healthcare Chaplain informed Yes ☐ N/A ☑

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13. Person Centred Care

What matters and is important to you whilst you are in hospital?
This should focus on the personal preferences, choices and goals of the individual of what is important to include in their plan of care.

n/k

N.B. Participating in 'What Matters to Me' should be offered to all patients

Informal Support

Who is important to you, to help support you whilst you are in hospital?

daughter

NB. If the person who helps is not a preferred contact please ensure their details are listed below.

Name: Courtney Kelly
Contact Details: 07487 257039

How do you want the people who matter to you to be involved in your care?

Do you have someone who looks after you or someone that helps you, i.e. an informal carer?

Yes ☑ No ☐ daughter

If yes, has the help or support listed above been confirmed with the patient's family/ friends?
(please tick) Yes ☐ No ☐

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Required Support

Has the patient and / or carer been advised of the hospital Support and Information Service?
Yes ☐ No ☑
Referrals can be made via the central phone number: 0141 452 2387

Has the carer been advised of the Carers Information Line?
Yes ☐ No ☐ Not appropriate at this time ☑
Carers Information Line: 0141 353 6504
Carers Information Leaflet provided?
Yes ☐ No ☐

Are you:
Employed ☐ Unemployed ☑
Self-employed ☐ Retired ☐
Full time education ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☐ Not applicable ☑

Do you have any money worries?
Yes ☐ No ☐ Not appropriate to ask at this time ☑
If yes would you like referred to a money advice service that can offer confidential advice/ support?
Yes ☐ No ☐ If yes when was patient referred ___/___/___

Would you like a referral to a service that can support you with employment / education/ training/ skills volunteering?
Yes ☐ No ☐ Not applicable ☐ Not appropriate to ask at this time ☑
If yes when was patient referred ___/___/___

Na
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Risk Assessments/Other Documentation

Additional NHSGGC Documentation	Required		Required documents completed		Date, Print and Sign when completed
	Yes ✓	No ✓	Yes ✓	No ✓	
Glasgow Assessment and Management of Alcohol (GAMA)		✓			
Generic Pain Scale Assessment Chart		✓			
Abbey Pain Scale (if unable to self report pain)		✓			
4AT and TIME for Detection, Management and Prevention of Delirium		✓			
Getting to Know Me – Relatives to complete		✓			
What Matters to Me		✓			
Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS)		✓			
Malnutrition Universal Screening Tool (MUST)	✓				
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓				
Adult Wound Assessment and Management Chart		✓			
Moving and Handling Assessment	✓				
Falls Risk Assessment	✓				
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
28/9/19	[redacted] c/o of a 4days	
0130	old female c/o	
	epig pain → Back	
	Nausea	
	O/A chs – SpO2 95% RA	
	pulse 100 apyrexial	
	news -2	CNO

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Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
28/9/19	awaiting blood	
Cont -	results	
	awaiting Rsan / MSSA	
	If +ve	
	Fasting → awaiting RH	
	Mdale + self-caring	
	Pink cannula L wrist	
		C.Kelly
		G.MITCHELL RN
28/9/19	Slept well	
7c.	Uneventful night	
	IV fluids.	
	PO fluids tolorated well.	
	? gastritis	
	PO PPI OD	
	Bloods → WCC 13.2 Esfr 760	P BOYLE.
WR	Fast for OGD	E Gould
28/9/19 1120	Independent ins self care,	
	Resumed to diet and fluids	
	NEWS=1 p91.	
	IV fluids discontinued at present	
	Analgesia and antiemetic given as charted.	
	Commenced on IV omeprazole	
	For OGD tomorrow due to	
	vomiting small amounts of	K.CONNELL
	blood.	K.Connell RN

Name: _____
Address: _____
_____
_____
DoB: _____
CHI: _____
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
28/9/19 1945	Patient managed to eat evening meal without any issues. Soon after patient reported that she vomited. Blood - small amount present, No foodstuff present. Requesting analgesia prn, medication given as chart. Please note GP has provided reducing dose of dihydrocodeine in her dosset box. Patient's aim is stop this medication	K. Connell K. Connell (RGN)
29/9/19 04:30	Slept well uneventful night. antiemetic. analgesia. for OGD today. BM ☐. TED stockings. ☐ fasted.	
29/9/19 1115	Independent in self care. Can have fluid + diet from 1220. Had throat spray @ 1020 NEWS=2, sats 97% on O2 4LPM post OGD.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

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Date & Time		Signature, Print Name & Designation
	OGD = NAD for cause of vomiting blood.	K CONNELL
		K Connell
29/9/19 13:45	Oramorph has been discontinued patient informed of this	K CONNELL K Connell SN
29/9/19	Evening meds given. Remains settled.	
18:00	Reviewed on ward round; discharge home tonight. Bloods + Scope review. Asset box returned to parent.	CMOS CMOS

