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	☐
IEW 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	☐		
"/ESTERN INFIRMARY RECORDS	☐		

Including:

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

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

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

Ward: 6b

Discharge destination: Home.

Estimated Discharge Date (1) / /

Estimated Discharge Date (2) / /

Final date of discharge : 13/9/19

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

Time of Discharge: 1600

Nurse's signature: [signature]

Designation: SIN Date 13/9/19

My Admission Record

NHS Greater Glasgow and Clyde

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

Hospital: GRI Ward: 67
Date of Admission: 0320 Time: 0320
Information obtained from:-Name: LAURA TURNER
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: ~~Deborah~~ Debbie
Age: 46 Telephone Number: 07713718392 urine ☐
Consultant: Mr CK 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	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

1/7 Central Abdominal Pain / Epigastric 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 ☐ Penecillin (rash)

Relevant past medical history

- Fundoplication (9 years ago) - HTN - T2DM
- Pancreatitis - Lap chole (21 years ago) - PTSD
- Fybromyalgia - 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

Nan
Add
0712726128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
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** ☐

Nam
Addr 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
DoB: Easterhouse
Glasgow, Lanarkshire
CHI: G34 9JE
Affix patient ID label

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): LAURA TURNER Signature: Lturner

Designation: S/N Date: 10/9/19

My Assessment Record

0712726128
SULLIVAN
Deborah F
Flat 0-1, 8 Boyndie Street 07/12/1972
Easterhouse
Glasgow, Lanarkshire
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: _____		✓	

Name: _____
Ac
0712726128
SULLIVAN F
Deborah 07/12/1972
Dc Flat 0-1, 8 Boyndie Street
Ch Easterhouse
Glasgow, Lanarkshire
Afl G34 9JE

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

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.

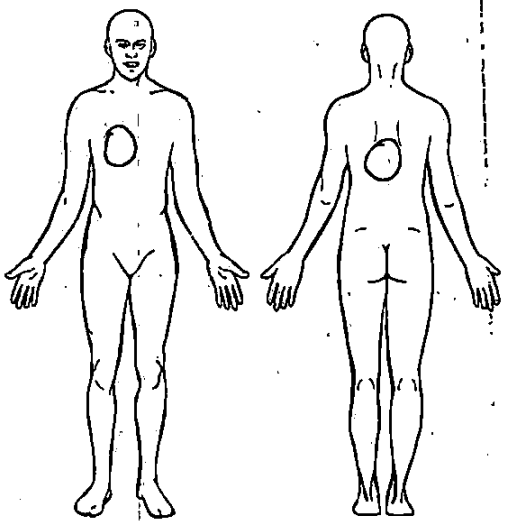
Can you describe any chronic pain that you have?

Pain all over.

What makes the pain better?

Pregabalin

Mark current pain on body chart



Nam 0712726128
Addr SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
DoB Glasgow, Lanarkshire
CHI: G34 9J
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?

none.

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		

Nan
Add
0712726128
SULLIVAN
Deborah F
Flat 0-1, 8 Boyndie Street 07/12/1972
Do Easterhouse
CH Glasgow, Lanarkshire
Aff G34 9J

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)		

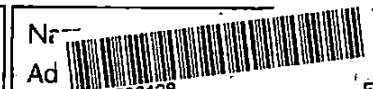
Do you have any further issues which may affect your ability to eat and drink normally during this hospital admission?

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		



Na
Ad
DoB
CHI
Affix ... 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? 8/9/19

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

Name:
Adc
0712726128
SULLIVAN F
Deborah 07/12/1972
DoI :
CHI
Affi:

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 ☑ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service** (as appropriate)

Datix completed (if appropriate) Yes ☐ No ☑ Datix Ref. Number _____

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

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

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?	✓	✓	

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

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer		

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☐ Not appropriate at this time ☐

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

Are you:
Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☑ Retired ☐

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

Yes ☐ No ☐

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 the 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 the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☑

If yes, how can we support you with these?

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

13. 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 ☑

Name (Please PRINT): LAURA TURNER Signature: Lturner

Designation: S|N Date: 10|9|19

Name:
0712723128
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972
Ai

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	✓		✓		Rhumer S/N LT
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)	✓		✓		Rhumer S/N LT
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓		✓	
Bristol Stool Chart		✓		✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		Rhumer S/N LT
Assessment Chart for Wound Management		✓		✓	
Moving and Handling Assessment	✓		✓		Rhumer S/N LT
Falls Risk Assessment	✓		✓		Rhumer S/N LT
Bedrail Risk Assessment		✓		✓	

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
10/9/19 0435	Patient admitted to ward 67 with abdo/epigastric pain.	
	NEWS 2 due to tachy + temp ↑.	
	Patient for rpt bloods (check amylase) and ? scan in AM.	
	Spoken with middle grade. Allow to eat + drink.	S/N Rhumer LT/RHUMER

0712726128
SULLIVAN
Deborah
F
07/12/1972

Patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
WDIS	Commenced on Erthromycin ⓔ Allow to settle, repeat bloods -	
D15	Independent with needs. Tolerating D+f as	
12pm	able. Passing urine	
	News (2).	
	oral meds as charted	(SIN) Sullivan
	oramorph as charted for pain relief	SULLIVAN
16[00]	Vomited sons of blood stained phlegm. FYI informed. News 2.	
	BP 106/69.	(SIN) Sullivan
11/9/19 [20]00	T/F from ward 65 last night, alert + orientated to ward.	
	News stable as charted.	
	medications given as per	
	Kardex. Passing urine. NO	
	issues settled at time of	
	recording	N. Barrett SIN.
11/9/19 16[20]	Care as planned. News unchanged	
	complaining of nausea & vomiting	
	antiemetics given with some effect.	
	Lunchtime medications not tolerated ED EARLHG	SN

Name:
Addr [redacted]
0712726128
SULLIVAN
Deborah F
DoB 07/12/1972
CHI
Affi

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
11/9/19 20 16	vomited. Complaining of abdominal pain analgesia given as charted. Seen on ward round, awaiting to continue as planned for ECG. No EOD at present.	EN ENROLLED SN
12/9/19 03-00	Settled overnight NEWS-2 → Tachycardic as before coughed up approx 50mls blood stained phlegm FYI aware, monitor meantime for ax/R ☐ ECG → NAD unable to obtain bloods as poor IV Access. oral analgesia given regularly for pain R/. No further phlegm at this time	EN ENROLLED SN
0730	vomited breakfast this am, foodstuff + blood (small amount)	K Tompkinson
120919 1000	Patient settled and contacted, buzzed to hand as per care card Medication as per kardex - entonesto and analgesia administered with good effect NEWS as charted Ind mobile	Comp RN

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

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
120919	Passing urine.	
1040	Vomit - no haematemesis - small blood clots noted - fresh.	
	To get bloods and cum @ when pt fit.	GP Reviewed
21.00	NEWS 3 - Sats 96% on air, p 96, BP 108/58.	
	Oral antiemetic and analgesia.	
13/9/19	Slept for long spells.	
05.00	Vomited ½ teaspoon watery blood.	
	Fyl aware. Observations satisfactory.	MHENDERSON
	Dramorph for pain.	M Henderson RN
130919	Patient settled and orientated, buzzer	
0900	to hand as per care plan.	
	Medication as per kardex - news	
	as charted.	
	Requirement for antiemetics and	
	analgesia as per kardex - with	
	good result.	
	Vomiting blood clots - on sips	
	anxiety. Medical team aware	
	Bloods today, enema, antiemetics	
	and home when pain regulated — GM	
	Ind mobile, passing urine	Reviewed
	No BM charted in last 48hrs — RN	

Care Rounds Checklist

Date: 13/9/19

Attach Address

0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS
Greater Glasgow and Clyde

Ward: 66

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 M Henderson Name M HENDERSON 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	02/00	06/08	10/20																	
	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	Y																	
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	I																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	S	R																	
		Chair Assist to walk or stand (W/ST)		S	S	NA																	
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?		N	N	N																	
		Drink taken?		S	S	Y																	
		Food, snack, or supplement taken?		S	S	NA																	
		Has oral hygiene been carried out as per care plan?		S	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?		Y	Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		S	S	N																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	NA	NA																	
			Care provider / role	BG NURSE	BG NURSE	BG NURSE																	

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 12/9/19

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 [illegible] Name [illegible] Designation JW
2. Signed _____ Name _____ Designation _____
3. Signed M Henderson Name M HENDERSON Designation RN

Attach Address

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

'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	10 00	14 00	18 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	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	N	Y	Y	Y	Y
S	3	**SKIN INSPECTION** Pressure areas checked:	I	N	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	Y	Y	Y	I	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	—	B	B	R	R	R
		Chair Assist to walk or stand (W/ST)	—	/	NA	NA	NA	/
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	Y	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.	NT	NT	N	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA
		Care provider / role	JC HC	HC SN	[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • GCC0098

Care Rounds Checklist

Date: 11/9/19

Attach Add

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 N. Barretto Name Nicola Barretto Designation SHN
2. Signed [signature] Name [illegible] Designation GSH
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 00	06 00	10 00	14 00	18 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	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	S	Y	Y	Y	Y
S	3	**SKIN INSPECTION** Pressure areas checked:	S	S	✓	✓	✓	✓
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		S	–	–	–	–
K	4	**KEEP MOVING** Has the patient moved or walked?	I	S	✓	✓	✓	✓
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	S	B	L	B	–
		Chair Assist to walk or stand (W/ST)		S	NA	NA	NA	–
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	S	✓	✓	✓	✓
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	S	N	N	N	N
		Drink taken?	S	S	Y	Y	Y	Y
		Food, snack, or supplement taken?	S	S	Y	N	Y	N
		Has oral hygiene been carried out as per care plan?	S	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?	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	S	NT	Y	Y	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	S	NA	NA	NA	NA
		Care provider / role	NB	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

mi • 278936 v2.1 • CGC0098

Care Rounds Checklist

Date: 10/9/19

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

Attach Ad

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 [signature] Name TURNER Designation S/N
2. Signed [signature] Name S SUTHERLAND Designation SN
3. Signed [signature] Name RYDER MACK Designation SN

'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	04 00	11 am	16	20 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	Y	Y	Y
S	3	**SKIN INSPECTION** Pressure areas checked:	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
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – 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	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	YES	N	N	N
		Drink taken?	N	Y	Y	Y
		Food, snack, or supplement taken?	N	N	N	N
		Has oral hygiene been carried out as per care plan?	I	I	I	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	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA
		Care provider / role	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

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

NHS
Greater Glasgow and Clyde

Name Unit No.:

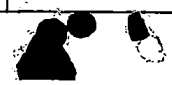
Date:		10/9	10/9	10/9	11/9	12/9							
Time of Result:		02[RD]	0449	0700									
WCC	4-11	(10·6)		(10·2)	9·2	7·9							
Hb	M - 13-18 F - 11.5-16.5	147		143	135	129							
Plat	150-400	300			231	244							
Amylase	<100	(H)	51	46	75								
CRP	<10		5	6	8	(11)							
Na+	135-145	(H)	137	137	137	137							
K+	3-5-50	(H)	4·1	5·	4·5	4·1							
Cl-	98-108	(H)	103	105	102	101							
Bic	21-28												
Urea	2.5-7.5	(H)	4·3	4·8	3·6	2·1							
Creat.	57-113	(H)	51	47	49	47							
EGFR	60>	(H)	>60	>60	>60	>60							
Glucose	3.5-5.5												
Bilirubin	3-22	(H)		8	6	5							
ALT	<50	(H)		38	40	41							
AST	<40	(H)		38	35	33							
G-GT	<55												
Alk. Phos.	40 -150	89	89	100	94	92							
Albumin	32-45	37	37	37	36	34							
Mg^+			0·80										
Ca	2.1-2.6	2·23	2·23										
Adj Ca	2.1-2.6	2·26	2·26										
PO4	0.7-1.4	1·29	1·29										
PT	9-12					11/1							
APTT	25-37					29/0.9							
TCT	11-15					12/0.9							

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

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



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

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
10/9/19 LT	As per NEWS	
	2, 3. Communication and senses	
10/9/19 LT	Alert + orientated – communicates needs well.	
	4. Cognitive status	
10/9/19 LT	Alert + Orientated.	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
10/9/19 LT	N/A	
	5. Hydration and Nutrition	
10/9/19 LT	Normal Diet + Fluids	
	6. Elimination	
10/9/19 LT	Ka continent, RSOU[illegible]	

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
10/9/19 LT	Independent + mobile.		10/9/19 LT	Nurse call system explained.	
				10. Sleep and Rest	
			10/9/19 LT	Promote.	
	8. Mobility				
10/9/19 LT	Independent + mobile.			12. Privacy, dignity and sexuality	
			10/9/19 LT	Maintain	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

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

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 10/9/19 Time 0430 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	98.55 Kg	☐	☐	

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

Patients reported normal weight 100 Unable to Recall ☐

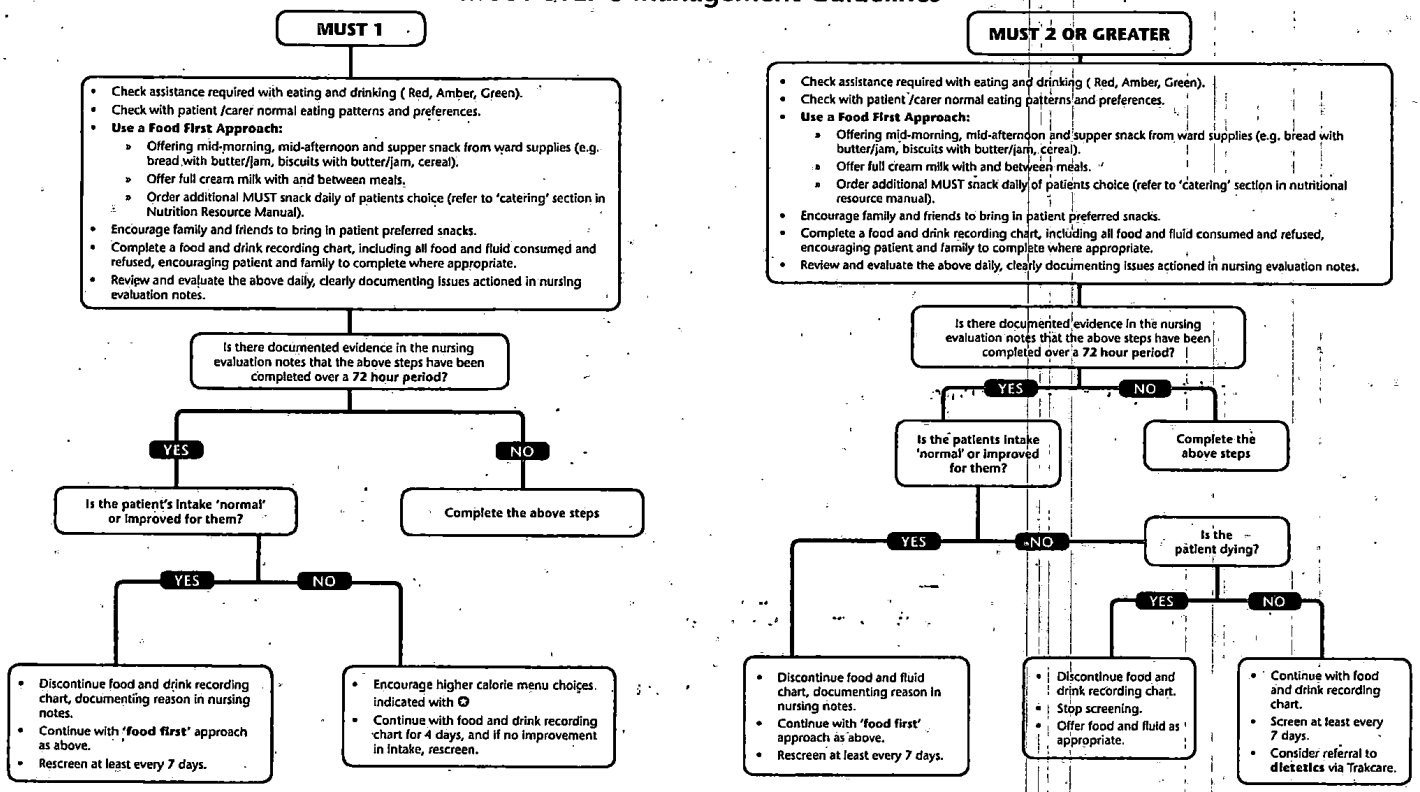
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☑ Don't Know ☐

Date	10/9/19							
Time	0430							
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)	98.55							
BMI	32							
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	17/9/19							
Signature	Dunner							

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 • 2858884 v3.0 • GGC0250

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 F SULLIVAN 07/12/1972 Deborah Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 67	**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 mobillse?
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	Mobillty	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
10/9/19	04:20	N	N	N	N	N	N	4 hrly	Skinner
11/9/19	02:00	N	N	N	N	N	N	4 hrly	N Barrett
12/9/19	06:30	N	N	N	N	N	N	04 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 Interventi al 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: _____

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

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: G7 Date: 10/9/19 Time: 0420	Ward: G6 Date: 10/9/19 Time: 23.30	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	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Available	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Appropriate	✓			
5. If glasses are worn, check they are available and in use.	N 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	Rhimer		N Barrett							

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

Pe 0712726128 ent) Moving and Handling Assessment Form

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

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

1. Gen

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 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

	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:	10/9/19		
Assessor's signature:	[signature]		
Proposed Review date:	17/9/19		

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 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:			

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

CHI: _____
Address: _____
Hospital: _____

NHS Greater Glasgow and Clyde

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

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: 9/9/19 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 10/9/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	SS
Day 1 Check 2 Night 10/9/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☐	NB
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:** 9/11/19

***Reason For Removal:** NOT INSITU

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

Name
Addres: 0712726128
SULLIVAN
Deborah F 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
CHI No G34 9JE
DoB

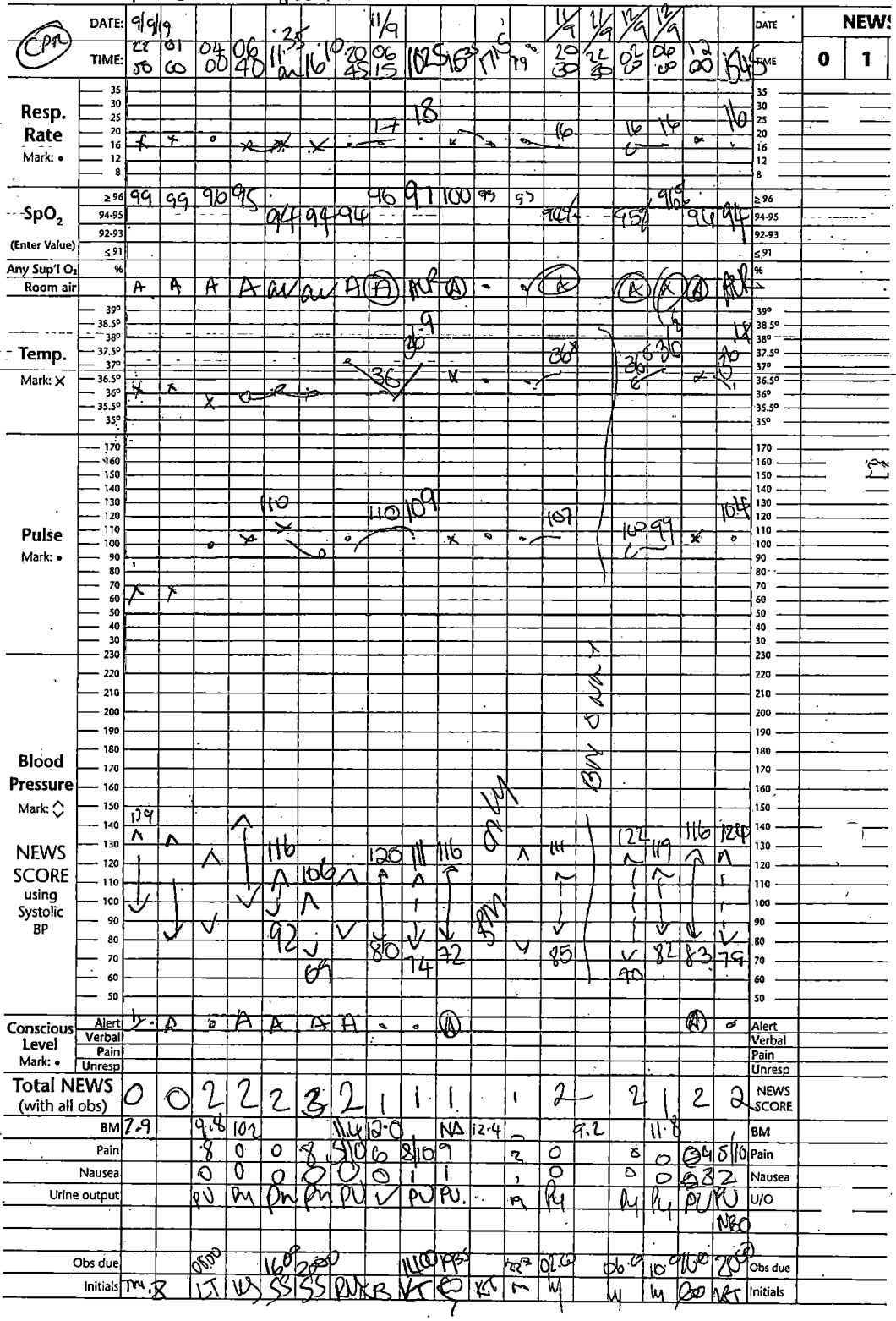
	Date	Ward
Admitted		
Transferred		66
Transferred		

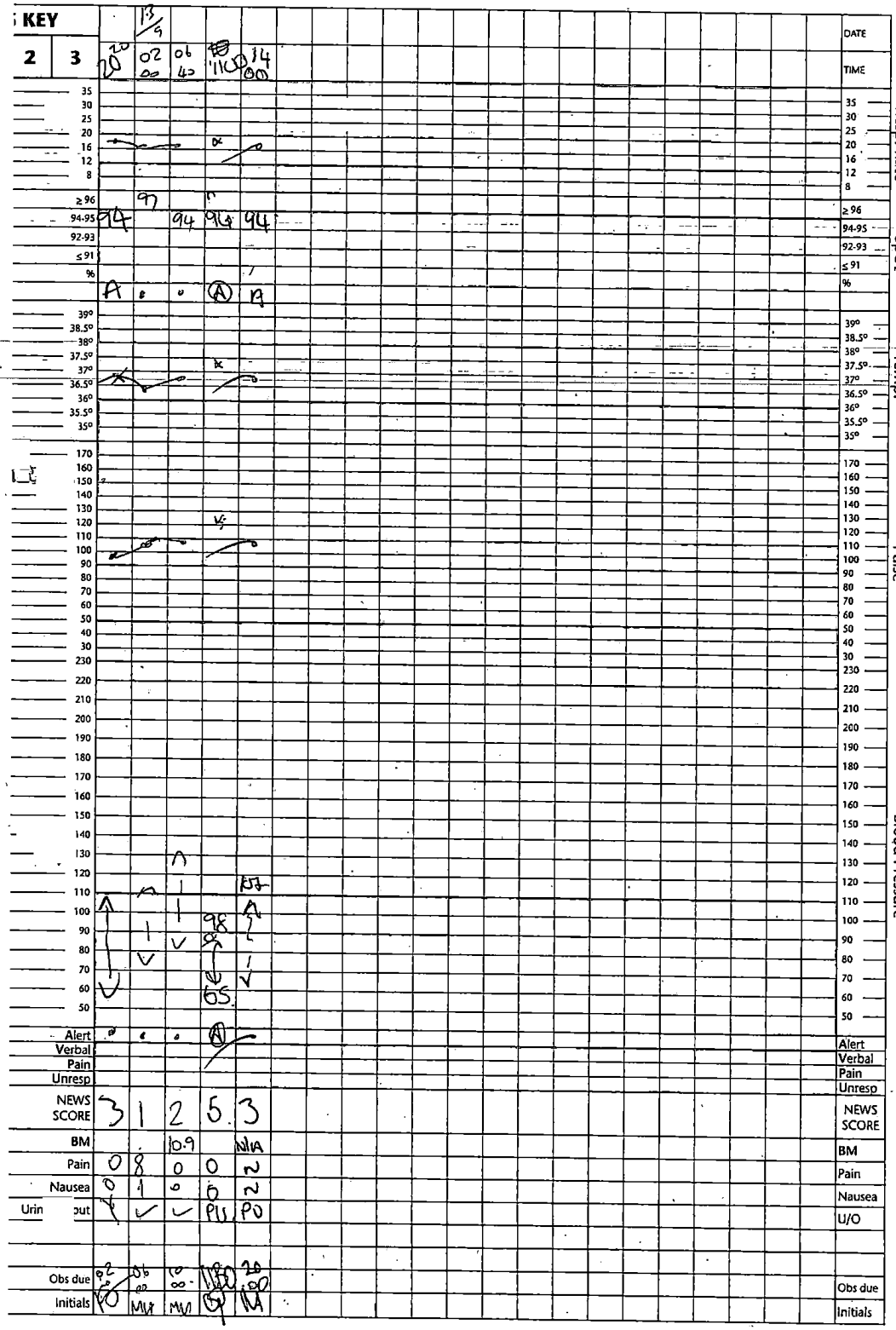
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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


DARNAH Sullivan
CPR
DATE
TIME
NEWS
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
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urin
out
U/O
Obs due
Initials
3 1 2 5 3
10.9
N/A
0 8 0 0 2
0 1 0 0 2
PU PO
65

Glasgow Coma Scale

Pupil size (mm)

1 2 3 4 5 6 7 8

AFFIX PATIENT ID

Neurological Observations

| | | |

Emergency Department Nursing Documentation

NHS Greater Glasgow and Clyde

Presenting Complaint - ? PANCREATITIS

Date: 9/9/19 Time: 2200

aph Label

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

Assessment Complete by: Name NURSE (Ple

on call ward.

Patient Prep / Investigations (Please tick/circle when completed)		Medication (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 - 9/9/19. Signature - EZRO Jmalle	

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 speciality 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
9/9/19 2300	Pt asleep sleeping while on bed bathing	
	long of nappies IV gun with sec [illegible]	

Nursing Notes		
Date and Time		Print Name and Signature

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: 0712726128 SULLIVAN F
Unit number: Deborah 07/12/1972
CHI number:
Apply addressograph label

Ward: L60
Discharge destination: Home
Estimated Discharge Date (1) 13 / 8 / 19
Estimated Discharge Date (2) / /
Final date of discharge: 13 / 8 / 19

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓			
Relative/carer informed	✓	✓		
Others informed: Care Home		✓		
Transport arranged				
Own transport (preferred option)	✓			
Ambulance-1 man/ 2 man am/pm		✓		
Other: Flight, Air ambulance etc.		✓		
Discharge medication				
Discharge prescription completed	✓			
Compliance aids e.g. Dossette Box (involve pharmacist)	✓			
Medication received	✓			
Medication explained to patient and/or relative/carer	✓			
Own medication returned to patient	–	✓		
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓		
Informed of discharge				
Social work/ Other agencies/Home help		✓		
Physiotherapist		✓		
Occupational Therapist		✓		
Dietician		✓		
Speech and Language Therapist		✓		
Clinical Nurse specialist e.g. Care Home Liaison		✓		
Liaison/ District Nurse/Practice Nurse		✓		
Other discharge items				
Access arrangements (e.g. keys, door entry)	✓			
Patients clothing available for day of discharge	✓			
Valuables e.g. cashier		✓		
Intravenous cannula removed	✓			
Equipment ordered (inc. walking aids) in place for discharge		✓		
Part 2 Discharge letter - Required		✓	✓	
- Completed		✓		
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				Gastric emptying studies TBA
If unknown at time of discharge state reason				
Additional information / leaflets / factsheets				
Time of Discharge: 10:30				
Nurse's signature:	**Designation:** CN		**Date:** 13/8/19	

My Admission Record

NHS Greater Glasgow and Clyde

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

Hospital: GRI Ward: 67
Date of Admission: 9.8.1 Time: 20
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐
Preferred Name:
Age: 47 Telephone Number: 07713718392
Consultant: D. Cheng

Urine - Leuk +
HCG - Neg.
- 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	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

11/8 CT - (N)

Epigastric pain

Bloods (N)

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

Prev. Endometriosis, TAH, Cholecystectomy
Fibromyalgia, 2° Fundoplication, HTN

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

Name:
Ac 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Dc Easterhouse
Cl Glasgow, Lanarkshire
G34 9JE
Afl

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? April 2019

Never smoked ☐

End

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 ☐ last 2yrs ago stop 19

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): R Robertson Signature: RR

Designation: SW Date: 9.5.19

My Assessment Record

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

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?

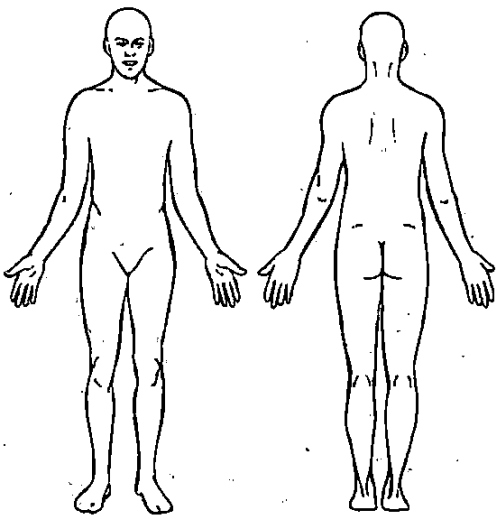
Morphine

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?

What makes the pain better?

Mark current pain on body chart



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

4. Cognitive Status THINK DELIRIUM

	Admission Presentation ✓	Normal for the patient ✓	Assessment of the patient's cognitive status
Alert and orientated	✓	✓	Anxious
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?

Not Fussy

What do you not like to eat and drink?

HIGH SUGAR

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		

Name:
Ac 0712726128
— SULLIVAN F
— Deborah 07/12/1972
Dc Flat 0-1, 8 Boyndie Street
Ch Easterhouse
Glasgow, Lanarkshire
Afl G34 9JE

Assessment of the patient's hydration and nutrition needs

T2DM

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		

Name:
Adc
0712726128
SULLIVAN F
Deborah 07/12/1972
DoB
CHI
Affi:

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? 9.8.19

How often in a day/week do you have a bowel movement? Per day 2 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 Loose
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?			

Name
Addr 0712726128
SULLIVAN
Deborah F
07/12/1972
DoB:
CHI:
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 ☐ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service (as appropriate)**

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

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

Na 0712726128
Ad SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Dc Glasgow, Lanarkshire
Ch G34 9JE
Affix patient ID label

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 10mg ✓
Do you do or use anything to help you sleep?	✓		

Nan
Add 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
DoE Easterhouse
Glasgow, Lanarkshire
CHI: G34 9JE
Affi:

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?		✓

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer		✓

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☑ Not appropriate at this time ☐

Nam
Addr 0712726128 F
SULLIVAN 07/12/1972
Deborah
Flat 0-1, 8 Boyndie Street
DoB: Easterhouse
CHI: Glasgow, Lanarkshire G34 9JE
Affix pa... ID label

Are you:
Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☑ Retired ☐

PAID OFF DUE TO

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑

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 the 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 the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

NONE

Do you have any anxieties or fears that staff should be aware of?
Yes ☑ No ☐

If yes, how can we support you with these?

NONE

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

13. 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)?

—

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 (Please PRINT): [illegible] Signature: [illegible]

Designation: SN Date: 9.6.19

Nam
0712726128
Addi SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
DoB Glasgow, Lanarkshire
CHI: G34 9JE
Affix patient ID label

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)	✓		✓		RGP 9/8
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan					
Bristol Stool Chart					
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		RGP 9/8
Assessment Chart for Wound Management					
Moving and Handling Assessment	✓		✓		RGP 9/8
Falls Risk Assessment	✓		✓		RGP 9/8
Bedrail Risk Assessment					

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
9.8.19 2030	MEWS-0 CRP - 4 (normal) Patient admitted to W67 for epigastric pain overnight on relieved by GTN and paracetamol No vomiting at present	

Nam
Addr
DoB:
CHI:
Affix patient ID label

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

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
9/8/19 20	Patient had a morphine PCA, paracetamol and anti emetic in ED. at present gr. pain Free. Settled on new ward. Awaiting Sr. review prior to CTAP	
10.8.19 0340	Senior review commenced on IV fluids fast 6am ? for repeat OGD bloods to be repeated	JAIRAGH JCy SN
10/8/19 WR	For CTAP today. —	OI Rennie
10/8/19 1430	Independent in self care. Resumed to diet and fluid. NEWS=0 Medication given as charted. IV fluids given as charted, ? can discontinue. Paracetamol and dihydrocodeine given for pain	K KONNELL K.Connell(SN)
11.8.19 0200	Observations as charted NEWS 1 as BP 101/60 asymptomatic. Attended CTAP & fast NAD for OGD. Oral analgesia given with effect. Settled right	JAIRAGH
	All cares as planned.	J Cy SN
11/8/19 0900 WR	- Not for OGD - Observe, F+D.	K.CONNELL K.Connell(SN)

Nan
Add 0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
DoE Easterhouse
CHI Glasgow, Lanarkshire
G34 9JE
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
11/8/19	NEWS=1 due VR=95.	
10:45.	Medications given as charted.	
	Passing urine spontaneously. Bowels inactive.	
	Independent with ADL. NO complaints	Cayanmish M.CAYANGSULLA
11/8/19	I/V Stevenson	
18:50	Plan: N/Cout with antiemetics + analgesia Hartd	Cayanish M.CAYANGSULLA
12/x	continues to have pain	
0300	oromorph as per reorder	
	managing oral fluids	
	Continue to observe	
	News 1- sats 95%.	Wohn SK
12/8/19 WR	Commence Sucrafate.	
	for outpatient gastric	(SN)
	empty study.	MBennet
	Repeat Bloods today.	O'Brien
1235	Independent with	
	personal care.	
	Medication given	
	as charted.	
	Observations	
	NEWS 1 RR 1.	
	Tolerating fluid and	
	light diet	
	Voiding urine	(SN)
	Spontaneously.	MBennet
	Settled at present.	O'Brien

Nam
Addr 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB:
CHI:
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
12/8/19	Pt transferred to ward 66	
2240	AJO, D+C, Incl mobile	
	Dossette box on drug	
	trolley.	
	Plan (FU) tomorrow.	
0900	WARD ROUND: Home today	
	with gastric outlet studies	
	+ follow up at clinic.	[signature] ST ENDRITE
1030	All nursing care as per care	
	plan. patient has own	
	transport.	
	IDLS ☑ meds ☑	
	patient discharged to	
	home from ward 66	[signature] [illegible] RN

Care Rounds Checklist

Date: 13·8·19.

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 J. McKerrow Designation SN
2. Signed [signature] Name Arlene Willis Designation STN
3. Signed _____ Name _____ Designation _____

'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	0200	0600	1000																			
	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)	–	–																				
K	4	**KEEP MOVING** Has the patient moved or walked?	S	S	I																			
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	L																				
		Chair Assist to walk or stand (W/ST)	NA	NA																				
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?	N	N	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	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																			
	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	[signature]	[signature]	[signature] 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: 12.8.19

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 Johnson Name L JOHNSON Designation SN
2. Signed Tracey Name R TRACEY Designation SN
3. Signed [illegible] Name J. McKeown Designation SN

'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	12 04 MN	3045	09 45	13 25	18 30													
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	S	N	N	N													
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.	N	S	Y	Y	Y													
S	3	SKIN INSPECTION Pressure areas checked:	-	S	I	I	I													
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	S	-	-	Int													
K	4	KEEP MOVING Has the patient moved or walked?	Y	S	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	I	S	I	I	I													
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?	N	N	N	N	N													
		Drink taken?	Y	S	Y	Y	Y													
		Food, snack, or supplement taken?	N	S	Y	Y	Y													
		Has oral hygiene been carried out as per care plan?	I	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.	NT	NT	Y	Y	NT													
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA													
		Care provider / role	EB SHA AHA	SHA	AHA	AHA 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 • CGC0098

Care Rounds Checklist

Date: 11.8.19

Attach
0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Ward: 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 J G Name [illegible] Designation SN
2. Signed [illegible] Name H. CALLAN FOSTER Designation SN
3. Signed _____ Name _____ Designation _____

'Must dos' for me. Ask the patient if there is anything they want specifically done today:
no thank you

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

		Times	12 MN	04 30	8	20 BC
	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	N	N	Y
S	3	**SKIN INSPECTION** Pressure areas checked:	S	–	I	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	Y	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	–	I	–
		Chair Assist to walk or stand (W/ST)	S	–	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
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	N	N
		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	NT	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NT	NT	NA	N
		Care provider / role	SN	EN HCA	MC 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 • GCC0098

Care Rounds Checklist

Date: 10/08/19

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
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 M Bennet Designation SN
2. Signed [signature] Name [illegible] Designation SEN
3. Signed [signature] Name [illegible] Designation SN

'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	12.00	16	20																
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N																
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	N	N																
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I	I																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	X	X	X	–																
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	I	I																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	B	X	–																
		Chair Assist to walk or stand (W/ST)	X	X	X	–																
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?	Y	N	N	N																
		Drink taken?	N	Y	Y	Y																
		Food, snack, or supplement taken?	N	Y	Y	Y																
		Has oral hygiene been carried out as per care plan?	I	[illegible]	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	N	N																
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	N																
		Care provider / role	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: 9.8.19

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 [redacted] Name [redacted] Designation SN
2. Signed [redacted] Name M Donnet Designation SN
3. Signed _____ Name _____ Designation _____

Attach Ac

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

Ward:

NHS Greater Glasgow and Clyde

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

N/A

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

		Times	10																	
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	O																	
	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?	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.	N																	
		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

Subject Access Request Team
Health Records Department
Glasgow Royal Infirmary
8 – 16 Alexandra Parade
Glasgow
G31 2ER

NHS
Greater Glasgow and Clyde

Private

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

Date: 8th May 2026
Your Ref: 100016
Our Ref: SAR / ACCESS / CF
Enquiries to: Caroline
Direct Line: 0141 201 3380
Email: Caroline.Forsyth@ggc.scot.nhs.uk

Dear Sir / Madam

Re: Subject Access Request under the General Data Protection Regulation

Patient: Deborah Sullivan D.O.B: 07/12/1972

Thank you for your recent request in which you seek a copy of your client's personal information.

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

GLASGOW ROYAL INFIRMARY RECORDS / STOBHILL ACH RECORDS
PRINCESS ROYAL MATERNITY RECORDS / DENTAL HOSPITAL RECORDS

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

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

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

- Patient health records, photographs or radiology images
- Video/telephone recordings, including CCTV images
- Witness statements
- Incident reports
- Complaints files
- Emails

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

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

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

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

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

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

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

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

Yours sincerely

Subject Access Request Team

Fluid Balance Chart

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

Hospital: GRI
Ward: 6ST
Date: 11.8.19

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																	
02:00																	
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		

*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

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

Hospital: GRI
Ward: 65
Date: 10/08/19

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					IVF	500			500								
04:00																	
05:00																	
06:00																	
07:00																	
08:00					IVF	500			1000								
09:00																	
10:00																	
11:00										wet							
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		

*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

Glasgow R

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

NHS
Greater Glasgow and Clyde

Name: Unit No.:

Date:		10/8	11/8	12/8								
Time of Result:			1101	1102								
WCC	4-11	11.0	6.5	7.2								
Hb	M - 13-18 F - 11.5-16.5	141	127	130								
Plat	150-400	284	234	250								
Amylase	<100	HAEMNA	54									
CRP	<10	10	11	13								
Na+	135-145	137	141	140								
K+	3-5-50	NA	3.5	3.8								
Cl-	98-108	106	104	102								
Bic	21-28											
Urea	2.5-7.5	3.5	4.3	4.3								
Creat.	57-113	58	56	59								
EGFR	60>	>60	>60	>60								
Glucose	3.5-5.5	7.2										
Bilirubin	3-22	5	8	9								
ALT	<50	39	32	36								
AST	<40	NA	30	32								
G-GT	<55											
Alk. Phos.	40 -150	82	73	78								
Albumin	32-45	36	35	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											
Lac		1.0										

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

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

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: 67	**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
9/8/19	20:00	N	N	N	N	N	N	4hrly	
10/8/19	02:20	N	N	N	N	N	N	4hrly	
11/8/19	02:00	N	N	N	N	N	N	4hrly	
12/08/19	10:00	N	N	N	N	N	N	4hrly	
13/8/19	01:00	N	N	N	N	N	N	4hrly	
/ /	:							___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_ _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 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: _____

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

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: G7 Date: 9.8 Time: 2000	Ward: 66 Date: 12/8/19 Time: 22:40	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.	Broken ✓	N/A			
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	[signature]		[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

Feb 17 mi • 294647c Version 1_0 •GGC0233

Perso[illegible] Moving and Handling 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 I

B[illegible] h comprehension, behaviour, co-operation (specify):

Weight	Height
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			
	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:	9.8.19	13/8/19	
Assessor's signature:	[illegible]	[illegible]	
Proposed Review date:	16.8.19	20/08/19	

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 Atmit)			

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:			

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

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 9/8 Time 20 20 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 159 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	9/8							
Time	20 20							
Ward	G7							
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	32							

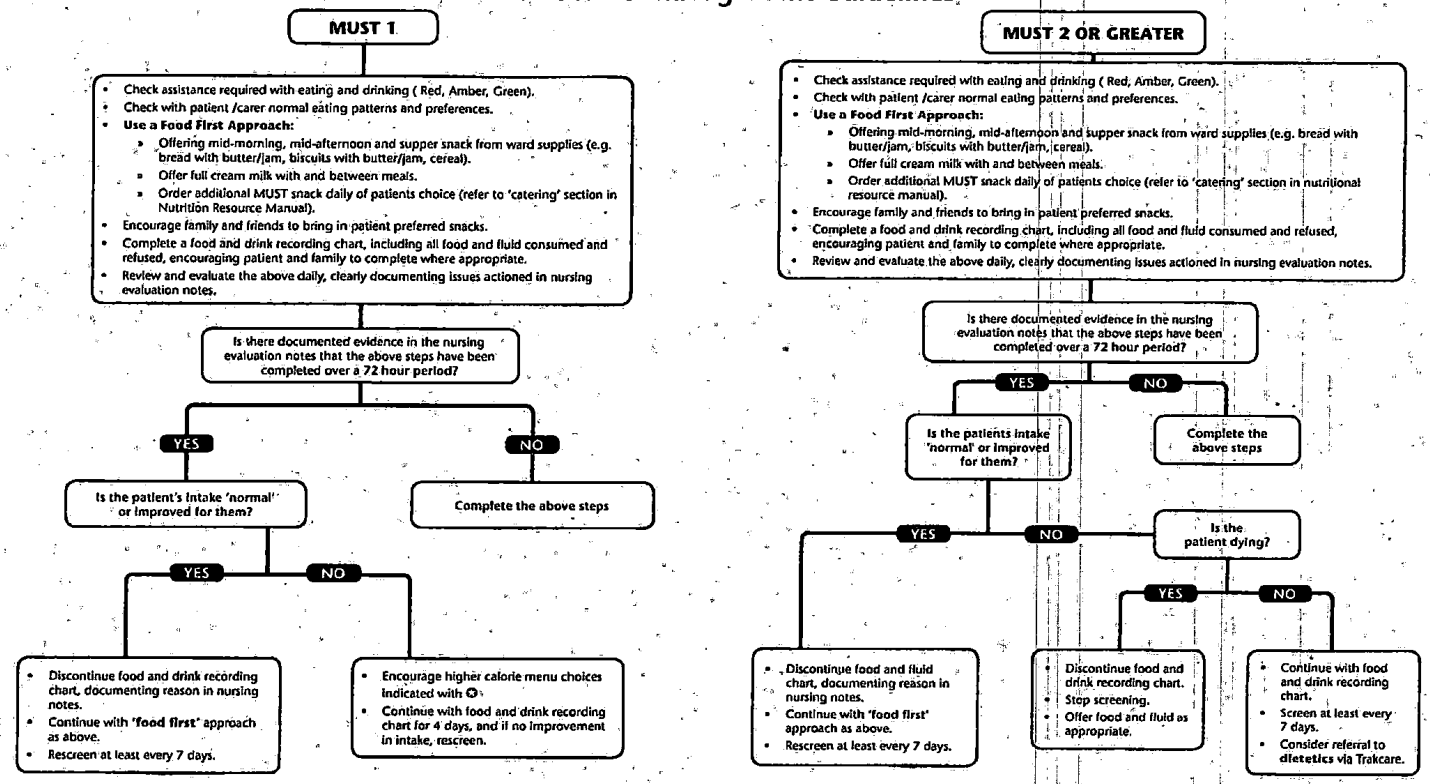
Malnutrition Universal Screening Tool (MUST) to be completed at least every 7 days

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	1/52							
Signature	[illegible]							

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/

fmi • 285884 v3.0 • GGC0250

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

Care Plan

NHS
Greater Glasgow and Clyde

Care discussed with patient Unable	☑ Yes	☐ No	☐
Care discussed with family Unable	☐ Yes	☑ No	☐

If unable, give reason:

If unable, give reason: NOT PRESENT

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature
YES PAP	AS PER NEWS	
	2, 3. Communication and senses	
YES PAP	ALERT	
	NO ISSUES	
	4. Cognitive status	
YES PAP	NO ISSUES	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
	5. Hydration and Nutrition	
YES PAP	NBM	
12/8/19 JL	Diet	
	6. Elimination	
YES PAP	NO ISSUES	

p1/2 PTO

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
13/08/19	AUDRA + CRC in use - Independent with personal hygiene needs		13/08/19	Nurse call system explained fun use - Pain score as per NEWS	
				10. Sleep and Rest	
			13/08/19	promote restful environment	
	8. Mobility			12. Privacy, dignity and sexuality	
13/08/19	Independent - MTH and fully NOR assessment complete		13/08/19	Maintain at all times	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mi • 285668 Version 1_0 • GGC0127

Adult Peripheral Vascular Cannul

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: 9/8/19 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: _____

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 10/8/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	RB
Day 1 Check 2 Night 10/8/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	JL
Day 2 Check 1 Day 11/8/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	MC
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: 11/8/19

*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

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

	Date	Ward
Admitted		
Transferred	13/6/19	66
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.

(6) Deborah Sullivan

9/8/19 DATE:

TIME:

NEWS 0 1

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
Mark: •
Alert
Verbal
Pain
Unresp

Total NEWS (with all obs)

BM

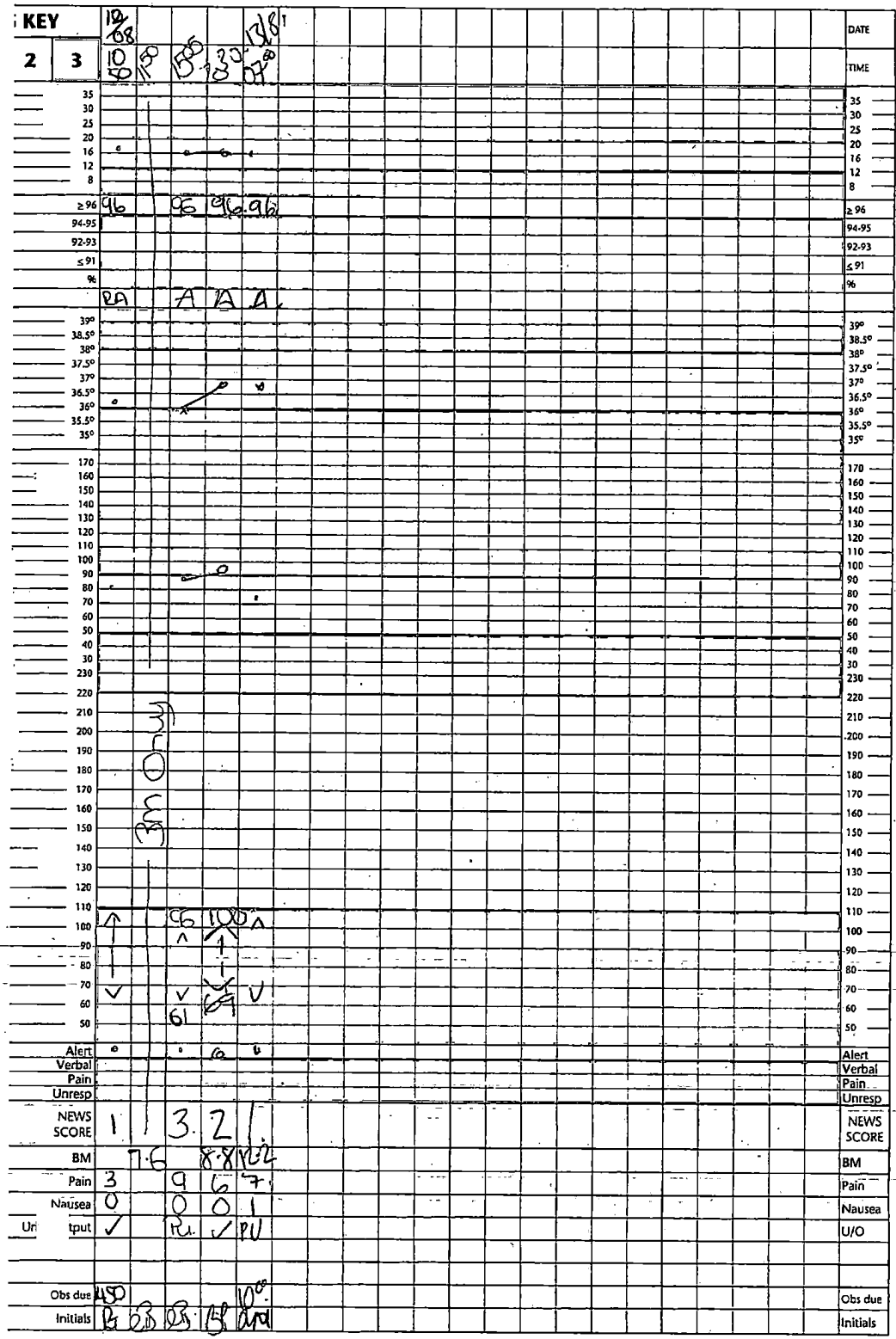
Pain

Nausea

Urine output

Obs due

Initials


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

Pupil size (mm)

1 • 2 ● 3 4 5 6 7 8

Neurological Observations

| | | |

Emergency Department Nursing Documentation

Presenting Complaint -

Date: ____/____/____ Time: _____

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

bel

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

Nursing Notes		
Date and Time		Print Name and Signature

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	
Address	0712726128 SULLIVAN F Deborah 07/12/1972 FLAT 0-1 8 BOYNDIE ST 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.