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Care Plan

NHS Greater Glasgow and Clyde

Care discussed with patient Unable	☑ Yes	☐ No	☐	If unable, give reason:	
Care discussed with family Unable	☐ Yes	☐ No	☐	If unable, give reason:	

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
28/9/19 CMcL	News - 2 O/A		28/9/19 CMcL	N/A	
				5. Hydration and Nutrition	
			28/9/19 CMcL	Normal Diet.	
	2, 3. Communication and senses				
28/9/19 CMcL	wears glasses				
				6. Elimination	
	4. Cognitive status		28/9/19 CMcL	Awaiting Rsou.	
28/9/19 CMcL	alert + orientated				

Patient Label

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	7. Personal Hygiene, oral care, skin care and wound care	Date Discontinued and Signature	Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
28/9/19 CtheU	Independant		28/9/19 CtheU	Orientated to ward	
				10. Sleep and Rest	
			28/9/19 CtheU	Promote restfull sleep	
	8. Mobility				
28/9/19 CtheU	Fully Mobile			12. Privacy, dignity and sexuality	
			28/9/19 CtheU	Maintain @ all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date_____ Time_____ of initial height and weight on admission to hospital		Actual	*Patient reported	*If unable to obtain height and / or weight (check portal / trak for previous weights) document alternative measures and use subjective criteria to assess risk of malnutrition
Admission Height	5'9" cm	☐	☑	
Admission Weight	100 Kg	☐	☑	

*Obtain accurate height/weight and rescreen as soon as possible

Patients reported normal weight _____ Unable to Recall ☐

Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date	27/9							
Time	01A							
Ward	65							
Oedema/ Ascities present Y/N	N							
Scales Used ST = Standing, CH = Chair HT = Hoist, UW = Unable to weigh, record reason and document subjective assessment of risk in nursing notes	/							
Weight (kgs)	100							
BMI								
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days								
Step 1 BMI Score >20 = 0 18.5-20 = 1 <18.5 = 2	0							
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0							
Step 3 Acute disease effect If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0							
Step 4 Overall Risk of Malnutrition TOTAL	0							
Rescreen on	1/5/2							
Signature	CP							

Step 5 Management Guidelines (excludes patients who are Nil by Mouth)

Overall Risk of Malnutrition	Ensure plan of care for specific nutritional requirements, MUST score and plans to improve / increase nutritional intake are documented in the patients care plan
0	LOW RISK - Repeat screening every 7 days
1	MEDIUM RISK - Follow the flowchart for MUST 1 overleaf
2 or greater	HIGH RISK - Follow the flowchart for MUST 2 or greater overleaf

MUST STEP 5 Management Guidelines

MUST 1

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in Nutrition Resource Manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patient's intake 'normal' or improved for them?

YES

- Discontinue food and drink recording chart, documenting reason in nursing notes.
- Continue with **'food first'** approach as above.
- Rescreen at least every 7 days.

NO

- Encourage higher calorie menu choices indicated with ✪
- Continue with food and drink recording chart for 4 days, and if no improvement in intake, rescreen.

NO

Complete the above steps

MUST 2 OR GREATER

- Check assistance required with eating and drinking (Red, Amber, Green).
- Check with patient /carer normal eating patterns and preferences.
- **Use a Food First Approach:**
  - Offering mid-morning, mid-afternoon and supper snack from ward supplies (e.g. bread with butter/jam, biscuits with butter/jam, cereal).
  - Offer full cream milk with and between meals.
  - Order additional MUST snack daily of patients choice (refer to 'catering' section in nutritional resource manual).
- Encourage family and friends to bring in patient preferred snacks.
- Complete a food and drink recording chart, including all food and fluid consumed and refused, encouraging patient and family to complete where appropriate.
- Review and evaluate the above daily, clearly documenting issues actioned in nursing evaluation notes.

Is there documented evidence in the nursing evaluation notes that the above steps have been completed over a **72 hour period?**

YES

Is the patients intake 'normal' or improved for them?

YES

- Discontinue food and fluid chart, documenting reason in nursing notes.
- Continue with 'food first' approach as above.
- Rescreen at least every 7 days.

NO

Is the patient dying?

YES

- Discontinue food and drink recording chart.
- Stop screening.
- Offer food and fluid as appropriate.

NO

- Continue with food and drink recording chart.
- Screen at least every 7 days.
- Consider referral to dietetics via Trakcare.

NO

Complete the above steps

DISCHARGE

If the patient is due for discharge and concerns remain regarding their oral intake, provide NHSGGC "*Eating to Feel Better" booklet discussing the reason why the information is being given e.g. reduced appetite and / or weight loss before or during hospital admission.

www.nhsggc.org.uk/patients-and-visitors/information-for-patients/food-in-hospital/discharge-from-hospital/

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Pe SULLIVAN Deborah F 07/12/1972 ent) Moving and Handling Assessment Form

Person's Name:	Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Named Nurse:		Person is totally independent (tick here and go to data box)	✓

1. Ge...

Body Build	
Weight	Height
Kg	cm
BMI	
Risk of Falls: Yes	No

Problems with comprehension, behaviour, co-operation (specify):

Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 / 2 / >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N/A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Independent bridging			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 / 2 / >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 / 2 / >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 / 2 / >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 / 2 / >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alent)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 / 2 / >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	1st Assessment	2nd Assessment	3rd Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:	28/9/16		
Assessor's signature:	CT		
Proposed Review date:	/		

Continuation Sheet

1. General Information (Only complete this section if changed from overpage)

Body Build		
Weight	Height	Problems with comprehension, behaviour, co-operation (specify):
Kg	cm	
BMI		Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
Risk of Falls: Yes	No	

2. Sit to Stand to Sit Transfers (Including to and from bed, wheelchair, commode and toilet)

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
Model		Aid Type	People: 1 2 >3	Additional Information / Equipment:	
Sling type					
Sling Size					

3. Toileting

Hoist	Standaid	Walking Aid	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details		see 'sit to stand transfers'	People: 1 2 >3	Additional Information:	

4. Move on / off bed pan

Hoist	Manoeuvre	Assistance	Supervision	N / A
See No 2 Sit to Stand Transfers for details	Roll patient	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Person bridges			

5. Move up / down bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Sliding sheets	People: 1 2 >3	Additional Information:	
	Monkey pole			
	Rope ladder			

6. Lateral Transfer to / from trolley / bed

Hoist	Handling Aids	Assistance	Supervision	Independent
See No 2 Sit to Stand Transfers for details	Rigid Transfer Board	People: 1 2 >3	Additional Information / Equipment (eg sliding sheets):	
	Other (Please specify)			

7. Sit up over side of bed

Bed Rest	Assistance	Supervision	Independent
	People: 1 2 >3	Additional Information / Equipment (eg rope ladder, swivel cushion):	

8. Into Bath or Shower

Equipment	Handling Aid	Assistance	Supervision	Independent
Shower	Shower chair	People: 1 2 >3	Additional Information / Equipment (eg sling lifting hoist after risk assess):	
Variable / Fixed height bath	Shower trolley			
Bed bath	Bathing hoist (eg Alerti)			

9. Walking

No Walking	Walking Aid	Assistance	Supervision	Independent
	see 'sit to stand transfers'	People: 1 2 >3	Additional Information / Equipment (eg hoist with walking sling, dist. Walked)	

10. Other Instructions / Observations / Equipment Used

	4th Assessment	5th Assessment	6th Assessment
Recording Symbol:	/ Forward slash	X Where a forward slash exists, add a back slash to make a cross	* Where a slash or cross exists add slashes to make a star
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

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FALLS RISK ASSESSMENT

To Be Completed For All Patients Within 24 Hrs of Admission and on Transfer to Another Ward

NHS Greater Glasgow and Clyde

GENERAL SAFETY PRECAUTIONS TO BE UNDERTAKEN FOR ALL PATIENTS

Action the following safety precautions on admission to your ward. Update weekly or on change of condition.

	Ward: 65 Date: 28/9/19 Time: ---:---	Ward: Date: Time: ---:---	Ward: Date: Time: ---:---	Ward: Date: Time: ---:---	Ward: Date: Time: ---:---
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	✓ G				
2. Check walking aid (if required) is in reach and in use.	NA				
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	✓ G				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	✓ G				
5. If glasses are worn, check they are available and in use.	✓ G				
6. If hearing aid/s are worn, check they are working and in use.	NA				

RISK ASSESSMENT

If Yes to any of the 5 questions below complete the falls interventional plan (overleaf).
Whether Yes or No, update this assessment weekly in acute wards or, at the time of a fall or, upon a change in patient's clinical condition.
ALL patients in older people's wards must have an interventional plan in place (overleaf)

Tick Yes or No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Has the patient fallen in the last 6 months – including during this admission?		✓								
2. Does the patient have cognitive impairment or a possible delirium?		✓								
3. Does the patient attempt to walk alone although unsteady or unsafe?		✓								
4. Does the patient or their relative have a fear or anxiety of the patient falling?		✓								
5. Based on your clinical judgement, is this patient at high risk of falling?		✓								
Signature of nurse completing assessment / update	GT 1152									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTION CHECKLIST

NHS Greater Glasgow and Clyde

Complete for all patients identified at risk of falling.