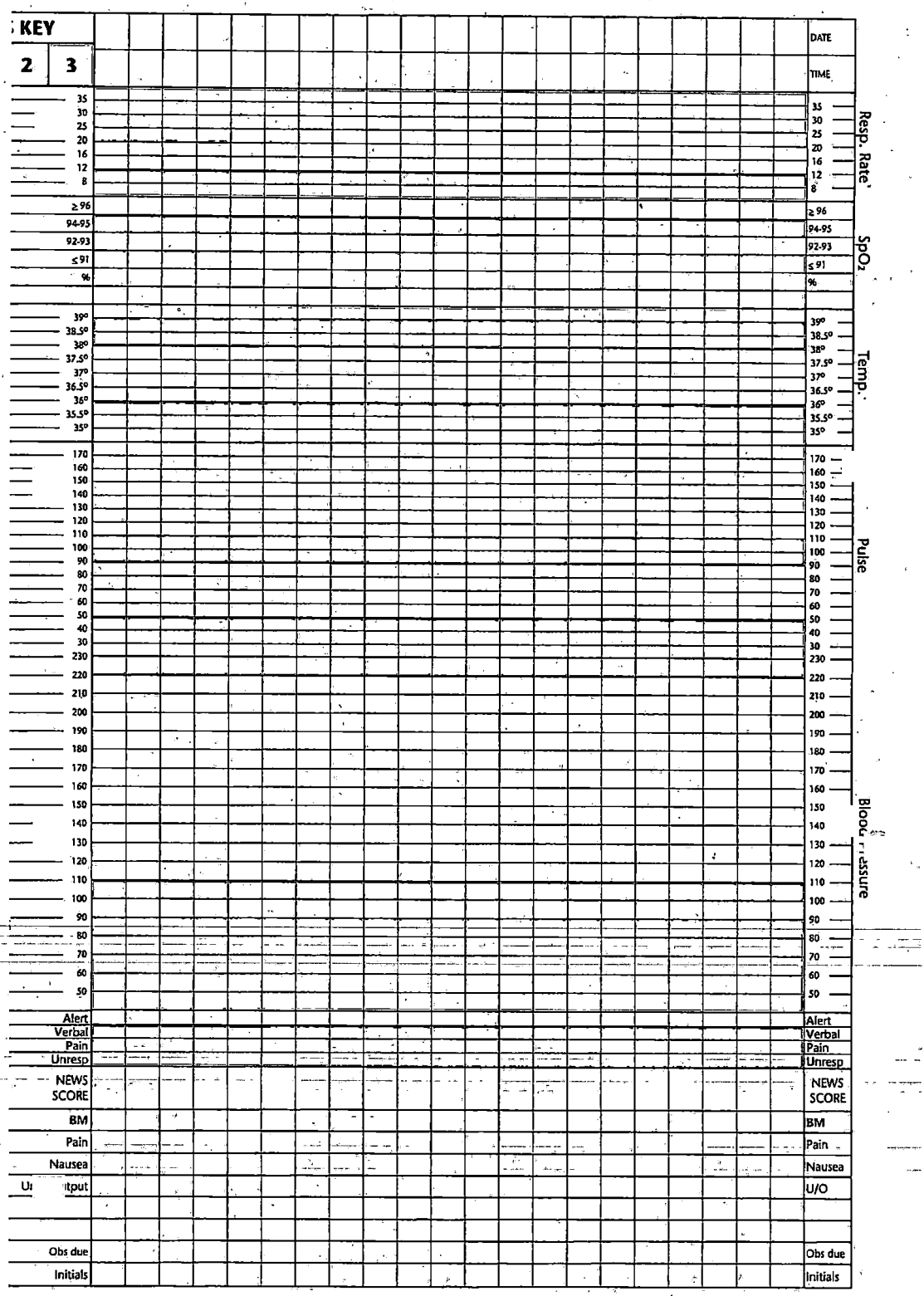
See NEWS Actions Reference Tool for local escalation policy

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

(8)

| | | |


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
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm) • • 1 2 3 4 5 6 7 8

Neurological Observations

Date:																							
Time:																							
COMA SCALE	E Eyes open	Spontaneously	4																				
		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 [illegible]nd 10. Use the diagram below to assist the patient. If patient's [illegible]ain 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

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
3 BOYNDIE ST
Glasgow, Lanarkshire
G34 9J

RSOU

AMU af

NHS Greater Glasgow and Clyde

Daily Summary of Fluid Balance

Date	Oral	I.V.	Other	Total	Urine	Gastric	Other	Total

Routine Urine Chart

Date	26/07/19							
Protein								
24hr Volume								
Colour	/							
S.G.								
Reaction								
Sugar	ve							
Ketones								
Bilirubin								
Urobilinogen	/							
Blood								
Nitrite								
Leucocyte								
Sample Sent	NO							

Stool Chart

Date	Time	Colour	Consistency	Abnormalties	F.O.B.	
					- ve	+ ve

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

PATIENT DETAILS:
NAME:
DOB:
UN:

CORE CARE PLAN

Date	No	Problem/Need	Patient Goal/Nursing Outcome	Action	Eval. date	Sig.
25/7/19	1.	Orientation. 4AT: AMT:	▪Familiarise patient with new surroundings. ▪Detect signs of new/increasing confusion. ▪Treat cause(s) of confusion.	▪Introduce yourself and other staff on admission. ▪Show patient ward layout as soon as mobile. ▪Observe for changes in mental state-consider behaviour chart. ▪Carry out relevant investigations. ▪Commence TIME bundle	1/8/19	am
25/7/19	2.	Observations	▪Record NEWS. ▪Detect abnormalities and escalate as per deteriorating patient protocol.	▪Ensure appropriate baseline observations are obtained, then repeated as indicated on NEWS chart. ▪Ensure frequency of recordings is marked on observation chart and reviewed following each NEWS score. ▪Use variance section on back page if required.	1/8/19	am
25/7/19	3.	Hydration and Nutrition.	Ensure fluid and nutrition requirements are met.	▪Complete MUST ▪If problems are detected: ▪Refer to dietician ☐ date: ▪If patient requires special diet, ensure this is ordered and available ☐ date: ▪Assess RAG status ☐ date: ▪Consider 3 day food chart ☐ date:	1/8/19	am

Date	No	Problem/Need	Patient Goal/Nursing Outcome	Action	Eval date	Sig
25/7/19	4.	Elimination.	▪Maintain normal elimination where possible and assess need for appropriate intervention where required.	▪Bristol Stool Chart ☐ ▪Urinary Catheter Care Plan ☐ ▪Maintain privacy and dignity at all times. ▪Promote hand hygiene following use of toilet.	1/8/19	au
25/7/19	5.	Mobility.	▪Optimise mobility.	▪Assess and record baseline mobility on M+H assessment. ▪If potential for improvement, refer to physio: Referred to physio: ☐ Date:	25/7/19	au
25/7/19	6.	Patient Hygiene.	☑ Independent with ADLs.	▪Provide any supplies required and inform of options for washing	25/7/19	au
			☐ Requires some assistance with ADLs.	▪Assess patient and offer either: ▪Assisted wash at bedside or, ▪Assisted shower / bath.		
			☐ Requires all care	▪Provide bed-bath and oral hygiene with two nurses.		
25/7/19	7.	Oral Hygiene	☑ Independent with ADLs.	▪Provide any supplies	25/7/19	au
			☐ Requires some assistance with ADLs.	▪Assist with tooth brushing/denture cleaning/mouth care as require. Delete as appropriate.		
			☐ Requires all care	▪Ensure 2-3 hour mouth care is completed using pink sponges and appropriate cleansing agent. ▪Apply lubricant to lips.		

Fluid Balance Chart

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972

Hospital: CU
Ward: ST
Date: 25/7/19

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: Quay Designation: S/N

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																
07:00																
08:00																
09:00																
10:00																
11:00																
12:00																
13:00																
14:00																
15:00																
16:00																
17:00																
18:00		Admitted @ 1900								Admitted @ 1900						CM
19:00																
20:00																
21:00	T+T	200														
22:00																
23:00									GH							SP
								*Total Intake							*Total Output	

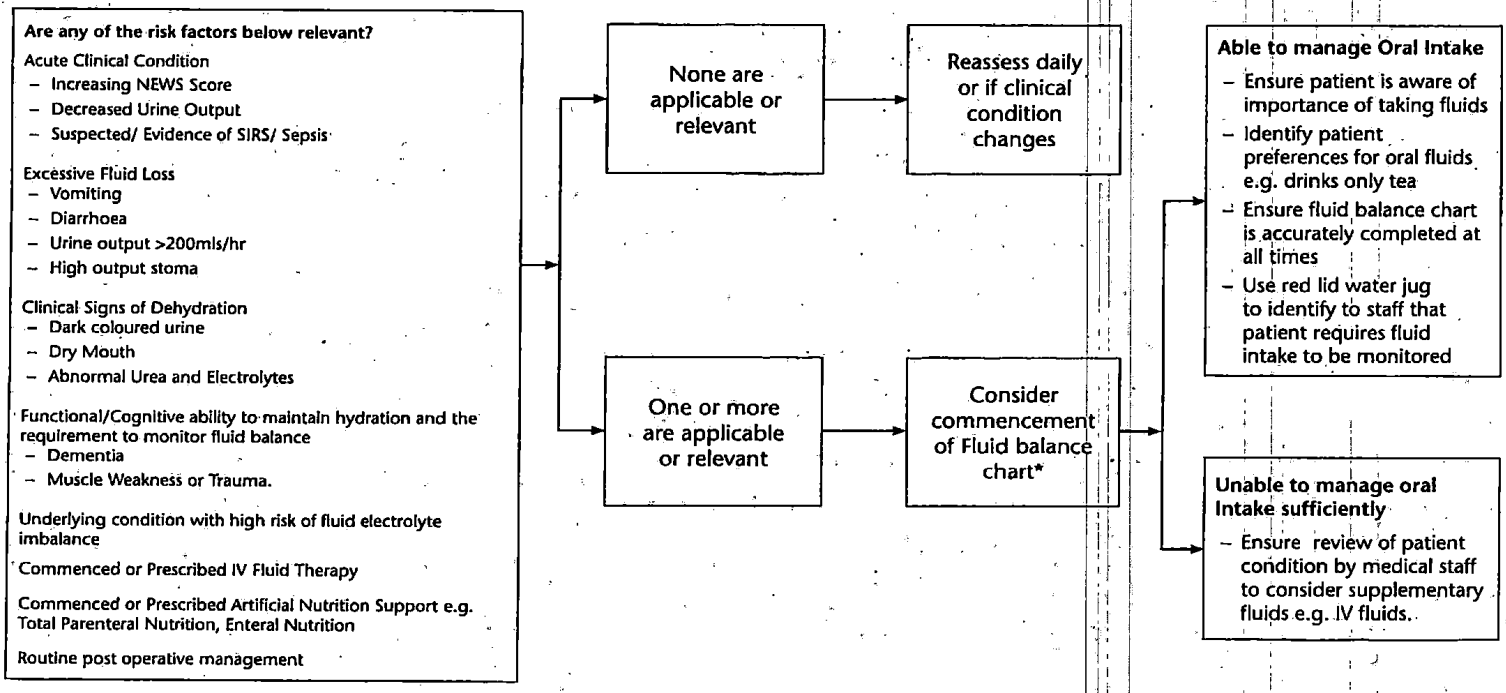
*24 hr Fluid Balance +/-

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

220665

Guide to commencing fluid balance charts

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



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

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

MIS • EDU • 237971-2

Care Rounds Checklist

Date: 25/7/19

Attach Ad
0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
BOYNDIE ST
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 Away Name AWAY 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	30/7/19	23/7/19
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	NT	Y
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	-	Int
K	4	**KEEP MOVING** Has the patient moved or walked?	N	N
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	L
		Chair Assist to walk or stand (W/ST)	W	-
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N
		Drink taken?	Y	Y
		Food, snack, or supplement taken?	Y	Y
		Has oral hygiene been carried out as per care plan?	N	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	Int
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A
		Care provider / role	AW	SP

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: 26.07.19

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 Alway Name ALWAY Designation SN
2. Signed S.R Name C.DAGGHAN Designation SN
3. Signed _____ Name _____ Designation _____

Attach / 0712726128
SULLIVAN F
Deborah 07/12/197
FLAT 0-1
8 BOYNDIE ST
Ward: 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:
N/K

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

		Times	07:45	06:40	08:45	12:40																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	N	N																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	N	N	N																		
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	NT	NT																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)			/	/																		
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	Y	Y																		
		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	/	/																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	N	N																		
		Drink taken?	Y	Y	Y	Y																		
		Food, snack, or supplement taken?	N	N	Y	Y																		
		Has oral hygiene been carried out as per care plan?	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	Y																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA																		
		Care provider / role	MD	MD	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

Fluid Balance Chart

Name: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

Hospital: GRI
Ward: SI
Date: 26.07.19

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: SN

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

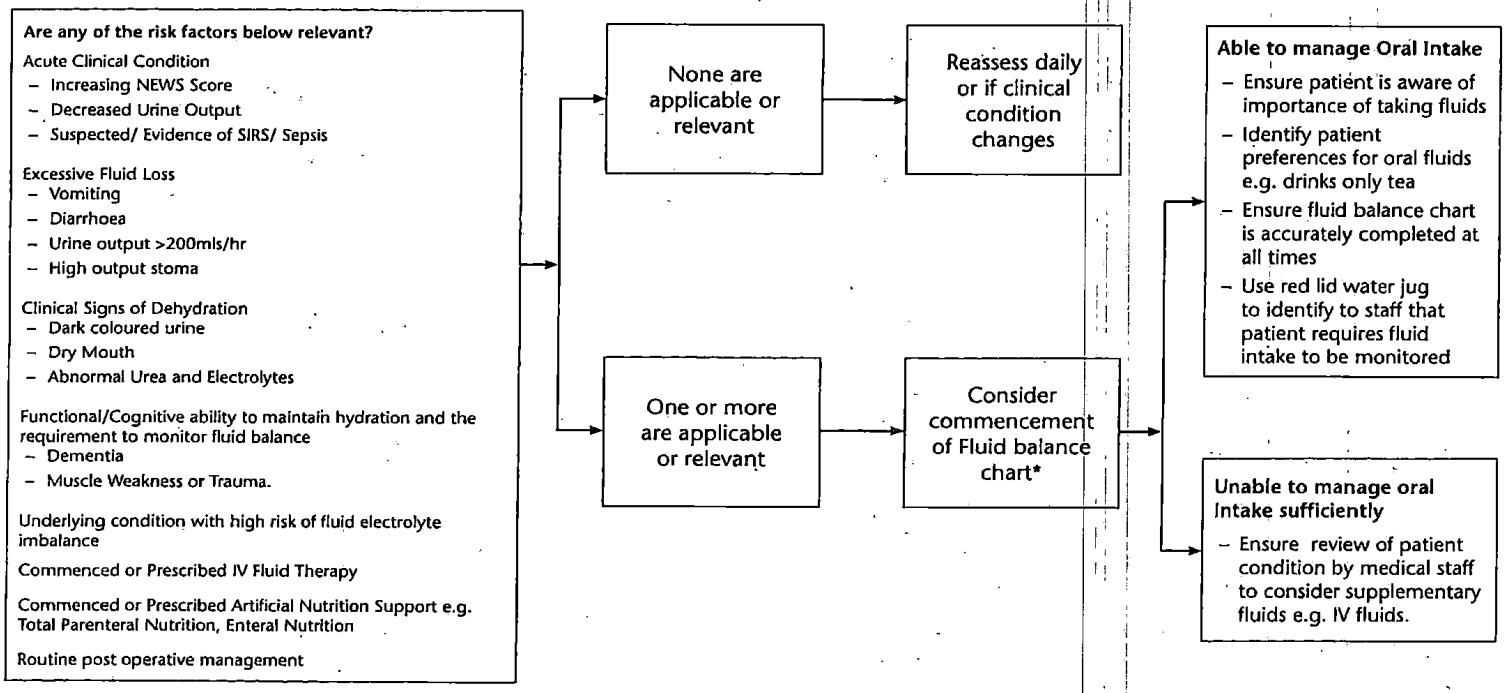
Time	Input								Running Total	Output							Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type			
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT								OUTPUT	
00:00																		
01:00																		
02:00					IVF	500			500									
03:00																		
04:00																		
05:00																		
06:00	Water	600							1100	PU								
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.



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

Adult Peripheral Vascular Cannula Insertion and Maintenance Care Plan

0712726128
SULLIVAN
Deborah
FLAT 0-1
3 BOYNDIE ST
Glasgow, Lanarkshire
G34 9J

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: 25/7/19 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: verbally explained

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 26/07/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☑ N/A ☐	MVD
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: 26/07/19

*Reason For Removal: Tissued.

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 ST Glasgow, Lanarkshire G34 9J	Hospital: QEU Ward: 57	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
25/7/19	20 00	N	N	N	N	N	N	4 hrly	[illegible]
26/07/19	06 40	N	N	N	N	N	N	4 hrly	MO
/ /	:							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 Intervent 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 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: _____

0712726128
SULLIVAN F
Deborah 07/12/1972

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: 51 Date: 25/7/19 Time: 20.00	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.	✓				
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.	✓				

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

Pe[illegible]nt) Moving and Handling Assessment Form

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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

1. Gene

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 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:	25/7/19		
Assessor's signature:	[signature]		
Proposed Review date:	1/8/19		

Continuation Sheet

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

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			
	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 tilting 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:			

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

0712726128
SULLIVAN
2 Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
07/12/197

NHS greater Glasgow and Clyde

Patient Name:

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	25/7/19						
	TIME	2000						
	WARD	87						
	HOSPITAL	QV						
SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓						
2	Has the patient requested the use of bedrails?								
IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?								
4	Is the patient stressed, delirious or restless?								
5	Is the patient small in stature?								
6	Does the patient have an unusually large or small head that might present an entrapment issue?								
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?								
IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?								
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition								
10	Has the use of bedrails been discussed with relatives/carers?								
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?								
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?								
IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	Will bedrails be used for this patient at the present time?		✓						
14	Rationale for use of bedrails: (Please insert code in the box on the right)	E							
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed								
	E – Patient request								
15	Bedrail risk assessment completed by:	[illegible]							
16	Bedrails checked by:	[illegible]							
17	Date	25/7/19							
Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here									

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

Emergency Department Nursing Documentation

Presenting Complaint -

Date: 9 / 7 / 19 Time: bay 2305

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print)
Jen

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 requested

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 - 9/7/19 Time - 2305 Signature - Jcamem	

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:

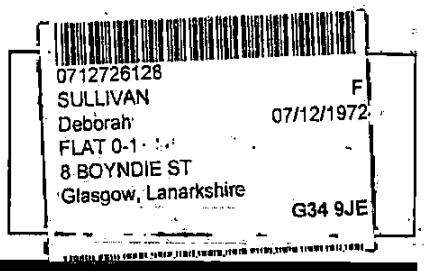
- Prioritise transfer of care to specialist geriatric assessment service in line with local guidance.

Screening Tools / ACTIVE CARE

(Please tick/circle when completed)

			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		Y/N			
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.
9/7/19	2300	JC												



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
9/7/19 2340	patient brought to cubicle. Changed into gown. Oramorph administered on arrival to bay. Medics obtained IV access/bloods. Antiemetic and IV analgesia as per Kardex. Awaits further plan.	JAMIESON
10/7/19 @ 0100	Analgesia + antiemetic given as prescribed on Kardex. IV fluids commenced. Awaiting repeat bloods (as requested) + bed in W67, patient aware —	

Nursing Notes		
Date and Time		Print Name and Signature

My Admission Record

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

F
07/12/1972

Hospital: GRI Ward: 67
Date of Admission: 10/7/19 Time: 0230
Information obtained from: Name: R. TRACEY
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: Debbie
Age: 46 Telephone Number: 07713718392
Consultant: N. Jamieson.

Urine ☑ Trace pro

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: 07743936178	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.

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

Fybromyalgia, PTSD, pancreatitis, Anxiety, Ovarian cysts, HTN, Appendicectomy, T2DM, cholecystitis, gallstones, ↑cholestrol.

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 ☑

Name
Address
0712726128
SULLIVAN
Deborah
F
07/12/1972
DOB
CHI
Affix

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** ☐

Na
Ad 0712726128
SULLIVAN F
Deborah 07/12/1972
Do
CH
Aff

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? unable to recall

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): REBEKAH TRACEY Signature: RTracey

Designation: SN Date: 10/7/19

My Assessment Record

Name:
Addr: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
G34 9JE
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 ymptoms 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: _____			

Nam
Addr 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
G34 9JE
Affix patient 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?

Stabbing pain.

Have you had treatment / intervention for the pain?

YES.

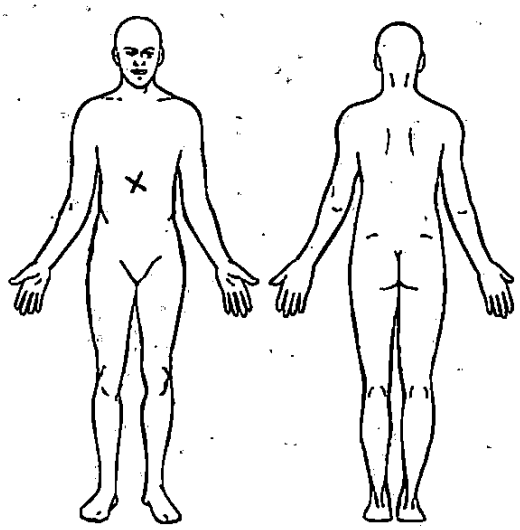
N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

NO

What makes the pain better?

Mark current pain on body chart



Nam
Addr
0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB 8 BOYNDIE ST
CHI Glasgow, Lanarkshire
G34 9JE
Affix

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?

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		

Nar
Add 0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
DoB. Glasgow, Lanarkshire
CHI:
Affix patient ID label
F
07/12/1972
G34 9JE

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:
A
0712726128 F
SULLIVAN 07/12/1972
Deborah
Do FLAT 0-1
CH 8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE
Affi

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? Yesterday.

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

Name:
A
0712726128
SULLIVAN
Deborah
F
07/12/1972
D FLAT 0-1
8 BOYNDIE ST
Cl Glasgow, Lanarkshire
G34 9JE
Af

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 ☑ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service** (as appropriate)

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

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

Name:
Ad
0712726128
SULLIVAN
Deborah
F
07/12/1972
Dof FLAT 0-1
CHI: 8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
Affix

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?	✓		

Name: SULLIVAN, Deborah F
Addr: FLAT 0-1, 8 BOYNDIE ST, Glasgow, Lanarkshire
DoB: 07/12/1972
CHI: 0712726128
Affix patient label 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?	✓	

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?		

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer		

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☑ Not appropriate at this time ☐

Name: [redacted]
Addr: 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB:
CHI:
Affix patient ID label

Are you:
Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☑ Retired ☐

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

Yes ☐ No ☐

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 the 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 the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

No

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☑

If yes, how can we support you with these?

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

13. Emotional and Spiritual Care

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

No

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

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 (Please PRINT): REBEKAH TRACEY Signature: RTracy

Designation: SN Date: 10/7/19

Name:
Add
0712726128
SULLIVAN F
Deborah 07/12/1972
DoB
CHI:
Affix

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)	✓		✓		RT 10/7/19.
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		RT 10/7/19
Assessment Chart for Wound Management		✓			
Moving and Handling Assessment	✓		✓		RT 10/7/19
Falls Risk Assessment	✓		✓		RT 10/7/19.
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
10/7/19	Patient admitted following	
0315	RUQ / Epigastric pain.	
	Recent pancreatitis	
	Observations charted.	
	NEWS (2) HR 92 sats 94% on	
	air IVF running from A+E.	REBERAL TRACEY
	currently FASTED for surgical r/v.	RTraceySN

Name: Deborah
Address: Sullivan

DoB:
CHI: 0712726128
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
10/7/19	Seen by surgical registar -	
06[15]	? gastritis ?2° to pancreatitis	
	Plan: IVF, keep FASTED	REBEKAH TRACEY
	?OGD today.	RTraceyJN
WIK	OGD today	
	NBM	K STEWART RN
	OP CTAP ———	K S
10/7/19	Deborah settled @	
1505	present.	
	Obs - BP 102/68 -	
	apyrexial	
	news - 1	
	awaiting blood results	
	awaiting RSON/MSSA if	
	+ve	
	Has pnld this am.	
	reg mods	
	Analgesia as rad	
	IV fluids insty	
	Fasting - for ogd.	
	Consent ✓	
	Checklisted	
	blue canula @ wrist	
	Mobile + self-cares	SH

Name: Deborah Sullivan
Address:
DoB:
CHI: 0712726128
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
10/7/19	wlc Mr Jamieson —	
1645	ogd wont be Tonight	
	Allow FTD	
	Fast mln for ogd	
	Marc'	CMcL
11/7/19	Patient vomited, bedding and	
02:30	gown changed. Patient now	
	settled. All medications as per	
	kardex. NEWS as charted.	RMcHenry (STN)
11/7/19	Pt seen on WLR - for	N. Barrett SN
08:30	OGD today and then	
	r/v later.	Awilkie (STN)
11:30	Pt returned from OGD	
	alert & orientated at	
	present. NEWS (3) HR 91,	
	3L of O2 97%. Pt unable	
	to eat or drink until	
	12:30pm due to throat	
	spray. Pt complaining	
	of some pain at	
	present. Advised to	
	use buzzer system	
	on first instance of	
	leaving bed.	Awilkie (STN)
12/7/19	Deborah required analgesia o/n	
0510	as charted, obs as charted	
	hypotensive, tachycardic,	

Name: SULLIVAN, Deborah — F
Address: FLAT 0-1, 8 BOYNDIE ST, Glasgow, Lanarkshire, G34 9JE
DoB: 07/12/1972
CHI: 0712726128
Affix

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
cont.	otherwise settled. for r/v in am.	Dr Warren
12/7/19	Pt been settled so	SW
12:00	far, required prn.	
	analgesia. NEWS as	
	charted, medication	
	given as per kardex.	
	Pt awaiting blood	
	results then ? home	
	later.	A Wilkie (SW)
12.7.19.	Patient complaining of pain ondansetron	
1330	4mg admin post vomit of 2 soft	
	undigested food. Pain score 9.	
	Oral morphine admin with effect.	
	BM 13.3 mmol post med. News 1	
	Patient appears comfortable & the	
	aim of meds	Ellen Currie RGN
15.50	Pt seen on W/R -	
13/7/19 0115	Deborah required analgesic oin, for	
	pain: obs stable, settled at time	
	of entry all medications given as	
	per kardex, pain ongoing issue	
	for review in am	Dr Warren
13/7/19	Patient settled this AM.	SW
1505	Obs stable. NEWS 1	
	Medication as per Kardex.	
	Enema given today as BNO since	
	Monday - BO small amount.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Deborah Sullivan
07127261128.

Date & Time		Signature, Print Name & Designation
	Vomitted small volume this afternoon - food stuff.	
	Pain ongoing; continue current management.	R Lucewood. RGN & CN
14/7/19	care as planned	
03	NEWS ① Pulse 93/min	
	passed urine, bowel inactive meds taken; pain problematic	
	oramorph given PRN a few	
	times overnight	SJ Abu. L. Abor SN
14/7	Ind with personal care	
1800	News 2 Off PLU RNO.	
	All meds as per Kardex	
	pt has been vomitting over	
	the afternoon.	
	pain continues to be an issue	
	oramorph as prescribed	
	Ward Round - titrate OHIBV	
	and stop.	
	for gastric empty investigation	
	? requires further Eneida	
15/7/19	pain remain an issue, oramorph	
N/S	given PRN, News ② BP 112/	
	O2 SAT 94% Pulse 99/m	
	independently mobile	
	passed urine, No bowel movement	
	3 days, on lactulose given	
	for gastric empty investigation	SJ Abu. L. Abor SN

83949 GGC0072

Date & Time		Signature, Print Name & Designation
15/7/19	Patient independent with	
14[00]	personal hygiene needs this	
	morning. Ambulising independently.	
	Passing urine. Reports Bowels	
	not active since Saturday.	
	Patient requested phosphate	
	enema before d/c. Enema	
	given this afternoon, awaiting	
	results. No reports of being	G Gall ST/N
	in pain or nauseated. for	Lllancini
	Home today. No new issues.	Laura Mancini
14[10]	All medications given as per	
	Kardex. Observations as charted	G Gall Gall ch
	NEWS-2. pulse 105, SpO_2 95%.	Lllancini
	on Room ~~fire~~ air. NO concerns.	Laura Mancini
14[15]	for follow up appointment with Miss	
	Craig. 4-6 weeks ———	Lauramancini

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Address
0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
CHI No. G34 9JE
DoB

	Date	Ward
Admitted	9/7/19	ED
Transferred	10/7/19	66
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.

16 Deborah Sullivan

2019

DATE: 9/7 | 10/07 | 10/07 | | | | 10/x | 11/7 | 11/7 | | | | 11/7 | 12/7 | 12/7 | 12/7 | 12/7 | DATE

TIME: 22 10 | 03 00 | 06 30 | 11 20 | 15 | 19 05 | 21 30 | 06 50 | 11 30 | 16 45 | 17 00 | 18 00 | 21 00 | 02 10 | 07 05 | 9 50 | 12 50 | 16 00 | TIME

NEWS: 0 | 1

Resp. Rate — Mark: •

SpO2 — (Enter Value)

Any Sup'l O2 — Room air

Temp. — Mark: X

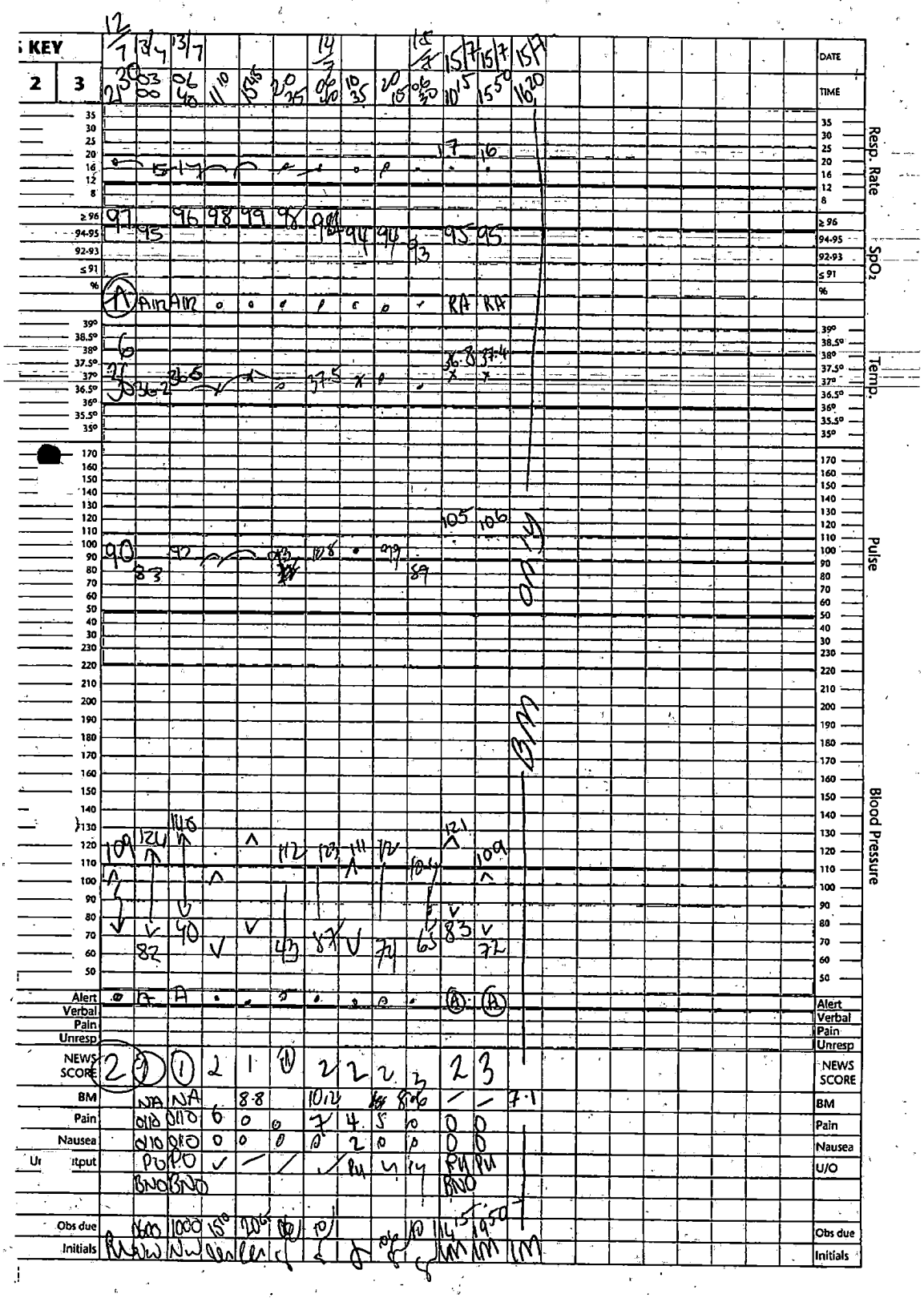
Pulse — Mark: •

Blood Pressure — Mark: ◇

NEWS SCORE using Systolic BP

Conscious Level — Mark: • — Alert / Verbal / Pain / Unresp

Total NEWS (with all obs)	2	2	0	0	1	3	3	2	3	4	4	3	(1)	4	(1)	1	0	0	NEWS SCORE
BM	6.5	6.7	9.1	9.6	5.7				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	—	13.3	BM
Pain	4	0	0	0	4/10	/	6	0	8	4	8	0	2/10	0/10	3/10	0	8	8	Pain
Nausea	N	0	0	0	0	/	0	0	7	1	8	0	0/10	N/0	0/10	0	0	2	Nausea
Urine output	N	PU	NU	PU	PU	PU	PU	PU	PU	PU	PU	PU	PO	PO	PU	PU	V	PU	U/O
													BWD	BWD	BWD	BWD			
Obs due		0600	1000		2000	0200	0600	1000	1400	1800	2200	0200	0600	1000	1400	1800	2200	0200	Obs due
Initials	TB	RT	RT	CL	L	SM	SM	RD	AW	AW	AW	AW	AW	NW	NW	NW	AW	STN	Initials


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
RA
RA

Glasgow Coma Scale

Pupil size (mm)

1 2 3 4 5 6 7 8

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

Care Rounds Checklist

Date: 15/7/19

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
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 [illegible]
2. Signed [signature] Name GGA Designation CN
3. Signed _____ Name _____ Designation _____

'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 00	10 14	18 22
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		S	S	N	N
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		S	S	N	N
S	3	SKIN INSPECTION Pressure areas checked:		S	S	I	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	I	I
		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	I
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		S	S	N	N
		Drink taken?		S	S	Y	Y
		Food, snack, or supplement taken?		S	S	N	Y
		Has oral hygiene been carried out as per care plan?		S	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?		S	S	Y	Y
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		S	S	N	N
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		S	S	N	N
		Care provider / role		[illegible]	[illegible]	[illegible]	[illegible]

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance		Sign & Print Name

mi • 278936 v2.1 • GGC0098

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 FLAT 0-1 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE	Hospital: GRI (163) Ward: 67 / 66	**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 NO	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
10/07/19	03:00	N	N	N	N	N	N	4 hrly	
11/7/19	11:30	N	N	N	N	N	N	4 hrly	Awilkie
12/7/19	05:20	N	N	N	N	N	N	4 hrly	NWarren
13/7/19	04:25	N	N	N	N	N	N	4 hrly	NWarren
14/7/19	10:00	N	N	N	N	N	N	4 hrly	
15/7/19	08:30	N	N	N	N	N	N	4 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[illegible]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 INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan: 13/7/15	Check: • Pressure areas 4 hourly. • Skin under medical devices 4 hourly. • Specify medical devices used:	Specify: • Mattress: Foam • Cushion: • Detail additional pressure redistributing equipment:	• Reposition Ψ 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 Ψ 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:

0712726128
SULLIVAN
Deborah F
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
10/7/19 RT	Known HTN.	
	NEWS ② on admission.	

Date commenced & signature	2, 3. Communication and senses	Date discontinued & signature
10/7/19 RT	No issues.	

Date commenced & signature	4. Cognitive status	Date discontinued & signature
10/7/19 RT	No issues.	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
	N/A	

Date commenced & signature	5. Hydration and Nutrition	Date discontinued & signature
10/7/19 RT	Normal D+F.	

Date commenced & signature	6. Elimination	Date discontinued & signature
10/7/19 RT	No issues.	

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
10/7/19 RT	Independant with personal hygiene. No skin problems.		10/7/19 RT	Buzzer system explained.	
			10/7/19 RT	10. Sleep and Rest No issues.	
10/7/19 RT	8. Mobility Independant.		10/7/19 RT	12. Privacy, dignity and sexuality Bedside curtains used.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care N/A.	

Care Rounds Checklist

Date: 14/7/19

0712726128
At 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 _____ Name _____ Designation SN
2. Signed _____ Name _____ 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	0620	1000	1400	1800	2200
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	S	N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y	S	Y	Y	Y	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	S	N	N	N	N
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	S	I	I	I	I
K	4	**KEEP MOVING** Has the patient moved or walked?	I	S	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	L	S	B	L	R	B
		Chair Assist to walk or stand (W/ST)	/	S	W	W	W	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	I	S	I	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	S	N	N	N	N
		Drink taken?	N	S	Y	Y	Y	Y
		Food, snack, or supplement taken?	N	S	—	—	—	N
		Has oral hygiene been carried out as per care plan?	N	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?	Y	S	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	S	N	N	N	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	S	N	N	N	NA
		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

Care Rounds Checklist

Date: 13/9/19

Attach Addre

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
F
07/12/1972
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 NWarren Name Nicola Warren Designation SIN
2. Signed [illegible] Name Anonymous 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	02 00	06 00	14 00	17 30	21 30																
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	N	N	N																
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	Y	N	N	N																
S	3	**SKIN INSPECTION** Pressure areas checked:	S	N	I	I	I																
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	Ind	INT	✓	I																
K	4	**KEEP MOVING** Has the patient moved or walked?	S	Y	Y	Y	Y																
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	B	L	B	I																
		Chair Assist to walk or stand (W/ST)	S	Ind	I	I	C																
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	Ind	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	Y	Y	N																
		Has oral hygiene been carried out as per care plan?	S	Y	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																
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	N	N	NT	NT																
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	NA	NA	NA	NA																
		Care provider / role	NAC	NAC	RN	RN	RN																

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 • GCC0098

Care Rounds Checklist

Date: 10/07/19

Attach

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

F
07/12/1972

Ward: 67

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 R.Tracey Name R. TRACEY Designation SN
2. Signed [signature] Name [illegible] Designation SN
3. Signed [signature] Name N. Docherty Designation SHN

'Must obs' 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 | 03 05 | 06 30 | 18 00 | 15 00 | 21 40 | | |

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: 12/7/19

Attach Address: 0712726128 SULLIVAN Deborah F 07/12/1972

NHS Greater Glasgow and Clyde

Ward: 66

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 SIN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'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	22 00	06 00	10 00	14 00	22 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	2	N	N	N	2
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	4	S	N	N	4
S	3	**SKIN INSPECTION** Pressure areas checked:	2	S	I	1	1
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	S	–	/	INT
K	4	**KEEP MOVING** Has the patient moved or walked?	4	S	I	Y	4
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	S	–	B	B
		Chair Assist to walk or stand (W/ST)	Ind	S	–	/	Ind
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	Ind	S	I	1	Ind
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	2	S	N	N	2
		Drink taken?	4	S	Y	Y	4
		Food, snack, or supplement taken?	4	S	Y	Y	4
		Has oral hygiene been carried out as per care plan?	4	S	I	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?	4	S	Y	Y	4
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	4	S	N	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	S	NA	NA	NA
		Care provider / role	NW SN	NW SN	NW SN	NW SN	NW 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 • CGC0098

Care Rounds Checklist

Date: 14/7/19

Attach A

07/12726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
8 BOYNDIE ST
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 RDoherty Name R Doherty Designation SIN
2. Signed _____ Name _____ Designation _____
3. Signed N Warren Name Nicola Warren Designation SIN

'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	22 00	06 00	10 30	14 00	18 00	22 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	O	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	Y	O	N	N	N
S	3	**SKIN INSPECTION** Pressure areas checked:	S	I	O	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	—	—	/	/	/	—
K	4	**KEEP MOVING** Has the patient moved or walked?	S	I	O	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	NA	/	/	/	/
		Chair Assist to walk or stand (W/ST)	NA	W	/	/	/	/
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	I	O	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	Y	O	N	N	N
		Drink taken?	S	NA	/	Y	Y	Y
		Food, snack, or supplement taken?	S	NA	/	Y	Y	Y
		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	O	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	N	O	N	N	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	/	NA	NA	NA
		Care provider / role	SH	SH	RD	AW	AW	DM

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 Cannula

Insertion and Maintenance Care Plan

Write or affix patient label

Name: Deborah Sullivan CHI: 071272612B

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: 10/7/19 Hospital: GRI Area: ED ☐ Theatre ☐ ITU/HDU ☐ Ward ☐ 67 Unknown ☐
Insertion site:	R Hand ☐ R Arm ☐ (wrist) 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 10/7/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	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 11/7/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	Awilkie (STN)
Day 2 Check 2 Night 11/7/19	Yes ☐ No ☑ If No, remove PVC and record date and reason*.	VIP: 0	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: 13/7/19

*Reason For Removal: No longer required RA

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
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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: 10 /07 /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: 10/07/19

*Reason For Removal: Dislodged / Leaked

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

0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
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 Date: 10/7/19 Time: 03:00	Ward: 66 Date: 13/7/19 Time: 06:25	Ward: 63 Date: 13/7/19 Time: 17:20	Ward: 6 Date: Time: ----:----	Ward: Date: Time: ----:----
1. Document mobility status in clinical record and complete a moving and handling assessment (if appropriate).	Indep	Independant	✓		
2. Check walking aid (if required) is in reach and in use.	NO	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.	YES	Yes In Reach	✓		
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	YES	✓ Safe	✓		
5. If glasses are worn, check they are available and in use.	YES	✓ Worn	✓		
6. If hearing aid/s are worn, check they are working and in use.	NO	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		Bracey		DWarren						

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

0712726128

Pers SULLIVAN (F) nt) Moving and Handling Assessment Form

Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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

1. General

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	NO
Kg	cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
BMI		NO
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:	10/7/19	13/7/19	
Assessor's signature:	RTro	NWarren	
Proposed Review date:	17/7/19	19/7/19.	

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 tilting 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:			

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

F
07/12/1972

Date 10/7/19 time 0300 of initial height and weight on admission to hospital 5'8		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	173 cm	☐	☑	
Admission Weight	98·8 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	10/7/19	14/7						
Time	0300	1000						
Ward	67	63						
Oedema/ Ascities present Y/N	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	ST						
Weight (kgs)	98·8	99.5						
BMI	33	33						
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	0						
Step 2 Weight loss score <5% = 0 5-10% = 1 >10% = 2	0	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	0						
Step 4 Overall Risk of Malnutrition TOTAL	0	0						
Rescreen on	1152	21/7						
Signature	R	SA						

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/

mi • 285884 v3.0 • CGC0250

Emergency Department Nursing Documentation

16

0712726128
SULLIVAN F
Deborah 07/12/1972

NHS Greater Glasgow and Clyde

Presenting Complaint -

Date: 29/6/19 Time: 2015

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 PCH Allergy	☑
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) 29/6 22cm 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	**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)

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 [signature]				
Sign - [signature]				

Nursing Notes		
Date and Time		Print Name and Signature
29/6/19	To team request for scan.	[signature]

My Admission Record

NHS Greater Glasgow and Clyde

N
A 0712726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
DC 8 BOYNDIE ST
CH Glasgow, Lanarkshire G34 9JE
Affi . patient ID label

Hospital: GRI Ward: 67
Date of Admission: 30/6/19 Time: 2330
Information obtained from: Name:
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: Debbie
Age: 46 Telephone Number 07713718392
Consultant: Mr. Madra

Glucose +++
HCG neg

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

Epigastric pain radiating to back.

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 ☐ PENICILLEN

Relevant past medical history

Fybromyalgia, PTSD, Pancreatitis, Anxiety, Ovarian cyst, Hypertension, Appendicectomy, T2DM, Cholecystitis, Gallstones, High cholesterol, Sphincter oddi dysfunction

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

Nam
Add 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB Glasgow, Lanarkshire
CHI G34 9JE
Affix patient ID label

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
Addre
0712726128
SULLIVAN
Deborah
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
Affix patient ID label
F
07/12/1972
G34 9JE

Lifestyle

Smoking

Are you a: smoker ☐ ex- smoker ☑ when did you stop? 111 days

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): KIMBERLEY CONNELL

Signature: K Connell

Designation: Staff Nurse

Date: 30/6/19

My Assessment Record

Nan
Add 07126726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Dof Glasgow, Lanarkshire
CHI: G34 9J
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 ymptoms 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: _____			

Nam
Addr 2712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
3 BOYNDIE ST
DoB Glasgow, Lanarkshire
CHI: G34 9J
Affix patient 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?
Intermittent stabbing pain

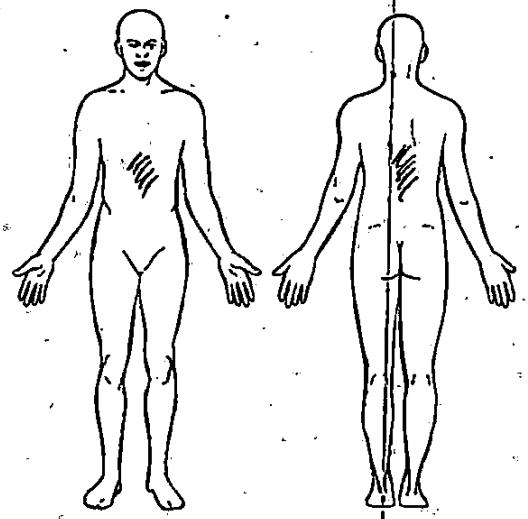
Have you had treatment / intervention for the pain?
DF118, Morphine -IV.

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



Nam
Addr
0712726128 F
SULLIVAN
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
Glasgow, Lanarkshire
CHI: G34 9J
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?

Nil

What do you like to eat and drink?

Can eat anything

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		

Name [redacted]
Addre 0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
Affix [redacted]

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		

Nam [redacted]
Addr: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
Affix 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? Friday 28/6

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		✓	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?			

Na
Ad 0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
D Glasgow, Lanarkshire
Cl G34 9JE
Af

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 ☑ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service (as appropriate)**

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

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

Nam 0712726128
Addi SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
DoB: G34 9JE
CHI:
Affix patient ID label

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?	✓		Temazepam

N [barcode] 0712726128
A SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
Glasgow, Lanarkshire
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? Daughter will look after cat	✓	

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?		

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓
If yes, what do they do?		
What involvement do you want them to have in your care while in hospital?		
N.B. If the person who helps is not a preferred contact please ensure their details are listed below		
If yes, has the help or support listed above been confirmed with the patient's informal carer		

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☐ Not appropriate at this time ☐

Na
Ad 07126128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
Dc Glasgow, Lanarkshire
Chl: G34 9JE
Affix patient re-label

Are you:
Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☑ Retired ☐

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

Yes ☐ No ☐

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 the 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 the patient referred ___/___/___

2. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

Nothing

Do you have any anxieties or fears that staff should be aware of?

Yes ☐ No ☑

If yes, how can we support you with these?

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

3. Emotional and Spiritual Care

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

Roman 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 (Please PRINT): KIMBERLEY CONNELL Signature: K.Connell

Designation: Staff Nurse Date: 30/6/19

Nam
Addr 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
Affix

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)	✓		✓		30/6/19 K.Connell K.CONNELL
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		30/6/19 K.Connell K.CONNELL
Assessment Chart for Wound Management		✓			
Moving and Handling Assessment	✓		✓		30/6/19 K.Connell K.CONNELL
Falls Risk Assessment	✓		✓		30/6/19 K.Connell K.CONNELL
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
30/6/19 0130	46 year old woman admitted with epigastric pain radiating through to back. NEWS2 1, p99, BM 10.4mmol. Fasting, waiting for review	K.CONNELL K.Connell SN

Name: _____
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: ___ Glasgow, Lanarkshire
CHI: ___ G34 9JE
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
30/6/19 0630	- Voiding urine well.	
	- News 0 as HR 107bpm. Otherwise obs stable.	
	- Settled since admission.	
	- IV fluids running.	Wallace TSNP
30/6/19 1900	Transferred to WGS.	
	WR - for outpatient CT.	GORMLEY RGN
01/07/19 0215	Settled and slept. Obs stable, N=0. Meds given as pxd, IVf continue. PV freely as charted. No c/o pain or nausea	K STEWART
	No new issues o/n.	
WR:	Stop IV fluids r/v later. ? Home later.	A Bell ABELL
1100	Independent with personal care. Can eat + drink. Bowels macric. Voiding urine well. Obs as charted. oral antiemetics & aromorph given. IV fluids stopped.	A Bell ABELL
	O2 ↓ 88-91% on average. FYI informed. c/o O2 therapy at 2litre.	A Bell ABELL
	SaO2 ↑ 99% on 2L O2.	A Bell ABELL
WR	Was at CXR at this time.	A Bell ABELL
	CXR - NAD. O2 ↓ SaO2 95% on RA.	A Bell ABELL

Name: [redacted]
Address: 0712726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire G34 9JE
Affix patie

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
2/7/19.	Pt transfered to Wd 66.	
N/S.	a&O, D&F, PU.	
	meds as pxc	
	obs charted.	
	Plan - monitor sats & r/v	S/N.
	on W/R	[redacted]
2/7/19	Seen on w/r - bloods	
08:30	& Sats ok today then	
	(H) with CT as cp.	
	Home with laxido,	
	for enema.	Awilkie (STN)
2/7/19	Patient had settled	
13:00	morning so far, NEWS	
	as charted. Enema	
	given to patient -	
	small bowel movement	
	noted. Patient	
	alert and orientated	
	Home later if blood	
	results fine, sats	
	97%.	Awilkie (STN).
18:30	Bloods imprared,	
	patient emplaining	
	of SOB, encouraged	
	pt to mobilise as	
	much as possible	
	and sit up on chair	Awilkie (STN).

Name
Addre 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
3/7/19.	Pt settled o/n.	
01[30]	meds as per - prn oramorph given	
	obs charted - SpO_2 better	
	D+F, PU.	S/N.
~~st/19~~	Plan (H) when pain settles	
08:30)	seen on w/R - Home later today c/o CT.	Awaited
10:00	Patient discharged from ward 66, alert and orientated, not complaining of pain —	Awaited (S/N)

Care Rounds Checklist

Date: 3/7/19

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 J MCKEOWN Designation SN
2. Signed [signature] Name J MCDONALD Designation S/N
3. Signed _____ Name _____ Designation _____

Attach Address

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

F 07/12/1972

NHS Greater Glasgow and Clyde

Ward: 66

'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 00	06 00																	
	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.	S	Y																	
S	3	**SKIN INSPECTION** Pressure areas checked:	S	L																	
		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																	
		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																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	N																	
		Drink taken?	S	Y																	
		Food, snack, or supplement taken?	S	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?	Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	NA																	
		Care provider / role	JL HCA	JL 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

Care Rounds Checklist

Date: 2/7/19

Attach Add
0712726128
SULLIVAN F
Deborah Su 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
Ward: G6 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 J. Meekson Designation SN.
2. Signed Awilkie Name Arlene Wilkie Designation STN
3. Signed _____ Name _____ Designation _____

'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	2[00]	6[00]	10[00]	14[00]	18[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	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:	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	Y	Y	Y	Y
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	R	B	✓	✓
		Chair Assist to walk or stand (W/ST)	–	–	✓	✓	W	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?	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?	Y	Y	Y	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	Y	Y	N	Y	Y	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA
		Care provider / role	KD	KD	AW SN	AL	AW	DM CL

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: 1/7/19

Attach Add: As D Sullivan, LAT 0-1, [illegible] BOYNDIE ST, 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 [signature] Name K-STEWART Designation SN
2. Signed [signature] Name ABell Designation SN
3. Signed [signature] Name J McCOLL Designation SN

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

T/F K ward 66

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

		Times	00 30	06 30	10 30	14	18 30	20 30	22
	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	Y	Y	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)	✓	✓	INT	INT	✓	✓	–
K	4	**KEEP MOVING** Has the patient moved or walked?	S	I	I	I	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	X	✓	X	X	✓	–	B
		Chair Assist to walk or stand (W/ST)	✓	✓	X	X	✓	–	–
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?	✓	Y	Y	Y	Y	Y	Y
		Food, snack, or supplement taken?	✓	Y	Y	Y	Y	N	N
		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	NT	NT	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	✓	NA	NA	NA	NA	NK	NA
		Care provider / role	KS	KS	KS	KS	KS	KS	KS

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: 30/6/19.

Attach Addre: 0712726128 SULLIVAN [illegible] F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
Ward: 67

NHS Greater Glasgow and Clyde

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

1. Signed K.Bonnell Name K.CONNELL 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	01:00	04:00	08:00	12:30	16:15
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N		N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	Y		N	~~N~~	Y
S	3	**SKIN INSPECTION** Pressure areas checked:	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
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – 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	PR	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y	[illegible]	N	N	N
		Drink taken?	NA	R	N	Y	Y
		Food, snack, or supplement taken?	NA		N	N	N
		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		NT	M	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA		NA	[illegible]	[illegible]
		Care provider / role	KC SN	[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
30/6/14	1800	2	PAIN: patient given pain killers by staff nurse	SHARON SMITH SR

Fluid Balance Chart

Ms D Sullivan
FLAT 0-1
8 BOYNDIE ST
Glasgow
Lanarkshire
G34 9JE

Hospital: GRI
Ward: 65
Date: 1/7/19

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										200							
01:00					IVF	520											
02:00																	
03:00										250							
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00										UTI							
12:00	lunch	400															
13:00																	
14:00	tea	150															
15:00										UTI							
16:00																	
17:00	dinner	900															
18:00																	
19:00																	
20:00					Disc												
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

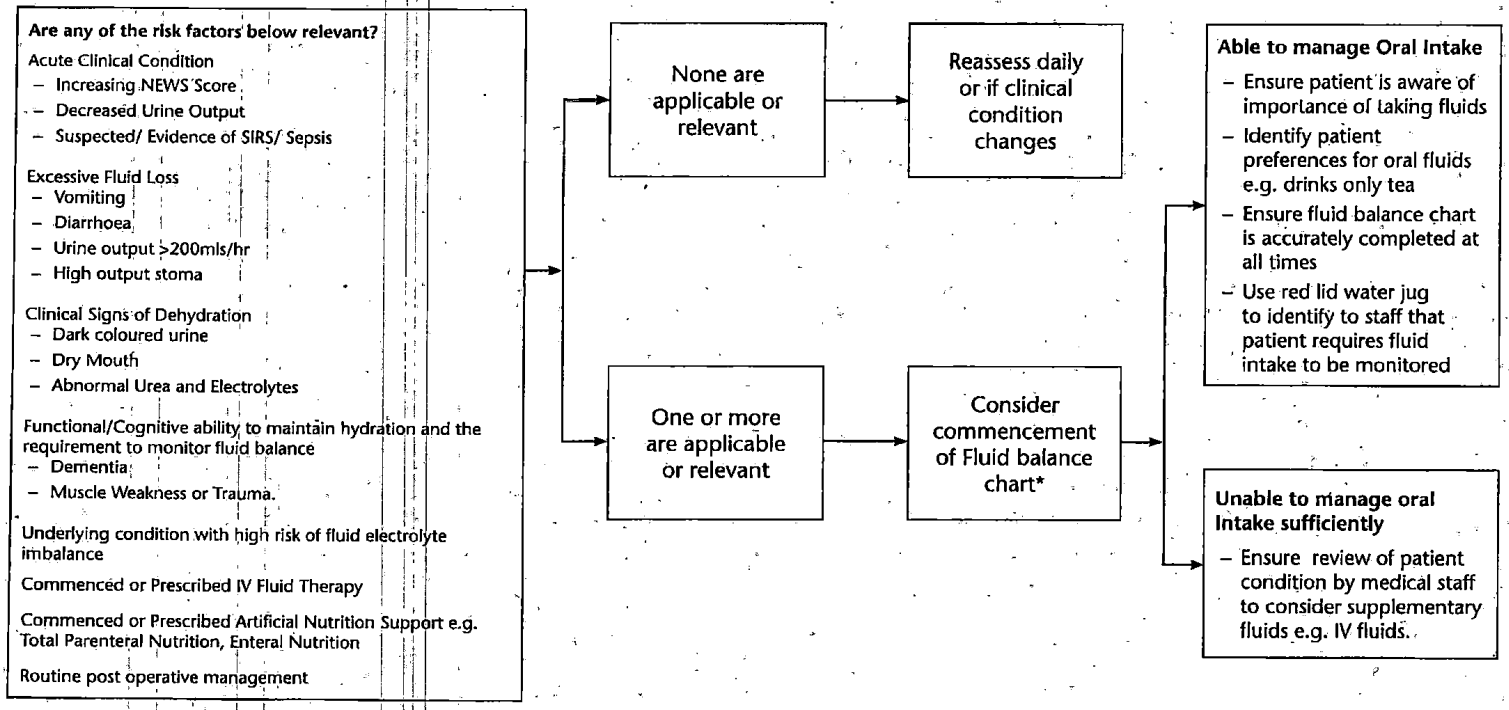
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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



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

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

MIS • EDU • 237971-2

Fluid Balance Chart

Name: Deborah Sullivan
DoB: .....
Chi number: 0719726128
Affix patient data label

Hospital: GRI
Ward: 67
Date: 30/6/19

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								Running Total INPUT	Output						Running Total OUTPUT	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00	Asleep																
02:00																	
03:00																	
04:00																	
05:00	↓	---			Hartmanns	1000				300						300	ww
06:00																	
07:00																	
08:00																	
09:00					IVF	500											
10:00	Wtr	150			—												
11:00																	
12:00	Lunch	100															
13:00																	
14:00	Wtr	150															
15:00																	
16:00																	
17:00	Dinn	350								250	Food SL						
18:00					IVF	500											
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.

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

Glasgow Royal Infirmary

46 ♀ Chole + fundo many yrs ago
? CD. Appendicectomy ✓
Fibromyalgia
Recurrent central / upper abdo pain

NHS Greater Glasgow and Clyde

Name: Deborah Sullivan Unit No.: 0 71 27 26128

Date:		29/6	30/6	1/7	2/7								
Time of Result:				12:31									
WCC	4-11	NA	(H)	7.5	7.8								
Hb	M - 13-18 F - 11.5-16.5	↓	(H)	125	120								
Plat	150-400	↓	(H)	251	228								
Amylase	<100	57	43										
CRP	<10	26	(18)	(25)	(19)								
Na+	135-145	142	136	142	139								
K+	3-5-50	4.4	4.6	4	3.8								
Cl-	98-108	102	105	102	100								
Bic	21-28												
Urea	2.5-7.5	3.4	3.3	2.7	2.4								
Creat.	57-113	52	50	62	57								
EGFR	60>	>60	>60	>60	>60								
Glucose	3.5-5.5												
Bilirubin	3-22	5	7	6	6								
ALT	<50	66	(58)	(51)	46								
AST	<40	53	(50)	30	30								
G-GT	<55												
Alk. Phos.	40 -150	94	79	80	77								
Albumin	32-45	39	32	(33)	32								
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												
Creatine Kinase		64											
C3				1.45 →									
C4				0.22 →									

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

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

0712726128
SULLIVAN
Deborah
F
07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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
30/6/19 K.Gowell	Observations as per NEWS.	
	2, 3. Communication and senses	
30/6/19 K.Gowell	No problem identified	
	4. Cognitive status	
30/6/19 K.Gowell	Alert + orientated	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
30/6/19 K.Gowell	n/a	
	5. Hydration and Nutrition	
30/6/19 K.Gowell	Fasting	1/7/19.
1/7/19 JM	D+F)	
2/7/19 AM	Update MUST weekly)	
	6. Elimination	
30/6/19 K.Gowell	Has urinary frequency but no new issues.	
2/7/19 AM	Bowels active.	

0712726128
SULLIVAN
Deborah
F
07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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
30/6/19 K.Gorrell	Independent		30/6/19 K.Gorrell	Buzzer system explained	
2/7/19 AW	PUDRA x Care		2/7/19 AW	Safe footwear	
	rounding in situ				
2/7/19 AW	24° ACP, PC states				
	[illegible] bowels skin intact			10. Sleep and Rest	
			30/6/19 K.Gorrell	Takes temazepam to aid sleep.	
	8. Mobility				
30/6/19 K.Gorrell	Independent			12. Privacy, dignity and sexuality	
2/7/19 AW	Update M+H assessment x falls risk assessment.		30/6/19 K.Gorrell 2/7/19 AW	No problem identified Promote at all times.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	--

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 30/6/19 Time 0030 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 5'9½ = 177 cm	☐	☑	
Admission Weight 99kg	☑	☐	

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

Patients reported normal weight 99kg Unable to Recall ☐

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

Date	30/6/19								
Time	0100								
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)	99kg								
BMI	32								
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	7/7/19								
Signature	K Farrell								

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/

mi • 285884 v3.0 • GGC0250

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN Deborah F FLAT 0-1 07/12/1972 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 67/68	**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
30/6/19	01:00	N	N	N	N	N	N	4 hrly	K Gamal
1/7/19	08:00	N	N	N	N	N	N	4 hrly	
2/7/19	03:15	N	N	N	N	N	N	4 hrly	
3/7/19	01:30	N	N	N	N	N	N	4 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 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: _____

0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
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 Date: 30/6/19 Time: 0030	Ward: 66 Date: 1/7/19 Time: 2300	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 required	N/A			
3. Check call bell is in reach and working. Provide and document alternative measures if patient is unable to use call bell.	Call bell with patient	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Has appropriate footwear	✓			
5. If glasses are worn, check they are available and in use.	not required	N/A			
6. If hearing aid/s are worn, check they are working and in use.	not required	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	R Connell									

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

0712726128
SULLIVAN
Deborah
07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

...ıtient) Moving and Handling Assessment Form

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

1. G...

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 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

	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:	30/6/19		
Assessor's signature:	K. Gavell		
Proposed Review date:	7/7/19		

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 Alerto)		

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:			

0712726128

SULLIVAN Peripheral Venous Cannula Care and Maintenance Plan
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

Write or affix patient label

Name: _____ CHI: _____
DOB: _____ Address: _____
Ward: 67 Hospital: CRH

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: 29/6/19 Hospital: CRH 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 __/__/__	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 1/7/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	QLS
Day 2 Check 2 Night 1/7/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	LS
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: 2/7/19

*Reason For Removal: Not Required

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

Name
Address
0712726128
SULLIVAN F
Deborah 07/12/1972

CHI No.
DoB

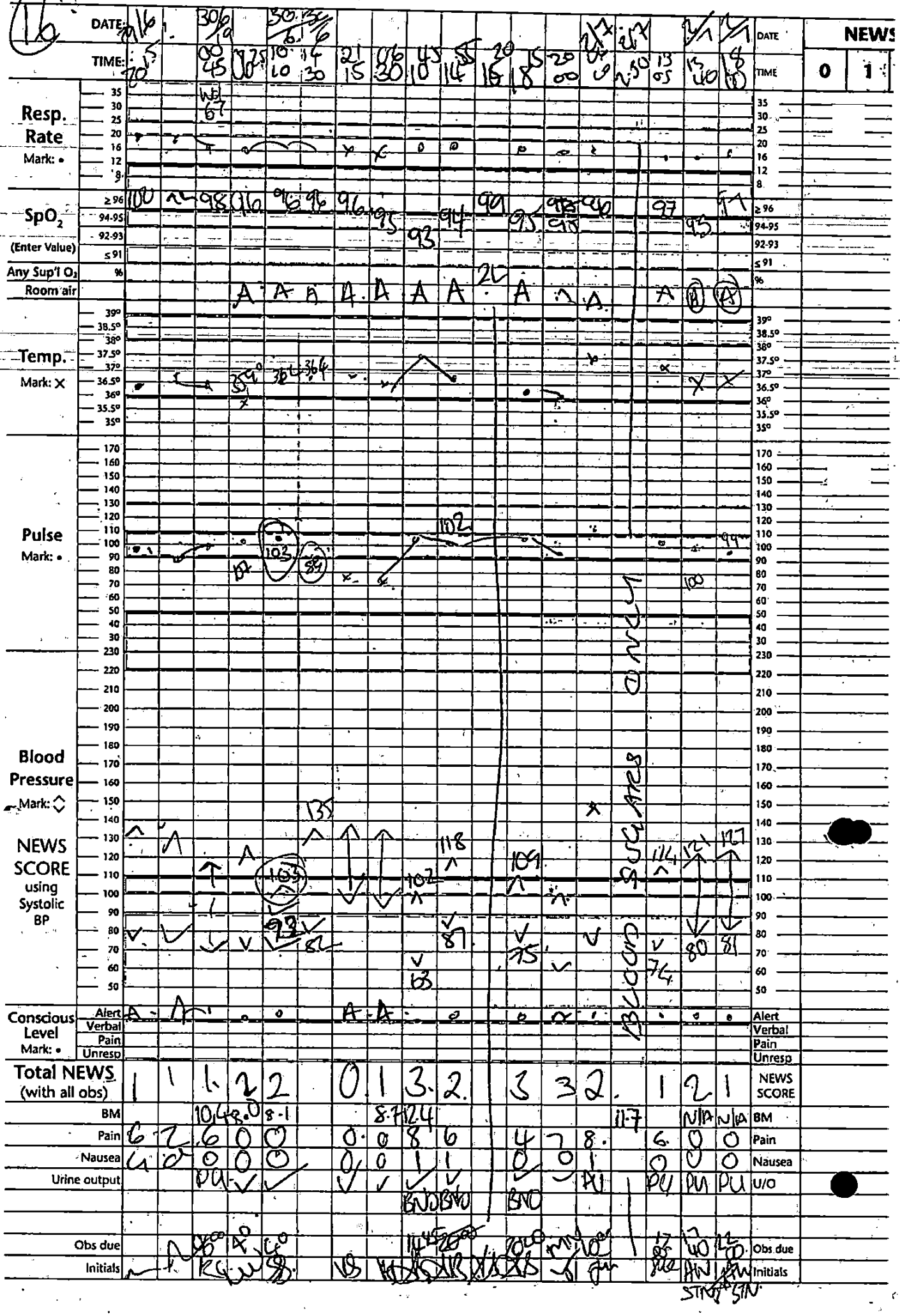
	Date	Ward
Admitted		
Transferred	17/9	66
Transferred		

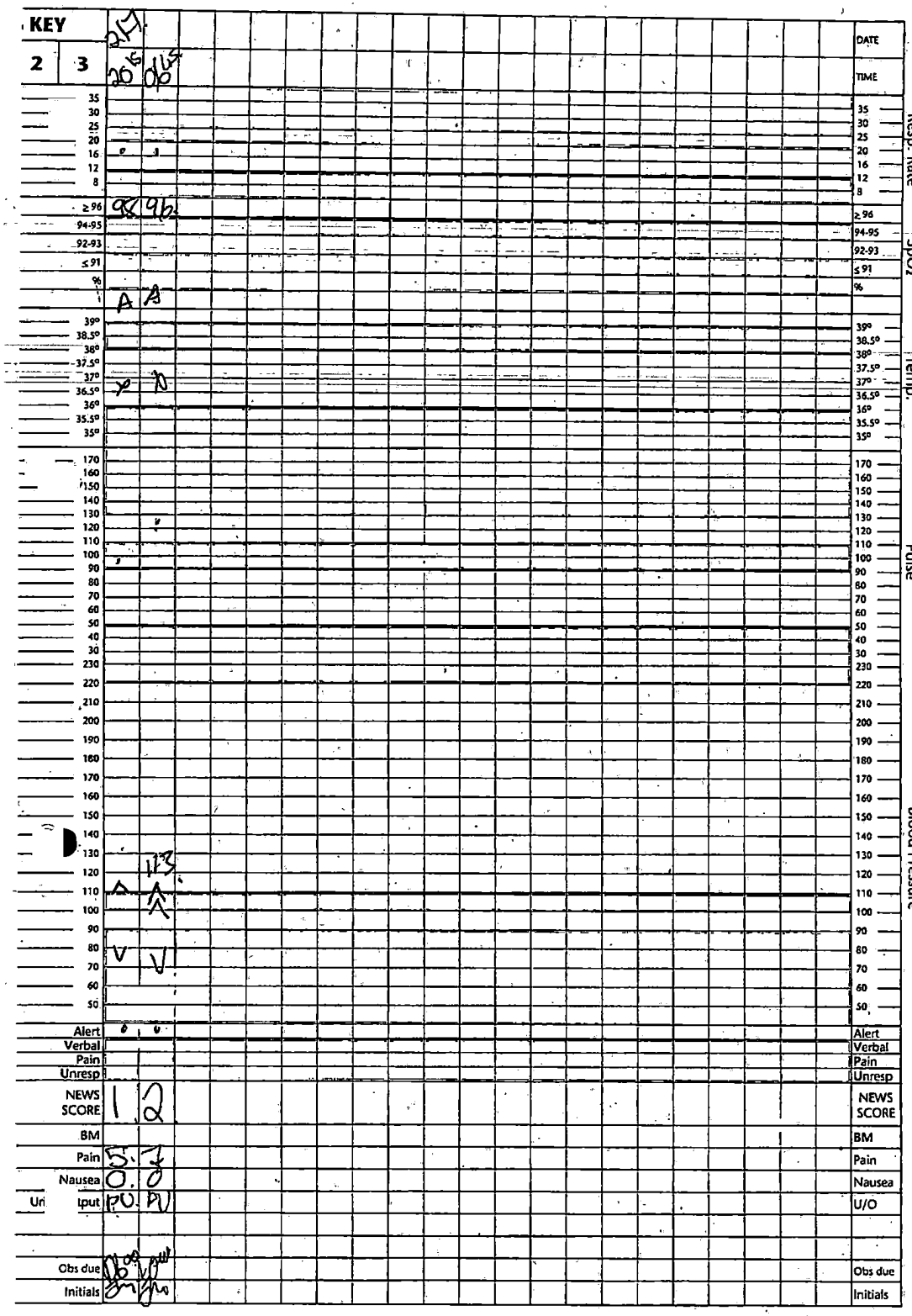
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

See NEWS Actions Reference Tool for local escalation policy

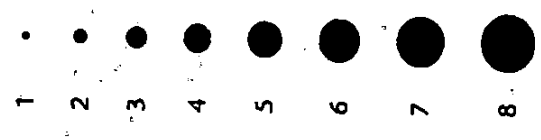
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need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


DATE
TIME:
NEWS
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
Alert
Verbal
Pain
Unresp
Mark: •
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS SCORE
U/O
Obs due
Initials


KEY
2
3
DATE
TIME
21/7
20:15
06:45
Resp. Rate
SpO2
%
Temp.
Pulse
Blood Pressure
113
Alert
Verbal
Pain
Unresp
NEWS SCORE
1
2
BM
Pain
5
7
Nausea
0
0
Urine Output
PU
PU
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)



AFFIX PATIENT ID

Neurological Observations

| | | |

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's name: [redacted]	Ward: 66
Unit number: 0712726128	Discharge destination: Home
CHI number: SULLIVAN, Deborah, F, 07/12/1972, FLAT 0-1, 8 BOYNDIE ST, Glasgow, Lanarkshire, G34 9JE	Estimated Discharge Date (1) / /
Apply address graph	Estimated Discharge Date (2) / /
	Final date of discharge : 02-07-19

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

Time of Discharge:		
Nurse's signature: Awilkie	Designation: STN	Date: 02 07 19.

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
raph label

Ward: 66

Discharge destination: Home

Estimated Discharge Date (1) / /

Estimated Discharge Date –(2) / /

Final date of discharge : 19/3/19

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		DT	
Relative/carer informed				
Others informed: Care Home				
Transport arranged				
Own transport (preferred option)	✓		M	
Ambulance-1 man/ 2 man am/pm				
Other: Flight, Air ambulance etc.				
Discharge medication				
Discharge prescription completed				
Compliance aids e.g. Dossette Box (involve pharmacist)				
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient				
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)				
Informed of discharge				
Social work/ Other agencies/Home help				
Physiotherapist				
Occupational Therapist				
Dietician				
Speech and Language Therapist				
Clinical Nurse specialist e.g. Care Home Liaison				
Liaison/ District Nurse/Practice Nurse				
Other discharge items				
Access arrangements (e.g. keys, door entry)				
Patients clothing available for day of discharge				
Valuables e.g. cashier				
Intravenous cannula removed	✓		M	
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: 14.00

Nurse's signature: [signature] Designation: SN Date: 19/3/19

My Admission Record

NHS Greater Glasgow and Clyde

Name:
Address:
0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST.
Glasgow, Lanarkshire
G34 9J

Hospital: GRI Ward: 67
Date of Admission: 18/3/19 Time: 03.45
Information obtained from: Name: Deborah
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 46 Telephone Number:
Consultant: P Chong

RSOU ☑ Trace bilirubin

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: Dona	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 + LUQ 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 Pancreatitis
Fibromyalgia
Anxiety
Depression
GORD
Cholecystectomy
Open fundoplication
PTSD

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: ___
Address: ___ 0712726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
8 BOYNDIE ST
DoB: ___ Glasgow, Lanarkshire G34 9JE
CHI: ___
Affix patient 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** ☐

Name: _____
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: ___ Glasgow, Lanarkshire
CHI: ___ G34 9J
Affix patient ID label

Lifestyle

Smoking

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

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): R. PURSS Signature: R. Purss

Designation: SN Date: 18/3/19

My Assessment Record

Name: SULLIVAN Deborah F
Address: FLAT 0-1 8 BOYNDIE ST Glasgow, Lanarkshire G34 9J
DoB: 07/12/1972
CHI: 0712726128
Affix patient 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			on Ramapril.
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: [redacted]
Address: [redacted]
0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9J
F
07/12/1972
DoB:
CHI:
Affix patien

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.

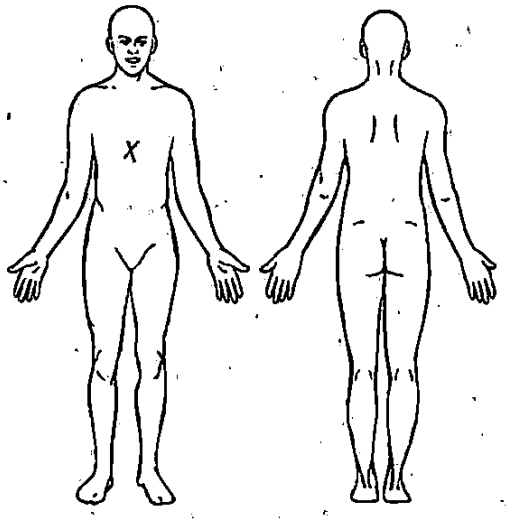
Have you had treatment / intervention for the pain?

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: __
Address: _ 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
Affix patie...

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 food allergies.

What do you like to eat and drink?

likes most things.

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		

Name: _____
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
DoB: ___
CHI: ___
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: [redacted]
Address [redacted]
0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
G34 9JE
Affix pat

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? 17/3/19

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	✓	✓	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?		✓	

Name: _
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
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 ☑ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service** (as appropriate)

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

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

Name: SULLIVAN Deborah F
Address: 0712726128
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
DoB: 07/12/1972
CHI:
Affix patient ID label

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?	✓		

Name: _____
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
Affix pati 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?		✓

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?		✓

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer		✓

Required Support

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☐ Not appropriate at this time ☑

Name: 0712726128
Addres: SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
G34 9JE
Affix patient ID label

Are you:
Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☑ Retired ☐

Has your health had an impact on your ability to carry out your day to day activities at work?
Yes ☐ No ☑

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 the 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 the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?
No thank you.

Do you have any anxieties or fears that staff should be aware of?
Yes ☐ No ☑

If yes, how can we support you with these?

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

13. 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 ☑

Name (Please PRINT): R. PURSI Signature: R. P

Designation: SN Date: 18/3/19

Name: ___
Address: _ 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
G34 9JE
Affix patient label

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)	✓		✓		RP RP SN
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓			
Bristol Stool Chart		✓			
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		RP RP SN
Assessment Chart for Wound Management		✓			
Moving and Handling Assessment	✓		✓		RP RP SN
Falls Risk Assessment	✓		✓		RP RP SN
Bedrail Risk Assessment		✓			

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
18/3/19 04:20	Patient admitted to ward 67 with epigastric & LUQ pain.	
	Observations stable - NEWS 1.	
	Independent with care.	
	Remains fasted for review.	
	No pain at present.	R. Press SN

Name: [redacted]
Address: [redacted]
0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB: Glasgow, Lanarkshire
CHI: G34 9JE
Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
18/3/19 07:00	Reviewed by FY2:	
	Clear fluids only.	
	Continue IV fluids	
	?CTAP.	R. Ross SN
9am NAD	Reviewed by Mr P Chang	
	Continue IV fluids	
	Analgesia Allow fluid	
	and diet.	[redacted]
	Allow to settle.	[redacted]
15:00	Settled at present.	
	Fully mobile.	
	Oral analgaesia given	[redacted]
16:00	R/B Mr P Chang's team	
	No changes in present	
	management.	[redacted]
19/3/19	Transferred from ward 65.	
00:15	news 3 - HR 95, SpO2 95%	
	Bp 108/60. IV fluids	
	Continue as prescribed	
	(PSG). for R/V in AM	[redacted]
	Settled at this time.	[redacted]
09:00	wr - (H) no follow up	[redacted]

Name: __
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire
Affix pati G34 9JE

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

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

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

Care Rounds Checklist

Date: 19.3.19

Attach Addressograph Label

Deborah Sullivan

Ward: 66 07/12/1972

NHS Greater Glasgow and Clyde

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

1. Signed [signature] Name [illegible] Designation SW
2. Signed [signature] Name [illegible] 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	12.00	6.00	10 20																		
	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)	/	/	—																		
K	4	**KEEP MOVING** Has the patient moved or walked?	S	S	I																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	R	—																		
		Chair Assist to walk or stand (W/ST)	/	/	—																		
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	S	I																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	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	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																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	S	N																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A																		
		Care provider / role	SC HCA	SC HCA	M																		

Care Rounds Variance Sheet

Attach Addressograph Label

Ward:

NHS Greater Glasgow and Clyde

Codes

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

N.B. Record what and to whom escalated.

Date	Time	Code	Variance	Sign & Print Name

m • 278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 18/3/19

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 R. Russ Name R. RUSS Designation SN
2. Signed [signature] Name SINCOONAND Designation CA
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 Addres:
0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
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:
No Thank you

		Times	04[05]	08[30]	09	13[30]	17[30]	22[30]
	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	Y	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?	Y	Y	Y	N	N	N
		Drink taken?	N	N	N	Y	Y	Y
		Food, snack, or supplement taken?	N	N	N	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	NT	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N/A	N/A	N/A	NA	N/A	N/A
		Care provider / role	RR SN	RR SCN	[illegible]	HH SIN	KM SIN	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

mi • 278936 v2.1 • GCC0098

Fluid Balance Chart

0712726128
SULLIVAN F
Deborah 07/12/1972

Hospital: GRI
Ward: 65
Date: 19.3.19

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 _____

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					EVI	83											
01:00						83											
02:00						83											
03:00						83											
04:00						83											
05:00						83											
06:00						83											
07:00						83											
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		

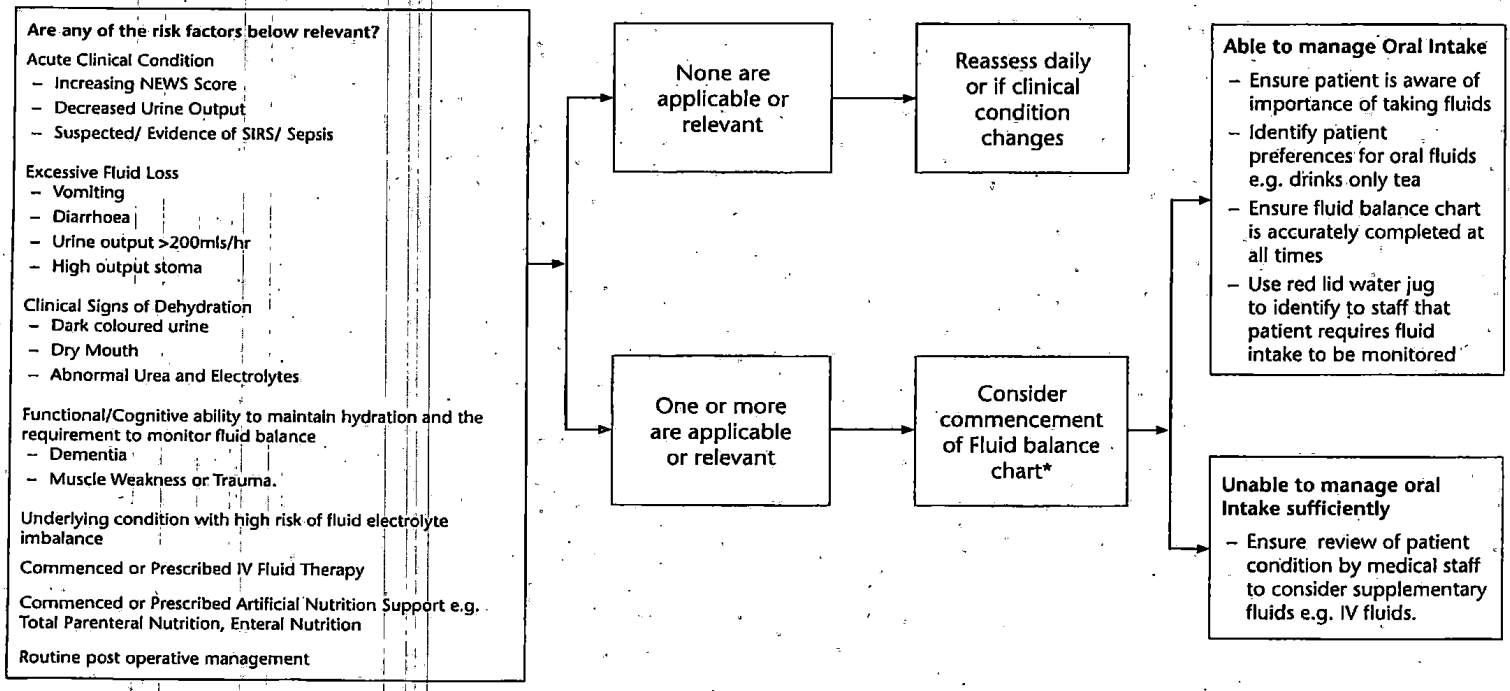
*24 hr Fluid Balance +/-

*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.



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

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

MIS • EDU • 237971-2

Fluid Balance Chart

Name: DEBORAH SULLIVAN
DoB: 07/12/72
Chi number: 0712726128
Affix patient data label

Hospital: GRI
Ward: 67
Date: 18/3/19

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																	
02:00																	
03:00																	
04:00					IVF	500			500								
05:00					IVF	500			1000	300						300	
06:00																	
07:00																	
08:00																	
09:00	Tea	200							1200								
10:00																	
11:00																	
12:00																	
13:00																	
14:00																	
15:00										P.U.							
16:00																	
17:00																	
18:00										P.U.							
19:00																	
20:00					W/Bag	1000			2200								
21:00	Tea	200							2400	P.U.							
22:00																	
23:00																	
		400				2,00		*Total Intake	2,400						*Total Output	300 + P.U.	

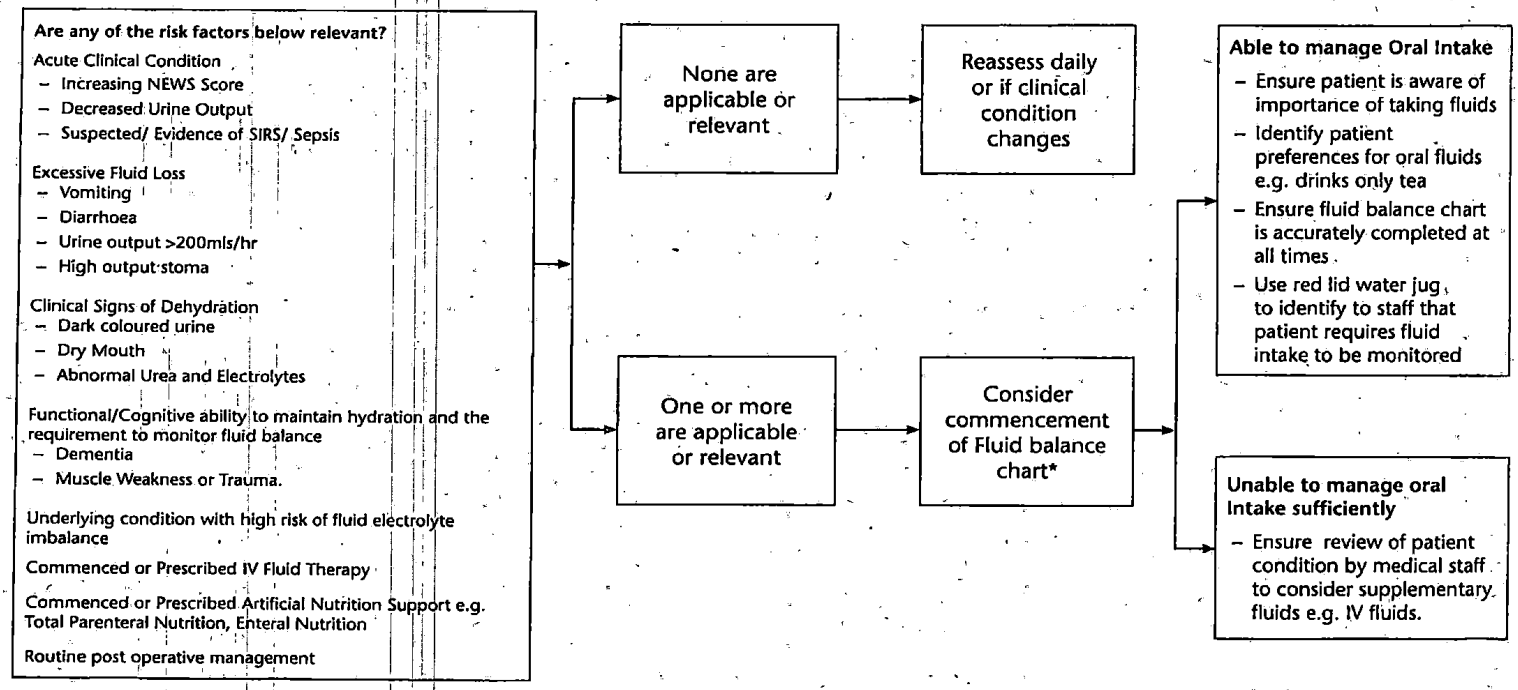
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*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

Glasgow

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

F
07/12/1972

NHS
Greater Glasgow and Clyde

Name:

Unit No.:

Date:		18/3	18/3/19										
Time of Result:		01:19	1052										
WCC	4-11	10.6	9.06										
Hb	M - 13-18 F - 11.5-16.5	132	130										
Plat	150-400	281	204										
Amylase	<100	68											
CRP	<10	2	2										
Na+	135-145	140	139										
K+	3-5-50	5.0	4.5										
Cl-	98-108	107	108										
Bic	21-28												
Urea	2.5-7.5	6.9	8.4										
Creat.	57-113	50	56										
EGFR	60>	>60	>60										
Glucose	3.5-5.5												
Bilirubin	3-22	4	4										
ALT	<50	37	34										
AST	<40	32	32										
G-GT	<55												
Alk. Phos.	40 -150	70	65										
Albumin	32-45	38	34										
Mg^+													
Ca	2.1-2.6	2.40											
Adj Ca	2.1-2.6	2.42											
PO4	0.7-1.4	1.31											
PT	9-12	12/1.0											
APTT	25-37	30/0.9											
TCT	11-15	13/1.0											
Trop I hs		1											

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

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

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 FLAT 0-1 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: 67	**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
18/3/19	04:10	N	N	N	N	N	N	4 hrly	SN
19/3/19	09:15	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 Interventional Plan

NHS Greater Glasgow and Clyde

Attach Addressograph

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

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

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

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
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 Date: 18/3/19 Time: 04:10	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 without aid.				
2. Check walking aid (if required) is in reach and in use.	No aid.				
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 use.				
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Footwear appropriate				
5. If glasses are worn, check they are available and in use.	Reading glasses				
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	RP SN 25/3/19									

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

0712726128

Per SULLIVAN Deborah F 07/12/1972 ent) Moving and Handling Assessment Form

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

1. Gene... 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 tilting 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:	18/3/19		
Assessor's signature:	R. Pun		
Proposed Review date:	25/3/19		

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 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:			

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

5R 9

Date 18/3/19 Time 04.10 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	101 kg	☑	☐	

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

Patients reported normal weight _____ Unable to Recall ☐

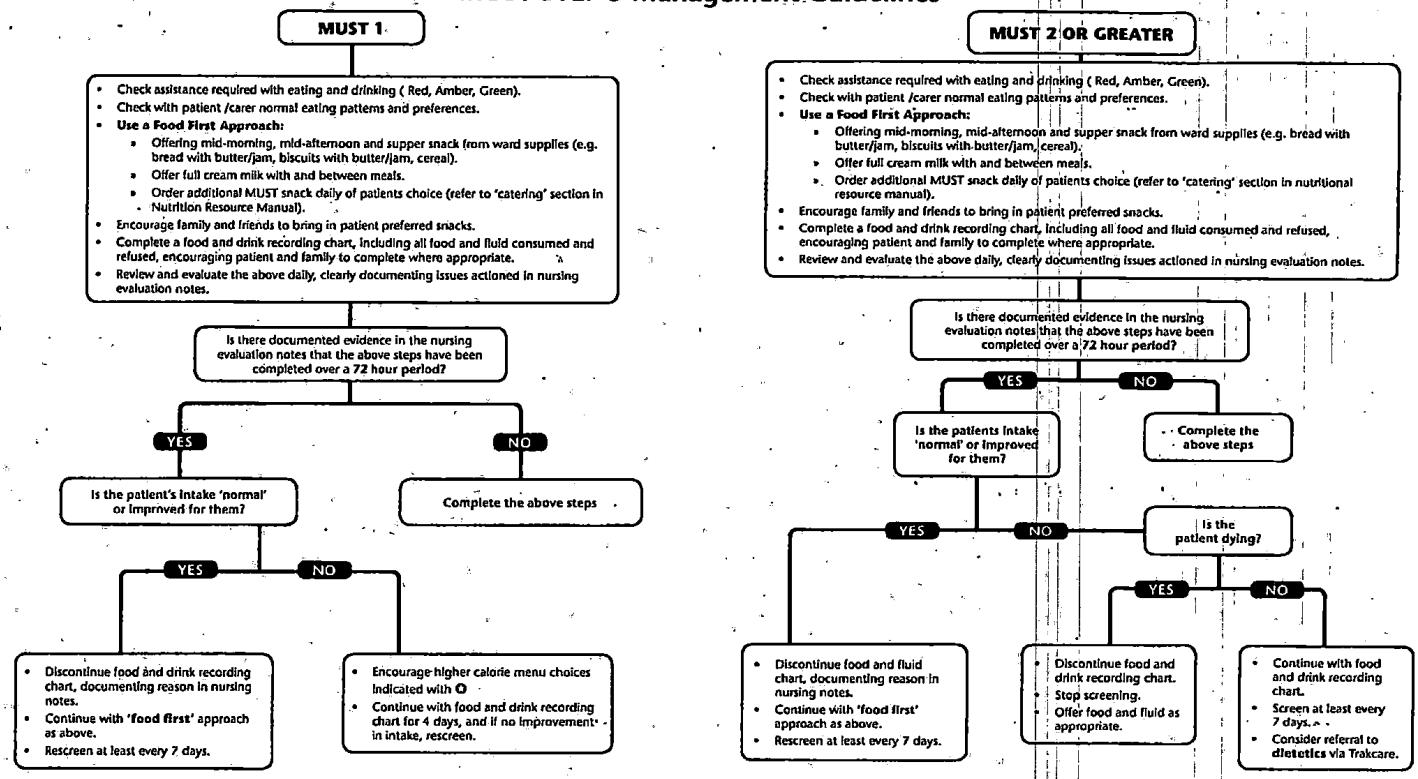
Any unplanned weight loss in the last 6 months Yes ☐ how much_____ No ☐ Don't Know ☐

Date	18/3/19							
Time	04.10							
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)	101							
BMI	32							
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	25/3/19							
Signature	RB							

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

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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
18/3/19 RP	Independent with all care. Reports all skin intact		18/3/19 RP	Call buzzer explained.	
				10. Sleep and Rest	
				Takes temazepam. Wakes regularly	
	8. Mobility				
	Independent without aid. No falls reported			12. Privacy, dignity and sexuality	
				No concerns.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mi • 285668 Version 1_0 • GCC0127

0712726128 F
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE
07/12/1972

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
18/3/19 RP	Regular obs.		18/3/19 RP	Not Required at present.	
	Known hypertension				
				5. Hydration and Nutrition	
				MUST 0.	
				Normal diet + fluids	
	2, 3. Communication and senses				
	Communicates well				
	Wears reading glasses				
				6. Elimination	
	4. Cognitive status			Bowels regular.	
	Alert & onentated			No urinary symptoms.	