	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----	Ward: Date: Time: -----:-----
BED AND SEATING					
Check the patient's bed and chair are at the right height for the patient. Consider referral to OT/ Physiotherapy for transfer, mobility or specialist seating advice. (Patient care plan 8)					
Assess if a low bed is required (Patient care plan 9)					
SAFETY					
Complete / update bedrails risk assessment if bedrail in use. (Patient care plan 9)					
Review the frequency of care rounding prescribing in relation to the falls risk – consider the use of a patient monitoring chart. (Patient care plan 9)					
If the patient is cognitively impaired or has poor mobility and known not to ask for assistance, provide close observation whilst using commode, toilet, bath or shower.					
HEALTH					
Complete /Document 4AT – follow THINK DELIRIUM guidelines. (Patient care plan 4)					
Document continence problems and link to care rounding (Patient care plan 6)					
Record lying and standing blood pressure. If results show deficit, follow protocol for ongoing monitoring and inform medical staff of any concerns. (Patient care plan 1)					
If medication is suspected of contributing to the patient's falls risk – highlight to medical staff.					
COMMUNICATION					
Give the patient / relatives / carers an inpatient falls prevention leaflet. Discuss safety precautions with patient / carer / relative. (Patient care plan -negotiated care)					
Update the ward team of the patient's mobility status. (Patient care plan 8)					
Discuss the patient's fall risk at safety briefs and MDT meetings. (If appropriate)					
Consider a referral to the Hospital Falls Service for advice using trackcare. (If appropriate)					
Signature of nurse completing interventional plan / or update					

If a fall has occurred, refer to the Post Fall Poster and report in Datix. Share post fall lessons learned with the team

EVIDENCE ALL INTERVENTIONS IN NURSING CARE PLAN

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 Flat 0-1, 8 Boyndie Street Easterhouse graph Glasgow, Lanarkshire G34 9JJ	Hospital: GRI Ward: 65	**Points to consider:** • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

1	**Pressure Damage**	Does the person have redness and/or existing pressure damage? IF YES, prescribe a minimum of 2 HOURLY Active Care to avoid further damage occurring and complete the pressure ulcer interventional plan overleaf.

Date	Location of redness / ulcers	Grade of ulcer	Date	Location of redness / ulcers	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

2	**Mobility**	Does the person require assistance to mobilise?
3	**Continence**	Does the person have continence issues with urine and/or faeces?
4	**Nutrition**	Does the person appear malnourished and/or unable to eat or drink?
5	**Skin**	Is skin compromised by any other source, e.g. neurological deficit; surgery; medication; diabetes; co-morbidities?
6	**Judgement**	In your clinical judgement, is this person at risk of developing pressure damage? If Yes, please give details:

Record YES/NO answers in the grid below. If YES to any of the questions 2-6, the person is at risk of developing pressure damage. Prescribe a minimum of 4 HOURLY Active Care interventions and complete the pressure ulcer interventional plan overleaf.

If NO to all statements, continue Active Care Prescribing as assessed for individual need and re-assess daily.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
28/9/19	01	N	N	N	N	N	N	4 hrly	SJT
29/9/19	8:30	N	N	N	N	N	N	4 hrly	EW
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	
/ /	:							___hrly	

Complete prevention of pressure ulcer interventional plan overleaf for all patients with redness/pressure damage and for those at risk.

Prevention of Pressure Ulcer Intervent hal Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

Aim: To incorporate effective pressure ulcer prevention strategies to reduce/eliminate potential for pressure ulcer development.

Outcome: To prevent pressure ulcer development through establishment of effecting work practices in line with SSKINS bundle.

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree plan with patient / family/ carer YES ☐ NO ☐ • "Prevent Pressure Ulcers" leaflet given to patient / family / carer? YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued: _____
Date Reviewed:	Check: • Pressure areas _____ hourly. • Skin under medical devices _____ hourly. • Specify medical devices used:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment:	• Reposition _____ hourly in bed and chair. • Overnight patient / carer has agreed to repositioning _____ hourly • Specify any manual handling equipment used:	• Skin care to be carried out _____ hourly. • Specify products required for increased moisture / continence management:	• Optimise nutrition and hydration. • Refer to MUST	• Discuss and agree updated plan with patient / family/ carer YES ☐ NO ☐	Date discontinued: _____

Care Rounds Checklist

Date: 28/9/19

I have evaluated and deemed that the frequency of care delivery over the next work shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed [signature] Name GMITHAGL Designation SIO
2. Signed K. Connell Name K. CONNELL Designation SN
3. Signed _____ Name _____ Designation _____

Attach [barcode]
0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Ward: 65

NHS Greater Glasgow and Clyde

'Must dos' for me. Ask the patient if there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