Adult Peripheral Vascular Cannula

Insertion and Maintenance Care Plan

Writ 0712726128
Nam SULLIVAN
DOE Deborah 07/12/1972
Ward

Fill: _____
dress: _____
spital: _____

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: 18/3/19 Hospital: GRI Area: ED ☑ Theatre ☐ ITU/HDU ☐ Ward ☐ _____ Unknown ☐ _____
Insertion site: _____	R Hand ☐ _____ R Arm ☐ _____ R Foot ☐ L Hand ☐ L Arm ☐ L Foot ☐ Other: L wrist
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 18/3/19	Yes ☑ No ☐ If No, remove PVC and record date and reason*.	VIP: 0	Yes ☑ No ☐	Yes ☐ No ☐ N/A ☑	JMS
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: 19/03/2019

*Reason For Removal: Tissue Swelling + Discomfort

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
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

	Date	Ward
Admitted	18/3/19	
Transferred		
Transferred		

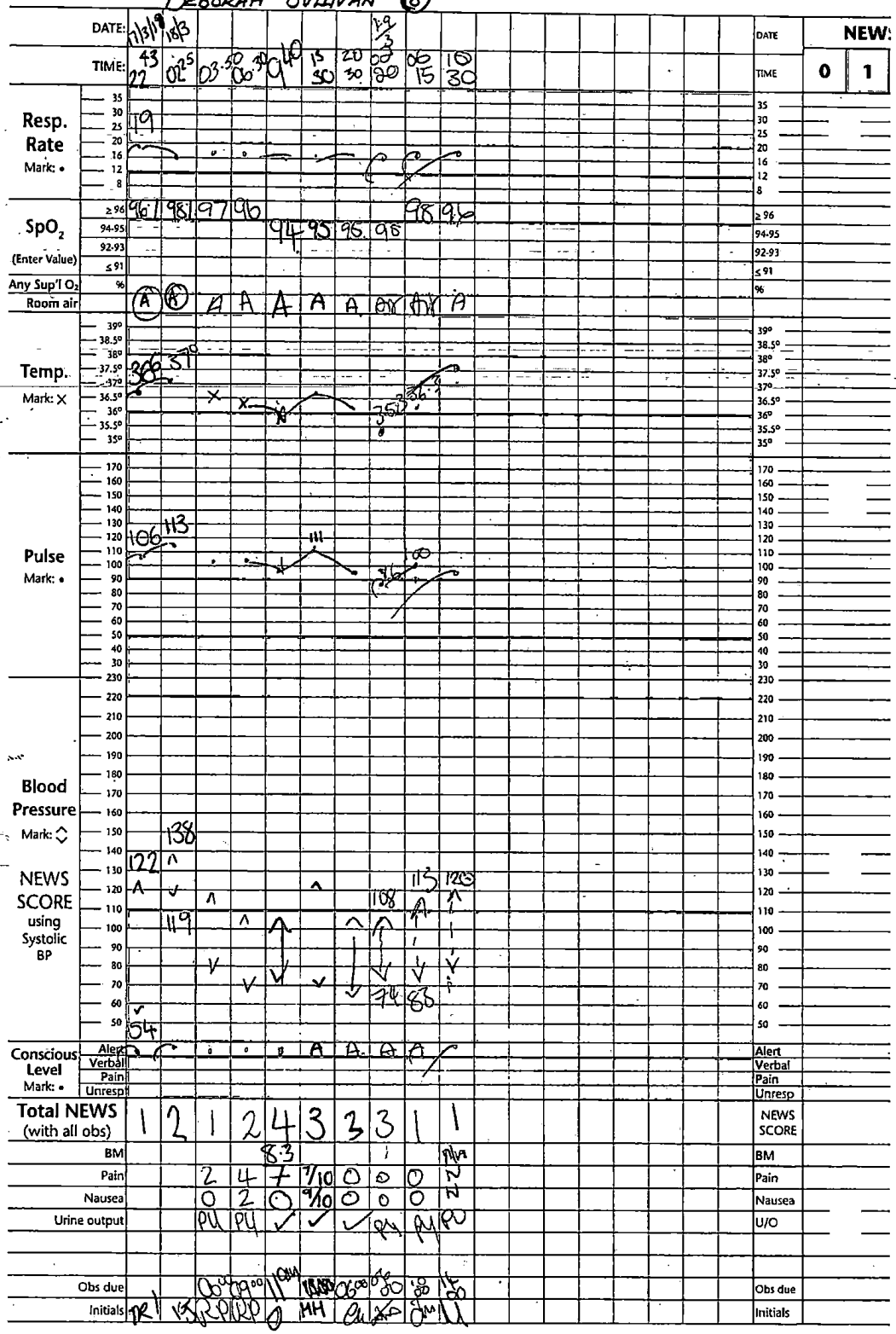
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

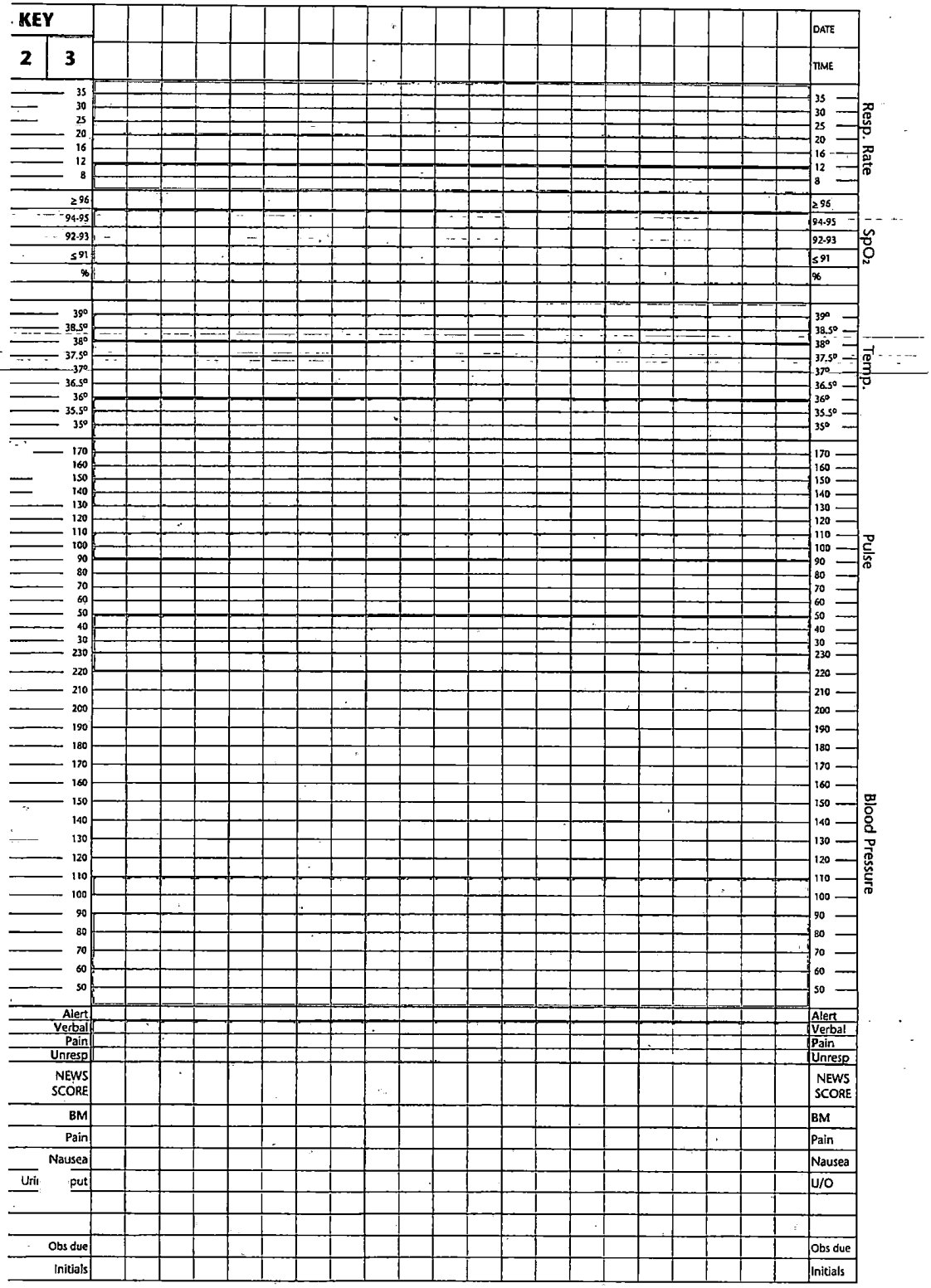
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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 (8)




KEY
2
3
DATE
TIME
35
30
25
20
16
12
8
Resp. Rate
≥ 96
94-95
92-93
≤ 91
%
SpO2
39°
38.5°
38°
37.5°
37°
36.5°
36°
35.5°
35°
Temp.
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
Pulse
Blood Pressure
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine Output
U/O
Obs due
Initials

Glasgow Coma Scale

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

Emergency Department Nursing Documentation

Presenting Complaint - CHEST PAIN

Date: 18/3/19 Time: 0045

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

bel

NHS Greater Glasgow and Clyde

Assessment Complete by: Name NURSE (Please Print) L. CARRUTHERS

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 - 1 (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)

			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		Y/N			
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

Nursing Notes		
Date and Time		Print Name and Signature

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patie [redacted] 0712726128 F Unit) SULLIVAN Deborah 07/12/1972 CHI n FLAT 0-1 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE [redacted] bel	Ward: 66 Discharge destination: GP Estimated Discharge Date (1) / / Estimated Discharge Date (2) / / Final date of discharge : / /

Checklist	Yes	N/A	Initials	Comments
Patient informed	✓		MD	
Relative/carer informed		✓	MD	
Others informed: Care Home		✓	MD	
Transport arranged				
Own transport (preferred option)	✓		MD	
Ambulance-1 man/ 2 man am/pm		✓	MD	
Other: Flight, Air ambulance etc.		✓	MD	
Discharge medication				
Discharge prescription completed	✓		MD	
Compliance aids e.g. Dossette Box (involve pharmacist)		✓	MD	
Medication received				
Medication explained to patient and/or relative/carer				
Own medication returned to patient	✓		MD	
Dressings/continence aids (7 day supply, ensure District Nurse referral completed)		✓	MD	
Informed of discharge				
Social work/ Other agencies/Home help		✓	MD	
Physiotherapist		✓	MD	
Occupational Therapist		✓	MD	
Dietician		✓	MD	
Speech and Language Therapist		✓	MD	
Clinical Nurse specialist e.g. Care Home Liaison		✓	MD	
Liaison/ District Nurse/Practice Nurse		✓	MD	
Other discharge items				
Access arrangements (e.g. keys, door entry)		✓	MD	
Patients clothing available for day of discharge		✓	MD	
Valuables e.g. cashier		✓	MD	
Intravenous cannula removed		✓	MD	
Equipment ordered (inc. walking aids) in place for discharge		✓	MD	
Part 2 Discharge letter - Required		✓	MD	
- Completed		✓	MD	
Out patient clinic appointment e.g. Anticoagulation clinic				
Arranged / To follow				
If unknown at time of discharge state reason				
Additional Information / leaflets / factsheets				
Time of Discharge:				
Nurse's signature: [redacted]	**Designation:** SHO		**Date:** 4/2/19	

My Admission Record

NHS Greater Glasgow and Clyde

N
A 0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972
Affix patient ID label

Hospital: GRI Ward: 65
Date of Admission: 3/2/19 Time: 0800
Information obtained from: Name: M. Boylan
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name: Debbie
Age: 46 Telephone Number: 07713718392
Consultant: P. Chong

SOUD ✓ glucose protein — sent blood

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: ~~0141 843~~ 07743956178 Is this person aware of your admission? Yes ☐ No ☑ on holiday - due home Thurs am Can we share information with this person? Yes ☑ No ☐ PE will phone her today	Name: Relationship: 42 nss ☐ Address: Telephone: Is this person aware of your admission? Yes ☐ No ☐ Can we share information with this person? Yes ☐ No ☐

Presenting Complaint / Diagnosis

abdo 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 - rash

Relevant past medical history

cholecystectomy PTSD
fibromyalgia
chronic pancreatitis

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

Power of Attorney / Guardianship / Adult with Incapacity

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

Yes ☐ No ☑

OR

Does someone have Guardianship?

Yes ☐ No ☑

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

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

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

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

POA/ Guardian

Name: _____ Relationship: _____ Contact Tel Number _____

Name: _____ Relationship: _____ Contact Tel Number _____

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

N[illegible]
A[illegible]
0712726128
SULLIVAN F
Deborah 07/12/197[illegible]
D FLAT 0-1
8 BOYNDIE ST
Cl Glasgow, Lanarkshire
Af 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** ☐

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
F
07/12/1971

...ix patient ID label

Lifestyle

Smoking

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

Never smoked ☐ 5/day

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): M Baylon Signature: M Baylon

Designation: SN Date: 3/2/19

My Assessment Record

Nai
Ad
Do
CH
Affix patient ID label

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
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:			

Ni
Ac 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Do Glasgow, Lanarkshire
G34 9JE
Ch
Aff.

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?

Sharp.

Have you had treatment / intervention for the pain?

morphine

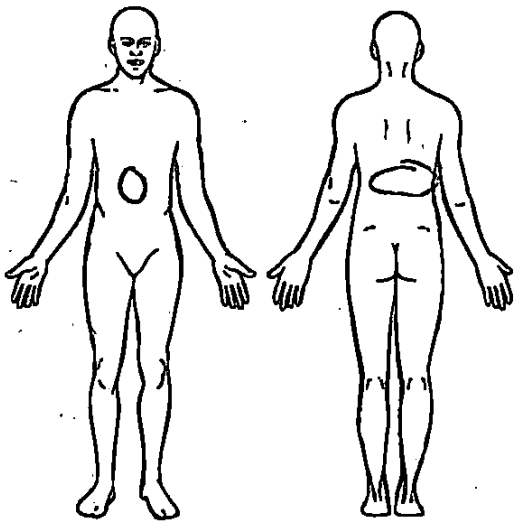
N.B. Complete generic pain assessment chart. If unable to self report complete Abbey Pain Scale.

Can you describe any chronic pain that you have?

fibromyalgia

What makes the pain better?

Mark current pain on body chart



Nar
Adc 0712725128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
Do Glasgow, Lanarkshire
CH G34 9JE
Aff

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?

spice

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		

N [redacted]
A 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
D Glasgow, Lanarkshire
C G34 9JE
Affix patient ID [redacted]

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:
A 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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? yesterday

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		✓	feels 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?			

Name: _____

Addr [redacted]

0712726128 F

SULLIVAN 07/12/1972

Deborah

DoB: FLAT 0-1

CHI: 8 BOYNDIE ST

Glasgow, Lanarkshire G34 9JE

Affix p:

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 ☑ **If yes, record on Pressure Ulcer Safety Cross**
Please describe location and grade of ulcer **Refer to Tissue Viability Service (as appropriate)**

Datix completed (if appropriate) Yes ☐ No ☐ Datix Ref. Number _____

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

Name: 0712726128 F
Address: SULLIVAN Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE
DoB:
CHI:
Affix patient ID label

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?	✓		takes temazepam

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
F
07/12/1972
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?		

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?		

Informal Support	**Yes** ✓	**No** ✓
Do you have someone who looks after you or someone that helps you, i.e. an informal carer?		✓

If yes, what do they do?

What involvement do you want them to have in your care while in hospital?

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

If yes, has the help or support listed above been confirmed with the patient's informal carer		

Required Support

Name: [redacted]
Addres 0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972
DoB:
CHI:
Affix pa

Has the carer been advised of the Carers Information Line (provide carer information leaflet)?

Yes ☐ No ☐ Not appropriate at this time ☑

Are you:

Employed ☐ Self-employed ☐ Full Time Education ☐ Unemployed ☑ Retired ☐

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

Yes ☑ No ☐

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 the 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 the patient referred ___/___/___

12. Person Centred Care

What do we need to know about you as a person to help give you the best possible care whilst in hospital?

Do you have any anxieties or fears that staff should be aware of?

Yes ☑ No ☐

If yes, how can we support you with these?

gets flashbacks - PTSD

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

13. Emotional and Spiritual Care

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

R.C.

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 (Please PRINT): M. Boylan Signature: MBoylan

Designation: N Date: 3/2/19

N 0712726128
A SULLIVAN
– Deborah
– FLAT 0-1
– 8 BOYNDIE ST
[Glasgow, Lanarkshire
(G34 8JE
Affix patient ID here

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)	✓		✓		3/2/19 MB
Adult Urethral Urinary Catheter (UCC) Insertion and Maintenance Care Plan		✓		✓	
Bristol Stool Chart		✓		✓	
Pressure Ulcer Daily Risk Assessment (PUDRA)	✓		✓		3/2/19 MB
Assessment Chart for Wound Management		✓		✓	
Moving and Handling Assessment		✓		✓	
Falls Risk Assessment	✓		✓		3/2/19 MB
Bedrail Risk Assessment		✓		✓	

Clinical Notes

Date and Time	Notes	Print Name, Signature and Designation
3/2/19 0835	Pt. admitted to wd 65	
	w/m abdo pain ?pancreatitis.	
	NEWS 1 o/a. HR 91bpm.	
	SOU requested.	M.Boylan
	Fasting for surgical r/v.	MBoylan
	Seen by medical staff –	
	for MUSS tomorrow, analgesia - I C	

Name: [redacted]
Addr: 0712726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
DoB: 8 BOYNDIE ST
CHI: Glasgow, Lanarkshire G34 9JE
Affix

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	AUSS NAD then ? MRCP/GRCP.	[illegible] SIN
3/2/19	W/R Reg	
2000	USS Mane	[illegible]
04/2/19	Settled and Slept following	
03.00	transfer from W665	
	NEWS-2 slightly hypotensive	
	P100.	
	Oral analgesia as required	
	Fasted 06.00 for AUSS.	[illegible]
4/2/19 1110	All care as per care plan. Pt ind	
	mobile ind with own personal hygiene	
	Pt as abe as been for uss scan.	
	passing urine & NII PR. clr d/rhoea	
	News stable. No clr pain. clr nausea	
	Pt had anti-emetic given pt for PPI	
	& med staff ? epsteritis, to stop	
	naproxen. Pt for (H) later if scan	MVBRONNEW
	OK. All meds as per kardex. No issues.	MN SIN
	Pt is ? CPE However was over	
	15years ago & Infection control	
	said not necessary only in past	
	12 months does pt need swabs.	MN SIN
	Pt stated very thirsty if staff would	
	check her BM. 6.9. RD She has	
	now had dinner. Pt for (H) IDCS	MN SIN
	& meds requested. Own cassette boy given	MN

Nam [redacted]
Addi 0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
DoB Glasgow, Lanarkshire
CHI G34 9JE
Affix [redacted]

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
4/2/19 1800	↳ await gaviscon from pharmacy	MR SJN
	pt IDs ↳ meds requested today	
	at approx 1500 still not done	
	pt wants to go (H) ↳ no	
	IDs or meds doc, pt stated she	
	will go to own GP ↳ get meds	
	from them tomorrow. Charge nurse	MRN
	aware ↳ suggested this.	MR SJN

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

Care Rounds Checklist

Date: 3/2/19

Attach

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
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 MBaylon Name M-Baylon Designation SN
2. Signed [illegible] Name EBRENNAN Designation SN
3. Signed [illegible] Name [illegible] Designation SN

'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 20	13 00	18 00	23 55
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.		Y	Y	Y	Y
S	3	**SKIN INSPECTION** Pressure areas checked:		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
		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
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?		Y	Y	Y	N
		Drink taken?		N	N	N	Y
		Food, snack, or supplement taken?		N	N	N	N
		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	N	Y
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		NA	N	N	NA
		Care provider / role		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

278936 v2.1 • GGC0098

Care Rounds Checklist

Date: 4/2/19

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 SN
2. Signed [illegible] Name WHATTON Designation GN
3. Signed [illegible] Name MBROWN Designation SCN

Attach Addressograph Label
Deborah Sullivan 07127726128
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	24 08	08 14	20 00	02 08	10 14	16 20	18 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	S	S	N	N	N	
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	S	S	N	N	N	
S	3	**SKIN INSPECTION** Pressure areas checked:	S	S	S	I	I	I	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	S	S	—	—	—	
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y	S	I	I	I	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	B	B	S	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	S	I	I	I	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	Y	N	N	N	
		Drink taken?	S	S	S	N	N	Y	
		Food, snack, or supplement taken?	S	S	S	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?	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	S	NA	NT	NT	NT	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA	NA	NA	NA	
		Care provider / role	GN	GN	AJ	JC	JC	JC	

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

r. irmary

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE

F
07/12/1972

NHS
Greater Glasgow and Clyde

Unit No.:

Date:		03/02											
Time of Result:		0701											
WCC	4-11	10.4											
Hb	M - 13-18 F - 11.5-16.5	135											
Plat	150-400	262											
Amylase	<100	70											
CRP	<10	8											
Na+	135-145	139											
K+	3-5-50	4.3											
Cl-	98-108	103											
Bic	21-28												
Urea	2.5-7.5	6.6											
Creat.	57-113	54											
EGFR	60>	>60											
Glucose	3.5-5.5	(8.7)											
Bilirubin	3-22	4											
ALT	<50	29											
AST	<40	23											
G-GT	<55												
Alk. Phos.	40 -150	71											
Albumin	32-45	35											
Mg^+													
Ca	2.1-2.6												
Adj Ca	2.1-2.6												
PO4	0.7-1.4												
PT	9-12	11/1.0											
APTT	25-37	30/0.9											
TCT	11-15	13/1.0											
	lactate	1.7											

MIS 239455/GRI

Microbiology Results Sheet

Name: CHI:

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

0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 3/2/19 Time 0820 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 9 175 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	3/2/19							
Time	0820							
Ward	65							
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	r							
Weight (kgs)	97							
BMI	32							
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	10/2/19							
Signature	MB							

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

N ST STEP 5 Management Guidelin

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/

mi • 285884 v3.0 • GGC0250

0712726126 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1 [illegible]
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE

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
3/2/19 MB	NEWS 1, HR 91bpm	
	No breathing or	
	circulation issues.	
3/2/19 MB	2, 3. Communication and senses	
	Glasses for reading.	
3/2/19 MB	4. Cognitive status	
	Alert + orientated.	

Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
3/2/19 MB	N/A at present	
3/2/19 MB	5. Hydration and Nutrition	
	MUST = 0	
	BMI = 32.	
	Varied diet.	
3/2/19 MB	6. Elimination	
	SOU requested. B.L.O.	
	yesterday. Uses	
	laxatives regularly.	

p1/2 PTO

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
3/2/19 MB	Independent.		3/2/19 MB	Buzzer in reach.	
			3/2/19 MB	10. Sleep and Rest	
				Takes temazepam to sleep.	
3/2/19 MB	8. Mobility				
	Independently mobile.		3/2/19 MB	12. Privacy, dignity and sexuality	
				No issues.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mll • 285668 Version 1_0 • GGC0127

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 FLAT 0-1 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE	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
3/12/19	08:20	N	N	N	N	N	N	4 hrly	MBayles
4/12/19	08:00	N	N	N	N	N	N	4 hrly	MB
/ /	:							___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[illegible]nal Plan

NHS Greater Glasgow and Clyde

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.

Attach Addressograph

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCONTINENCE / MOISTIIRE	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: _____

0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/197
8 BOYNDIE ST
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: 65 Date: 3/2/09 Time: 08:20	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).	✓				
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.	✓				
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	MBoylan									

Highlight risk of fall at the ward safety brief.

Patient Details

FALLS INTERVENTIC 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
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE

07/12/197

Specific (Inpatient) Moving and Handling Assessment Form

	Named Nurse:		Person is totally Independent (tick here and go to date box) ✓

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 Alex) ☐			

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:	8/2/19		
Assessor's signature:	MBayles		
Proposed Review date:	10/2/19		

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 Ateria)			

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)	

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:			

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	0712726128 SULLIVAN Deborah F 07/12/1971
Address	FLAT 0-1 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE
CHI No.	
DoB	

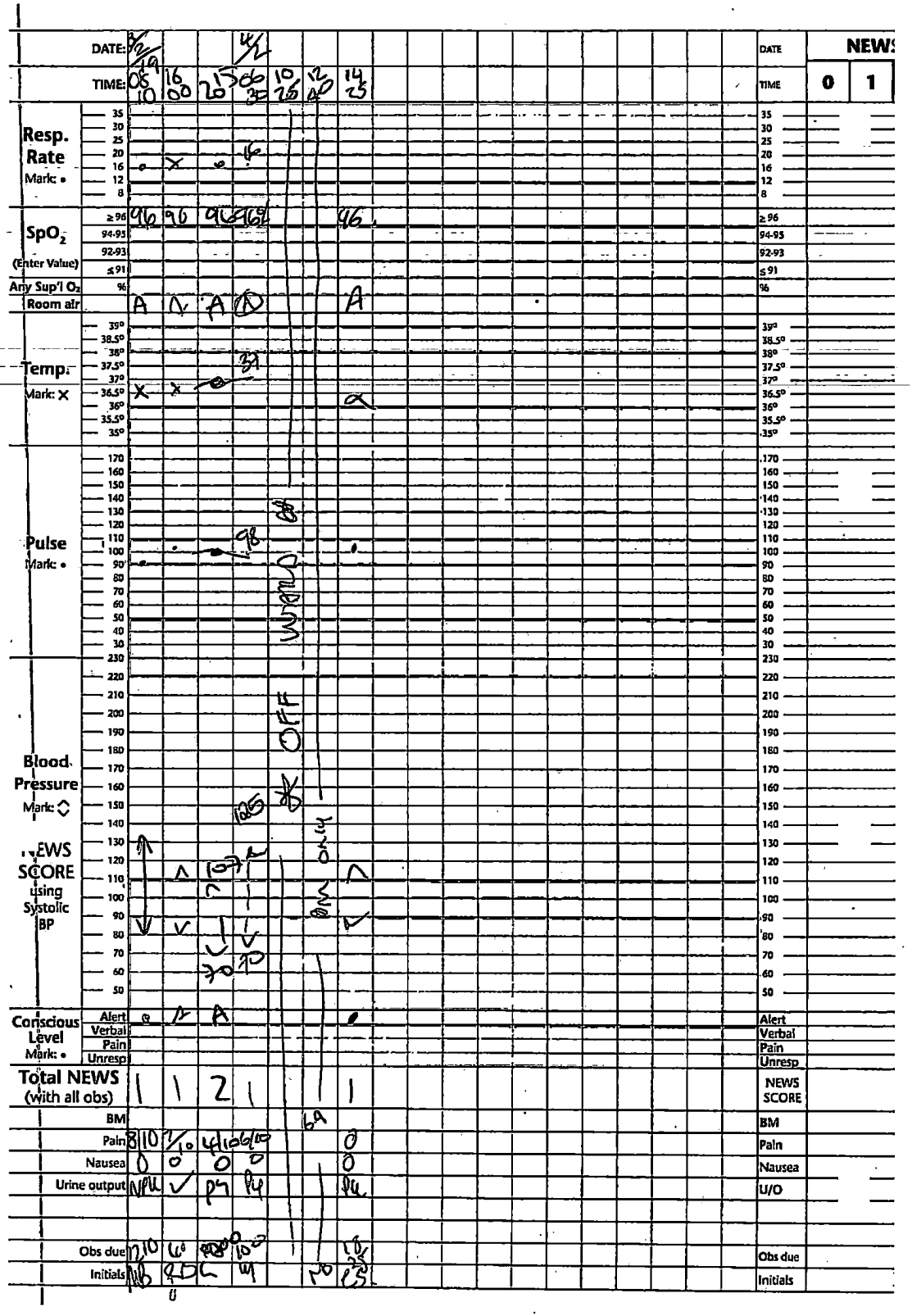
	Date	Ward
Admitted		
Transferred		
Transferred		

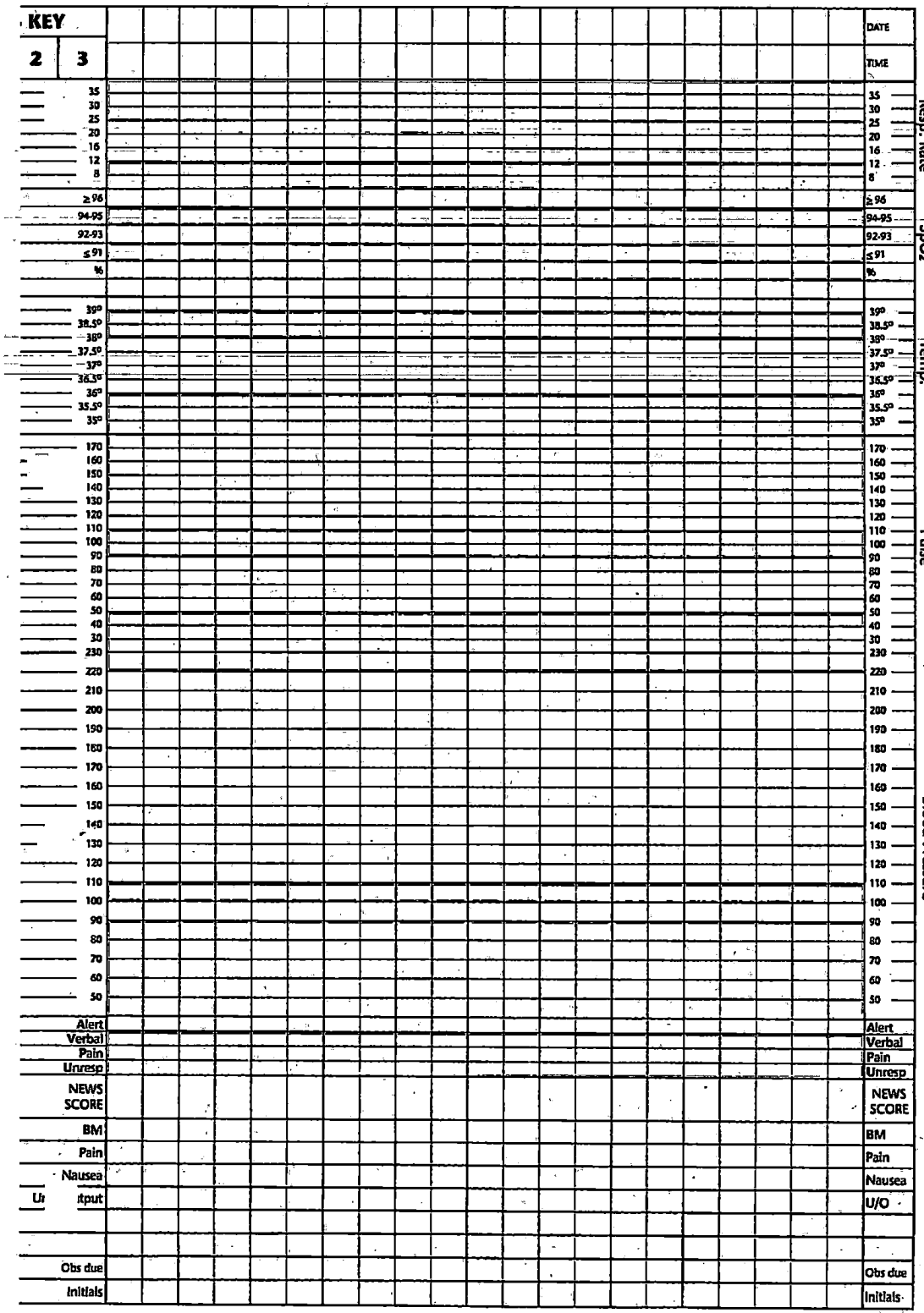
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

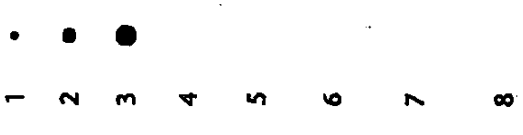
NEWS Score	Frequency of Monitoring	Clinical Response
0	Minimum 12 hourly	• Continue routine NEWS monitoring with every set of observations.
Aggregate 1- 4	Minimum 4 hourly	• Inform trained nurse. • Trained Nurse assessment: - Assess the patient - Review frequency of monitoring required - Assess need 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
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
Consciousness Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS
0
1
NEWS SCORE
U/O


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

Pupil size (mm)



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 ain is chronic, use generic tool. If patient is unable to communicate, se 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

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name
Addre 0712726128
F SULLIVAN F
'72 Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
CHI NE G34 9J
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

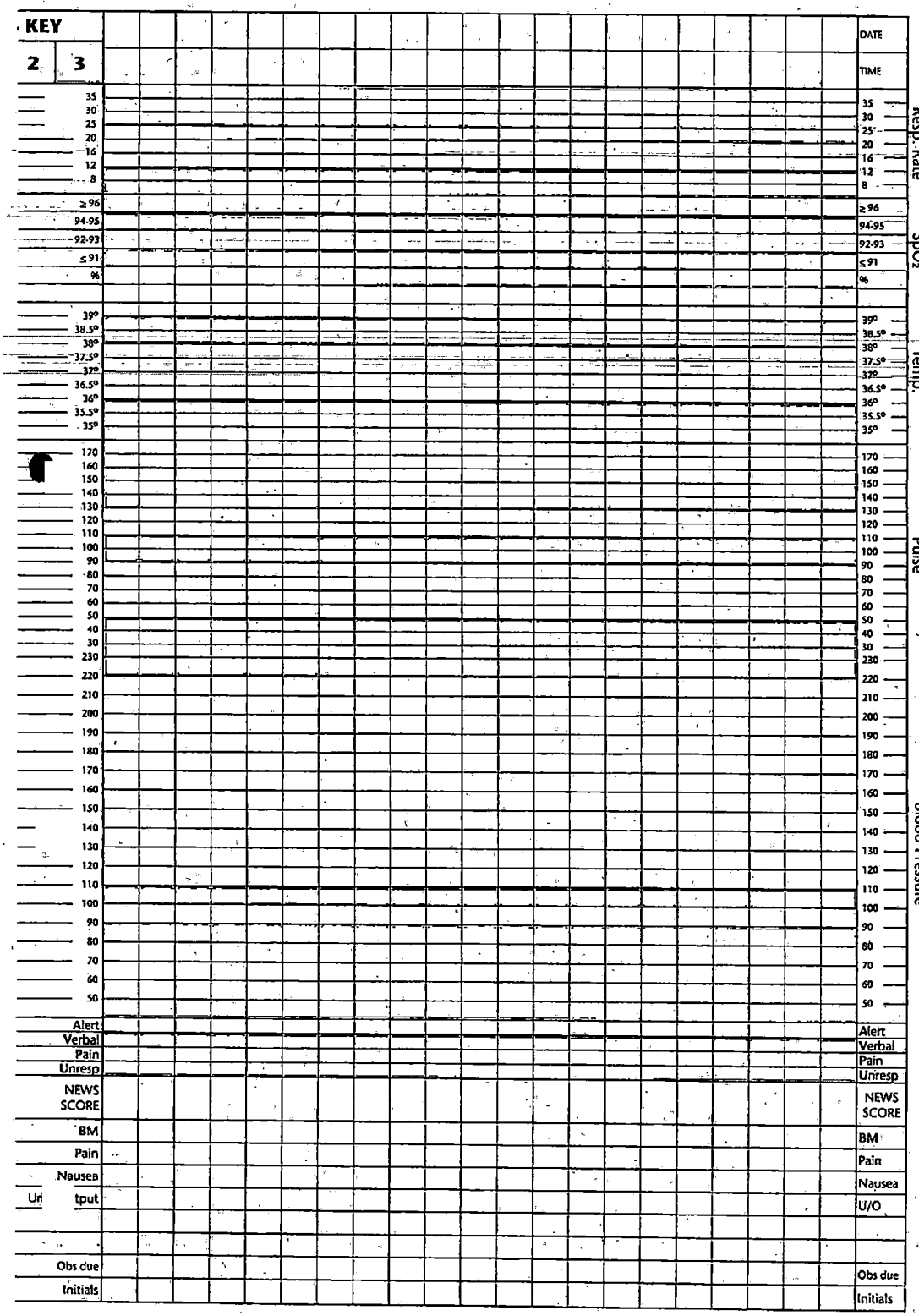
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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.

12 - Deborah Sullivan

| | | |


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
96
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

Pupil size (mm) • 1 • 2 ● 3 4 5 6 7 8

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			

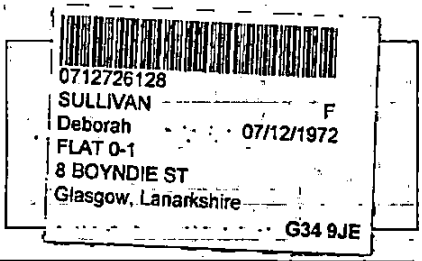
Nausea and Vomiting
0 = None
1 = Mild (*Not distressing – no retching/vomiting*)
2 = Moderate (*Troublesome – occasional retching/vomiting*)
3 = Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

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

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



Surgery planned or expected

All other patients start here
Is patient bed-bound or expected to have reduced mobility relative to normal state?

Yes ☐ No ☑

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

Gynaecological surgery except uncomplicated diagnostic laparoscopy/hysteroscopy/other minor day case procedures	☐	Current significant medical condition *Respiratory or inflammatory disease, serious infection, heart failure*	☐
Pregnancy or <6 weeks post partum	☐	Dehydration	☐
Age >60	☐	Current use of oestrogen-containing contraceptive therapy	☐
Obesity (BMI >30)	☐	Current use of hormone replacement therapy	☐
Acute surgical admission with inflammatory or intra-abdominal condition including PID	☐	Personal history or first degree relative with a history of VTE	☐
Active cancer or cancer treatment	☐	Known thrombophilia	☐
Critical care HDU/ITU admission	☐	Varicose veins with phlebitis	☐

- No thromboprophylaxis required
- Continue to reassess every 48 hours or sooner if conditions changes
- Document all reassessment in drug Kardex
- **Complete Risk Assessment Result box at bottom of page**
- Risk Assessment now complete

Yes, 1 or more risk factors identified ☐

No risk factors identified ☑

Does the patient have any contraindications to pharmacological prophylaxis? (Tick all that apply)

Significant active bleeding	☐	Uncontrolled hypertension *(230/120 mmHg or higher)*	☐
Acquired bleeding disorders *(e.g acute liver failure)*	☐	Recent stroke	☐
Concurrent use of anticoagulants *(such as warfarin with INR>2)*	☐	Untreated inherited bleeding disorders *(e.g haemophilia or von Willebrand's)*	☐
Thrombocytopenia *(<75 x 10^9/l)*	☐	Lumbar puncture or epidural/spinal anaesthesia expected within the next 12 hours	☐
Lumbar puncture or epidural/spinal analgesia within previous 4 hours	☐	Other procedure with high bleeding risk *– discuss with senior if unsure*	☐

- **Discuss with senior clinical staff before prescribing pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g AES unless contraindicated
- Reassess patient every 48 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical (planned or expected) patients – enoxaparin 40mg + AES* ☐
*prior to application please check contraindications to AES

Other patients – enoxaparin 40mg ☐
Prescribe enoxaparin at 6pm
[On day of surgery, at the later of either 4h post-op or 6pm]
Reduce enoxaparin to 20mg if <50kg or eGFR <30ml / minute / 1.73^2 ☐

Discontinue at discharge or when returned to pre-morbid mobility

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

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

Risk Assessment Result (please tick all that apply)

VTE Risk factors: YES ☐ NO ☑
Prescribed: LMWH ☐ AES ☐ NONE ☑
Contraindications to pharmacological prophylaxis YES ☐ NO ☐
Patient informed of VTE risks and benefits of thromboprophylaxis: YES ☐ NO ☐ N/A ☑
Information leaflet supplied: YES ☐ NO ☐

Assessors Name [Print name]: GOSMAN
Assessors signature:
Date: 25/9/18

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

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: not present

Date commenced & signature	1. Breathing and circulation	Date discontinued & signature	Date commenced & signature	Getting to Know Me / What Matters to Me	Date discontinued & signature
25/9/18	observations ok		25/9/18	Has fibromyalgia.	
Eleanor	per manual chart		Eleanor		
	no issues				
				5. Hydration and Nutrition	
			25/9/18		
			Eleanor		
	2, 3. Communication and senses				
25/9/18	Alert + orientated				
Eleanor					
				6. Elimination	
	4. Cognitive status		25/9/18	Urinary retention	
25/9/18	no issues		Eleanor	on admission +	
Eleanor				one only catheter	
				Loose stools	

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
25/9/18	Independent	
E Thomson		
	8. Mobility	
25/9/18	Independent	
E Thomson		

Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
25/9/18	Orientated to room	
E Thomson	Nurse call bazzer	
	10. Sleep and Rest	
25/9/18	Remote sleep	
E Thomson		
	12. Privacy, dignity and sexuality	
25/9/18	Use of bed curtains	
E Thomson	as appropriate	
	Negotiated care - Please record any planned involvement of patient/family in delivery of care	

MI • 285668 Version 1_0 • GGC0127

Care Rounds Checklist

Date: 25/9/18

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 SW
2. Signed _____ Name _____ Designation SW
3. Signed _____ Name _____ Designation _____

Attach

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow Lanarkshire G34 9JE

Ward: B3

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	09	13 30																		
	1	THINK DELIRIUM Is the patient more confused or drowsy than normal? If YES, inform registered nurse.		N	N																		
	2	PAIN: assess and address Is the patient distressed or in pain? If YES, inform registered nurse.		Y	Y																		
S	3	SKIN INSPECTION Pressure areas checked:		I	I																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		Intact	Intact																		
K	4	KEEP MOVING Has the patient moved or walked?		I	I																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – 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																		
N	6	FOOD, FLUIDS AND NUTRITION Is the patient nil by mouth?		N	N																		
		Drink taken?		Y	Y																		
		Food, snack, or supplement taken?		N	N																		
		Has oral hygiene been carried out as per care plan?		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																		
	8	INFORMATION Is there anything else I can help you with? Inform patient of the time of return.		NT	NT																		
	9	ESCALATION Escalate any issues to the registered nurse and document overleaf.		NA	NA																		
		Care provider / role		SC	SC 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

ml • 278936 v2.1 • GCC0098

Fluid Balance Chart

Name: 0712726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE

Hospital: GRI
Ward: SDA
Date: 23/9/18.

Reason for Fluid Balance Chart: Urinary retention
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: [signature] Designation: SHO

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					NaCl from NJ tube				500	300		Only	Catheter			300	SJ
02:00																	
03:00																	
04:00	H20 850	850							1300.								
05:00										100		Loose ✓	Simple SUT			400	
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	[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.

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

NHSGGC Bedrail Risk Assessment

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

0712726128
SULLIVAN
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE
F
07/12/1972
Patient Nam
CHI Numbe
NHS Greater Glasgow and Clyde

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	25/11/12						
	TIME	0900						
	WARD	S6						
	HOSPITAL	GRI						
SECTION ONE – GENERAL		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
1	Is the patient likely to fall, roll, slip or slide from the bed?		✓						
2	Has the patient requested the use of bedrails?		✓						
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED								
SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?		✓						
4	Is the patient stressed, delirious or restless?		✓						
5	Is the patient small in stature?		✓						
6	Does the patient have an unusually large or small head that might present an entrapment issue?		✓						
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?		✓						
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf								
SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?		✓						
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition	✓							
10	Has the use of bedrails been discussed with relatives/carers?		✓						
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?		✓						
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?		✓						
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf								
SECTION FOUR – DECISION MAKING		**Y**	**N**	**Y**	**N**	**Y**	**N**	**Y**	**N**
13	Will bedrails be used for this patient at the present time?								
14	Rationale for use of bedrails: (Please insert code in the box on the right)								
	A – Risk of falling from the bed								
	B – Risk of rolling from the bed								
	C – Risk of slipping from the bed								
	D – Risk of sliding from the bed								
	E – Patient request								
15	Bedrail risk assessment completed by:								
16	Bedrails checked by:								
17	Date								

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

0712726128
SULLIVAN
Deborah F
FLAT 0-1 07/12/1972
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 25/9/18 Time 0700 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	178 cm	☐	☐	
Admission Weight	92.8 Kg	☑	☐	

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

Patients reported normal weight 92.8 Unable to Recall ☐

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

Date	25/9							
Time	0700							
Ward	Sba							
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	St							
Weight (kgs)	92.8							
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	1/52							
Signature	[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/

mi • 285884 v3.0 • GGC0250

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN Deborah F FLAT 0-1 [illegible] 07/12/1972 8 BOYNDIE ST Glasgow, Lanarkshire G34 9JE	Hospital: GRI Ward: S6	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 no	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
SA 18	21 00	no	no	no	no	no	no	4 hrly	[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 Interv[illegible]tional 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:

Write or affix label

Name:
Address:

CH 0712726126 F
DO SULLIVAN 07/12/1972
Hos Deborah Ward
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer						
Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☐ ✓	Fluids ☑	Transfusion ☐	
PVC inserted:	Date: 22/9/18	Hospital: Gart.	ED ☐	Theatre ☐	TU/HDU ☐	Ward ☐ _____
Insertion site:	L Arm ☐	R Arm ☐	L Hand ☑	R Hand ☐	L Foot ☐	R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☑	Green ☐	White ☐	Grey ☐	Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

Write or affix label
Name:
Address:
CHI:
DOB:
Hospital & Ward:

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer						
Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☐		Fluids ☑	Transfusion ☐
PVC inserted:	Date: 24/9/18	Hospital: Ore	ED ☑	Theatre ☐	ITU/HDU ☐	Ward ☐ _____
Insertion site:	L Arm ☐	R Arm ☑	L Hand ☐	R Hand ☐	L Foot ☐	R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☑	Green ☐	White ☐	Grey ☐	Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address

CHI No. 0712726128 F 07/12/1972
DoB SULLIVAN
Deborah
FLAT 1-1
34 Pendeen Pl
Glasgow, Lanarkshire G33 4UG

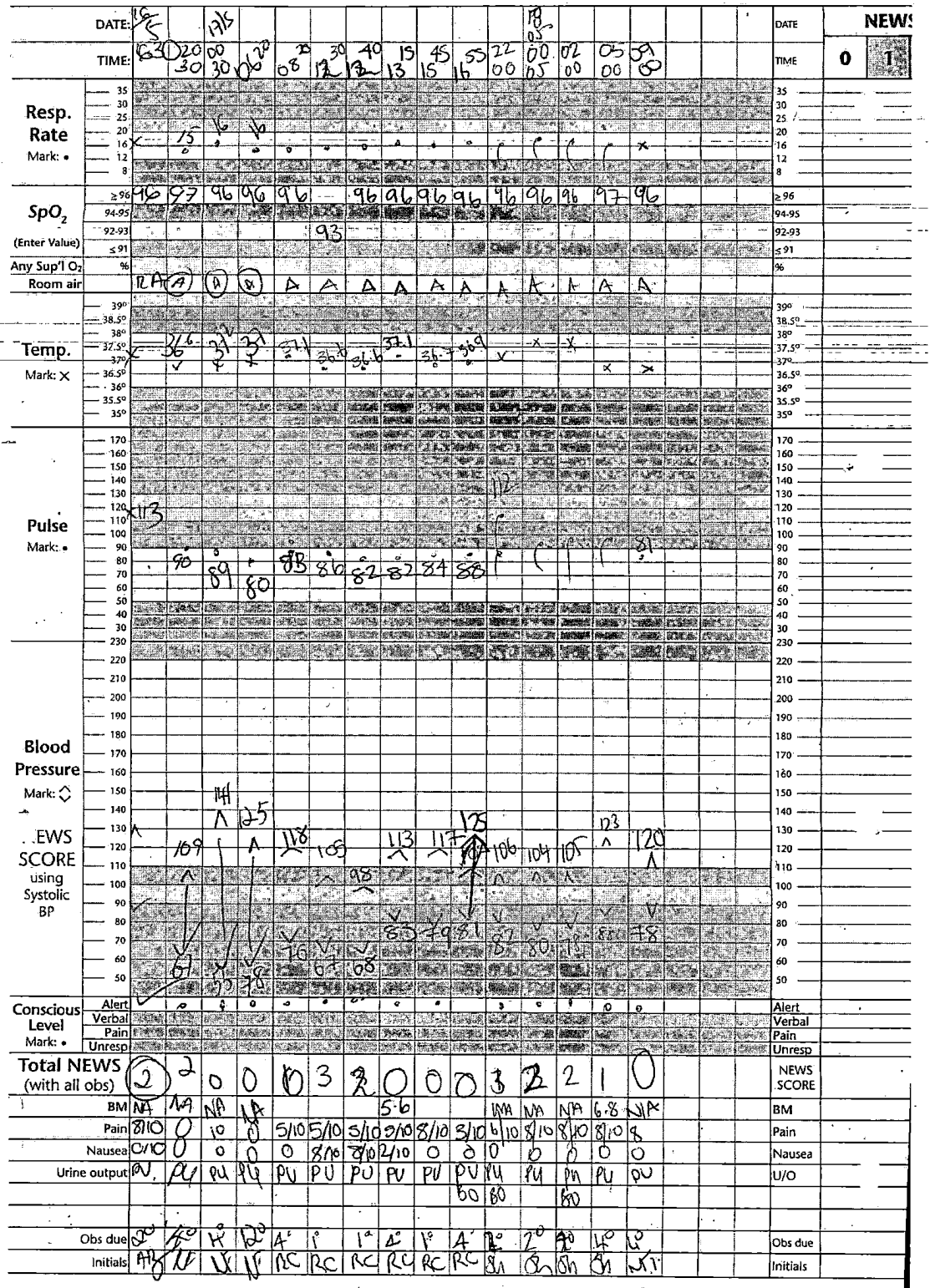
	Date	Ward
Admitted		
Transferred		
Transferred		

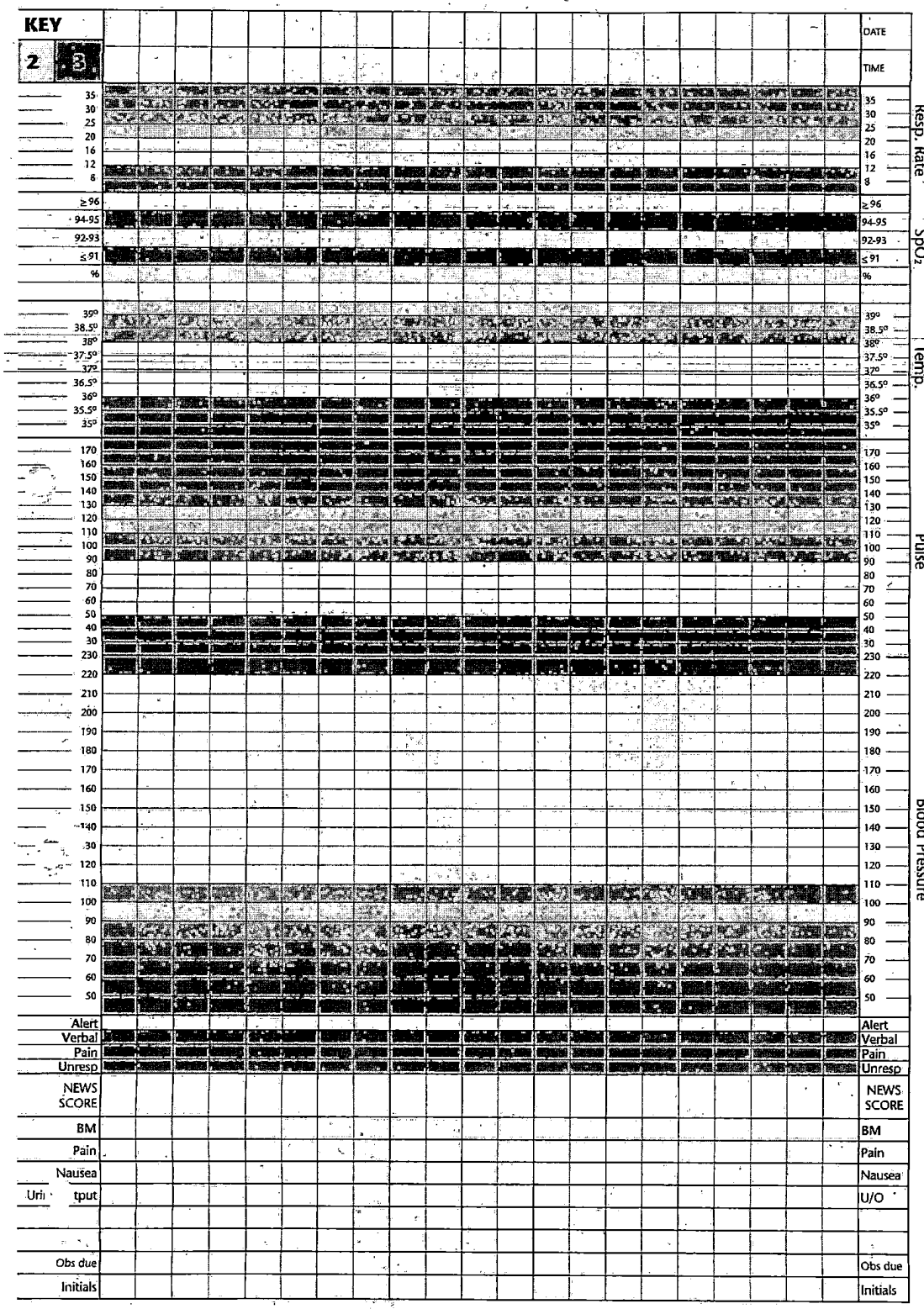
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8			12-20		21-24	≥25
Oxygen Saturations	<91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

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

See NEWS Actions Reference Tool for local escalation policy

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


DATE
TIME
NEWS
0
1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
EWS SCORE using Systolic BP
Conscious Level
Mark: •
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
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
Urine output
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

1	2	3	4	5	6	7	8
•	●						

Neurological Observations

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

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

Name	0712726128
Address	SULLIVAN F Deborah 07/12/1972 FLAT 1-1 34 Pendeen Pl Glasgow, Lanarkshire G33 4UG
CHI No.	
DoB	

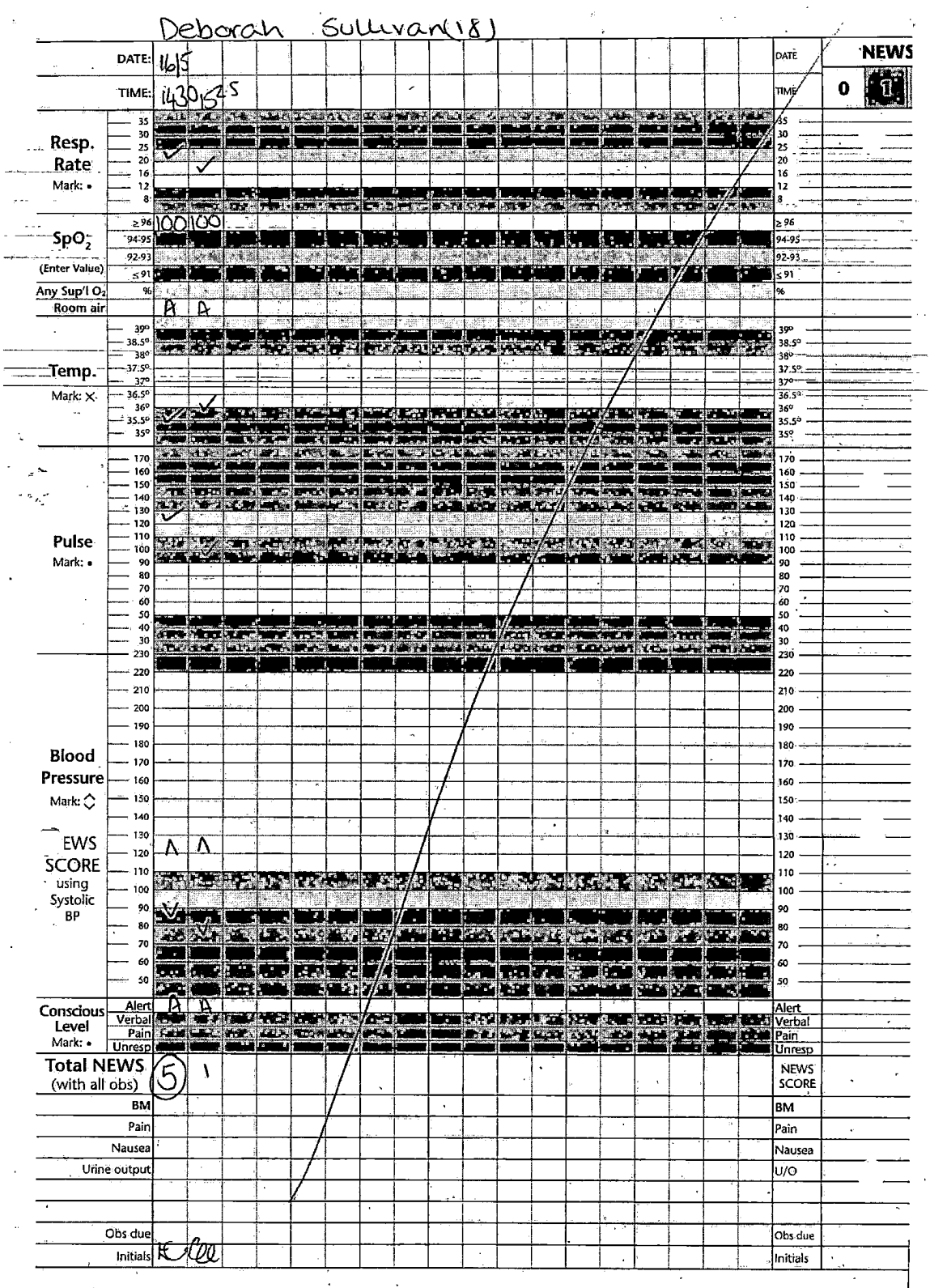
	Date	Ward
Admitted	16/5/18	ate
Transferred		
Transferred		

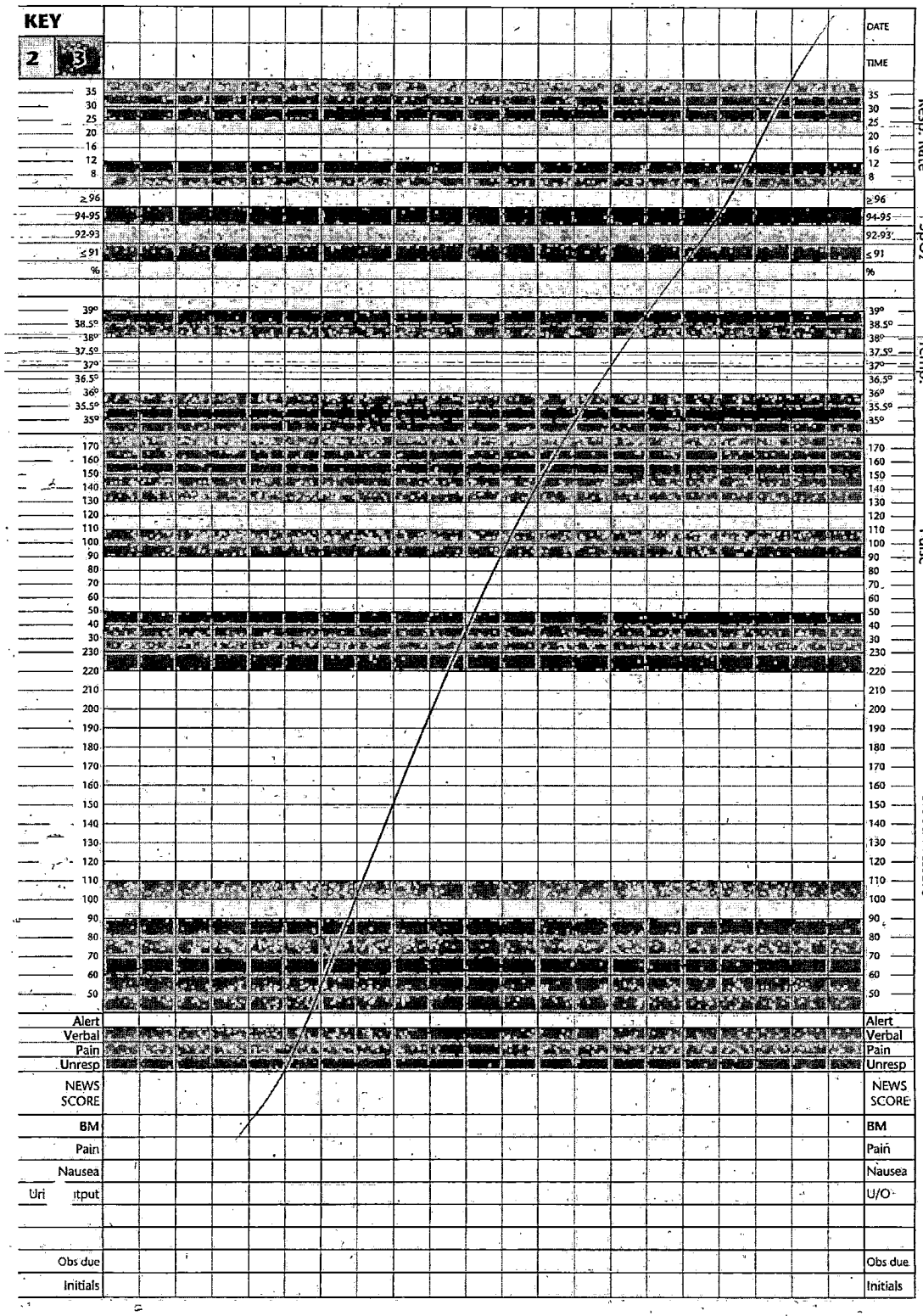
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8			12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39.0°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic 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)
DATE: 16/5
TIME: 1430 1545
NEWS
0 1
Resp. Rate
Mark: •
SpO2
(Enter Value)
Any Sup'l O2
Room air
Temp.
Mark: ×
Pulse
Mark: •
Blood Pressure
Mark: ◇
EWS SCORE using Systolic BP
Conscious Level
Alert
Verbal
Pain
Unresp
Mark: •
Total NEWS (with all obs)
5
1
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
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
Uri itput
U/O
Obs due
Initials

Glasgow Coma Scale

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			

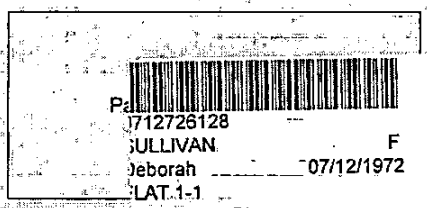
Nausea and Vomiting	
0	= None
1	= Mild (*Not distressing – no retching/vomiting*)
2	= Moderate (*Troublesome – occasional retching/vomiting*)
3	= Severe (*Distressing – frequent retching/vomiting*)

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

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

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



Surgery planned or expected

All other patients
Is patient bed-bound or expected to h
normal stay

Yes ☐ No ☐

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

Gynaecological surgery except uncomplicated diagnostic laparoscopy/hysteroscopy/other minor day case procedures	☐	Current significant medical condition *Respiratory or inflammatory disease, serious infection, heart failure*	☐
Pregnancy or <6 weeks post partum	☐	Dehydration	☐
Age >60	☐	Current use of oestrogen-containing contraceptive therapy	☐
Obesity (BMI >30)	☐	Current use of hormone replacement therapy	☐
Acute surgical admission with inflammatory or intra-abdominal condition including PID	☐	Personal history or first degree relative with a history of VTE	☐
Active cancer or cancer treatment	☐	Known thrombophilia	☐
Critical care HDU/ITU admission	☐	Varicose veins with phlebitis	☐

- No thromboprophylaxis required
- Continue to reassess every 48 hours or sooner if conditions changes
- Document all reassessment in drug Kardex
- **Complete Risk Assessment Result box at bottom of page**
- Risk Assessment now complete

Yes, 1 or more risk factors identified ☐

No risk factors identified ☐

Does the patient have any contraindications to pharmacological prophylaxis? (Tick all that apply)

Significant active bleeding	☐	Uncontrolled hypertension *(230/120 mmHg or higher)*	☐
Acquired bleeding disorders *(e.g acute liver failure)*	☐	Recent stroke	☐
Concurrent use of anticoagulants *(such as warfarin with INR>2)*	☐	Untreated inherited bleeding disorders *(e.g haemophilia or von Willebrand's)*	☐
Thrombocytopenia *(<75 x 10^9/l)*	☐	Lumbar puncture or epidural/spinal anaesthesia expected within the next 12 hours	☐
Lumbar puncture or epidural/spinal analgesia within previous 4 hours	☐	Other procedure with high bleeding risk *– discuss with senior if unsure*	☐

- **Discuss with senior clinical staff before prescribing pharmacological prophylaxis**
- Consider mechanical prophylaxis e.g AES unless contraindicated
- Reassess patient every 48 hours or sooner if condition changes

No contraindications to pharmacological prophylaxis identified ☐

Contraindications to pharmacological prophylaxis identified ☐

Surgical (planned or expected) patients – enoxaparin 40mg + AES* ☐
*prior to application please check contraindications to AES
Other patients – enoxaparin 40mg ☐
Prescribe enoxaparin at 6pm
[On day of surgery, at the later of either 4h post-op or 6pm]
Reduce enoxaparin to 20mg if <50kg or eGFR <30ml / minute / 1.73^2 ☐
Discontinue at discharge or when returned to pre-morbid mobility

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

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

Risk Assessment Result (please tick all that apply)

VTE Risk factors: YES ☐ NO ☐ Contraindications to pharmacological prophylaxis YES ☐ NO ☐
Prescribed: LMWH ☐ AES ☐ NONE ☐
Patient informed of VTE risks and benefits of thromboprophylaxis: YES ☐ NO ☐ N/A ☐ Information leaflet supplied: YES ☐ NO ☐

Assessors Name [Print name]: Assessors signature: Date:

Fluid Balance Chart

Name: DEBORAH SULLIVAN
DoB: 07/12/1972
CHI number: 0712726128
Affix patient data label

Hospital: GRI
Ward: 56A
Date: 17/5/18

Reason for Fluid Balance Chart: IV FLUIDS
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: [illegible] Designation: SN

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	VENFLON ASILOGED				IVI	500			500	PU	BO					2	NF
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00	BFast	200															
09:00	Water	200							900								
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		[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.

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

Name: DEBORAH GILLIGAN

DoB: 03/12/1972

Chi number: 0712272628

Affix patient data label

Hospital: GRI

Ward: 56A

Date: 16/5/18

Reason for Fluid Balance Chart: IV FLUIDS

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: [illegible] Designation: SN

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																	
02:00																	
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					IV HARTMANS			500	500	UTT						22	NF
21:00	TEA	200							200								
22:00	420	400							1100								
23:00																	
						*Total Intake			[redacted]					*Total Output		[redacted]	

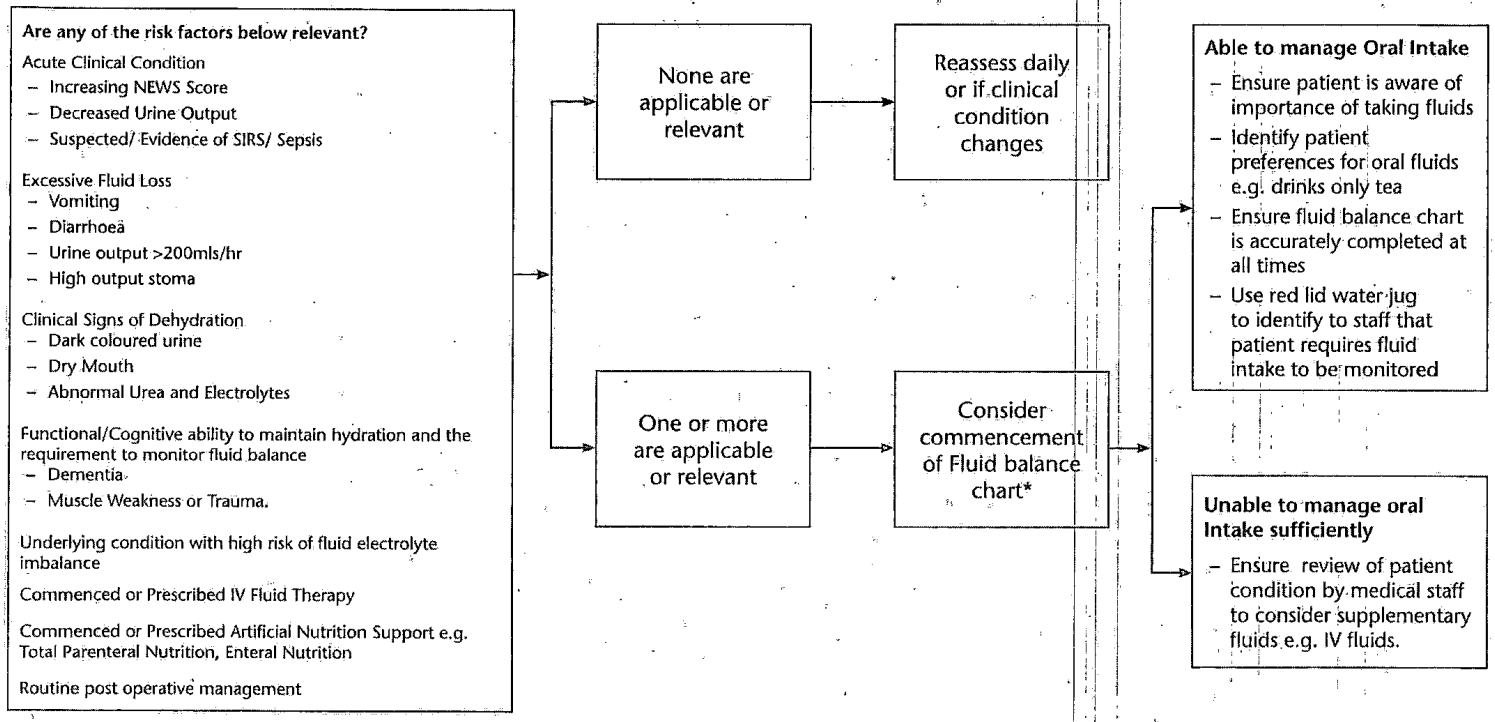
*24 hr Fluid Balance +/-

*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

1712726128 F SULLIVAN 07/12/1972 Sh Deborah FLAT 1-1 4 Pendeen Pl Glasgow, Lanarkshire G33 4UG	Hospital: RAH Ward: 56A	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
16/5/2018	17:00	N	N	N	N	N	Y	4 hrly	
17/5/18	18:40	N	N	N	N	N	X	4 hrly	
18/5/18	08:40	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 Interv tional 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: _____

NHSGGC Bedrail Risk Assessment

NHS Greater Glasgow and Clyde

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

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

Patient Name: DEBORAH SULLIVAN

CHI Number: 0712726128

	Use guidance on the reverse of this document when completing this Risk Assessment								
		DATE	16/5/18						
		TIME	2200						
		WARD	56A						
		HOSPITAL	GRI						
	SECTION ONE – GENERAL		Y	N	Y	N	Y	N	Y	N
1	Is the patient likely to fall, roll, slip or slide from the bed?			✓						
2	Has the patient requested the use of bedrails?			✓						
	IF NO TO BOTH QUESTIONS IN SECTION ONE THEN THERE IS GENERALLY NO NEED FOR BEDRAILS, EXCEPT WHEN THE PATIENT IS BEING TRANSFERRED									
	SECTION TWO – COGNITIVE AND PHYSICAL STATUS									
3	Is the patient at risk of climbing out of bed?									
4	Is the patient stressed, delirious or restless?									
5	Is the patient small in stature?									
6	Does the patient have an unusually large or small head that might present an entrapment issue?									
7	In your opinion, does using bedrails present a higher risk to the patient than falling out of bed?									
	IF YES TO ANY OF THE QUESTIONS IN SECTION TWO, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION THREE – COMMUNICATION									
8	Has the patient been consulted regarding the use of bedrails?									
9	Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/cognitive condition									
10	Has the use of bedrails been discussed with relatives/carers?									
11	Has the patient/relatives/carers been given a copy of the bedrail information leaflet?									
12	Consent obtained for the use of bedrails via patient or AWI treatment plan?									
	IF NO TO ANY OF THE QUESTIONS IN SECTION THREE, BEDRAILS MAY NOT BE APPROPRIATE – See Guidance overleaf									
	SECTION FOUR – DECISION MAKING		Y	N	Y	N	Y	N	Y	N
13	Will bedrails be used for this patient at the present time?			✓						
14	Rationale for use of bedrails: (Please insert code in the box on the right)									
	A – Risk of falling from the bed									
	B – Risk of rolling from the bed									
	C – Risk of slipping from the bed									
	D – Risk of sliding from the bed									
	E – Patient request									
15	Bedrail risk assessment completed by:		NFISHER							
16	Bedrails checked by:									
17	Date		16/5/18							

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

7712726128
SULLIVAN
Deborah F
LAT 1-1 07/12/1972
4 Pendeen Pl
Glasgow, Lanarkshire
G33 4UG

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: S6 Date: 16/6/2020 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).	✓				
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.	✓				

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	CL									

Highlight risk of fall at the ward safety brief.

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 1-1
14 Pendeen Pl
Glasgow, Lanarkshire
G33 4UG

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

Write or affix label

N
A
0712726128 F
CI SULLIVAN 07/12/1972
DO Deborah
Ho FLAT 1-1
34 Pendeen Pl
Glasgow, Lanarkshire G33 4UG

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

Modified V.I.P (Visual Infusion Phlebitis) Score	
IV site appears healthy	0
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 cannula
All of the following are evident: pain,redness,hardening of surrounding tissue	3 Phlebitis/Thrombophlebitis Remove cannula
As above including: palpable venous cord	4 Remove cannula Seek further advice
As above including :pyrexia	5

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
ED Theatre Ward_____	16/5/2018	(e) arm	PINK	

Clinical indication	IV Fluids/IV Medication ☑	Urgent access ☐	Interventional procedures ☐	Other Please state:

Insertion Criteria (If no: please explain in comments below)	Clean field used	Hand hygiene	Skin asepsis	Dressing affixed	Non touch technique (do not re- contaminate cleaned skin)
	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☐ No ☐ Unknown ☑	Yes ☑ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☑

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed 13/5/18 Reason for PVC removal FELL OUT Reason PVC in greater than 72 hours_____

Date & time	PVC no.	Comments	Signature

MIS 269426
81117

CHI:	Modified V.I.P (Visu	sion Phlebitis) Score
	IV site appears healthy	0
	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 easily accessible)
	All of the following are evident: pain,redness,hardening of surrounding tissue	3 Phlebitis/thrombophlebitis Remove cannula Seek further advice
	As above including: palpable venous cord	4
	As above including :pyrexia	5

Insertion – Complete all sections					
PVC inserted ED Theatre Ward_____		Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:	
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily							
PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation **Record VIP score**	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ; document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ:							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

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

Care Rounds Checklist

Date: 18·5·18

Ms D Sullivan
FLAT 1-1
Att 34 Pendeen Pl
Glasgow
Lanarkshire
G33 4UG

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 SCullchnor Name SUSAN GILCHRIST Designation C/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 05	03 40	08 00	12 00	16 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.	Y	N	Y	Y	Y												
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	I	I	Y	Y												
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT		Int	I	I												
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	I	I	Y	Y												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B																	
		Chair Assist to walk or stand (W/ST)	ST	N	N														
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	Y												
		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.	Y	Y	Y	N	N												
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	WR	N/A	N/A												
		Care provider / role	SN SW	SN SW	C	ND	ND												

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

NI • 278936 v2.1 • GCC0098

Care Rounds Checklist

Date: 17/5/18

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 NICOLA FISHER Designation SN
2. Signed [signature] Name SCHLICHTER Designation SN
3. Signed _____ Name _____ Designation _____

Attach Addressograph Label

0712726128
SULLIVAN
Deborah
FLAT 1-1
34 Pendeen Pl
Glasgow, Lanarkshire
07/12/1972
G33 4UG

NHS Greater Glasgow and Clyde

'Mu ...t 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 30	06 00	13 30	16 30	21 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	N	N	Y	Y													
S	3	**SKIN INSPECTION** Pressure areas checked:		N	N	N	I	I													
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)		/	/	I	SA														
K	4	**KEEP MOVING** Has the patient moved or walked?		Y	Y	Y	Y														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		L	B	L	R														
		Chair Assist to walk or stand (W/ST)		/	/	–	W	W													
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	Y	Y	Y													
		Has oral hygiene been carried out as per care plan?		N	N	–	Y	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	Y	Y													
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.		N	N	NT	Y	Y													
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.		N/A	N/A	NA	NA	NA													
		Care provider / role		NF	NF	RG	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 • GCC0098

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	0712726128 F SULLIVAN F
Address	972 Deborah 07/12/1972 1/1 34 Pendeen Place Glasgow JG G33 4L
CHI No.	
DoB	

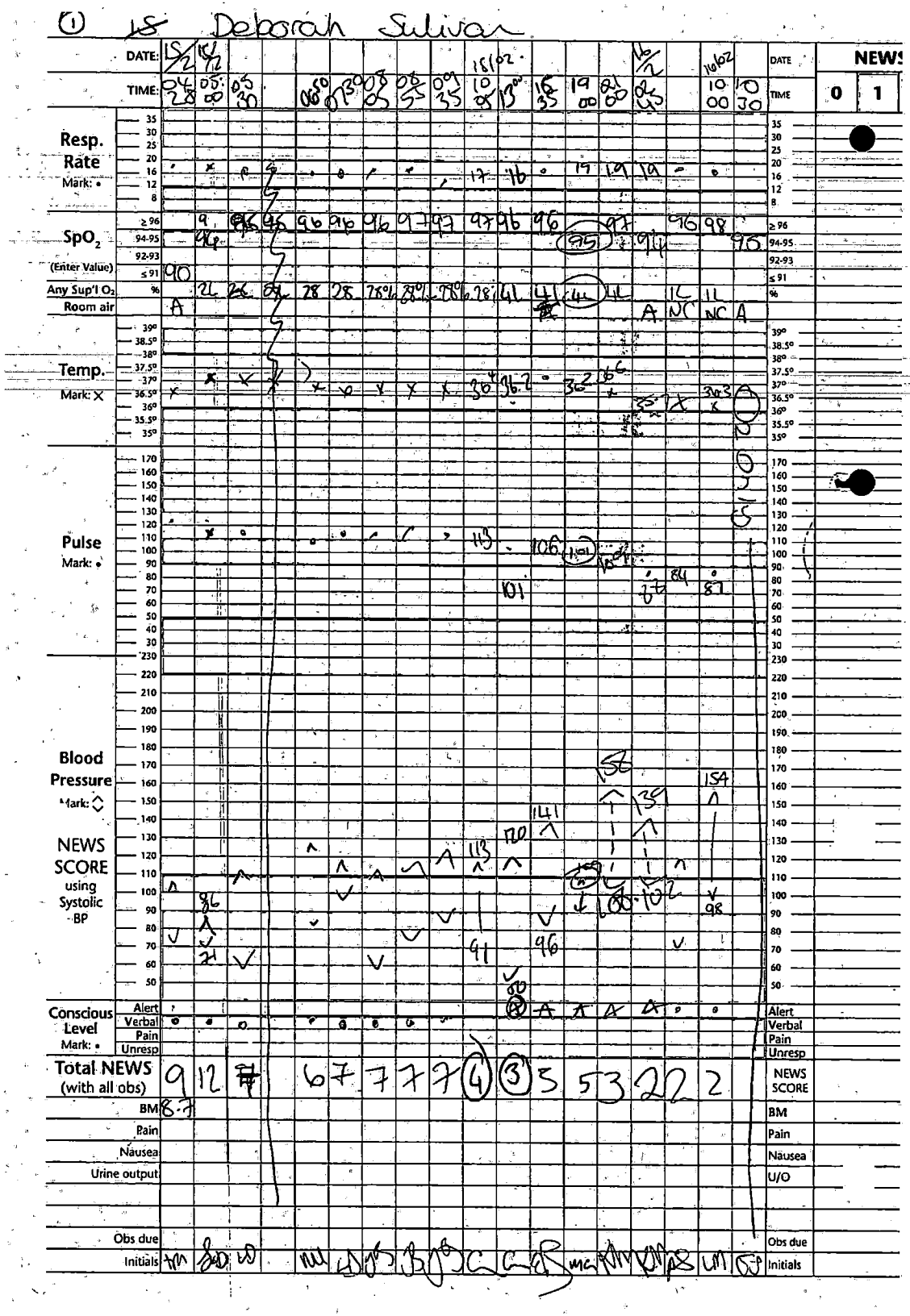
	Date	Ward
Admitted		
Transferred		
Transferred		

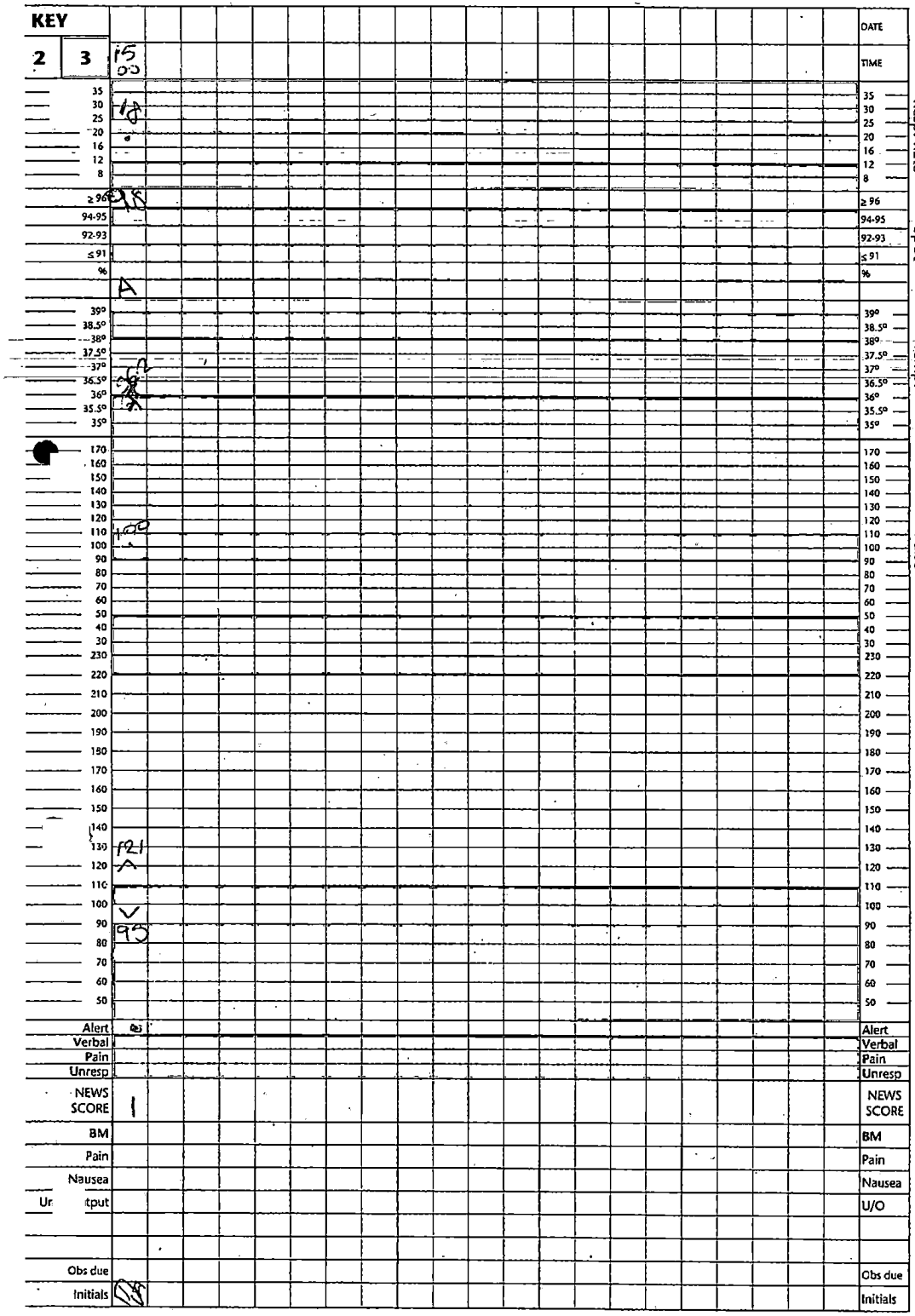
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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


① LS Deborah Sulivan
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


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

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

0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

Neurological Observations

| | | |

Care Rounds Checklist

Date: 16.2.18

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 N. FINNICAN Designation SN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

A
0712726128
SULLIVAN F
Deborah 07/12/1972
W 1/1 34 Pendeen Place
Glasgow
G33 4UG

NHS Greater Glasgow and Clyde

'N... ...ent 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	06 40	09 00	13 30																	
	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.	N	N	n																	
S	3	**SKIN INSPECTION** Pressure areas checked:	N	I	I																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	I	/																		
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	I	Y																	
		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	N	I	I																	
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	n																	
		Drink taken?	Y	Y	Y																	
		Food, snack, or supplement taken?	N	N	Y																	
		Has oral hygiene been carried out as per care plan?	N	I																		
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	Y	N	Y																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	N/A																		
		Care provider / role	BS	LM	SHC																	

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

Fluid Balance Chart

0712726128
SULLIVAN, Deborah F
1/1 34 Pendeen Place
Glasgow
G33 4UG
07/12/1972

Hospital: GRI
Ward: S3
Date: 16.2.18

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	Ascend																
06:00	Water	150															
07:00	Breakf	100															
08:00																	
09:00										600	(Urinalysis -ve)					600	CM
10:00																	
11:00																	
12:00	Lunch	200															
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]	

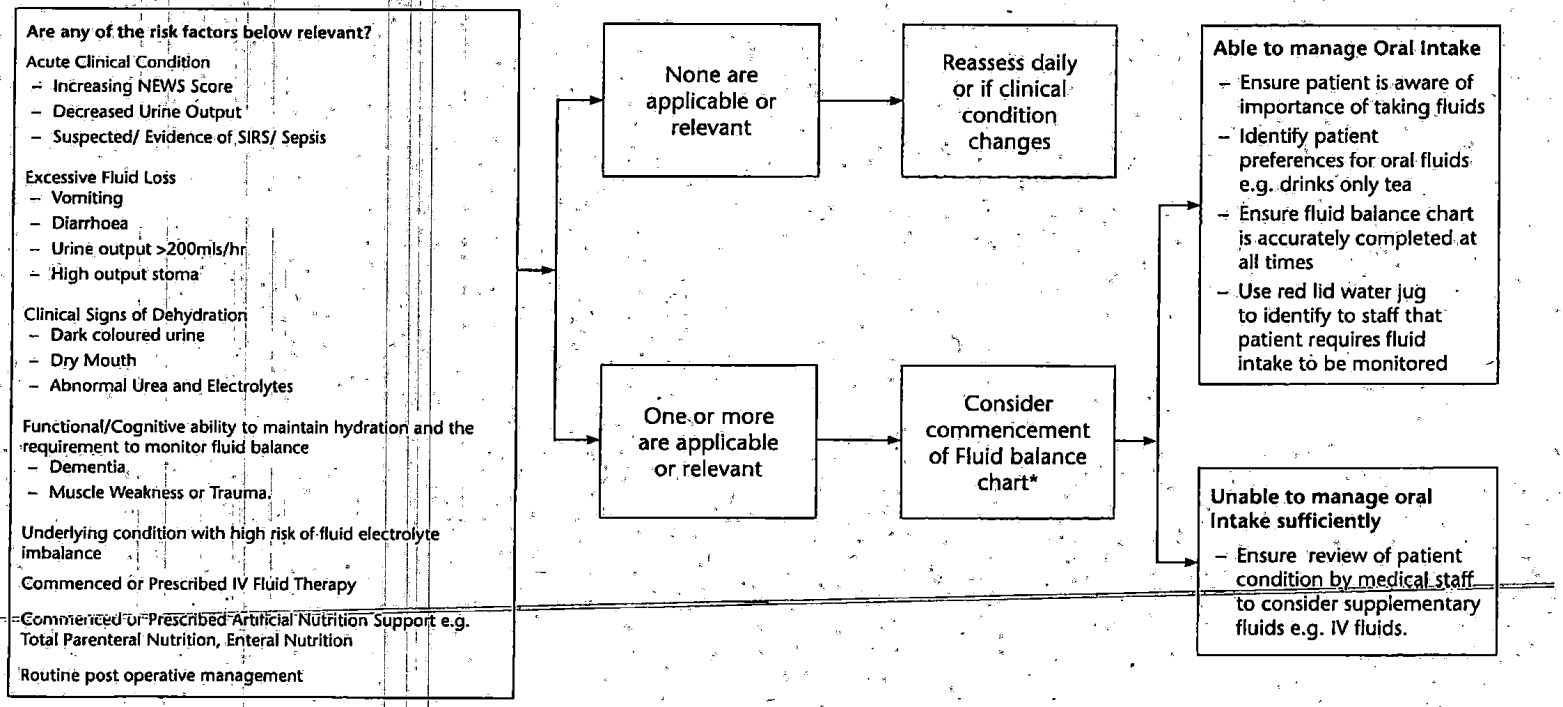
*24 hr Fluid Balance +/-

*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

0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

NHS
Greater Glasgow and Clyde

AMU

Daily Summary of Fluid Balance

Date	Oral	I.V.	Other	Total	Urine	Gastric	Other	Total

Routine Urine Chart

Date	16/02/18							
Protein	TRACE							
24hr Volume	/							
Colour	CLOUDY							
S.G.	-ve							
Reaction	-ve							
Sugar	-ve							
Ketones	-ve							
Bilirubin	-ve							
Urobilinogen	-ve							
Blood	+ve							
Nitrite	-ve							
Leucocyte	-ve							
Sample Sent	No							

Stool Chart

Date	Time	Colour	Consistency	Abnormalties	F.O.B.	
					- ve	+ ve

0712726128
SULLIVAN
Deborah F
1/1 34 Pendeen Place 07/12/1977
Glasgow
G33 4UG

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
15-2-18 CM	NO ISSUES		15-2-18 CM	NO ISSUES	
				5. Hydration and Nutrition	
				NO ISSUES	
	2, 3. Communication and senses				
	NO ISSUES				
				6. Elimination	
	4. Cognitive status			Independent	
	WAT 0/4				

Write or affix label

Name:
Addr. 0712726128
CH SULLIVAN F
DC Deborah 07/12/1972
Ho 1/1 34 Pendeen Place
Glasgow
G33 4UG

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer

Clinical indication:	Diagnostics ☑	Resuscitation / Chest Pain ☐	IV Drugs ☐	Fluids ☐	Transfusion ☐
PVC inserted: 1	Date: / /	Hospital: QMC	ED ☐	Theatre ☐	ITU/HDU ☐ Ward ☐
Insertion site:	L Arm ☐	R Arm ☐	L Hand ☑	R Hand ☐	L Foot ☐ R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☐	Green ☑	White ☐	Grey ☐ Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 16/7/18	Yes ☐ No ☑	VIP: 0	Yes ☑ No ☐	Left in situ ☑ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

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
				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	

Write or affix label
Name:
Address:
CHI:
DOB:
Hospital & Ward:

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer						
Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☐	Fluids ☐	Transfusion ☐	
PVC inserted:	Date: / /	Hospital: _____	ED ☐	Theatre ☐	ITU/HDU ☐	Ward ☐ _____
Insertion site:	L Arm ☐	R Arm ☐	L Hand ☐	R Hand ☐	L Foot ☐	R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☐	Green ☐	White ☐	Grey ☐	Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN Deborah F 1/1 34 Pendeen Place 07/12/1972 Glasgow G33 4UG	Hospital: Ward:	Points to consider: • Use within 6 hrs of admission to care area • Re-assess daily and more frequently if a person's condition changes

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

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

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

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

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

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Active Care Prescribed	Signature
5/2/18	10:00	N	N	N	N	N	Y	6 hrly	C
6/2/18	08:00	N	N	N	N	N	N	6 hrly	[illegible]
/ /	:							___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 Interver ɔnal 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: _____

0712726128
SULLIVAN
Deborah
F
07/12/1972

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: 152-18 Date: 83 Time: 17:36	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.	✓				
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.	✓				

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

0712726128
SULLIVAN
Deborah
1/1 34 Pendeen Place
Glasgow
G33 4UG
F
07/12/1972

Pe[illegible]ent) Moving and Handling Assessment Form

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

1. Ge[illegible]

Body Build	
Weight	Height
Kg	cm
BMI	

Risk of Falls: Yes / No

[illegible]oblems 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:	15-2-18		
Assessor's signature:			
Proposed Review date:			

Continuation Sheet

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

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS
Greater Glasgow and Clyde

NHSGGC Bedrail Risk Assessment

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

Patient N

THIS DOCUMENT DOES NOT REPLACE THE NEED FOR CLINICAL JUDGEMENT

CHI Number:

Use guidance on the reverse of this document when completing this Risk Assessment								
	DATE	15-2-1						
	TIME	16:30						
	WARD	6B						
	HOSPITAL	GRI						

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

Any issues relating to the use of bedrails including discussion with family/relatives/carers should be recorded here

A. Alternatives to bed rails:-

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

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

Is patient:-

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

C. Safe use and application of bedrails:-

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

D. Record keeping:-

All of the following should be recorded:-

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

Bedrail risk assessments should be made as follows:-

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

Fluid Balance Chart

0712726128 F
SULLIVAN 07/12/1972
Deborah
1/1 34 Pendeen Place
A Glasgow G33 4UG

Hospital: _____
Ward: _____
Date: _____

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? NHS Greater Glasgow and Clyde
Yes ☐ No ☐ Stage _____
Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:
1. Type _____ circle how many daily 1 2 3
2. Type _____ circle how many daily 1 2 3
Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00	admitted to ward																
13:00										UTI							
14:00																	
15:00																	
16:00																	
17:00	Juice	300							500	UTI							
18:00																	
19:00																	
20:00																	
21:00	IPU	200															
22:00																	
23:00																	
									*Total Intake						*Total Output		

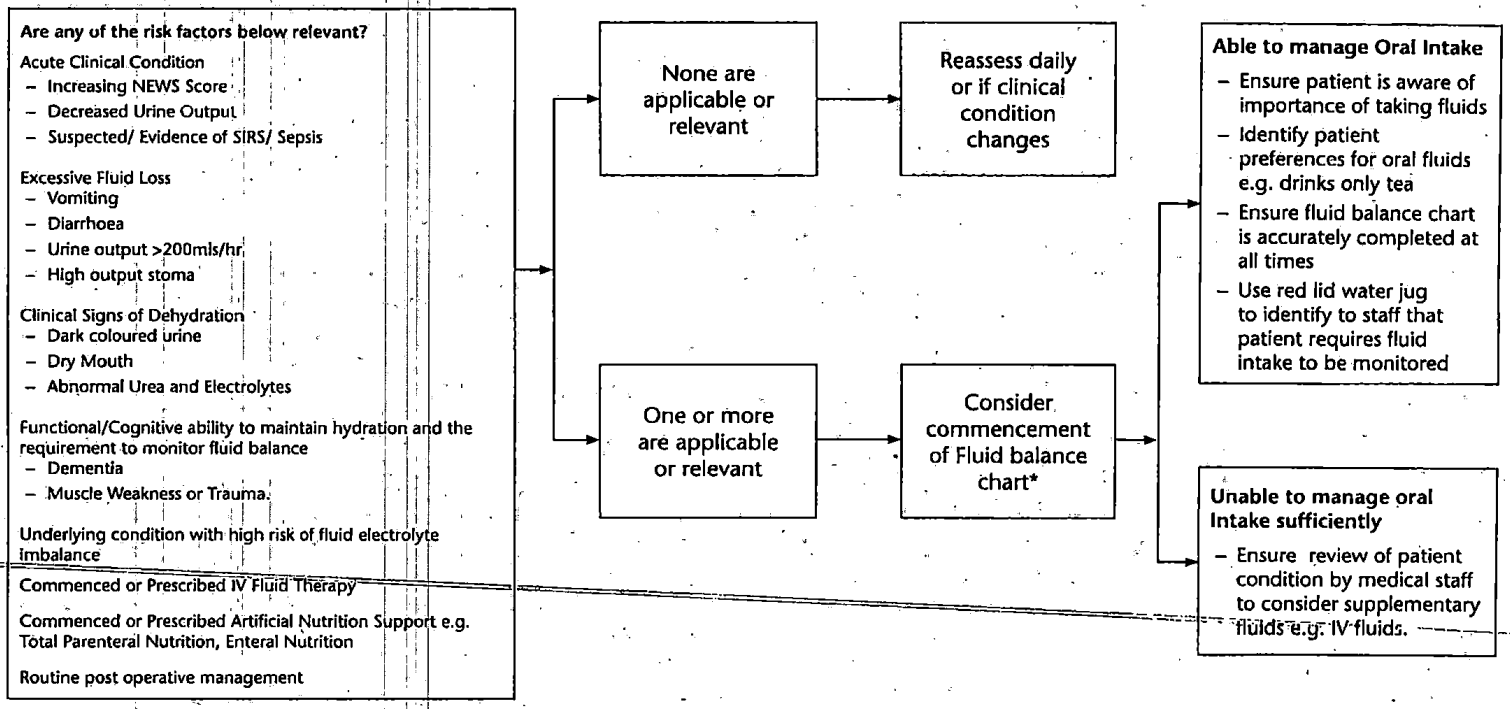
*24 hr Fluid Balance +/-

*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.



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: 15-2-18

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 mcdonald Name Charlene Designation S
2. Signed _____ Name _____ Designation _____
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

0712726128
SULLIVAN
Deborah
F
07/12/1972

Ward:

NHS Greater Glasgow and Clyde

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

		Times	15[illegible]	21/09																		
	1	**THINK DELIRIUM.** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	Y	Y																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N																		
S	3	**SKIN INSPECTION** Pressure areas checked:	Y	N																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	INT	I																		
K	4	**KEEP MOVING** Has the patient moved or walked?	Y	Y																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	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	Y/I																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N																		
		Drink taken?	Y	Y																		
		Food, snack, or supplement taken?	Y	N																		
		Has oral hygiene been carried out as per care plan?	I	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?	N	Y																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	Y																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	N	N																		
		Care provider / role	C	RN																		

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

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

Hospital:	ART	Ward:	67
Date of admission:	22/1/18	Time:	0155
Admitting Consultant:	Mitchell	Admitting Nurse:	Bland
Expected date of discharge:	/ /		

Nai [barcode] .....
Ad 0712726128
SULLIVAN F.....
..... Deborah 07/12/1972.....
1/1 34 Pendeen Place
Do Glasgow .....
CH G33 4UG .....

1. Patient Details

Preferred name: Debbie	Next of Kin (NoK): Caitrey Kelly
Age: 45	Relationship: Daughter
Religion:	NoK Address:
Telephone: 07713718392.	
GP: Dr. G MacAllister, Mcglone Practice	NoK Telephone: 07487257039.
GP address: Baillieston Health Centre, 20 Muirside Road baillieston, Glasgow, G69 7AD	NoK Aware of admission: ☐ Yes ☐ No
	Consent for information to be given to relative/carer/friend: ☐ Yes ☐ No
	Nominated relative/carer/friend contact:
	Telephone - Day:
GP telephone: 531-3050.	Telephone - Evening:

Is the patient a carer? ☐ Yes ☐ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No

If 'Yes' obtain a copy and file with patient notes.

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Have treatment / investigations:

Epig Pain ⇒ Back Nausea.

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

3. Allergies (including food allergies)

No known allergies: ☐ Penicillin

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
As per chart	Risk	0.	88	136/86	16.	97%	36.9°c
Urinalysis: ☐ Glucose Not +	BHCG sent		BM	NEWS Score	Weight Patient reported for weight / Actual	Height Patients reported height / Actual	BMI
			6.7.	0.	101 kg	1.78	32

5. Current Medication

As per kardex.

6. Relevant Past Medical History

Pancreatitis
Gallstones
IBS.
Fundoplication
TRAM

7. Risk Assessment

MUST Screening Tool

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

   Score 0
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% .....Score 0
   - 5-10% .....Score 1
   - >10% .....Score 2

   Score 0
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0

   Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☑ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☑ No

Na [barcode] .....
0712726128
Ad SULLIVAN F.....
Deborah 07/12/1972
..... 1/1 34 Pendeen Place .....
Do Glasgow .....
G33 4UG
CH .....

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

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

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☑ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

0. Lifestyle

Smoking:

Are you a smoker ☑ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day 12

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

☐ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

☑ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

1. Admission Documentation Completed By

Name (Please PRINT): BPaul	Signature: BPaul
Designation: SHO	Date: 22/1/18

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: GRI	Ward: 67
Date of Assessment: 22/1/18	Time: 0650

Nar [redacted]
Adc 0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
DoE Glasgow
CHI G33 4UG

1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [ ] No symptoms
- [x] known high blood pressure
- [ ] known angina
- [ ] current chest pain

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

Initial BP

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required [ ] Not required [x]

If required, provide details and arrangement made:

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome? [ ] Yes [x] No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted: [ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia? [ ] Yes [x] No

If 'Yes' please specify:

3. Senses

Senses:

Eyesight

- [ ] Normal vision
- [x] Glasses – [ ] Distance [x] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Cognitive Status

Cognitive Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Known dementia
- [ ] Unconcious

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

Initial BP

5. Hydration and Nutrition

Nan [redacted]
Add 0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
DoB Glasgow
G33 4UG
CHI

MUST Score: 0 If score is 1 or more, complete a Nutrition Profile.

Nutrition Profile completed ☐ Yes ☑ No
If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / / --

5a 1. Food likes / dislikes:

Eats most foods.

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☑ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☑ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☑ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

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

Initial BP

6. Elimination

Continent:
☑ Bladder
☑ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☑ No
If Yes is it urethral☐ suprapubic☐

If 'Yes' – Size: ..... fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☑ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☐ Constipated
☑ Diarrhoea / loose stools – normal for pt

Stoma: ☐ Yes ☑ No
If 'Yes' please specify and list appliances used:

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

Initial BP

7. Personal Hygiene, Oral Health and Skin Assessment.

Nan 0712726128
Add SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
DoB Glasgow
G33 4UG
CHI

Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent ☑ Yes ☐ No
Does the patient have a sore mouth ☐ Yes ☑ No
Does the patient have a non healing mouth ulcer ☐ Yes ☑ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:

Does the patient wear a denture plate?
☐ Yes ☐ No

If yes complete the following:
☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☑ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

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

Initial BP

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☐ Mobile with aid – Specify:

☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☐ Yes ☑ No

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

Initial BP

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☑ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:
☐ Required ☑ Not required

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

Initial BP

0. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap

☐ Morning nap

Sleep difficulties:

☑ None ☐ Disturbed

☐ Early wakening e.g. nocturia, insomnia

Medication required: ☑ Yes ☐ No

Nar 0712726128 .....