		Times	00	08	11	15	18	22													
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N	N	N													
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	Y	Y	N	N	N													
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I	I	I													
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	—	—	—	—	—	—													
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I	I	I	I													
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	—	—	—	—	—	—													
		Chair Assist to walk or stand (W/ST)	—	—	—	—	—	—													
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I	I	I	I	I													
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N	N	N													
		Drink taken?	NA	N	Y	Y	Y	Y													
		Food, snack, or supplement taken?	NA	N	Y	Y	Y	Y													
		Has oral hygiene been carried out as per care plan?	I	I	I	I	I	I													
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y	Y	Y	Y													
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N	N	N	N													
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	N	NA	NA	NA	NA													
		Care provider / role	SN	SN	SN	SN	SN	SN													

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 29/9/19

Attach

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Ward: Easterhouse
Glasgow, Lanarkshire
G34 9JE

NHS Greater Glasgow and Clyde

I have evaluated and deemed that the frequency of care delivery over the next ~~work~~ shift, based on the patient's most critical need should be every (please circle) 1hr 2hr 3hr (4hr)

1. Signed [signature] Name [illegible] Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'Must dos' for the [illegible] there is anything they want specifically done today:

USE FOLLOWING CODES:
Y = Yes N = No NA = Not applicable NT = No Thanks S = Sleeping O = Off the ward I = Independent

			Times	0																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		N																		
S	3	**SKIN INSPECTION** Pressure areas checked:		I																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		✓																		
K	4	**KEEP MOVING** Has the patient moved or walked?		I																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		–																		
		Chair Assist to walk or stand (W/ST)		✓																		
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC		I																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		N																		
		Drink taken?		Y																		
		Food, snack, or supplement taken?		N																		
		Has oral hygiene been carried out as per care plan?		I																		
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?		Y																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N/A																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		N/A																		
			Care provider / role	SN																		

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

1. Think Delirium	2. Pain	3. Skin Inspection	4. Keep Moving
5. Elimination	6. Food, Fluids and Nutrition	7. Environment	8. Information

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Fluid Balance Chart

Name: Deborah Sutherland
DoB: .....
Chi number: .....
Affix patient data label

Hospital: QA2S
Ward: 63
Date: 28/9/19

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids? Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00										300							
02:00	Water	200															
03:00																	
04:00	Water	200			IV	500			500								
05:00									900								
06:00										UTT							
07:00																	
08:00																	
09:00	Water	750							1650								
10:00										UTT							
11:00																	
12:00																	
13:00	Water	750															
14:00	Tea	150								UTT							
15:00																	
16:00																	
17:00	Water	750															
18:00	Tea	150							2355	UTT							
19:00																	
20:00																	
21:00	Well	200							2755	UT							
22:00																	
23:00																	
								*Total Intake							*Total Output		

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

The risk factors below must be considered when deciding if a patient requires their fluid intake & output to be accurately monitored. Please where possible discuss with the patient the need for fluid balance to be monitored and involve them in decisions regarding fluid balance e.g. drinking preferences, encouragement of fluids.

Are any of the risk factors below relevant?

Acute Clinical Condition
- Increasing NEWS Score
- Decreased Urine Output
- Suspected/ Evidence of SIRS/ Sepsis

Excessive Fluid Loss
- Vomiting
- Diarrhoea
- Urine output >200mls/hr
- High output stoma

Clinical Signs of Dehydration
- Dark coloured urine
- Dry Mouth
- Abnormal Urea and Electrolytes

Functional/Cognitive ability to maintain hydration and the requirement to monitor fluid balance
- Dementia
- Muscle Weakness or Trauma.

Underlying condition with high risk of fluid electrolyte imbalance

Commenced or Prescribed IV Fluid Therapy

Commenced or Prescribed Artificial Nutrition Support e.g. Total Parenteral Nutrition, Enteral Nutrition

Routine post operative management

None are applicable or relevant → Reassess daily or if clinical condition changes

One or more are applicable or relevant → Consider commencement of Fluid balance chart*

Able to manage Oral Intake
- Ensure patient is aware of importance of taking fluids
- Identify patient preferences for oral fluids e.g. drinks only tea
- Ensure fluid balance chart is accurately completed at all times
- Use red lid water jug to identify to staff that patient requires fluid intake to be monitored

Unable to manage oral intake sufficiently
- Ensure review of patient condition by medical staff to consider supplementary fluids e.g. IV fluids.

Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

MIS • EDU • 237971-2

Fluid Balance Chart

NHS 0712726128
SULLIVAN
Deborah F
Flat 0-1, 8 Boyndie Street 07/12/1972
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Hospital: ARI
Ward: 65
Date: 29/9/19

Reason for Fluid Balance Chart _____
Is patient fluid restricted? Yes ☐ No ☐
If yes how many mls in 24 hours? _____
Fluid balance from previous 24hrs +/- _____

Does patient require thickened fluids?
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
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17:00																	
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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Are any of the risk factors below relevant?