Adc SULLIVAN F .....

..... : Deborah 07/12/1972 .....

1/1 34 Pendeen Place

DoE Glasgow .....

G33 4UG

CHI .....

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

Temazepam

Initial BP

1. Social Circumstances

☐ Employed ☑ Unemployed ☐ Retired

☐ Health problems at work

☑ Lives alone

☐ Lives with Family

☐ Friend

☐ Dependants

☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services

Unpaid carer ☐ Yes ☐ No

If Yes are they Partner / Friend / Son / Daughter

What kind of care do they provide?:

☐ Private Carers

☑ None

If support services in place, please provide details:

Does the patient have any money worries? ☐ Yes ☑ No

If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support? ☐ Yes ☑ No

If Yes please identify date patient referred: ...../...../.....

Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering ☐ Yes ☑ No

If Yes please identify date patient referred: ...../...../.....

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

Initial BP

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?

☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?

☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?

☐ Yes ☑ No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"

☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☑

Nar 0712726128 .....
Adc SULLIVAN F .....
Deborah 07/12/1972 .....
1/1 34 Pendeen Place .....
Dot Glasgow .....
G33 4UG .....
CHI .....

Is the patient aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the patient's family aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☑ No

If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): BPaul

Signature: BPaul

Designation: SN Date: 22/1/18

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
22/1/18 0950	Epigastric GP & epig pain → back + nausea	
	fasting for RIV	
	RSU + bloods awaited.	BPaul BPAULSN
	S/B FY2 - Axl + Cxl keep	
	fasted for ? AUSS mane	
	IVF	BPaulSN
09[30]	WR. Mr Mitchell	

Clinical Notes continue on next page

Nan 0712726128
Addi SULLIVAN Deborah F
1/1 34 Pendeen Place 07/12/1972
DoB: Glasgow G33 4UG
CHI
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	For CTAP today	
	Allow oral fluids.	
	Monitor wee output.	
	D/C INF ☑	NURSE SN
0935	NEWS=1 temp 35.5 BM 4.8mmol/l	
	Independent on ward	
	Fasting for CTAP, allow water	
	Analgesia and antiemetic	
	administered.	
	Passing wee - continue to	
	monitor wee output	
	Settled at present	NURSE SN
1500	For CT Scan 12MD	
	tomorrow. Verbal 2	
	300mls water.	
	Returned to D+F.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

0712726128
SULLIVAN F
: Deborah 07/12/1972

Date & Time		Signature, Print Name & Designation
23/1/18	Settled overnight	
	Observations stable.	
	Oral analgesia as prescribed	
	Accompany	
	for CT - 1200 today.	L Watt S/N
0630	BP ↑ this am Pleased reassess	L Watt S/N
D/S	Mr Mitchell.	
	For CT scan today at 12no.	
09:30 am	Independent with shower	J Sutherland (SSM)
	F/F for scan.	
	Passing urine spontaneously	
	NEWS. 0.	
	Oramorph given as charted	
	for pain. Relief	J Sutherland (SSM)
	Attended scan which	
	was RAD → no cause	
	for pain.	
	- may need OGD → to	
	discuss with Mr Mitchell	J Sutherland (SSM)
24.1.18	Settled on ward to ward bb.	
0015	obs as NEWS.	
	Meds as pr. own meds on trolley	
	Ind. PU. Fed.	
	Analgesia req prn.	
	R/v am ? for OGD/hpylori test.	EMcAninch
11:25	D/c home, no meds required, IDL	
	given explained, no fix, own	MHiggins
	transport, Venflon removed ——	M Higgins SN

83949 GGC0072

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's n 0712726128	Ward: 67
Unit numl SULLIVAN Deborah F 07/12/1972	Discharge destination: Home
CHI numt 1/1 34 Pendeen Place Glasgow G33 4UG	Estimated Discharge Date (1) / /
	Estimated Discharge Date (2) / /
	Final date of discharge : / /

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

Glasgow 0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS
Greater Glasgow and Clyde

Name: Unit No.:

Date:		22/1		23/1										
Time of Result:		0640		0711										
WCC	4-11	(14.0)		8.7										
Hb	M - 13-18 F - 11.5-16.5	131		131										
Plat	150-400	297		251										
Amylase	<100	(H)	101	85										
CRP	<10	2		3										
Na+	135-145	136		140										
K+	3-5-50	(H)		4.0										
Cl-	98-108	106		106										
Bic	21-28													
Urea	2.5-7.5	5.0		4.2										
Creat.	57-113	51		59										
EGFR	60>	>60		>60										
Glucose	3.5-5.5	6.0		8										
Bilirubin	3-22	4		8										
ALT	<50	16		16										
AST	<40	(H)		16										
G-GT	<55	51												
Alk. Phos.	40-150	69		72										
Albumin	32-45	36		35										
Mg^+														
Ca	2.1-2.6	2.32												
Adj Ca	2.1-2.6	2.37												
PO4	0.7-1.4	1.21												
PT	9-12													
APTT	25-37													
TCT	11-15													

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

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

0712726128
SULLIVAN
Deborah
07/12/1972

Pe[illegible]ent) 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 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:	22/1/18		
Assessor's signature:	[signature]		
Proposed Review date:			

Continuation Sheet

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

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

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

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

3. Toileting

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

4. Move on / off bed pan

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

5. Move up / down bed

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

6. Lateral Transfer to / from trolley / bed

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

7. Sit up over side of bed

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

8. Into Bath or Shower

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

0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

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: 22/1/18 Time: 0450	Ward: 66 Date: 23·1·18 Time: 23:ce	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).	Yes	✓			
2. Check walking aid (if required) is in reach and in use.	NA	NA			
3. Check call bell is in reach and working: Provide and document alternative measures if patient is unable to use call bell.	Yes	✓			
4. Check footwear is safe (refer to NHSGGC Footwear guidance).	Yes	✓			
5. If glasses are worn, check they are available and in use.	Yes	✓			
6. If hearing aid/s are worn, check they are working and in use.	NA	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	BPaul		K							

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 [illegible] PLAN

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 1/1 34 Pendeen Place Glasgow G33 4UG	Hospital: GRI Ward: 67	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
22/1/18	06:00	N	N	N	N	N	N	4 hrly	BPaul.
23/1/18	11:30	NS	NS	NS	NS	NS	NS	4 hrly	SS
24/1/18	06:15	N	N	N	N	N	N	4 hrly	M Hogg
/ /	:							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 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:

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 22/1/18
Address: 0712726128 SULLIVAN F Deborah 07/12/1972 1/1 34 Pendeen Place Glasgow G33 4UG	Time: 0450
DoB:	HOSPITAL: GRI
CHI number:	Ward: 67
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 1.78 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 101 kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☑

Please state:

Food Allergies: Yes ☐ No ☑ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☑ No ☐ If 'Yes' why?:
Eats most foods.		RIV.

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): BPaul Signature BPaul Date: 22/1/18

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	22/1											
Initials	BP											
Height (see page 1) 1.78 Weight	101 kg											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	32											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK – *Routine Clinical Care*** • Repeat screening. Hospital Acute .....1.....Weekly Hospital Rehabilitation.....Monthly
1	**MEDIUM RISK – *Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK – *Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

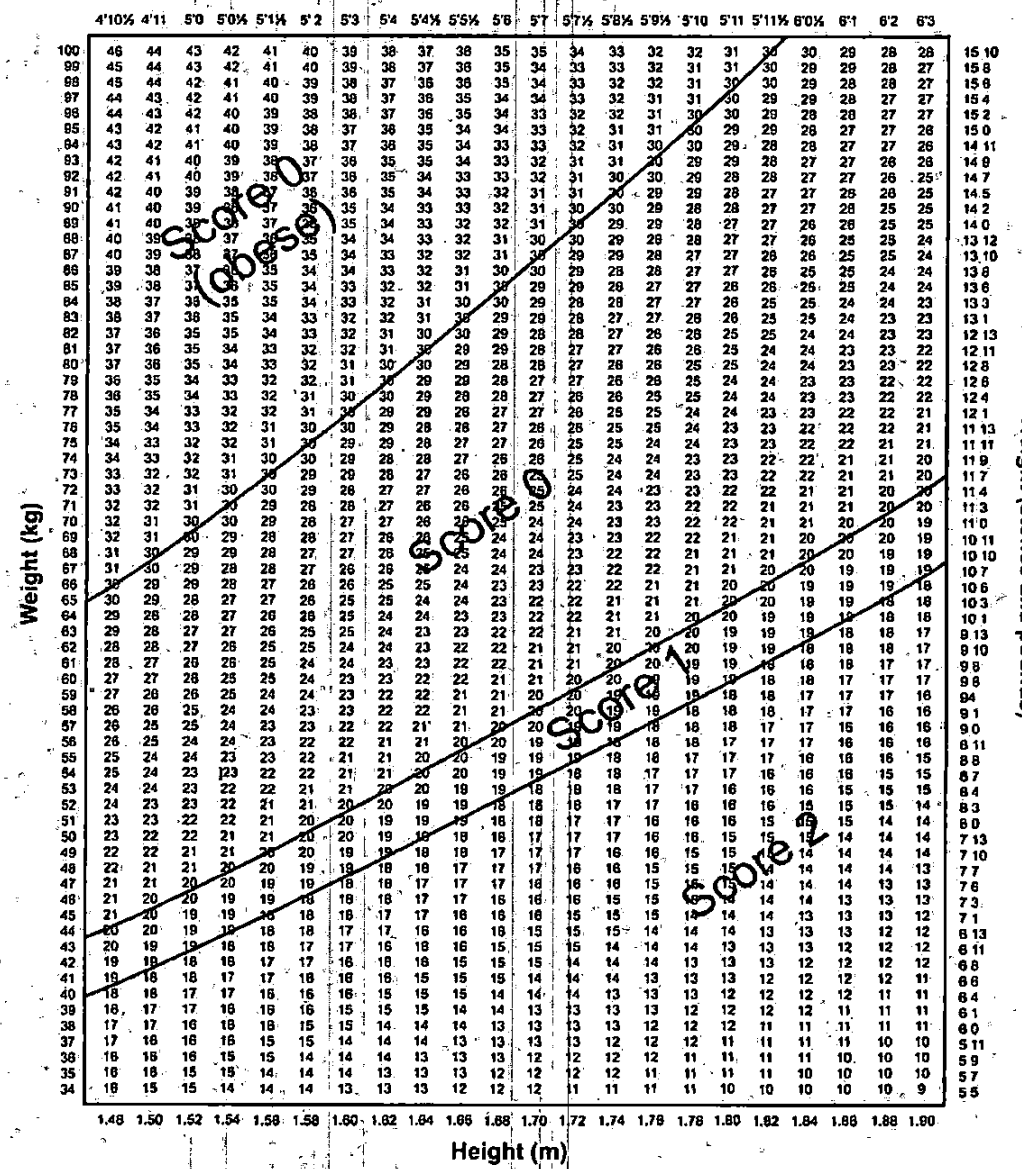
Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
22/1	0	No action reqd			BRawlSon

Step 1 - BMI Score

Height (feet and inches)



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <3%	Score 1 Wt loss 3-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <3%	Score 1 Wt loss 3-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Fluid Balance Chart

Name: .....
0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

Hospital: GRI
Ward: 66
Date: 24.1.18

Reason for Fluid Balance Chart: Mouth
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	Wat	150															
06:00										200							
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		

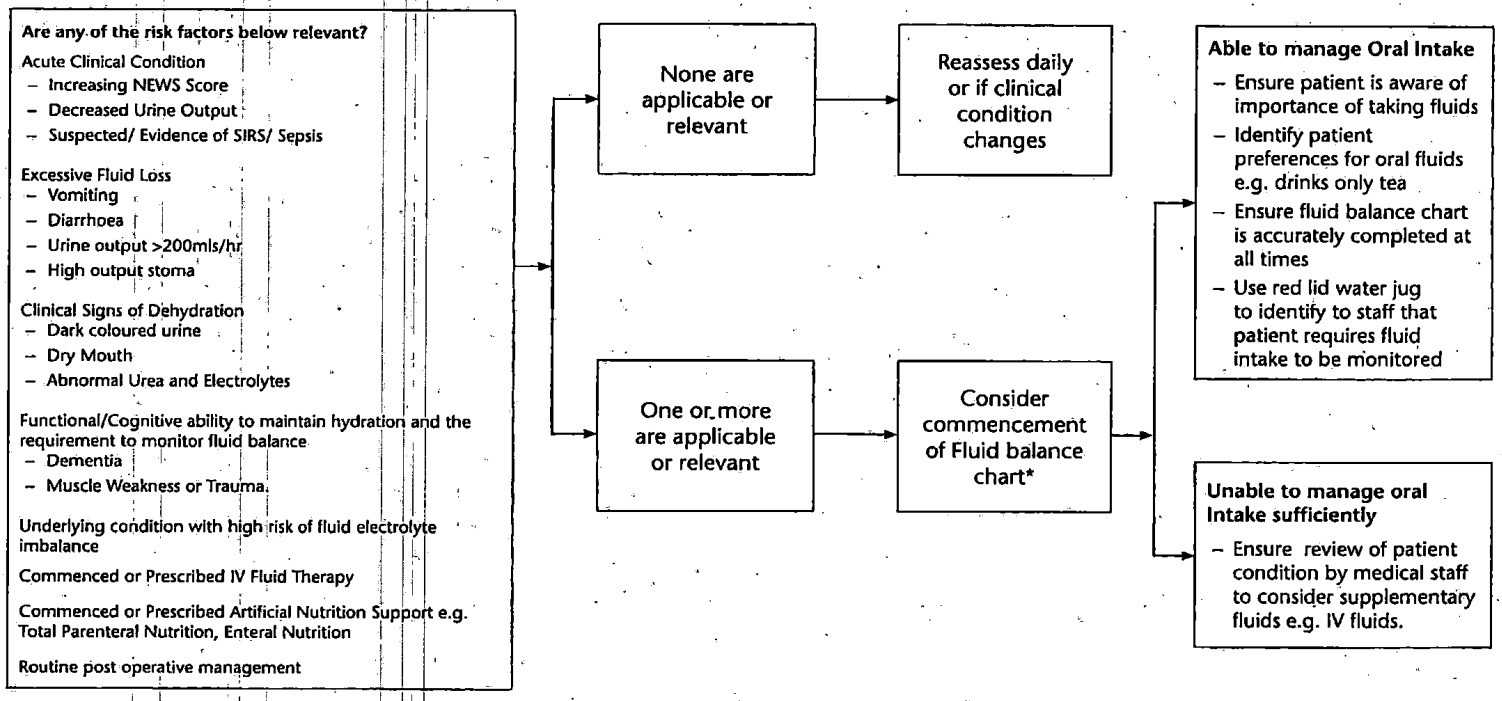
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*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

0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

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
22/1 BP	Obs as per news chart.		22/1 BP	MA.	
				5. Hydration and Nutrition	
			22/1 BP	Fasting	
			23.1.18 PL	normal diet	
	2, 3. Communication and senses				
22/1 BP	Wears glasses				
				6. Elimination	
	4. Cognitive status		22/1 BP	Indep	
22/1 BP	MA				

0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

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
22/1 BP	Indep		22/1 BP	Rsun as per NEWS Chart.	
				10. Sleep and Rest	
			22/1 BP	Good sleep Pattern.	
	8. Mobility				
22/1 BP	Indep			12. Privacy, dignity and sexuality	
			22/1 BP	MA.	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mi • 285668 Version 1_0 • GGC0127

Care Rounds Checklist

Date: 23/1/18

Attach Addr

0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG

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 [signature] Name EMcADAM Designation SW
2. Signed [signature] Name MITHOONS Designation SW
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	02:00	06:00	09:00																	
	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	Y																	
S	3	**SKIN INSPECTION** Pressure areas checked:	S	I	I																	
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	—	—	/																	
K	4	**KEEP MOVING** Has the patient moved or walked?	S	I	I																	
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	R	—	/																	
		Chair Assist to walk or stand (W/ST)	NA	—	/																	
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?	N	N	N																	
		Drink taken?	S	N	Y																	
		Food, snack, or supplement taken?	S	N	Y																	
		Has oral hygiene been carried out as per care plan?	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	N	Y																	
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	NT	NT																	
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA																	
		Care provider / role	MM	MM	CD																	

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

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address
0712726128
SULLIVAN F
Deborah 07/12/1972
1/1 34 Pendeen Place
Glasgow
G33 4UG
CHI No.
DoB

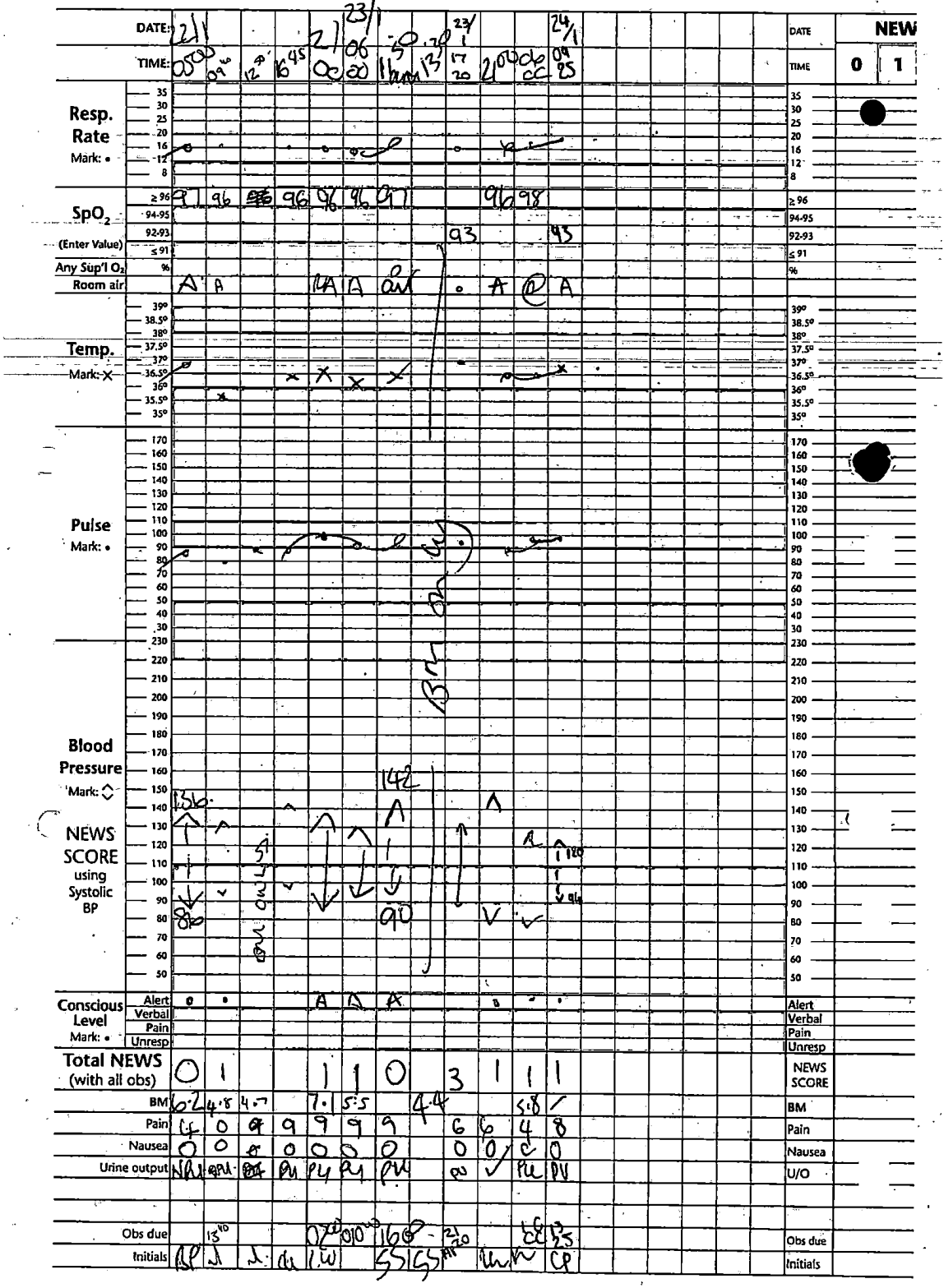
	Date	Ward
Admitted		
Transferred		
Transferred		

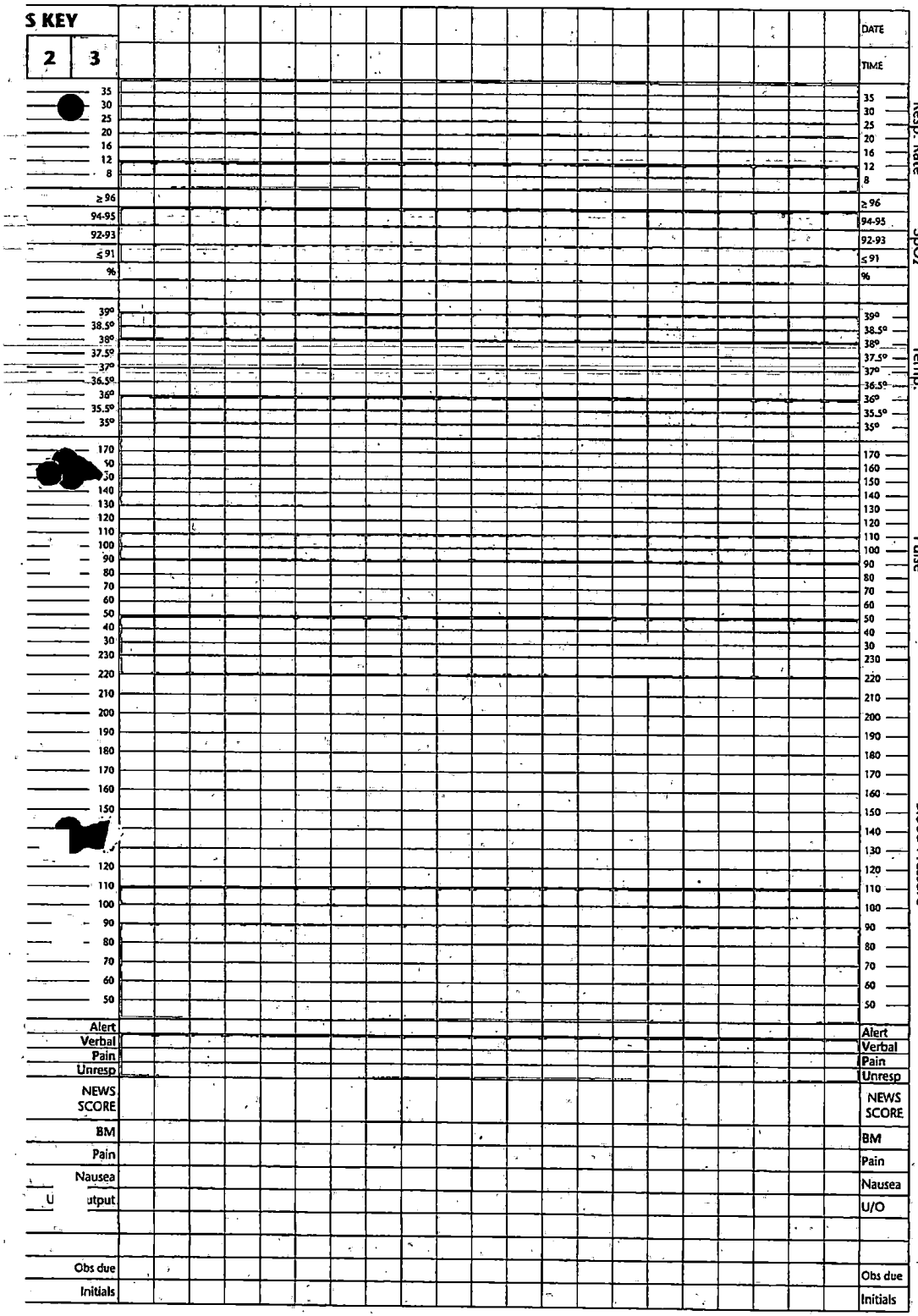
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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


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
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

Pupil size (mm)

1 2 3 4 5 6 7 8

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

Care Rounds Checklist

Date: 230118

Attac 0712726128 F
SULLIVAN 07/12/1972
Deborah
1/1 34 Pendeen Place
Glasgow G33 4UG
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 L. Watt Designation S/SN
2. Signed _____ Name S. SUTHERLAND Designation SEN
3. Signed _____ Name F MADAM Designation SN

'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	01 00	06 00	11 am	18 00	21 05	22 00
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	S	N	O	N	N	N
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	S	Y	O	N	Y	Y
S	3	**SKIN INSPECTION** Pressure areas checked:	S	I	O	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	S	–	O	–	–	–
K	4	**KEEP MOVING** Has the patient moved or walked?	S	–	O	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	–	O	–	–	R
		Chair Assist to walk or stand (W/ST)	S	–	O	–	I	W/ST
I	5	**ELIMINATION** Does the patient need the toilet? Independent = I Assistance given = A Incontinent of urine or faeces = IC	S	Y	O	I	I	I
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	S	N	O	N	N	N
		Drink taken?	S	Y	O	Y	Y	Y
		Food, snack, or supplement taken?	S	N	O	Y	N	N
		Has oral hygiene been carried out as per care plan?	S	–	O	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	O	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	S	N	O	N	NT	NT
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	S	NO	O	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

Patient n 0712726128 F
Date of b SULLIVAN Deborah 07/12/1972
1/1 34 Pendeen Place
CHI No:... Glasgow G33 4UG
label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
22/01		0-9% Nacl	500	IV	6°			

Administration details

Date	Time	Given by	Checked by	Comments
22/1	08[illegible]	✓		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)

Administration details - continued

Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Fluid Balance Chart

N 0712726128
D SULLIVAN F
Cl Deborah 07/12/1972
1/1 34 Pendeen Place
Aff Glasgow G33 4UG

Hospital: GRI
Ward: 65
Date: 23/01/18

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																	
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		

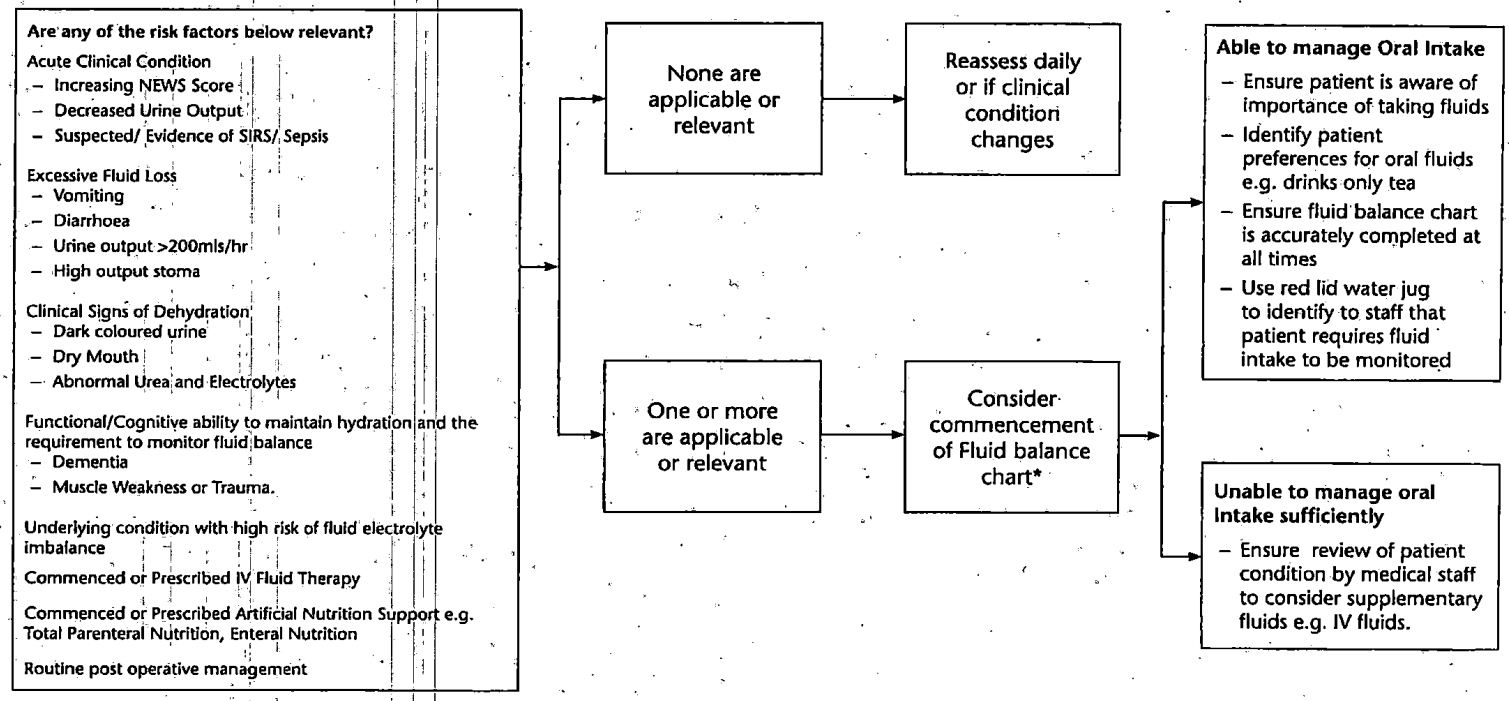
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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



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

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

MIS • EDU • 237971-2

Fluid Balance Chart

0712726128 F
SULLIVAN 07/12/1972
Deborah
1/1 34 Pendeen Place
Glasgow G33 4UG

Hospital: GRI
Ward: 67
Date: 22/1/18

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																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00		Commenced								UTT							
08:00																	
09:00	water	50			IVF	250			50								
10:00	in ATR	100							400								
11:00										600						600	JL
12:00																	
13:00	water	100							500	350						950	JL
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]	

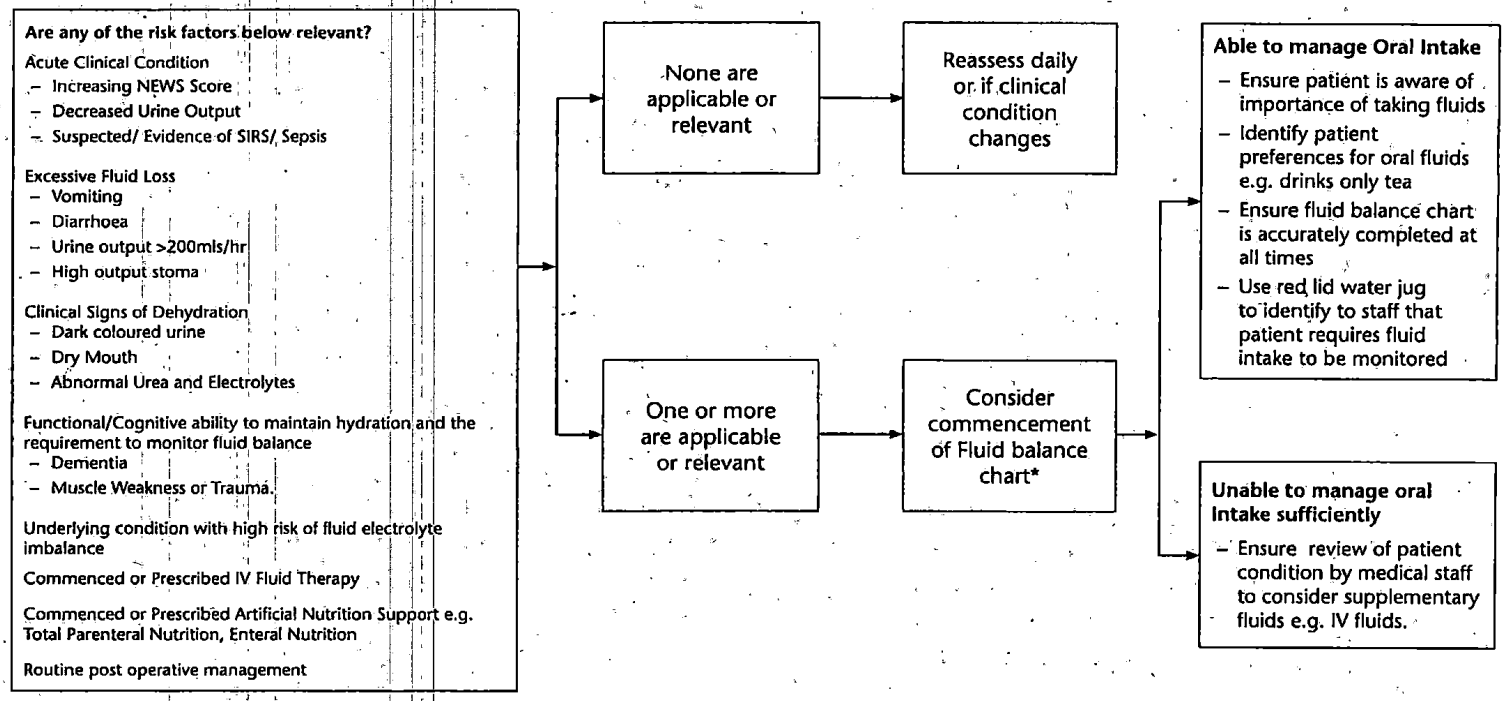
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*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.



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: 22/1/18

Attach Ad

0712726128
SULLIVAN
Deborah
F
07/12/1972

Ward: 62

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 BPaul Name BPAUL Designation SN
2. Signed Myles Name Myles Designation SN
3. Signed [illegible] Name [illegible] Designation SN

'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	09	21
	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	Y	N
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	I
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	NT	-	—
K	4	**KEEP MOVING** Has the patient moved or walked?	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
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	Y	Y	Y
		Drink taken?	N	FF	Y
		Food, snack, or supplement taken?	N	FF	Y
		Has oral hygiene been carried out as per care plan?	I	FF	N
	7	**ENVIRONMENT Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position?	Y	Y	Y
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	N	N	N
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	NA
		Care provider / role	BSN	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

fm • 278936 v2.1 • GGC0098

Acute Services Division

Nursing Admission & Assessment
1. Admission

NHS Greater Glasgow and Clyde

Name: .....
Addr: 0712726128 .....
..... SULLIVAN F .....
DoB: Deborah 07/12/1972
6 Muirhead Court .....
CHI n Baillieston .....
Glasgow, Lanarkshire
G69 7EP

Hospital: GRI	Ward: 65
Date of admission: 13/11/17	Time: 02:30
Admitting Consultant: M Quinn	Admitting Nurse:
Expected date of discharge: / /	

1. Patient Details

Preferred name: Debbie	Next of Kin (NoK): Courtney Kelly
Age: 44	Relationship: Daughter
Religion:	NoK Address:
Telephone: 07713718392	
GP:	NoK Telephone: 07487257039
GP address: Dr. G MacAllister, Meglone Practice, Baillieston Health Centre, 20 Muirside Road baillieston, Glasgow, G69 7AD	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relative/carer/friend: ☑ Yes ☐ No
	Nominated relative/carer/friend contact:
GP telephone:	Telephone - Day: Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☑ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....
Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☑ No
If 'Yes' obtain a copy and file with patient notes.
If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Have treatment / investigations:

Abdo pain

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

3. Allergies (including food allergies)

No known allergies: ☑ Penicillin

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
0 Risk	Pure	0.	98	119/85	14	99	36.8
Urinalysis: + blood ++ protein Hcg neg. ☐			BM	NEWS Score	Weight Patient reported for weight /Actual	Height Patients reported height / Actual	BMI
			5.8	1	95	1.78	31.

5. Current Medication

See Kardex

6. Relevant Past Medical History

Pancreatitis
Gallstones.
IBS
Fundoplication.
T2DM - diet controlled.

7. Risk Assessment

MUST Screening Tool

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

   Score 0
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% .....Score 0
   - 5-10% .....Score 1
   - >10% .....Score 2

   Score 0
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0

   Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☑ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☑ No

Name .....
Addr 0712726128 .....
SULLIVAN F
..... Deborah 07/12/1972 .....
DoB: 6 Muirhead Court .....
Baillieston
CHI n Glasgow, Lanarkshire .....
G69 7EP

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

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

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☑ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If 'Yes' to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

0. Lifestyle

Smoking:

Are you a smoker ☑ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day...20...

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☑ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☑ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

1. Admission Documentation Completed By

Name (Please PRINT): RDocherty	Signature:
Designation:	Date: 13/11/17

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: GRI	Ward: 65
Date of Assessment: 13/11/17	Time: 0030

Name: .....
Address: 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB: 6 Muirhead Court
CHI num Baillieston
Glasgow, Lanarkshire
G69 7EP

1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [ ] No symptoms
- [x] known high blood pressure
- [ ] known angina
- [ ] current chest pain

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

Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

English

Interpreter: Required [ ] Not required [x]

If required, provide details and arrangement made:

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome? [ ] Yes [ ] No

If 'Yes' please specify:

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted: [ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia? [ ] Yes [x] No

If 'Yes' please specify:

3. Senses

Senses:

Eyesight

- [ ] Normal vision
- [ ] Glasses – [ ] Distance [x] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Cognitive Status

Cognitive Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Known dementia
- [ ] Unconcious

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

Initial

5. Hydration and Nutrition

Nam
Addi
0712726128
..... SULLIVAN F .....
Deborah 07/12/1972
DoB: 6 Muirhead Court .....
CHI : Baillieston .....
Glasgow, Lanarkshire
G69 7EP

MUST Score: 0 If score is 1 or more, complete a Nutrition Profile.

Nutrition Profile completed ☑ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- If score is 0, reassess / screen patient in 7 days.
- Complete sections 5a to 5d.

Date of reassessment: / /

5a 1. Food likes / dislikes:

5a 2. Fluid likes / dislikes:

5c. Help needed with eating and drinking:
☐ Yes ☐ No
If 'Yes' provide details:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☑ No
If 'Yes' specify diet needed:

5d. Texture Modified Diet needed?
☐ Yes ☑ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

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

Initial

6. Elimination

Continent:
☑ Bladder
☐ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☑ Not required

Long-term urinary catheter in situ? ☐ Yes ☑ No
If Yes is it urethral ☐ suprapubic ☐

If 'Yes' – Size: .....fg Make:.....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☑ Not applicable

Containment products in use? Please specify:

☑ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☑ No
If 'Yes' please specify and list appliances used:

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

Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Name .....
Addre 0712726128 .....
..... SULLIVAN F
..... Deborah 07/12/1972
DoB: .. 6 Muirhead Court .....
CHI nu Baillieston .....
Glasgow; Lanarkshire
G69 7EP

Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☑ Yes	☐ No
Does the patient have a sore mouth	☐ Yes	☑ No
Does the patient have a non healing mouth ulcer	☐ Yes	☑ No

If the patient has a sore mouth or non-healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:

Does the patient wear a denture plate?
☐ Yes ☑ No

If yes complete the following:
☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:

☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☑ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

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

Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☑ Yes ☐ No

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

Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☐ Yes ☑ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:
☐ Required ☑ Not required

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

Initial

10 Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☑ None ☐ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☐ Yes ☑ No

Name [redacted]
Addre: 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB:.. 6 Muirhead Court
Baillieston
CHI nu Glasgow, Lanarkshire
G69 7EP

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

Temazepam.

Initial

11 Social Circumstances

☐ Employed ☑ Unemployed ☐ Retired
☐ Health problems at work
☐ Lives alone
☐ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services

Unpaid carer ☐ Yes ☑ No
If Yes are they Partner / Friend / Son / Daughter
What kind of care do they provide?:

☐ Private Carers
☑ None

If support services in place, please provide details:

Does the patient have any money worries? ☐ Yes ☑ No
If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?
☐ Yes ☐ No
If Yes please identify date patient referred: ...../...../.....
Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering
☐ Yes ☐ No
If Yes please identify date patient referred: ...../...../.....

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

Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?
☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☑

Nam [redacted]
Addı 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB: 6 Muirhead Court
Baillieston
CHI Glasgow, Lanarkshire
G69 7EP

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): RDocherty

Signature: RD SN

Designation: SN

Date: 13/11/17

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
13/11/17 0030	Patient admitted due to abdominal pain	
	Nausea	
	Mobile independently	
	passing urine	
	awaiting Review	RDocherty RD SN
13/11/17 0240	S/B S/B SpR.	
	? cause of pain	

Clinical Notes continue on next page

Name: [redacted]
Address 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB: 6 Muirhead Court
CHI nun Baillieston
Glasgow, Lanarkshire
G69 7EP

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	- For AXR ✓	
	- F&D	K. CONNELL K. Connell SN
13/11/17 0910	WIR MISS QUINN AXR - Faecal loading enema.	Chloe
12:45	Settled morning. NEWS (1) for pulse 102 BPM. Blood sugar 4.8mmol/L. C/O pain, no nausea. Analgaesia given as per Kardex. Morning meds not given as Kardex was not written at time. Tolerating fluid + diet. Voiding urine well. Phosphate enema given. Good result. Pt reports normal, medium sized stool passed. Once off Picolax given. No concerns.	SN H. R

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

Deborah Sullivan 07127726128

Date & Time		Signature, Print Name & Designation
13/11 1745	W/r MISS QUINN Bowels Moving Feels much better For D/C home with laxido has some @ home No Fly.	Cthell SN

83949 GGC0072

0712726128 F
SULLIVAN 07/12/1972
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire G69 7EP

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
13/11 RD	N/S		13/11 RD	NA		
			13/11 RD	5. Hydration and Nutrition		
				MUST 0		
13/11 RD	2, 3. Communication and senses					
	Speaks English					
			13/11 RD	6. Elimination		
13/11 RD	4. Cognitive status			bowels moving		
	Alert + Orientated			passing urine		

p1/2 PTO

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
13/11 Rel	Ind		13/11 Rel	Pressure area care pain management	
	wounds				
			13/11 Rel	10. Sleep and Rest	
				encourage sleep + rest	
13/11 Rel	8. Mobility				
	Ind		13/11 Rel	12. Privacy, dignity and sexuality	
				promote privacy + dignity	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mi • 285668 Version 1_0 • CCC0127

Glasgow

0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS
Greater Glasgow and Clyde

Name: Unit No.:

Date:			13/11	8/11									
Time of Result:			0259	0822									
WCC	4-11		11·2	11·2									
Hb	M - 13-18 F - 11.5-16.5		121	121									
Plat	150-400		250	250									
Amylase	<100		(H)	71									
CRP	<10		4	3									
Na+	135-145	139	134	138									
K+	3-5-50	4·1	(H)	4·3									
Cl-	98-108	103	104	107									
Bic	21-28												
Urea	2.5-7.5	5·5	4·3	3·8									
Creat.	57-113	57	46	54									
EGFR	60>	>60	>60	>60									
Glucose	3.5-5.5												
Bilirubin	3-22	6	<5	·5									
ALT	<50	20	28	23									
AST	<40	18	(H)	19									
G-GT	<55												
Alk. Phos.	40 -150	79	71	74									
Albumin	32-45	37	36	33									
Mg+													
Ca	2.1-2.6												
Adj Ca	2.1-2.6												
PO4	0.7-1.4												
PT	9-12		12/1.1										
APTT	25-37		27/0.9										
TCT	11-15		13/1.0										

MIS 238455/CRI

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
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
CHI No.
DoB G69 7EP

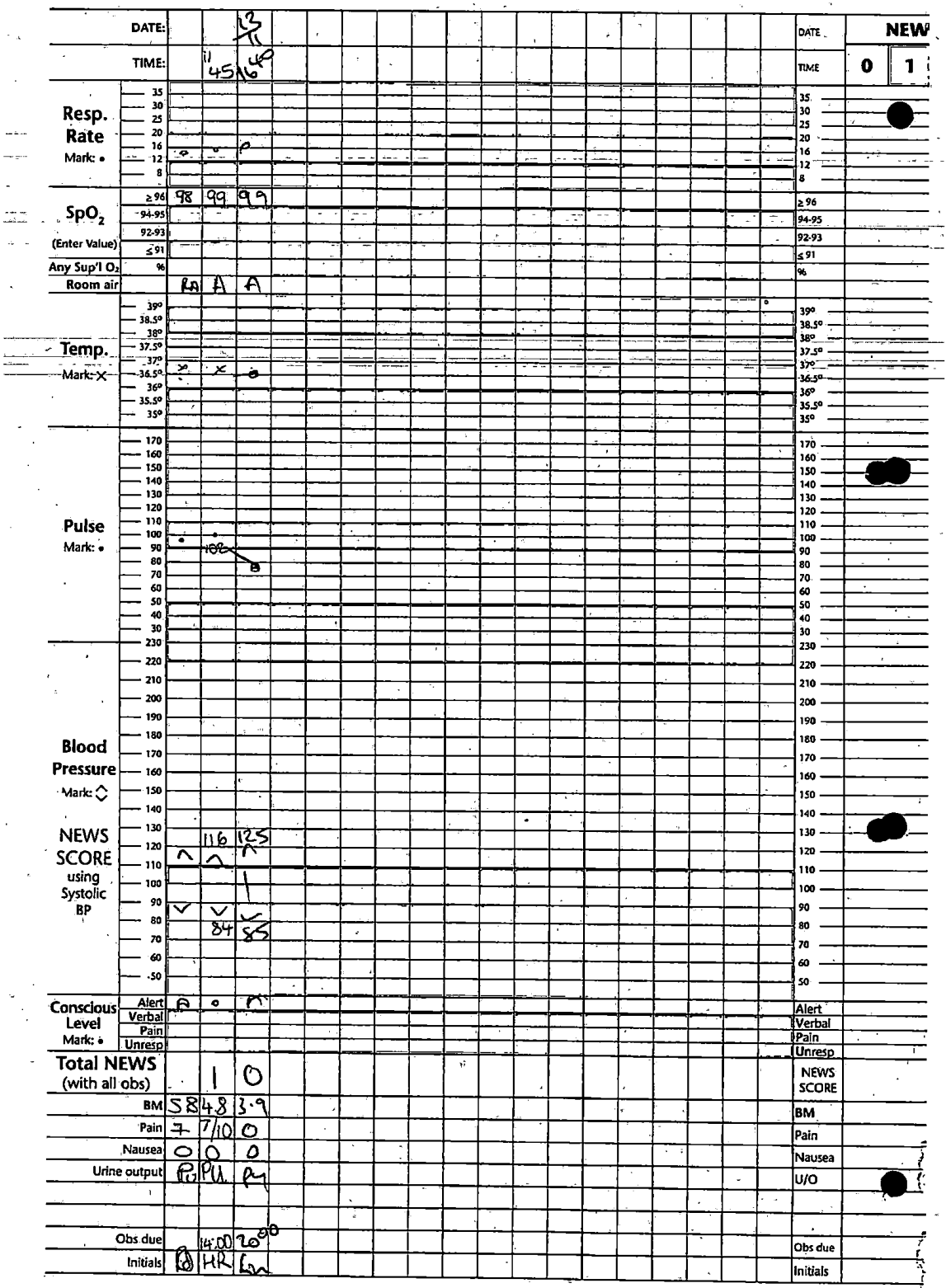
	Date	Ward
Admitted		
Transferred		
Transferred		

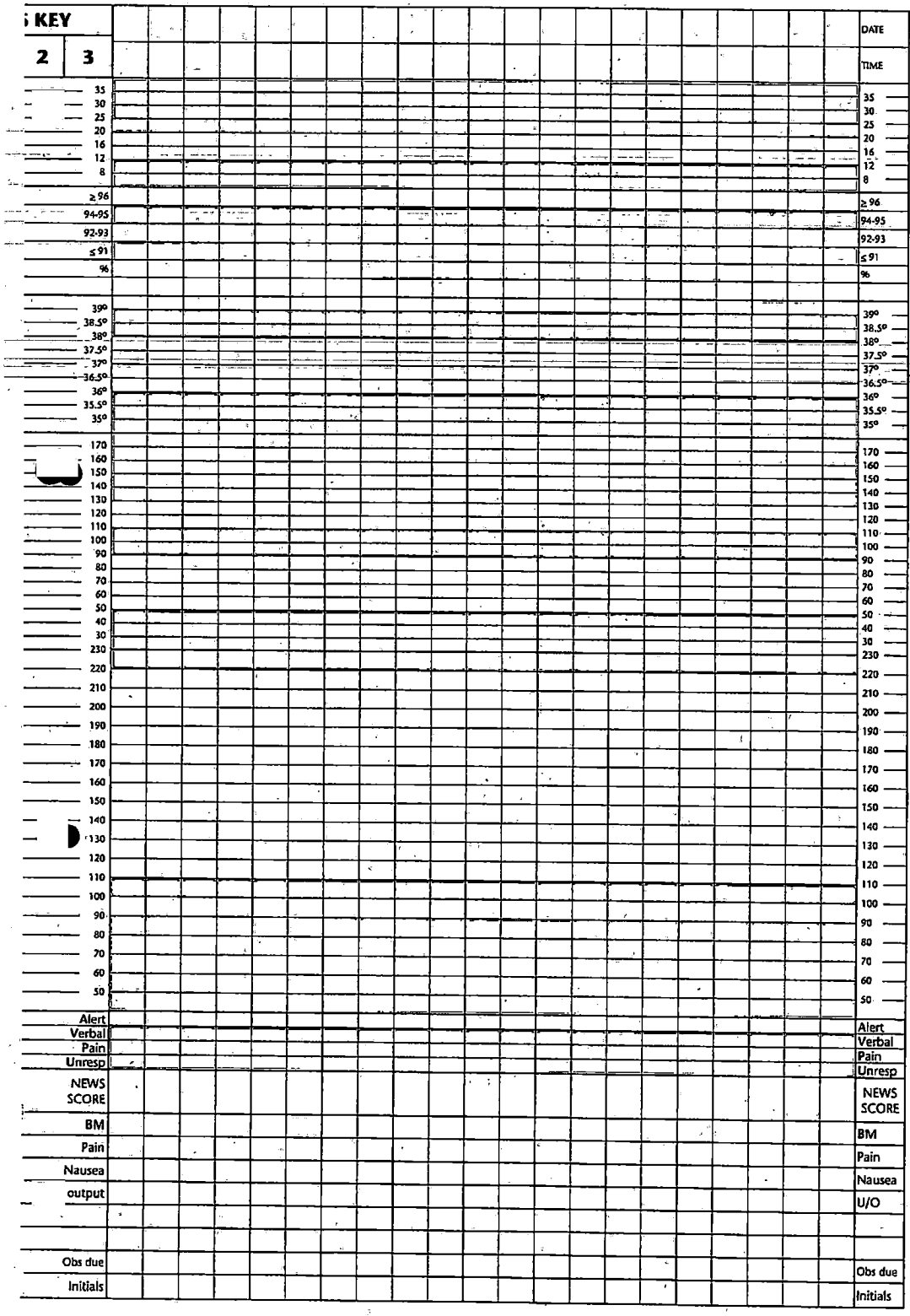
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic 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:
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
NEW
0
1


KEY
2
3
DATE
TIME
Resp. Rate
35
30
25
20
16
12
8
SpO2
≥ 96
94-95
92-93
≤ 91
96
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
output
U/O
Obs due
Initials

Glasgow Coma Scale

Pupil size (mm)

1 2 3 4 5 6 7 8

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

Care Rounding Checklist

Date: 13/11/17

Attach Addressogra

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

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) 6hr

1. Signed [signature] Name B Docherty Designation SN
2. Signed [signature] Name H. Ritchie 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
S = Sleeping | O = Off the ward | NT = No Thanks
I = Independent | V = Variance (record variance in nursing notes)

		Times	08 00	08 00	10 30	12 00	16 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.	Y	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)	—	✓	✓	✓	✓															
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** Check if the patient is nil by mouth? If not, encourage the patient to drink.	Y	Y	Y	N	N															
		Food, snack, or supplement taken?	N	N	N	Y	Y															
		Provide oral hygiene as per care plan.	N	N	NT	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	N	N	N	Y															
	9	**ESCALATION** Escalate any issues to the registered nurse.	NA	✓	N/A	N/A	NA															
		Care provider / role	KB SN	JSC SN/HCA	HC SN	HC SN	SC															

mi • 278936 v2.0 • GCC0098

Care Rounding Checklist

Date: _____

Attach Addressograph Label

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 6hr

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
S = Sleeping O = Off the ward NT = No Thanks
I = Independent V = Variance (record variance in nursing notes)

		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** Check if the patient is nil by mouth? If not, encourage the patient to drink.																	
		Food, snack, or supplement taken?																	
		Provide oral hygiene 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.																	
		Care provider / role																	

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	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** No	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
13/11/17	08:10	No	No	No	No	No	No	4 hrly	[illegible]
/ /	:							___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 Intervent[illegible]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 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: ____

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

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: [illegible] Date: 13/11/17 Time: 22:10	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.	NA				
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	[illegible] 2011.									

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

0712726128
SULLIVAN
Deborah 07/12/1972

Pe ent) 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
95 Kg 31 BMI	176cm

Problems with comprehension, behaviour, co-operation (specify): NIL

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

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
Sling type
Sling Size
Aid Type
People: 1 ☐ 2 ☐ ≥3 ☐
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 Aleno)
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:	13/11/17		
Assessor's signature:			
Proposed Review date:	20/11/17		

Continuation Sheet

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

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			
	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 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

	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:			

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 13/11/17
Address: 0712726128 SULLIVAN Deborah 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	Time: 0230
DoB: 07/12/1972 F	HOSPITAL: GRI
CHI number:	Ward: 65

To be recorded within 24 hours of admission*

Height: 1.78 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 95 kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☒

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☒ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☒

Please state:

Food Allergies: Yes ☐ No ☒ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☒ If 'Yes' why?:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☒

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☒

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☒

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☒

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☒

Profile completed by: Name (PRINT): K J Doherty Signature: Date: 13/11/17

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	13/11/12											
Initials	RB											
Height (see page 1) 1.78 Weight	95											
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	31											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese).....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% .....1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK – ***Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	MEDIUM RISK – ***Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK – ***Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

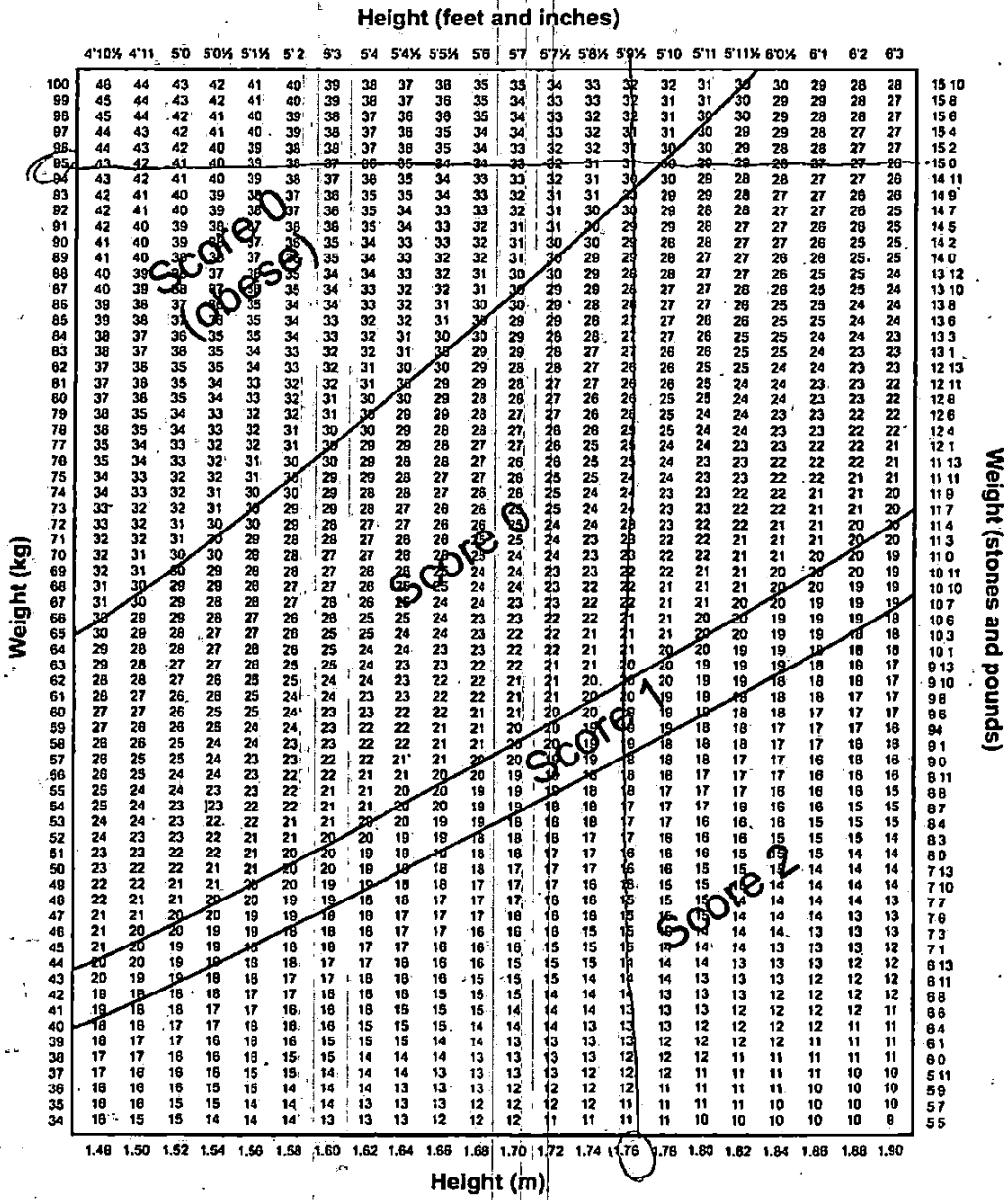
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation

Step 1 - BMI Score



Step 2 - Weight ____ Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Acute Services Division

Nursing Admission & Assessment
1. Admission

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Hospital: GRI	Ward: 10
Date of admission: / /	Time:
Admitting Consultant:	Admitting Nurse:
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): Daughter
Age: 49	Relationship: Carmody Kelly
Religion:	NoK Address: N/A
Telephone:	
GP: McGavin Baillieston Health Centre	NoK Telephone: 07457 257039
GP address: 20 Muirside Road Glasgow G69 7AD	NoK Aware of admission: ☑ Yes ☐ No
	Consent for information to be given to relative/carer/friend: ☑ Yes ☐ No
	Nominated relative/carer/friend contact: Daughter
	Telephone - Day: As Above
GP telephone:	Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☑ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No
If 'Yes' obtain a copy and file with patient notes.

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Have treatment / investigations: Headache Migraine

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

3. Allergies (including food allergies)

No known allergies: ☐ ✗ PENICILLIN ✗

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp

Urinalysis:	BM	NEWS Score	Weight Patient reported for weight /Actual	Height Patients reported height / Actual	BMI

5. Current Medication

6. Relevant Past Medical History

7. Risk Assessment

MUST Screening Tool

1. Is the patient's BMI:
   - > 20 .....Score 0
   - 18.5-20 .....Score 1
   - <18.5 .....Score 2
   - Score .....
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% .....Score 0
   - 5-10% .....Score 1
   - >10% .....Score 2
   - Score .....
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2
   - Not applicable: Score = 0
   - Score .....

MUST Score: ☐

If score 1 or more, complete full Nutrition Profile

Swallow Risk Assessment

Has the patient had, or is suspected of having, a stroke, a TIA or is suspected of having a swallowing difficulty? ☐ Yes ☐ No

If YES complete a STOPSS screening tool.

STOPSS completed ☐ Yes ☐ No

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

8. Cognitive Impairment / Delirium

Think Delirium

Do 4AT on all patients over 65 yrs

and

on patients of any age with one or more of the following:

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

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☐ Yes ☑ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☐ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☐ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☐ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☐ No If 'Yes obtain rectal swab and send to microbiology for CPE screen.

Rectal swab taken ☐ Patient refused ☐

0 Lifestyle

Smoking:

Are you a smoker ☐ ex-smoker ☐ never smoked ☐

If ex-smoker when did they stop? .....

If smoker how many cigarettes per day.....

If smoker, or recent ex-smoker, would they like to use nicotine replacement therapy to prevent withdrawal discomfort while in hospital? ☐ Yes ☐ No

If smoker, would they like to stop now with the support from stop smoking service? ☐ Yes ☐ No

If Yes refer to Smoking Cessation Service

Drugs: Does the patient use recreational drugs? ☐ Yes ☐ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

1 Admission Documentation Completed By

Name (Please PRINT):	Signature:
Designation:	Date:

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital:	Ward:
Date of Assessment: / /	Time:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

1. Breathing and Circulation

Breathing:

- [x] No symptoms or history of respiratory problems
- [ ] Dyspnoeic at rest
- [ ] Dyspnoeic on minimal exertion
- [ ] Dyspnoeic on maximum exertion
- [ ] Productive / non-productive cough evident
- [ ] Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- [ ] No symptoms
- [ ] known high blood pressure
- [ ] known angina
- [ ] current chest pain

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

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

.....

Interpreter: Required [ ] Not required [x]

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? [ ] Yes [x] No

b. A learning disability e.g. Down's Syndrome? [ ] Yes [x] No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted: [ ] Yes [x] No

c. A learning difficulty e.g. dyslexia, dyspraxia? [ ] Yes [x] No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- [ ] Normal vision
- [ ] Glasses – [ ] Distance [x] Reading
- [ ] Prosthesis – [ ] Left [ ] Right
- [ ] Contact lenses
- [ ] Registered blind

Hearing

- [x] Normal
- [ ] Hearing impaired
- [ ] Hearing aid – [ ] Left [ ] Right

4. Cognitive Status

Cognitive Status:

- [x] Orientated
- [ ] Confused
- [ ] Distressed
- [ ] Aggressive /Abusive
- [ ] Known dementia
- [ ] Unconcious

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

	Initial

5. Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutrition Profile completed ☑ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a.1 Food likes / dislikes:
Not fussy

5a.2 Fluid likes / dislikes:
Not fussy

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☑ No
If 'Yes' specify diet needed:

5c. Help needed with eating and drinking:
☐ Yes ☑ No
If 'Yes' provide details:

5d. Texture Modified Diet needed?
☐ Yes ☑ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

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

	Initial

6. Elimination

Continent:	Incontinent:	NHS GGC Stool Chart commenced:
☑ Bladder ☐ Bowel	☐ Bladder ☐ Bowel	☐ Required ☑ Not required

Long-term urinary catheter in situ? ☐ Yes ☑ No
If Yes is it urethral ☐ suprapubic ☐
If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☑ No ☐ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools
Has IBS

Stoma: ☐ Yes ☑ No
If 'Yes' please specify and list appliances used:

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

	Initial

7. Personal Hygiene, Oral Health and Skin Assessment

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Personal hygiene:
☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent	☑ Yes	☐ No
Does the patient have a sore mouth	☐ Yes	☑ No
Does the patient have a non healing mouth ulcer	☐ Yes	☑ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway).

Dentures:
Does the patient wear a denture plate?
☐ Yes ☑ No

If yes complete the following:
☐ Full set ☐ Upper set ☐ Lower set
☐ Dentures with patient on admission

Skin assessment:
☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☐ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

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

	Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☐ Yes ☐ No

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

	Initial

9. Maintaining a Safe Environment

Pain status:
Does the patient have pain? ☑ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:
Migraine - on analgesia

Bed rail assessment completed: ☑ Yes ☐ No

Bed rails required:
☐ Required ☑ Not required

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

	Initial

0 Sleep and Rest

Sleep habits:
- ☐ Less than 8 hours
- ☐ Afternoon nap
- ☐ Morning nap

Sleep difficulties:
- ☑ None
- ☐ Disturbed e.g. nocturia, insomnia
- ☐ Early wakening

Medication required: ☐ Yes ☐ No

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

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

	Initial

1 Social Circumstances

- ☐ Employed ☑ Unemployed ☐ Retired
- ☐ Health problems at work
- ☐ Lives alone
- ☑ Lives with Family
- ☐ Friend
- ☐ Dependants
- ☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:
- ☐ Social Services

Unpaid carer ☐ Yes ☐ No
If Yes are they Partner / Friend / Son / Daughter
What kind of care do they provide?:

- ☐ Private Carers
- ☑ None

If support services in place, please provide details:

Does the patient have any money worries? ☐ Yes ☑ No
If Yes would the patient like to be referred to a money advice service that can offer confidential advice / support?
☐ Yes ☐ No
If Yes please identify date patient referred: ...../...../.....
Would the patient like a referral to a service that can support them with employment / education/training/skills /volunteering
☐ Yes ☐ No
If Yes please identify date patient referred: ...../...../.....

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

	Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?
☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
☐ Yes ☑ No ☐ Not at this time

If 'Yes' please specify faith group:

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

Is the **patient** aware of their:

Diagnosis? ☐ Yes ☐ No

Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:

Diagnosis? ☐ Yes ☐ No

Prognosis? ☐ Yes ☐ No

Preferred place of care:

Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:

Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No

If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT):

Signature:

Designation:

Date:

Clinical Notes

Date and Time	Notes	Name, Signature and Designation

Clinical Notes continue on next page

Name:.....

Address:.....

.....

DoB:.....

CHI number:.....

Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation

Emergency Department Nursing Documentation

Presenting Complaint - Headache

Date - 18/7/17 **Time –**

Assessment Complete by: Name NURSE (Please Print) _____

Patient Prep / Investigations (Please tick 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)	☐
12 Lead ECG	☐	ID Band	☐
Weight :	☐	Peak Flow	☐
Blood Samples Obtained : YES ☐ NO☐		Xrays / CT Scan Performed:	☐
IV Access : YES ☐ NO☐		Relatives / NOK informed	☐
Blood Gas : VBG☐ ABG☐			

Urinalysis

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

Screening Tools (Please 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	**Time –**	
AMT 4 (> 65 YEARS) 1) Age 2) DOB? 3) Current Year 4) This Place?	/4 score	**Date –** **Signature -**	
At risk of falls? (clinical judgement) (consider alcohol, mobility, age, illness, cognitive impairment etc) *If at risk complete risk assessment*	Y/N	Child Protection Concern (considered in line with policy)	Y/N
		Adult Support and Protection	Y/N

Screening Tools / ACTIVE CARE (Please tick 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**			
			4) Nutrition – Does the person appear malnourished and / or unable to eat or drink?		Y/N
2) Mobility - Does the person require assistance?		Y/N	**5) Skin** – Is skin compromised by other source, eg. Neurological deficit, medication, substance, diabetes, co-morbidities?		Y/N
3) Continence – Does the person have continence issues with urine and / or faeces?		Y/N	**6) Judgment** – In your clinical judgment, is this person at risk of developing pressure damage? If YES – Details		Y/N

Patient Addressograph Label

Pause for Transfer / Discharge (Please tick when completed)		Tick when completed	N/A	Notes
Relatives informed of Admission / Discharge		☐	☐	Information on discussion with relatives
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 patient's medications)		☐	Always	Please note here if any other tasks required prior to transfer
SAS Transport REQ / REF No		☐	☐	
Print Name Sign –				

Nursing Notes

Date & Time		Print Name & Signature

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐
NURSING ☑

Please tick ✔ appropriate directorate

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow. Lanarkshire
G69 7EP

Date & Time	Nursing Day	Signature, Print Name & Designation
19/07/17	Ward 10 - GRI	
1320	44 year old female transferred from AAU having presented with a frontal headache	*ALLERGY TO PENICILLIN*
	* Patient has had gradual onset since Friday of headache getting gradually worse.	
	PMH - Chronic pancreatitis 2° gall stones - Anxiety + depression.	
	SH - Lives with daughter - Indep with ADL's - Current smoker (5cpd) - Normal diet + fluids - No alcohol. - Allergy to penicillin	
	Imp - ① Chronic migraine - ② CSF leak	
	Plan - DIW Neuro ☑ (PTO) - High flow O2 ☑ Trauma mask in situ. - Sumitryptan - Analgesia.	

83949 GGC0072

Date & Time		Signature, Print Name & Designation
	* Medics have discussed patient with neuro. Plan - Aspirin 900mg today with 10mg metoclopramide - Sumatriptan 50mg ø - Long term → prophylaxis with amitriptyline initially 10mg nocte + titrated up by 10mg weekly to max of 60mg - 75mg / day. - Neurology advises post LP headache / CSF leak highly unlikely given history.	K DEVINE K Devine (RGN)
20/7/17 02-25	MEDICATIONS ADMINISTERED AS PER KARDEX OBSERVATIONS AS CHARTED IN NEWS. MOBILISING TO TOILET INDEPENDENTLY. DIET & FLUIDS TOLERATED BEFORE GETTING. FEELS MUCH BETTER THAN PREVIOUSLY WAS. NO NEW CONCERNS AT THIS TIME. RECLINE CHECKS MAINTAINED OVERNIGHT	[signature] CSI
20/07/17 11:40	Nursing Day * OB's as Charted - NEWS score (3) due to SpO2 of 93% and Temp 35.7°C * Medication as per Kardex * Patient independent with all ADL's * Patient states she	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - MEDICAL ☐ NURSING ☑

Please tick ✔ appropriate directorate

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Date & Time		Signature, Print Name & Designation
	feels a lot better, headache resolved * Deemed fit for discharge. * Cannula removed * Daughter will collect meds and IDL later.	KDevine KDevine(RN)

83949.GGC0072

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 19/7/17

Attach Addressograph Label

Deborah Sullivan.

Ward: 10

NHS Greater Glasgow and Clyde

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

1. Signed ..... Name: THALSTED ..... Designation ... CN .....
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

.....

USE FOLLOWING CODE:

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

		Times	10 50	12 45	18 30	21 00
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A	S	N	N	N/A
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)	S	I	I	I
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	S	I	I	✓
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)	S	I	I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	S	B	B	–
		Chiar Assist to walk, stand or tilt (W /ST/ T)	S	W	W	W
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	S	I	I	I
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)	S	N	N	N
		Encourage the patient to drink? Y / N / N/A	S	Y	Y	Y
		Food, snack or supplement taken Y / N / N/A	S	Y	Y	N
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	S	Y	Y	Y
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S	S	NT	NT	NT
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A	S	na	na	N/A
		Nurse Initials	ND	MS	MP	AL

Attach Addressograph Label

Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 28/7/17

Attach Addressogr

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Ward: 10

NHS Greater Glasgow and Clyde

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

1. Signed ..... Name: ..... Designation ..... (SN)
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

.....

USE FOLLOWING CODE:

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

			Times	02 30																
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A		N/A																
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)		I																
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		✓																
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)		I																
		Bed Right side (30° tilt) – **R** Left side (30° tilt) – **L** Back – **B**		-																
		Chiar Assist to walk, stand or tilt (W /ST/ T)		W																
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I																
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)		N																
		Encourage the patient to drink? Y / N / N/A		N																
		Food, snack or supplement taken Y / N / N/A		N																
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		✓																
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		N																
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A		N/A																
			Nurse Initials																	

Attach Patient Label

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Ward Glasgow, Lanarkshire
G69 7EP

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed

Acute Services Division

Hospital / Department GRI Ward 10

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: ... 0712726128 SULLIVAN Deborah F 07/12/1972 6

Ward: ..... 6 Muirhead Court Baillieston Glasgow Lanarkshire G69 7EP

CHI number: ..... Unit/Hospital number .....

Contents

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

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

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 19/07 Ward: 10	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			1						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		5						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		As below						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

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

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

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

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

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

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

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

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

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

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

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

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
19/07/17 KD	Independent with personal hygiene. Pressure relief as per PUDRA + SACP.	
19/07/17 KD	8. Mobility Fully mobile.	

Date Commenced and Signature	9. Maintaining a safe environment, Technical Care	Date Discontinued and Signature
19/07/17 KD	Patient given call bridger + explained.	
	10. Sleep and Rest	
19/07/17 KD	No issues noted.	
19/07/17 KD	12. Privacy, dignity and sexuality Always maintained	
	Negotiated care - Please record any planned involvement of patient/family in delivery of care	

mi • 285668 Version 1_0 • GGC0127

0712726128
SULLIVAN F
Deborah 07/12/1972

Perso) Moving and Handling Assessment Form

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

1. General

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 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

	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:	20/7/17		
Assessor's signature:			
Proposed Review date:	27/7/17		

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:			

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah 07/12/197
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EI

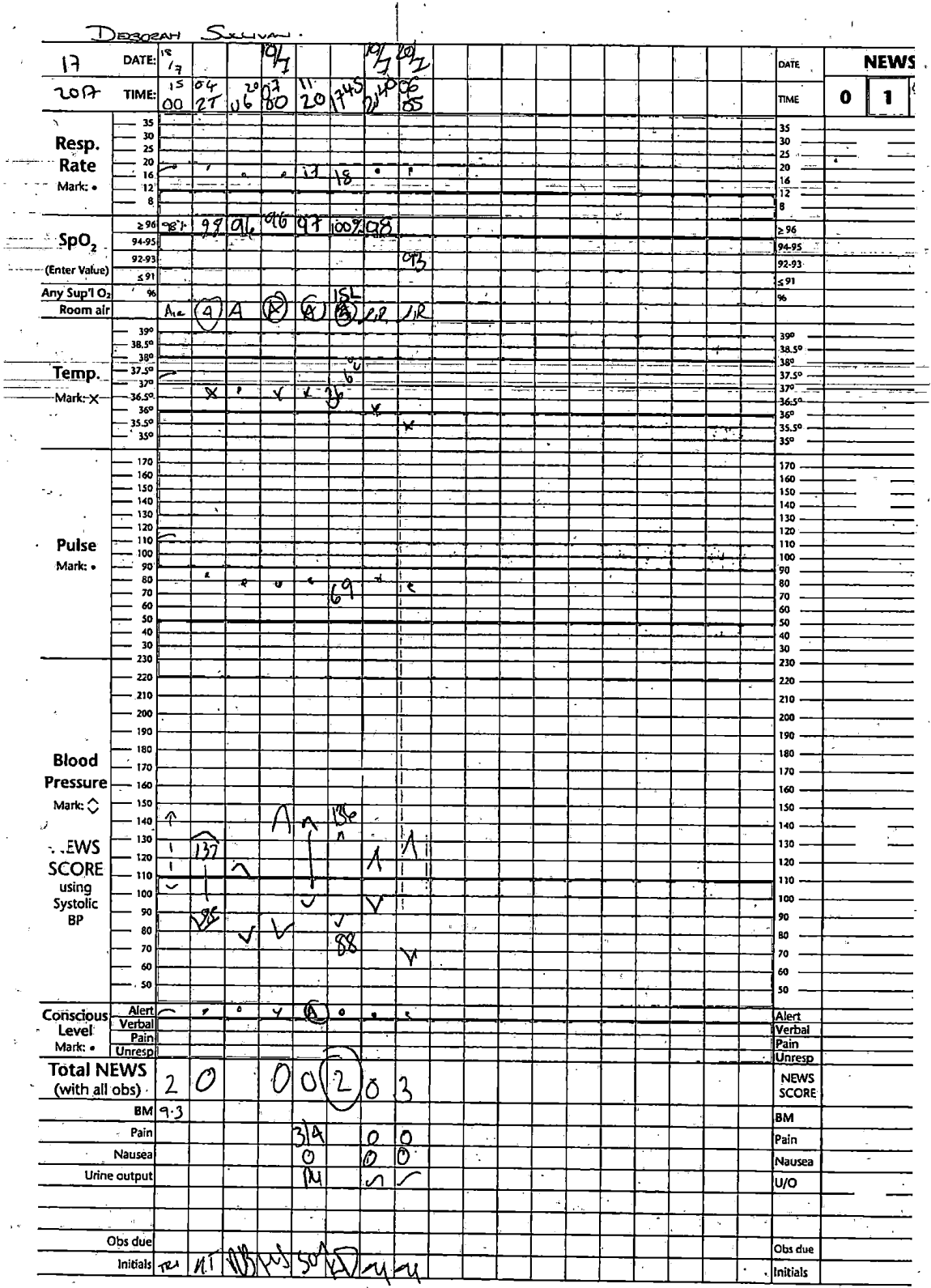
	Date	Ward
Admitted		
Transferred		
Transferred		

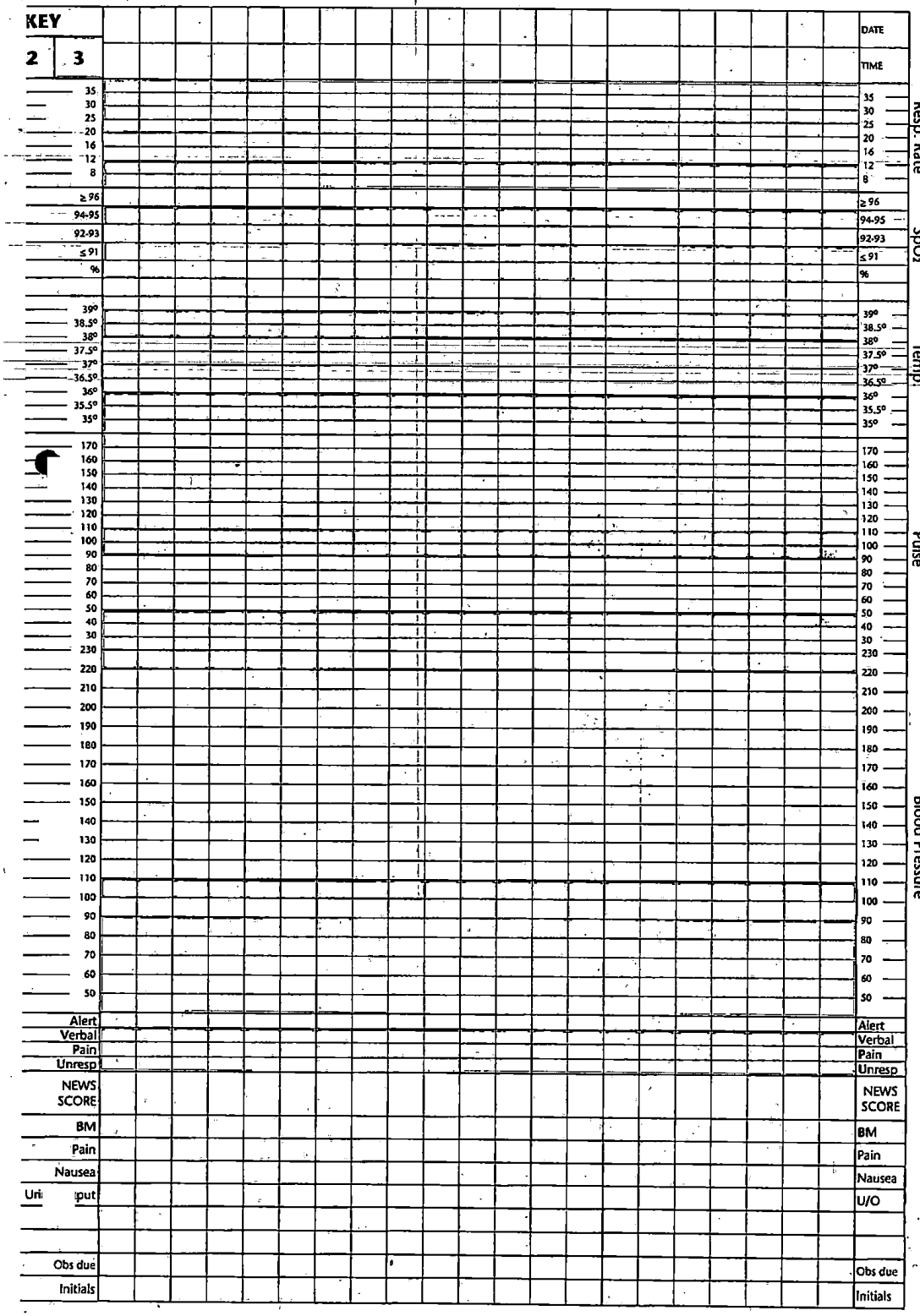
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic 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
DATE:
TIME:
NEWS
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
Alert
Verbal
Pain
Unresp
Total NEWS (with all obs)
BM
Pain
Nausea
Urine output
Obs due
Initials
NEWS SCORE
U/O


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
U/O
Obs due
Initials

Glasgow Coma Scale

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

0712726128
SULLIVAN
Deborah 07/12/197
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7E

Neurological Observations

| | | |

Nutrition Profile

NHS Greater Glasgow and Clyde

Name:	Date of admission: 19/7/17
Address: 0712726128 SULLIVAN F Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	Time:
DoB:	HOSPITAL: GRI
CHI number:	Ward: IU
Affix patient data	

To be recorded within 24 hours of admission*

Height: metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Food Allergies: Yes ☐ No ☐ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☐ If 'Yes' why?:

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental**? Yes ☐ No ☐

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☐

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☐

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): Signature: Date:

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')												
Date												
Initials												
Height (see page 1) ____ Weight												
Oedema or ascites present Y/N												
BMI (refer to chart on page 4)												
'MUST'												
Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2												
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2												
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0												
Step 4: Overall Risk of Malnutrition Total:												

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK – ***Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	MEDIUM RISK – ***Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK – ***Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

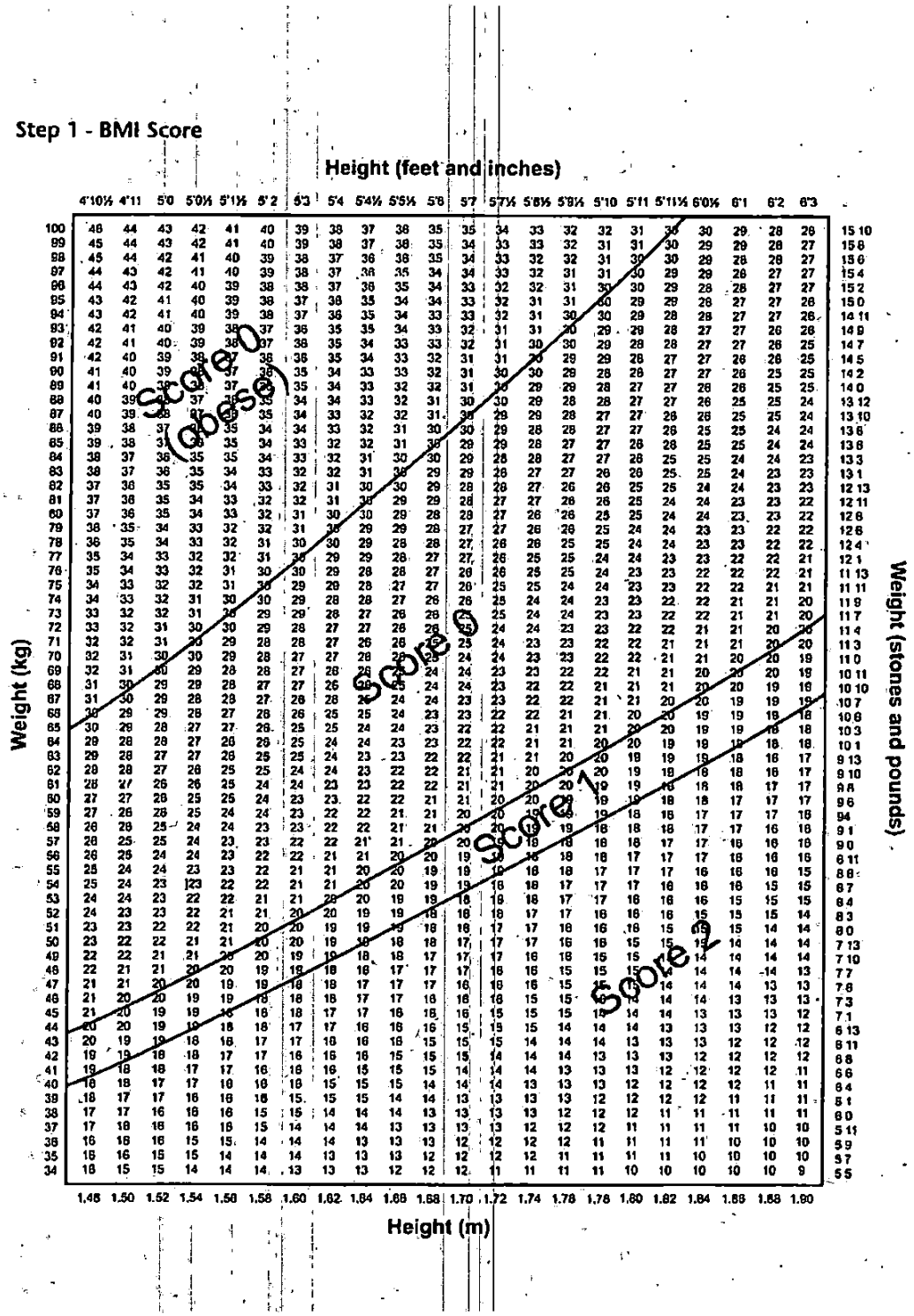
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 k	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Medical Illustration Services • 235261
STORES ORDER CODE 41850

Write or affix label

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP.

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer						
Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☐	Fluids ☑		Transfusion ☐
PVC inserted:	Date: 19/07/17	Hospital: GRI	ED ☐	Theatre ☐	ITU/HDU ☐	Ward ☑ AAU
Insertion site:	L Arm ☐	R Arm ☑	L Hand ☐	R Hand ☐	L Foot ☐	R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☑	Green ☐	White ☐	Grey ☐	Orange ☐

PVC 1 20/7/17	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 20/7/17	Yes ☑ No ☐	VIP: 0	Yes ☑ No ☐	Left in situ ☑ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___/___/___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

IVOS – consider changing from IV to oral

Write or affix label
Name:
Address:
CHI:
DOB:
Hospital & Ward:

Peripheral Vascular Cannula (PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer						
Clinical indication:	Diagnostics ☐	Resuscitation / Chest Pain ☐	IV Drugs ☐	Fluids ☐	Transfusion ☐	
PVC inserted:	Date: / /	Hospital: _____	ED ☐	Theatre ☐	ITU/HDU ☐	Ward ☐ _____
Insertion site:	L Arm ☐	R Arm ☐	L Hand ☐	R Hand ☐	L Foot ☐	R Foot ☐ Other
Colour of cannula:	Blue ☐	Pink ☐	Green ☐	White ☐	Grey ☐	Orange ☐

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 24 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 2 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours – review clinical reason and / or justify rationale for PVC to remain in situ; if not required consider removal.					
Day 4 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ___ / ___ / ___	Yes ☐ No ☐	VIP:	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

"'OS – consider changing from IV to or–'

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	Hospital: GRI Ward: 10	**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
19/7/17	15:00	N	N	N	N	N	N	6 hrly	
20/7/17	00:40	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 Interven nal Plan

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah F
6 Mulrhead Court 07/12/1972
Baillieston
Glasgow, Lanarkshire
G69 7EP

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:

NHSGGC Bedrail Risk Assessment

This Risk Assessment Tool is an aide memoire for staff. It should be used in conjunction with the Bedrails Algorithm (see reverse) and Guidelines for Prevention and Management of Falls (Adults). This document does NOT replace the need for clinical judgement.

0712726128
Patient Name: SULLIVAN Deborah F 07/12/1972
Ward: 6 Muirhead Court Baillieston
CHI Number: Glasgow, Lanarkshire G69 7EP

NHS Greater Glasgow and Clyde

Use algorithm on the reverse of this document when completing this Risk Assessment	DATE 19/07									DATE		
SECTION ONE	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Is the patient at risk of climbing out of bed or trolley?		✓										
Is the patient agitated or confused?		✓										
Does using bedrails present a higher risk to the patient than falling out of bed?		✓										
SEE ALGORITHM ON REVERSE FOR GUIDANCE												
SECTION TWO												
Has an alternative to bedrails been considered? i.e. see bedrails algorithm box 2			✓									
Is the patient likely to roll, slip or slide from the bed?	✓	✓										
Has the patient been consulted regarding the use of bedrails?	✓											
Does the patient understand the purpose of bedrails? Consider communication difficulties and physical/ cognitive condition.	✓											
Has the decision to use or not use bedrails been discussed with relatives / carers		✓										
Has the patient / relatives been given a copy of the bedrail information leaflet		✓										
IF YES, TO ANY OF SECTION 2, THEN BEDRAILS MAY BE APPROPRIATE HOWEVER, CONSIDER THE FOLLOWING POINTS												
SECTION THREE												
Is the patient small in stature?		✓										
Does the patient have an unusually large or small head?		✓										
When bedrail fitted is there a gap between the lower rail and mattress?		✓										
Are there large spaces between the bars of bedrails		✓										
Does the bedrail move away from the side of the mattress when in use?		✓										
Will the bedrail fall off the bed?		✓										
Will any of above create an entrapment hazard?		✓										
IF YES TO SECTION 3 BEDRAILS ARE NOT APPROPRIATE												
SECTION FOUR												
The gap between the bedrail and the headboard must be less than 60mm or greater than 250mm	✓											
Has the bedrail been fitted correctly?	✓											
Is the bedrail secure?	✓											
Is the bedrail compatible with the bed frame it will be fitted to?	✓											
Are the bedrails used in good working order?	✓											
Does the patient have access to the call buzzer at all times?	✓											
If pressure relieving overlay mattress, or air filled mattress in use, are extra height bedrails fitted?			✓									
If Bariatric bed in use is compatible extra wide mattress fitted?			✓									
SECTION FIVE - DECISION MAKING												
Has the decision been made to use bedrails?												
State rationale for using or not using bedrails												
Bedrails fitted and/or checked by												
Date												

Bedrails Algorithm

Rationale for the completion of the NHS GG & C Bedrails Risk Assessment

Is the patient at risk of falling from bed/trolley?
NB: for patients at risk of climbing over bedrails, alternatives must be considered. See boxes 2+3.

Yes

Patient understands purpose of the bedrails

- Patient consents to bedrail use → Bedrails could be used with caution. See boxes 1 + 3 below.
- Patient declines bedrail use → Bedrails inappropriate see boxes 2+3

Patient does not understand purpose of bedrails due to ...

- Communication difficulties → Consider:
  - Referral to appropriate speciality e.g. Audiology
  - Use of interpreter
  - Use of written or pictorial information
- Physical and/or cognitive condition → Consider actions in patient's best interest. See boxes 1, 2 + 3 below. → Agree plan of care with Next of Kin (if appropriate) and document outcome in nursing records.

No

- Patient requests bedrails → Bedrails could be used with caution. See boxes 1 + 3 below.
- Patient not requesting bedrails → Bedrails inappropriate see boxes 3

1. If bedrails are used consider:

- Risk of entrapment and harm to limbs
- Risk of patient climbing over the top
- The psychological effect of bedrails to the patient
- Use of air filled mattresses or mattress overlays require extra height bedrails
- Bariatric beds must be used with a compatible extra wide mattress.

2. Alternatives to bedrails

- Move patient to observable area to maximise supervision
- Bed Monitor (see criteria)
- Ensure bed returned to lowest height after care delivery
- Ensuring patient needs anticipated e.g. drinks are accessible, regular toileting, call bell to hand etc
- Nursing patient on mattress on the floor should be a last resort and safety checks should be made for hot pipes, trailing wires, electric sockets etc. Moving & handling risk assessment for staff must be completed
- Contact Hospital Falls Prevention Coordinator for advice

3. Remember to document in nursing records:

- Date and time assessment made
- Patient & NOK given bedrails information leaflet
- Rationale for decision made in care plan
- Where bedrails are considered appropriate and the patient has declined their use.
- Actions taken, including discussion with Next of Kin
- Care planning and reviews

Assessment should be made:

- On admission
- If patient's condition changes
- Daily / weekly depending on the situation

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 12-1-17

At ... Addre

0712726128
SULLIVAN
Deborah
6 Mulrhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

F
07/12/1972

Ward:

NHS Greater Glasgow and Clyde

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

1. Signed. Leanne Name: CARMICHAEL Designation S/N
2. Signed..... Name:..... Designation.....
3. Signed..... Name:..... Designation.....

Individual patient needs: Red mat required: Y / (N) Bed Rails: Y / (N)
'Must do's' for me. Ask the patient if there is anything they want specifically done today:
NO THANKS

USE FOLLOWING CODE:

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

			Times	4 08	12 16
	1	Pain: assess and address If in pain inform registered nurse Y / N or N/A		N	N
S	2	SKIN INSPECTION Pressure areas checked: Y / N or I (Independent)		I	I
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		—	—
K	3	KEEP MOVING: Have you moved or walked Y / N or I (Independent)		I	I
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		—	—
		Chiar Assist to walk, stand or tilt (W /ST/ T)		—	—
I	4	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I
N	5	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N
		Encourage the patient to drink? Y / N / N/A		Y	Y
		Food, snack or supplement taken Y / N / N/A		Y	Y
	6	ENVIRONMENT: Check: Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y
	7	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		Y	Y
	8	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		N/A	N/A
		Nurse Initials		LA	LA

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 13/01/17

Attach Ac [barcode]
0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Ward: Glasgow, Lanarkshire
G69 7EP

NHS Greater Glasgow and Clyde

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

1. Signed C. Cun ..... Name: C. Cun ..... Designation SN .....
2. Signed J Bell ..... Name: ABell ..... Designation S/N ...
3. Signed ..... Name: ..... Designation .....

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

USE FOLLOWING CODE:

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

			Times	08:00	11:45	16:45	20:45	05:30											
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A		Y	Y	Y	Y	Y	Y										
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)		I	I	I	I	I	I										
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		INT	INT	INT	INT	INT	INT										
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)		I	I	I	I	I	I										
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		B	B	X	–	B	B										
		Chiar Assist to walk, stand or tilt (W /ST/ T)			I	X	W												
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		I	I	I	I	A											
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	N	N	N										
		Encourage the patient to drink? Y / N / N/A		Y	Y	Y	Y	Y	Y										
		Food, snack or supplement taken Y / N / N/A		Y	Y	N	Y	Y	Y										
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y	Y	Y										
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		Y	N	N	N	N	N										
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A		N/A	N/A	N/A	N/A	N/A	N/A										
		Nurse Initials		EA	CB	JMD		DCB											

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed
3/04/17	09:00	7	Advised to use nurse call buzzer when mobilising	[illegible]

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 14/01/14

Attach Addressograph

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

NHS Greater Glasgow and Clyde

Ward: 65

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

1. Signed C. Name: C. Designation SN
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

.....

USE FOLLOWING CODE:

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

| | | | Times | | |

Attach Addressograph Label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 15/1/17

Attach Addressograph Label
Deborah Sullivan
7/12/72
Ward: 6B

NHS Greater Glasgow and Clyde

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

1. Signed ..... Name: ROBINSON ... Designation SCW ...
2. Signed ..... Name: S MEHAGAN ... Designation SIP ...
3. Signed ..... Name: ..... Designation .....

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

USE FOLLOWING CODE:

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

		Times	02 00	06	10 12	20	01	05												
	1	Pain: assess and address If in pain inform registered nurse Y / N or N/A	Y	Y	Y	Y	Y	S												
S	2	SKIN INSPECTION Pressure areas checked: Y / N or I (Independent)	I	I	I	I	I	S												
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	-	-	-	/	INT	S												
K	3	KEEP MOVING: Have you moved or walked Y / N or I (Independent)	I	I	I	I	I	S												
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	-	-	-	R	B	S												
		Chiar Assist to walk, stand or tilt (W /ST/ T)	-	-	-	/	/	S												
I	4	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	I	S												
N	5	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N	N	N	N	N	S												
		Encourage the patient to drink? Y / N / N/A	Y	Y	Y	Y	Y	S												
		Food, snack or supplement taken Y / N / N/A	N	N	N	N	N	S												
	6	ENVIRONMENT: Check: Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	Y												
	7	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S	N	N	N	NT	NT	S												
	8	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	N/A	N/A	N/A	N/A	N/A	S												
		Nurse Initials	SC	CR																

Attach Addressograph Label

NHS

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 16/1/17

Attach Address
0712726128
SULLIVAN F
: Deborah 07/12/1972

NHS Greater Glasgow and Clyde

Ward: 65

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

1. Signed... Name: ... Designation ... SN
2. Signed... Name: S. Mclaggan Designation ... SN
3. Signed... Name: ... Designation ...

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

USE FOLLOWING CODE:

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

		Times	10⁰⁰	12⁰⁰	15⁰⁰	18⁰⁰	21⁰⁰	23⁰⁰	01⁰⁰									
	1	Pain: assess and address If in pain inform registered nurse Y / N or N/A	Y	Y	Y	Y	Y	Y	S									
S	2	SKIN INSPECTION Pressure areas checked: Y / N or I (Independent)	I	I	I	I	I	I	S									
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)	INT	INT	INT	INT	INT	INT	S									
K	3	KEEP MOVING: Have you moved or walked Y / N or I (Independent)	Y	Y	I	I	I	I	S									
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	X	X	X	X	R	R	S									
		Chiar Assist to walk, stand or tilt (W /ST/ T)	X	X	X	C	/	/	S									
I	4	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	A	A	S									
N	5	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)	N	N	N	N	N	N	S									
		Encourage the patient to drink? Y / N / N/A	Y	Y	Y	Y	Y	Y	S									
		Food, snack or supplement taken Y / N / N/A	Y	Y	Y	Y	N	N	S									
	6	ENVIRONMENT: Check: Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	Y	Y									
	7	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S	N	N	N	N	N	N	S									
	8	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A	N/A	N/A	N/A	N/A	N/A	N/A	S									
		Nurse Initials	AS	AS	AS	AS	AS	AS	AS									

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 17/1/17

Attach Addressc
0712726128
SULLIVAN
Deborah
F
07/12/1972

Ward: 65

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the ~~next~~ work shift, based on the patients' most critical need should be every (please circle) 1hr (2hr) 3hr 4hr 6hr

1. Signed ..... Name: S. MCLEAN Designation SN
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

.....

USE FOLLOWING CODE:

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

			Times	03	05	07	09	11	13	14	16	18	20							
	1	Pain: assess and address If in pain inform registered nurse Y / N or N/A		S	S	N	Y	N	N	Y	Y	N	Y							
S	2	SKIN INSPECTION Pressure areas checked: Y / N or I (Independent)		S	S	I	I	I	I	I	I	I	I							
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		S	S	/	/	/	/	INT	INT	INT	INT							
K	3	KEEP MOVING: Have you moved or walked Y / N or I (Independent)		S	S	N	Y	Y	Y	Y	Y	Y	I							
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	S	B	B	B	B	R.	B	B	B							
		Chiar Assist to walk, stand or tilt (W /ST/ T)		S	S	/	/	/	/	X	/	/	/							
I	4	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		S	S	A	A	A	A	A	A	A	I							
N	5	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		S	S	N	N	N	N	N	N	N	N							
		Encourage the patient to drink? Y / N / N/A		S	S	Y	Y	Y	Y	Y	Y	Y	Y							
		Food, snack or supplement taken Y / N / N/A		S	S	Y	Y	N	Y	Y	Y	Y	Y							
	6	ENVIRONMENT; Check: Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y							
	7	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		S	S	N	N	N	N	N	N	N	N							
	8	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		S	S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A							
			Nurse Initials	SK																

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 18/1/17

Attach A

0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP
F
07/12/197

Ward: 65

NHS Greater Glasgow and Clyde

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

1. Signed BUARD ..... Name: BWard ..... Designation SN .....
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

.....