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- Suspected/ Evidence of SIRS/ Sepsis

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- Urine output >200mls/hr
- High output stoma

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Medical staff MUST review the patients fluid balance as part of their routine medical review if risk factors present give cause for concern.

*Palliative care patients may have the above risk factors present however it may not be necessary or appropriate to monitor fluid balance and this should be recorded in the patient's clinical notes

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Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

W 0712726128
N SULLIVAN
D Deborah
W
F 07/12/1972

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

PVC inserted: Day 0	Date: 27/9/19 Hospital: GC Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site: _____	R Hand ☐ R Arm ☐ _____ R Foot ☐ _____ L Hand ☑ wrist L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☐ Green ☑ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	Does the Patient require this PVC for any of the DRIFT criteria? (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	VIP score. (See Chart on back of care plan) If ≥ 2 remove PVC and record reason*.	Is the PVC dressing intact?	If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)	Initial
Day 1 Check 1 Day 28/9/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	KQ
Day 1 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night __/__/__	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: __/__/__ Reason for keeping PVC in after 72 hrs/ 3 days: _____

*Date PVC Removed: 29/9/19

*Reason For Removal: Pursued

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : Observe cannula
One of the following is evident : slight pain or redness near site	1	Possible first signs : Observe cannula
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : Remove & resite cannula
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: Remove & resite cannula
As above including: palpable venous cord	4	Seek further advice
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES → This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

Name: Deborah Sullivan CHI: 0712726128

DOB: 7/12/72 Address: _____

Ward: 65 Hospital: GRI

NHS Greater Glasgow and Clyde

Insertion criteria: Please complete this section at time of insertion.

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and bacteraemia and therefore should only be inserted if essential for ongoing care. To help with this decision, please use the criteria listed below (DRIFT) to justify the need for your patient to have a PVC. (Please see back of care plan for further information on DRIFT) Please tick all clinical criteria that apply:

Diagnostics ☐ **Resuscitation/Chest Pain** ☐ **IV Drugs** ☐ **Fluids** ☐ **Transfusion** ☐

PVC inserted: Day 0	Date: 29/9/19 Hospital: GRI Area: ED ☐ Theatre ☑ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site:	R Hand ☑ R Arm ☐ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: _____
Colour of cannula:	Blue ☐ Pink ☑ Green ☐ White ☐ Grey ☐ Orange ☐
Explanation and PVC leaflet provided to patient/ carer	Yes ☐ No ☐ If No, state reason: _____

PVC Maintenance Check	**Does the Patient require this PVC for any of the DRIFT criteria?** (Diagnostics, Resuscitation/ Chest Pain, IV Drugs, Fluids, Transfusion)	**VIP score. (See Chart on back of care plan)** If ≥ 2 remove PVC and record reason*.	**Is the PVC dressing intact?**	**If PVC used for IV antibiotics can these be switched to oral? (See IVOST Flowchart on back of care plan)**	**Initial**
Day 1 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 1 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 2 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 1 Day ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	
Day 3 Check 2 Night ___/___/___	Yes ☐ No ☐ If No, remove PVC and record date and reason*.	VIP: _____	Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐	

A PVC device should only be kept in if the patient needs one for any of the reasons listed in DRIFT. Please also check the IVOST guideline re switching from IV to oral antibiotics. If there is a clinical reason for requiring the PVC for longer than 3 days, please document your reason here.

Date: ___/___/___ **Reason for keeping PVC in after 72 hrs/ 3 days:** _____

***Date PVC Removed:** ___/___/___

***Reason For Removal:** _____

Modified Visual Infusion Phlebitis (VIP) Score

Modified V.I.P (Visual Infusion Phlebitis) Score		
IV site appears healthy	0	No phlebitis : **Observe cannula**
One of the following is evident : slight pain or redness near site	1	Possible first signs : **Observe cannula**
Two or more of the following are evident: pain, redness, swelling	2	Early stage of phlebitis : **Remove & resite cannula**
All of the following are evident: pain, redness, hardening of surrounding tissue	3	Phlebitis/Thrombophlebitis: **Remove & resite cannula**
As above including: palpable venous cord	4	**Seek further advice**
As above including: pyrexia	5	

DRIFT

Intravascular devices are associated with an increased risk of phlebitis, thrombosis, local infection and S. aureus bacteraemia. It is essential that you justify the need for your patient to have a PVC daily using the DRIFT mnemonic.

- ✓ **Diagnostics:** Does the patient need the cannula for a diagnostic procedure e.g. CT scan
- ✓ **Resuscitation:** Is the patient at risk of cardiac or respiratory arrest?
- ✓ **Intravenous:** Does the patient require IV medication? Could these be switched to oral?
- ✓ **Fluids:** Does the patient require intravenous fluids ? Could this be switched to oral fluids?
- ✓ **Transfusion:** Does the patient require a transfusion of blood products?

Adult IV → Oral Antibiotic Switch Therapy (IVOST) Guideline → Can I switch my patient from IV to oral antibiotics?

Review need for IV antibiotics DAILY:
Review & document patient progress/the IVOST plan within 72 hours of antibiotic initiation

Are all of the following IVOST criteria met?

- ✓ **CLINICAL IMPROVEMENT** in signs of infection e.g. temperature ≤ 37.9°C, reduction in the NEWS score, improving SEPSIS
- ✓ **ORAL ROUTE is available reliably** (eating/drinking and no concerns regarding absorption)
- ✓ **UNCOMPLICATED INFECTION** (specialist advice not required prior to IVOST). Certain infections need prolonged IV e.g. CNS infection, Cystic Fibrosis, S. aureus bacteraemia (min. 14 days IV), Endocarditis, Vascular graft or Bone/joint infection, Undrainable deep abcess

CRP does NOT reflect severity of illness or the need for IV antibiotics & may remain elevated as the infection improves

DO NOT use CRP in isolation to assess IVOST suitability. Most infections require 7 days TOTAL (IV + oral) therapy. Record the intended duration on the medicine kardex

YES

This patient may be suitable for switch to oral antibiotics. Please discuss with medical staff and refer to the full IVOST Guideline.

NO

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 6 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

	Date	Ward
Admitted		
Transferred		
Transferred		

Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤9°	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic BP	≤90	91-100	101-110	111-219			≥220
Conscious Level				A			V, P or U

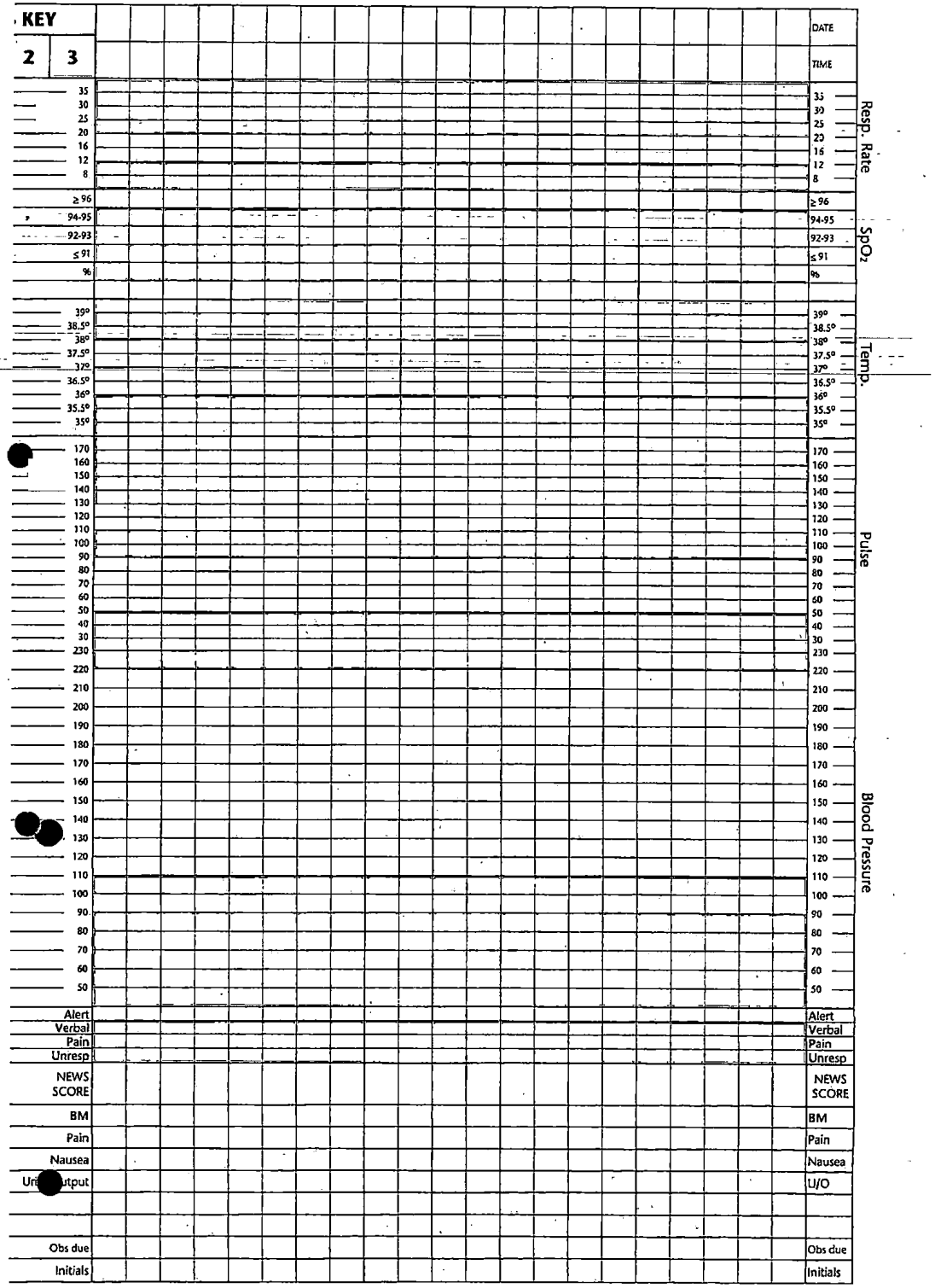
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

See NEWS Actions Reference Tool for local escalation policy

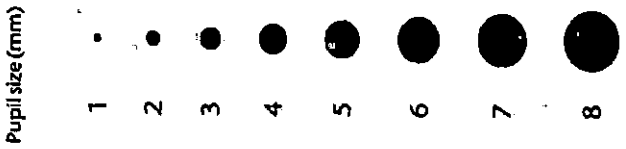
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need for escalation of clinical care and direct as appropriate.
Aggregate 5 or more or 3 in one parameter	Increased frequency to a minimum of 1 hourly	• Trained Nurse assessment. • Inform medical team caring for the patient. • Urgent assessment by a medical / surgical / nursing team with core competencies to assess acutely ill patients. • Consider level of monitoring required in relation to clinical care.
Aggregate 7 or more	Continuous monitoring of vital signs	• Trained Nurse to assess immediately. • Inform medical team caring for the patient – this should be at least senior medical staff level. • Emergency assessment by a clinical team with core competencies in the assessment of critically ill patients. This team will have critical care competencies and a practitioner/s with advanced airway skills and resuscitation skills. • Consider referral to high dependency or ITU.

Deborah Sullivan

| | | |


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
%
Temp.
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Pulse
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
230
220
210
200
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine Output
U/O
Obs due
Initials

Glasgow Coma Scale



AFFIX PATIENT ID

Neurological Observations

Date:																							
Time:																							
COMA SCALE	E Eyes open	Spontaneously	4																				
		To speech	3																				
		To pain	2																				
		None	1																				
	V Best Verbal response	Orientated	5																				
		Confused	4																				
		Inappropriate words	3																				
		Incomprehensible sounds	2																				
		None	1																				
	M Best motor response	Obeys	6																				
		Localises	5																				
		Flexion - withdrawal	4																				
		Flexion - abnormal	3																				
		Extension to pain	2																				
		None	1																				
TOTAL SCORE																							
PUPILS	R	Size																					
		Reaction																					
	L	Size																					
		Reaction																					
LIMB MOVEMENT	ARMS	Normal power																					
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					
	LEGS	Normal power																					
		Mild weakness																					
		Severe weakness																					
		Spastic flexion																					
		Extension																					
		No response																					

Eyes closed by swelling = C

Endotracheal tube or tracheostomy = T

Usually record the best arm response

+ reacts – no reaction c. eyes closed

Record right (R) and left (L) separately if there is a difference between the two sides

Pain Score

Ask the patient to rate his/her pain by choosing a number between 0 and 10. Use the diagram below to assist the patient. If patient's pain is chronic, use generic tool. If patient is unable to communicate, use observational tool.

0	1	2	3	4	5	6	7	8	9	10
No Pain	Mild Pain			Moderate Pain			Severe Pain			

Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Glasgow 0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS
Greater Glasgow and Clyde

Name: Unit No.:

Date:		27/9	28/9	29/9									
Time of Result:		2219	2203	1258									
WCC	4-11	(13·2)	8·5	8·3									
Hb	M - 13-18 F - 11.5-16.5	128	119	122									
Plat	150-400	318	220	248									
Amylase	<100	43											
CRP	<10	11	(20)	(18)									
Na+	135-145	138	137	138									
K+	3-5-50	n/a	4·3	4·1									
Cl-	98-108	104	102	103									
Bic	21-28												
Urea	2.5-7.5	4	2·9	3·3									
Creat.	57-113	40	63	48									
EGFR	60>	>60	>60	>60									
Glucose	3.5-5.5	(11·9)											
Bilirubin	3-22	6	5	6									
ALT	<50	36	35	37									
AST	<40	n/a	29	31									
G-GT	<55												
Alk. Phos.	40 -150	81	82	82									
Albumin	32-45	(33)	32.	33									
Mg^+													
Ca	2.1-2.6												
Adj Ca	2.1-2.6												
PO4	0.7-1.4												
PT	9-12		11/1										
APTT	25-37		28/0·8										
TCT	11-15		11/0·8										

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

Date	Specimen type	Specimen site	Result	Sensitivities
26/02/2014 Example	Blood	Peripheral	Staph aureus	Benzylpenicillin