USE FOLLOWING CODE:

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

			Times	06	10-00	12 00	14 55	17 05											
	1	Pain: assess and address If in pain inform registered nurse Y / N or N/A		S	4	4	2	2											
S	2	SKIN INSPECTION Pressure areas checked: Y / N or I (Independent)		S	1	1	1	1											
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		S	INT	INT	INT	INT											
K	3	KEEP MOVING: Have you moved or walked Y / N or I (Independent)		S	1	1	1	1											
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	–	–	–	–											
		Chiar Assist to walk, stand or tilt (W /ST/ T)		S	–	–	–	–											
I	4	ELIMINATION: Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		S	1	1	1	1											
N	5	FOOD, FLUIDS AND NUTRITION: Is the patient nil by mouth? Y / N (consider mouth care)		N	N	N	N	N											
		Encourage the patient to drink? Y / N / N/A		Y	Y	Y	Y	Y											
		Food, snack or supplement taken Y / N / N/A		Y	Y	Y	N	Y											
	6	ENVIRONMENT: Check: Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y	Y											
	7	INFORMATION: Ask: Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		N	N	N	N	N											
	8	ESCALATION: Escalate any issues to the Registered Nurse Y / N/A		NA	NA	NA	NA	NA											
			Nurse Initials	B	BD	BD	BD	BD											

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 19/1/17

Attach Addressogr

0712726128
SULLIVAN F
2 Deborah 07/12/197:
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EF

Ward:

NHS Greater Glasgow and Clyde

I have evaulated and deemed that the frequency of care delivery over the ~~next~~ work shift, based on the patients' most critical need should be every (please circle) 1hr **2hr** 3hr 4hr 6hr

1. Signed BUATWO ..... Name: BRIDGE ..... Designation SN .....
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

.....

USE FOLLOWING CODE:

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

			Times	06	08.00	12.00	16.00														
	1	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A		S	Y	Y	Y														
S	2	**SKIN INSPECTION** Pressure areas checked: Y / N or I (Independent)		S	N	N	N														
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		S	I	I	I														
K	3	**KEEP MOVING:** Have you moved or walked Y / N or I (Independent)		S	I	I	I														
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B		S	-	-	-														
		Chiar Assist to walk, stand or tilt (W /ST/ T)		S	-	-	-														
I	4	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces		S	I	I	I														
N	5	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)		S	N	N	N														
		Encourage the patient to drink? Y / N / N/A		S	Y	Y	Y														
		Food, snack or supplement taken Y / N / N/A		S	Y	Y	Y														
	6	**ENVIRONMENT: Check:** Is the patients' call buzzer to hand? Is the area clutter free, clean and safe? Doe's the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S		Y	Y	Y	Y														
	7	**INFORMATION: Ask:** Is there anything else I can help you with? Inform patient of the time of return Y/N/O/S		N	N	N	N														
	8	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A		N/A	N/A	N/A	N/A														
			Nurse Initials	BA	BC	BC	BC														

Attach Addressograph Label

Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 20-1-17

Attach Addressograph Label
Deborah Sullivan

Ward: 20-21 - G.R.I

NHS Greater Glasgow and Clyde

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

1. Signed ..... Name: Ann Smith Designation SN
2. Signed ..... Name: ..... Designation .....
3. Signed ..... Name: ..... Designation .....

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

USE FOLLOWING CODE:

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

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

Attach Addressograph Label

Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet – Care Number

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

Date	Time	Number	Variation	Signed

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

NHS
Greater Glasgow and Clyde

Unit No.:

Date:		13/1	13/01	14/01	15/01	17/01	17/01	18/1	19/1				
Time of Result:		10:00	0707	0622	06[illegible]11	0713	0709	1[illegible]59					
WCC	4-11	10.3	8.1	8.6	8.1	7.4	8.5	7.0	7.2				
Hb	M - 13-18 F - 11.5-16.5	133	117	118	121	123	119	119	120				
Plat	150-400	308	232	244	270	241	265	255	270				
Amylase	<100	66	55		[illegible]			62	68				
CRP	<10	4	9	9	6	4	3	3	3				
[illegible]	135-145	140	141	142	142	142	139	140	139				
[illegible]	3-5-50	4.7	3.9	3.7	4.2	3.8	4.0	4.1	3.7				
Cl-	98-108	109	109	106	107	107	104	104	104				
Bic	21-28												
Urea	2.5-7.5	3.1	2.9	2.9	2.0	2.3	2.9	3.4	3.4				
Creat.	57-113	68	54	55	56	54	53	50	57				
EGFR	60>	>60	>60	>60	>60	>60	>60	>60	>60				
Glucose	3.5-5.5	5.2											
Bilirubin	3-22	4	8	4	3	3	4	4	4				
ALT	<50	20	18	17	18	16	19	19	24				
AST	<40	21	20	17	15	14	18	19	21				
G-GT	<55												
Alk. Phos.	40 -150	60	54	58	59	63	58	62	65				
Albumin	32-45	37	32	33	33	32	32	32	30				
Mg^+				0.93	1.00	0.96	0.85	0.81	0.86				
Ca	2.1-2.6		2.10	2.15	2.09	2.13	2.16	2.21	2.23				
Adj Ca	2.1-2.6		2.21	2.24	2.18	2.24	2.27	2.32					
PO4	0.7-1.4		1.14	1.06	1.04	1.13	1.22	1.38	1.21				
PT	9-12	10/0.9	11/1.0	10/0.9			10/0.9						
APTT	25-37	26/0.8	32/1.0	30/0.9			33/1.0						
TCT	11-15	12/1.0	13/1.0	13/1.0			12/0.9						
	CK						<70						

MIS 238455/GRI

Microbiology Results Sheet

Name: CHI:

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

URINARY ELECTROLYTES
URINARY PH

Acute Services Division

Hospital / Department GRI

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

Patient name: 0712726128 SULLIVAN Deborah F 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Ward: 67

CHI number: Unit/Hospital number

Contents

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

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

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

FALL @17.25 - Fall's Board

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 12-1 Ward: 67	Date: 12/1 Ward: 65	Date: 15/11 Ward: 65	Date: 17/11/17 Ward: 65	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0	2	2	1+2			
Sex	Male 1	Female 2				2	2	2	2			
Age	13-59 0	60-70 1	71-80 2	81+ 1		0	0	0	0			
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0	0	0	2			
Medication type **	Medication for mental illness & drug / alcohol withdrawal 1	Blood pressure / water tablets 1	Sedatives / Analgesia / Night sedation 1	None of these 0		1	1	1	1			
Medical history	Cardiovascular Disease / Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0	0	0	0			
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chairbound / wheelchair 1		1	3	1	3			
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1	3	3	3+3			
				TOTAL SCORE		5	11	9	17			
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1,3,5	see below	1-6,7 8,23	1,2,3,4 8,14 22,23			
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE		[signature]	[signature]	[signature]	[signature]			

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

	NURSING INTERVENTIONS	Date: 12/1 Ward: L7	Date: 12/1 Ward: 65	Date: 12/1 Ward: 6 D	Date: 17/1/17 Ward: 65	Date: Ward:	Date: Ward:	Date: Ward:
Action code								
1	Falls prevention and general safety precautions discussed with patient and family.	✓	✓	✓	✓			
2	Move to more observable area of ward to optimise supervision.		✓	✓	✓			
3	Advise patient they may experience dizziness when they mobilise initially.	✓	✓	✓	✓			
4	Requires assistance with mobilisation.		✓	✓	✓			
5	Observe trip hazard due to invasive lines, drains and catheters.	✓	✓	✓				
6	Do not leave the patient unattended when using commode, toilet, in shower or the bathroom area.		✓	✓				
7	If patient is unable/unwilling to cooperate with intervention, advise medical staff and MDT.			✓				
8	Monitor lying and standing / sitting BP and pulse.			✓	✓			
9	A. Patient requires footwear or podiatry referral. (Date referred: / requested :) B. Request family / carer to provide suitable footwear.							
10	Commence continence assessment, follow Local Guidelines.							
11	Refer to Occupational Therapist.							
12	Select suitable seating (refer to policy).							
13	Non slip mat on chair /floor following advice from therapists.							
14	Refer to Physiotherapist.				✓			
15	Review Transfer techniques.							
16	Request medication review.							
17	Bed/chair monitor in use.							
18	Falls map in use for seven days for patient who has second or subsequent falls.							
19	Bed rails/bumpers to be used (refer to policy).							
20	Patient requires low bed / mattress on the floor (refer to policy.)							
21	Patient requires one to one nursing care.							
22	Refer to Hospital Falls Prevention Co-ordinator (see criteria on front cover).		✓	✓	Fsaw			
23	Other interventions. Nurse call Buzzer		✓	✓	✓			
	2 hrly active care		CP		Fte			

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

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

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

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

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

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

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

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

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

Patient 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
12-1-17	Needs assistance washing & dressing		12-1-17	Nurse call to hand. Arrange to see.	
				10. Sleep and Rest	
				Promote rest	
	8. Mobility				
	Mobile Independently.	16/1/17		12. Privacy, dignity and sexuality	
16/1/17	Mobile with assistance of 1 nurse -			NO ISSUES.	
	Has fallen x2 on ward				
				Negotiated care - Please record any planned involvement of patient/family in delivery of care.	

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

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
12-1-17	Observations charted	~~12-1-17~~	12-1-17	Getting well	
	News 0				
				5. Hydration and Nutrition	
				Soft diet	
	2, 3. Communication and senses				
	Speaks English				
	Communicates freely				
	Wears glasses reading				
				6. Elimination	
	4. Cognitive status			Suffers from IBS	
	Alert & orientated			passing urine spontaneously	

Acute Services Division

NHS
Greater Glasgow and Clyde

Hospital / Dept: GRI

Falls Map - 7 Day Assessment Chart

Patient name:	CHI number:	Ward:
	Unit/Hospital number:	

0712726128 F
SULLIVAN
: Deborah 07/12/1972

Instructions:

- Record all falls for a seven-day period.
- Select the appropriate box according to the day and time of the fall.
- Place the appropriate letter in the box selected from the Area Fall Occurred.

Area Fall Occurred: T = Toilet Co = Corridor
Ch = Chair O = Other
B = Bed

Date commenced: 16/1/17	Date discontinued:

	AM												PM											
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Mon																								
Tue																								
Wed																								
Thurs																								
Fri								✓																
Sat																								
Sun																								

FALLS RECORD

Date	Time	Place	Signature	Date	Time	Place	Signature

Lying and standing blood pressure

Please take the patient's lying/ standing blood pressure (early a.m. best) as follows:

1. Patient lying flat for > 5mins. Take BP.
2. Stand patient up. Take blood pressure immediately (0 mins).
3. Keep patient standing for 2 minutes.

Take BP at the end of one and then two minutes standing.

4. In the chart below, record symptoms at each level i.e.
   - a = Dizziness / feels faint
   - b. = Visual disturbance
   - c = Loss of consciousness
   - d = Unsteady

Date	Time	Lying BP	Any symptoms?	Standing BP (0 mins)	Any symptoms?	Standing BP (1 min)	Any symptoms?	Standing BP (2 mins)	Any symptoms?
REQUIRES MONITORING?	**YES ☐ NO ☐**								

Fluid Balance Chart

0712726128
SULLIVAN
Deborah F
6 Muirhead Court 07/12/1972
Baillieston
Glasgow, Lanarkshire
G69 7EP

Hospital: GRI
Ward: 6S.
Date: 18/1/17

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

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

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output							Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type			
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT								OUTPUT	
00:00																		
01:00																		
02:00																		
03:00																		
04:00																		
05:00																		
06:00																		
07:00	Tea	200							200	Po								
08:00																		
09:00	Water	200							400									
10:00	Water	150							550	Po								
11:00																		
12:00	Tea	200							750									
13:00										Po								
14:00	Water	200							950									
15:00																		
16:00									1150									
17:00	Milk	200								Po								
18:00																		
19:00	Water	200							1350									
20:00																		
21:00																		
22:00																		
23:00																		
								*Total Intake	1350						*Total Output			

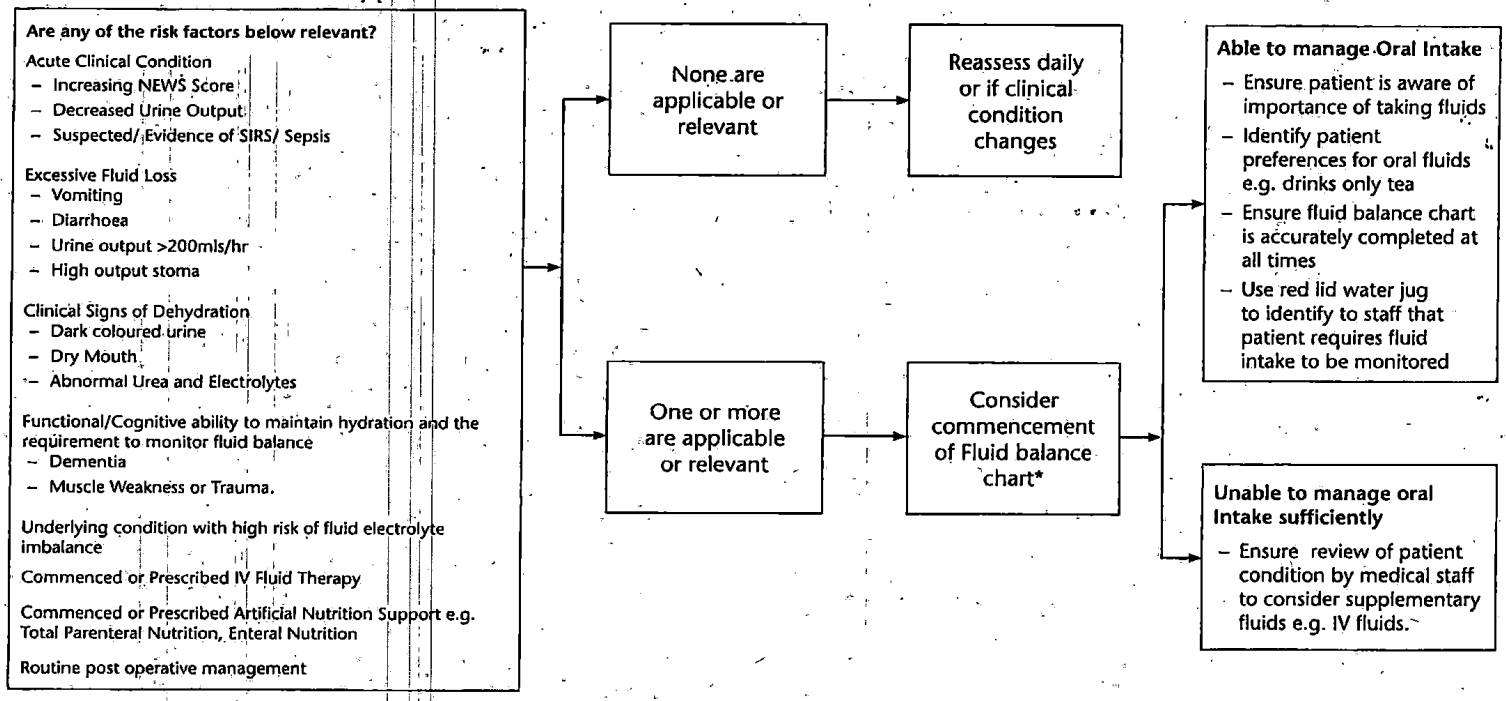
*Transfer Total Intake/Total Output/24hr Fluid Balance to Cumulative Fluid Balance on back of Food, Fluid and Nutrition Profile.

*24 hr Fluid Balance +/-

220665

Guide to commencing fluid balance charts

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



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

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

MIS • EDU • 237971-2

Fluid Balance Chart

N 0712726128
D SULLIVAN F
Deborah 07/12/197
6 Muirhead Court
Cl Baillieston
Glasgow, Lanarkshire
Affi G69 7EP

Hospital: GRI
Ward: 65
Date: 19/1/17

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

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

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

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
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]	

D/C

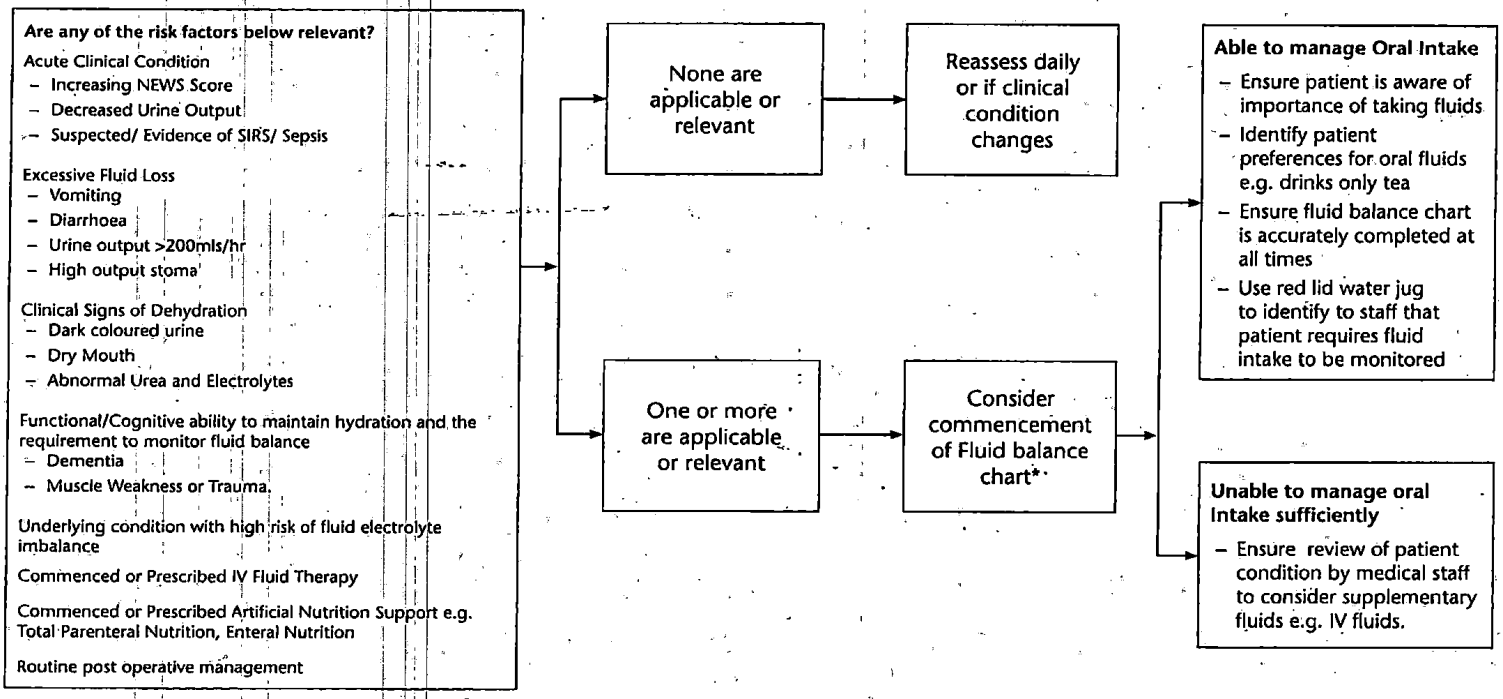
*24 hr Fluid Balance +/-

*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

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name	0712726128 SULLIVAN F
Address	Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire
CHI No.	G69 7EP
DoB	

	Date	Ward
Admitted		
Transferred	19/01/17	20/21
Transferred		

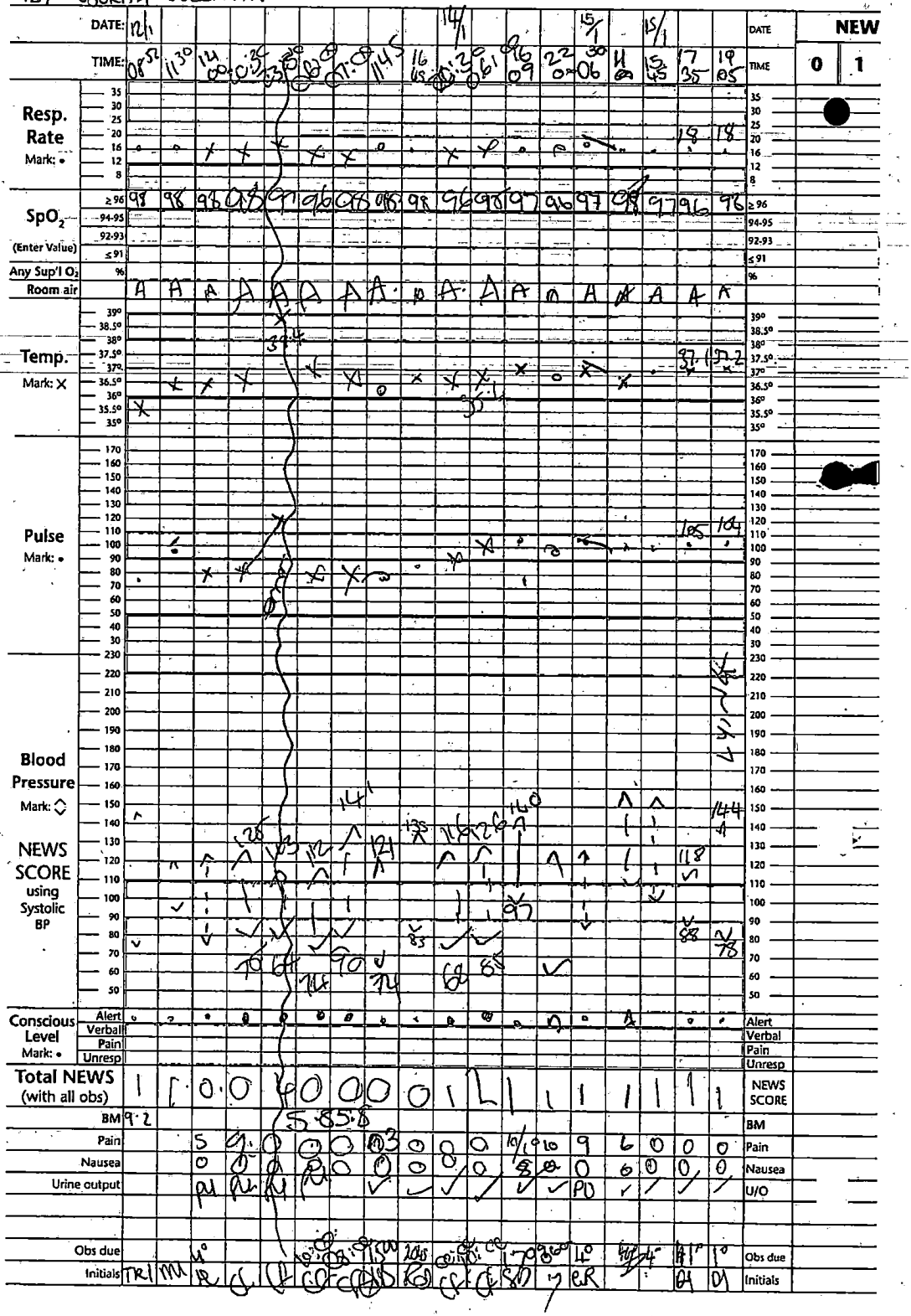
Physiological Parameter	NEWS – NHS Early Warning Score						
	3	2	1	0	1	2	3
Respiration Rate	≤8		9-11	12-20		21-24	≥25
Oxygen Saturations	≤91	92-93	94-95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0°		35.1-36.0°	36.1-38.0°	38.1-39°	≥39.1°	
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
Systolic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

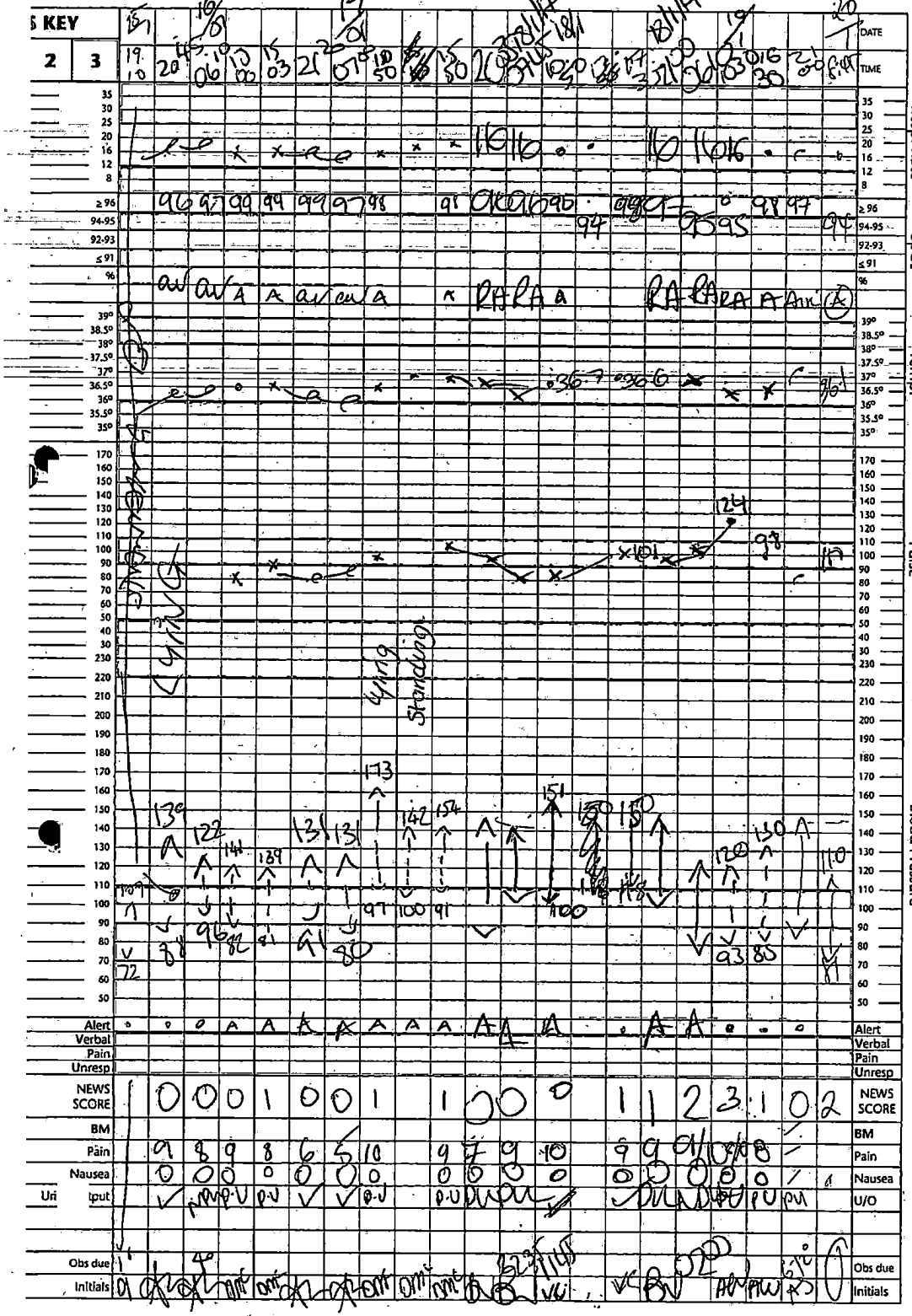
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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.

12/ DEBORAH SULLIVAN




KEY
2
3
DATE
TIME
Resp. Rate
SpO2
Temp.
Pulse
Blood Pressure
Standing
Alert
Verbal
Pain
Unresp
NEWS SCORE
BM
Pain
Nausea
Urine output
U/O
Obs due
Initials

Glasgow Coma Scale

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

0712726128
SULLIVAN F
Deborah 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

Neurological Observations

| | | |

Nutrition Profile

NHS Greater Glasgow and Clyde

Nam 0712726128	Date of admission: 12/1/17
Add SULLIVAN F Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	Time: 14.00
DoB	HOSPITAL: GRI
CHI number:	Ward: 67
Affix patient data label	

To be recorded within 24 hours of admission*

Height: 172 metres Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 91.15 kg Actual ☑ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☑

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☑ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☑ No ☐

Please state: Soft diet

Food Allergies: Yes ☐ No ☑ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☑ If 'Yes' why?:
Likes most foods	Tea	

Are there any contributing factors that may affect food intake such as physical (e.g. swallowing difficulties, loose teeth), physiological (e.g. nausea), psychological (e.g. dementia), social or environmental? Yes ☐ No ☑

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☑

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☑

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☑

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☑

Profile completed by: Name (PRINT): LCARMICHAEL Signature: Date: 12-1-17

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐
If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	12/1/17											
Initials	LL											
Height (see page 1) 172 Weight	91											
Oedema or ascites present Y/N												
BMI (refer to chart on page 4)	30											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days..... Score 2 Not applicable..... Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	LOW RISK – ***Routine Clinical Care*** • Repeat screening. Hospital Acute ..... once .....Weekly Hospital Rehabilitation .....Monthly
1	MEDIUM RISK – ***Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	HIGH RISK – ***Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

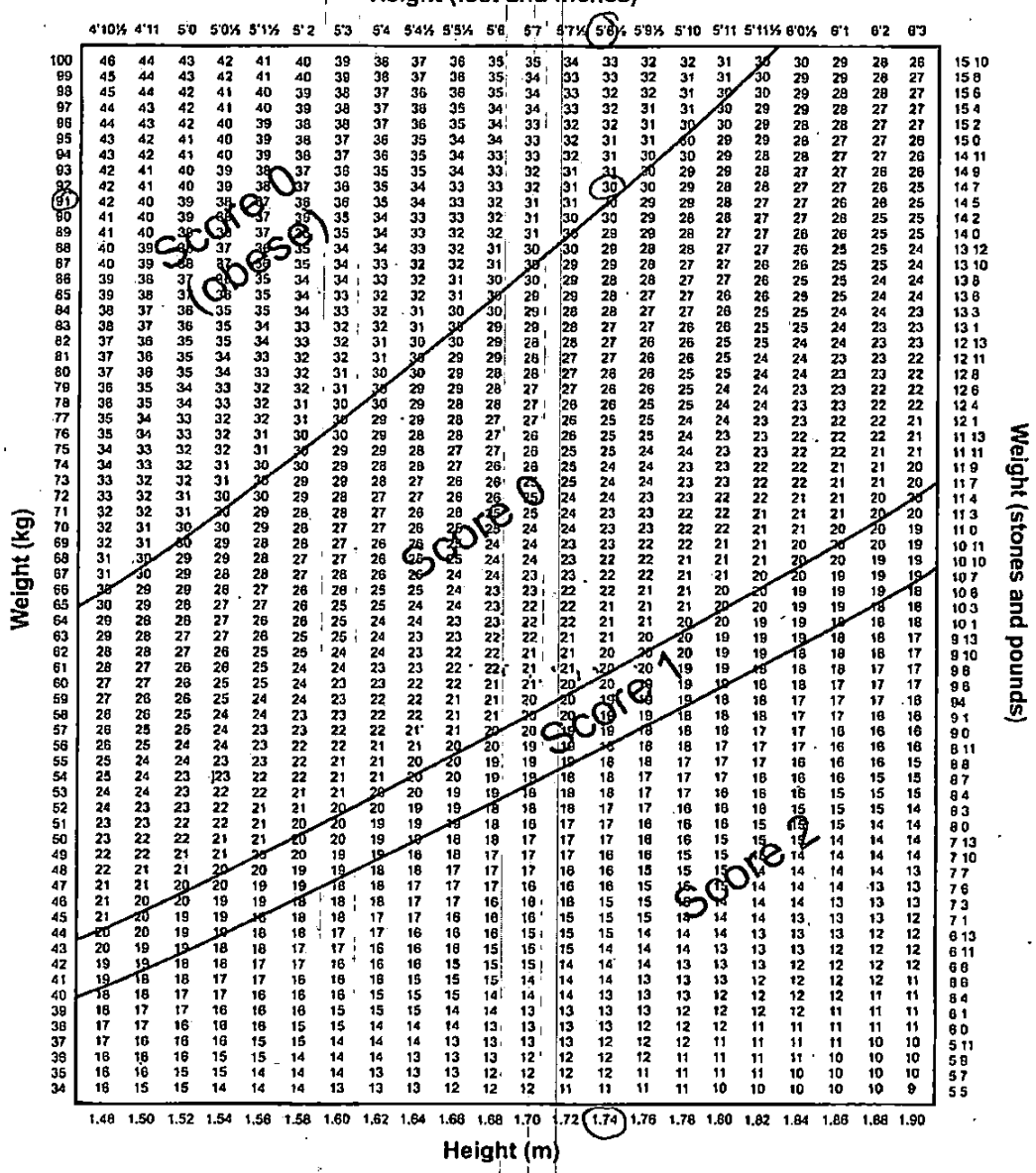
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Medical Illustration Services • 235261 GGC0045
STORES ORDER CODE 41850

Pressure Ulcer Daily Risk Assessment (PUDRA)

NHS Greater Glasgow and Clyde

0712726128 SULLIVAN F Deborah 07/12/1972 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	Hospital: GRI Ward: 67	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:
12/1/17	14:00	N	N	N	N	N	N	4 hrly	
13/1/17	11:45	N	4	N	N	N	N	3 hrly	
/ /	:							hrly	
/ /	:							hrly	
16/1/17	15:40	N	N	N	N	N	N	2 hrly	
17/1/17	14:30	N	[illegible]	N	N	N	N	2 hrly	
18/1/17	18:35	N	4	N	N	N	N	2 hrly	
19/01/17	21:30	N	N	N	N	N	N	6 hrly	
20/01/17	00:10	N	N	N	N	N	N	6 hrly	
21/1/17	0m	N	N	N	N	N	N	6 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..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 INCONTINENCE / MOISTURE	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of initial plan: 18/1/17	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: ASOX1	• 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 ☐	JLS 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:

0712726128
SULLIVAN
Deborah
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP
07/12/1972

Specific (Inpatient) Moving and Handling Assessment Form

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

1. Client Information

Body Build		Problems with comprehension, behaviour, co-operation (specify):
Weight	Height	
91.15 Kg	174 cm	Handling constraints, e.g. disability, weakness, pain, skin lesions, infusions (specify):
30 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 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

	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:	12-1-17		
Assessor's signature:	[signature]		
Proposed Review date:	19-1-17		

Continuation Sheet

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

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			
	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:			

0712726128
SULLIVAN
Deborah F 07/12/1972
6 Muirhead Court
Baillieston
Glasgow, Lanarkshire
G69 7EP

NHS Greater Glasgow and Clyde

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

Insertion – Tick appropriate answer

Clinical indication: Diagnostics ☑ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☑ Transfusion ☐

Insertion site: L Arm ☑ R Arm ☐ L Hand ☐ R Hand ☐ L Foot ☐ R Foot ☐ Other:

Date: 12/1/17 Time: 12:00

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 12/1/17	Yes ☐ No ☐	V.I.P: 0	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 24 hours - review clinical reason and/or justify rationale for PVC to remain in situ; if not required consider removal.							
Day 2 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours - review clinical reason and/or justify rationale for PVC to remain in situ; if not required consider removal.							
Day 4 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date removed _____ Reason for PVC removal _____ Reason PVC in greater than 72 hours _____

Date & time	Comments	Signature

[redacted] [redacted]

Write or affix label

Name:
Address:

CHI:
DOB:
Hospital & Ward:

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

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	

NHS Greater Glasgow and Clyde

Insertion – Tick appropriate answer

Clinical indication: Diagnostics ☐ Resuscitation/Chest Pain ☐ IV Drugs ☐ Fluids ☐ Transfusion ☐

Insertion site: L Arm ☑ R Arm ☐ L Hand ☐ R Hand ☐ L Foot ☐ R Foot ☐ Other:

Date: [redacted] **Time:**

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 [redacted]	Yes ☐ No ☐	V.I.P: 0	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	[redacted]
After 24 hours - review clinical reason and/or justify rationale for PVC to remain in situ; if not required consider removal.							
Day 2 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After 72 hours - review clinical reason and/or justify rationale for PVC to remain in situ; if not required consider removal.							
Day 4 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 ...../...../.....	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	Comments	Signature

Acute Services Division

Discharge Checklist

NHS Greater Glasgow and Clyde

Patient's n 0712726128 Unit numb SULLIVAN F : Deborah 07/12/1972 CHI numb 6 Muirhead Court Baillieston Glasgow, Lanarkshire G69 7EP	Ward: 20/21 Discharge destination: Home Estimated Discharge Date (1) / / Estimated Discharge Date (2) / / Final date of discharge : 20/1/17

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

Acute
Assessment Unit

NHS
Greater Glasgow and Clyde

Nursing
Documentation

Nam
Addr 0712726128
SULLIVAN F
Deborah 07/12/1972
DOB: 6 MUIRHEAD COURT
BAILLIESTON
CHI n Glasgow, Lanarkshire
G69 7EP
Affix patient data label

Mental Health Tool Assessment Stage one

Hospital: GRI

Date: 18.11.15 Time: 12.15

Triage Nurse: Katy Rooney

Transport SAS Self

Presenting Complaint

- 1/7 vomitting, looked like bile today
Painkillers not taken ~~tonight~~ or last night. RUQ pain
~~R sided~~, radiating to back

Entinox given by SAS

Chronic Pancreatitis
Gallstones 1996

Investigations

gies (including food allergies), No known allergies ☐ ID Band ☐

Penicillin

ives present Y/N Interpreter required Y/N

TEMP	PULSE	BLOOD PRESSURE	RESPIRATION	SaO2
36.5	74	126/82	20	96
D GLUCOSE	PEFR	NEWS SCORE	CATEGORY	GAP SCORE

ve Impairment - For all patients greater than 65 years, ask the following 4 AMT questions.

How old are you? ..... years

What is your date of birth? /

What is this place? .....

What year is it? .....

Score: ..... out of 4

Acute Assessment Unit

Nursing Documentation

NHS Greater Glasgow and Clyde

Name .....

Address .....

.....

DOB: .....

CHI number .....

Affix patient data label

Named Nurse/Team Leader: Raby/Wendy

Assessment Completed by: Name (PLEASE PRINT) KRooney

Patient Preparation

Prepare patient for examination	☑	IV Cannula (if required)		(Y)/N
Clothing bag labelled and stored	☑	Blood samples taken		(Y)/N
		If Y list requests	Amylase	
12 Lead ECG	☑	Cardiac Monitoring		Y/N
Xrays performed	☐	Height:	Weight:	☐

Urinalysis

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

Peripheral Venous Cannula Care Bundle

Reason for PVC Insertion

☑ IV fluids

☐ drugs

☐ Suspected haemorrhage

☐ Diagnostic tests

Insertion Date: 18/11/15

Insertion Time: 11.40

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

Size/Colour: pink Insertion site: _____

Signature: _____

Urinary Catheter

Reason for Insertion

Insertion Date: ___/___/___

Insertion Time: ____:____

Signature: _____

Hand hygiene performed immediately before PVC insertion.	☐
Skin antiseptic containing 70% isopropyl alcohol used to cleanse skin and left to dry.	☐
Aseptic technique maintained throughout insertion procedure.	☐

Size: _____

Acute
Assessment Unit

Nursing
Documentation

NHS
Greater Glasgow and Clyde

Name .....
Address .....
.....
DOB: .....
CHI number .....
Affix patient data label

Red Flags (Requires escalation / Vascular referral / Separate Risk Assessment)

Child Protection concern	☐	Learning Disabilities	☐
Adult Support and Protection	☐	Patient has Appointed Welfare Guardian/Power of Attorney	☐
Confused Patient	☐	Patient has Adult with Incapacity Section 47 certificate in place.	☐
Substance Misuse	☐	Infection Risk	☐
Has swallow test been carried out?	☐	STOPPS completed?	☐
Systemic inflammatory response syndrome (SIRS)	☐	Falls risk? (*If at risk, complete full Cannard Risk Assessment*)	☐

Pressure Ulcer Risk Assessment

Fully independent/independent using stick or other aid.	Yes/No	Fully continent	Yes/No.
Well nourished, able to eat and drink	Yes/No	Skin inspected and intact	Yes/No

If no to any questions commence with SSKIN Care Bundle:

Record of Fundamental Nursing Care (Complete every patient contact and document every 2 hours)

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

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Communication with Relatives — Signature — Time

Next of Kin:

Acute
Assessment Unit

Nursing
Documentation

NHS
Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah F
6 MUIRHEAD COURT 07/12/1972
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Nursing Notes

Date and Time		Print Name and Signature
18.11.15 13.40	Prepared for examination, ECG NAD. Bloods taken. PVC insitu. IV fluids running. Seen by SNP Mcdermid, likely acute pancreatitis. S/C morphine given. Currently being reviewed by SHO. ~~MC&NAM~~ Urine positive for nitrates and protein - MSSU sent. No further issues at present.	Lily Henry SN
1425	For transfer to ward 67, now seen by SHO.	Chris SN

cute
ssessment Unit

ursing Documentation

NHS
Greater Glasgow

Name .....

Address .....

DOB: .....

CHI number .....

Affix patient data label

Relatives informed	☐	☐	Information on discussion with relatives
Cannula	☐	☐	
Name band	☐	☐	
AMT4	☐	☐	
NEWS chart	☐	Always	
Infusions	☐	☐	
Drugs	☐	☐	
Fluids	☐	☐	
GMAWS	☐	☐	
Belongings (including patient's medications)	☐	Always	Please note here if any other tasks required prior to transfer
Bed requested, accepted and ward informed	☐	Always	
Notes: medical notes, GP letter, PRF	☐	Always	
CXR reviewed	☐	☐	Print name
ECG reviewed	☐	☐	
Bloods sent	☐	☐	
Bloods reviewed	☐	☐	
Patient on O_2: cylinder checked	☐	☐	
Patients requiring analgesia: sufficient	☐	☐	

Advice leaflets given	☐	☐	Information on discussion with relatives
Belongings (including patient's medications)	☐	Always	
New medications explained	☐	☐	
Cannula Removed	☐	☐	
Relatives Aware of Discharge	☐	☐	Please note here if any other tasks required prior to discharge
Social/ Support Services required & contacted	☐	☐	
SAS Transport required & ref no	☐	☐	Print name
Other means of transport arranged by nurse	☐	☐	

Acute
Assessment Unit

Nursing
Documentation

NHS
Greater Glasgow
and Clyde

Name .....
Address .....
.....
DOB: .....
CHI number .....
Affix patient data label

Nursing Notes

Date and Time		Print Name and Signature

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Hospital: GRI	Ward: 67
Date of admission: 18/11/15	Time: 1445
Admitting Consultant: MR CLOUG	Admitting Nurse: S/N STEVENSON
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): KATHLEEN SULLIVAN
Age: 42	Relationship: MOTHER
Religion:	NoK Address:
Telephone: 07936225898	
GP:	NoK Telephone: 237 1145
Dr. JJ Langan Mcglone Practice Baillieston Health Centre 20 Muirside Road baillieston Glasgow G69 7AD	NoK Aware of admission: ☐ Yes ☑ No
	Consent for information to be given to relatives: ☐ Yes ☑ No
	Nominated family contact:
	Telephone - Day:
	Telephone - Evening:

Is the patient a carer? ☐ Yes ☑ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☑ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☑

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

1/7 DAY HISTORY EPIGASTRIC PAIN RADIATING THROUGH TO BACK, NAUSEA + VOMITING

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

3. Allergies (including food allergies)

No known allergies: ☐ PENICILLIN (RASH)

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
4	3	0	80	126/79	16	97%	36.2
Urinalysis: Trace Protein -VE. not sent BHCG		AMT4 Score	BM	NEWS Score	Weight Estimated / Actual	Height Estimated / Actual	BMI
		N/A	N/A	0	79.8	5'10"	26

5. Current Medication

SEE KARDEX

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

CHRONIC PANCREATITIS
CHOLECYSTECTOMY, LAP RESECTION
ANXIETY & DEPRESSION, ALCOHOL EXCESS, DIAPHRAGMATIC HERNIA
PREVIOUS SUICIDE ATTEMPTS

7. Risk Assessment

MUST

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

   Score 0
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score 0
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:

   Score = 2

   Not applicable: Score = 0

   Score 0

MUST Score: 0

If score 1 or more, complete full Nutrition Profile

0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

F
07/12/1972

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... N/A ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade .....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☑ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If 'Yes' to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☑ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☑ Yes ☐ No

If 'Yes' how many per day: E-Cig

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have 8 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have 6 or more drinks on one occasion:

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

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT): S. STENSON	Signature:
Designation: S/N	Date: 18/11/18

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Name: .....
0712726128
SULLIVAN F
Deborah 07/12/1972

Hospital: GRI	Ward: 65
Date of Assessment: 8/11/15	Time: 1500

1. Breathing and Circulation

Breathing:

- ☐ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☐ Dyspnoeic on minimal exertion
- ☑ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details: .....

Circulation:

- ☑ No symptoms
- ☐ Known cardiac or circulatory problems

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

Initial: S

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

ENGLISH

Interpreter: Required ☐ Not required ☑

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☑ No

b. A learning disability e.g. Down's Syndrome?
☐ Yes ☑ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.
Liaison Learning Disability Team contacted:
☐ Yes ☑ No

c. A learning difficulty e.g. dyslexia, dyspraxia?
☐ Yes ☑ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- ☐ Normal vision
- ☑ Glasses – ☐ Distance ☑ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☑ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☑ Orientated
- ☐ Confused
- ☐ Distressed
- ☐ Aggressive /Abusive
- ☐ Unconcious

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

Initial: S

5. Hydration and Nutrition

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

MUST Score: ..... **If score is 1 or more, complete a Nutrition Profile.**

Nutition Profile completed ☐ Yes ☑ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:
NIL

5a 2. Fluid likes / dislikes:
NIL

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☑ No
If 'Yes' specify diet needed:

5c. Help needed with eating and drinking:
☐ Yes ☑ No
If 'Yes' provide details:

5d. Texture Modified Diet needed?
☐ Yes ☑ No
If 'Yes' specify texture: A☐ B☐ C☐ D☐ E☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1☐ 2☐ 3☐

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

Initial

6. Elimination

Continent:
☑ Bladder
☑ Bowel

Incontinent:
☐ Bladder
☐ Bowel

NHS GGC Stool Chart commenced:
☐ Required ☐ Not required

Long-term urinary catheter in situ? ☐ Yes ☑ No If 'Yes' – Size: ..... fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☑ No ☐ Not applicable

Containment products in use? Please specify:

☑ Bowels regular
☐ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☑ No
If 'Yes' please specify and list appliances used:

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

Initial

7. Personal Hygiene, Oral Health and Skin Assessment

A 0712726128
SULLIVAN
Deborah
07/12/1972
F
D
CI
...patient data label

Personal hygiene:
☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:
Self-caring and independent ☑ Yes ☐ No
Does the the patient have a sore mouth ☐ Yes ☑ No
Does the patient have a non healing mouth ulcer ☐ Yes ☐ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:
☐ Required ☑ Not required

Dentures:
☑ Not worn
☐ Upper set
☐ Lower set
☐ Full set
☐ Dentures with patient on admission

Skin assessment:
☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy
If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☑ Not applicable
Pressure ulcer evident: ☐ Yes ☐ No
If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

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

Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.
☐ Limited mobility
☐ Mobile with aid – Specify:
☐ Prosthesis – Specify:

Moving and Handling Plan commenced:
☑ Yes ☐ No

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

Initial

9. Maintaining a Safe Environment

Pain status:
Does the patient have pain? ☑ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:
☐ Required ☑ Not required

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

Initial

10. Sleep and Rest

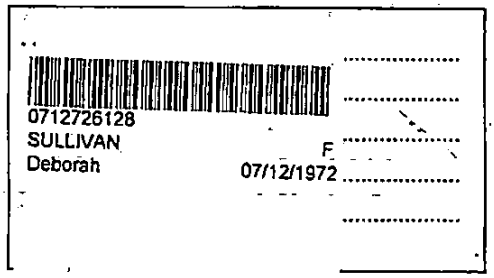
Sleep habits:

☑ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☐ Disturbed e.g. nocturia, insomnia
☐ Early wakening

Medication required: ☐ Yes ☑ No



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

	Initial

11. Social Circumstances

☐ Employed ☑ Unemployed ☐ Retired
☐ Lives alone
☑ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☑ None

If support services in place, please provide details:

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

	Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission?
☐ Yes ☑ No

If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)?
☐ Yes ☑ No

If 'Yes' please provide brief details:

Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of?
☐ Yes ☐ No

If 'Yes' please provide brief details:

Ask the patient:
"Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?"
☐ Yes ☐ No ☐ Not at this time

If 'Yes' please specify faith group:

0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

F
07/12/1972

14. Anticipatory Care
(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☑

Is the patient aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the patient's family aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:	Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐	Home: ☐ Hospital ☐ Hospice ☐
Current treatment – please identify (e.g. chemotherapy/ radiotherapy):	Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☐ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT): S. STEENSON
Signature:
Designation: SIN
Date: 18/11/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
18/11/15 1500	PATIENT ADMITTED FROM A&E	
	WITH H/X OF LVO/EMBOLIC	
	PNS VOMITING	
	FASTING AND IV FLUIDS	
	LFTS AWAITED ☐	SIN (SIGNATURE)
	CLEX and cytology for weeks	
W/C 16/11	S/B MISS THOMSET, CONTINUE IV FLUIDS	
	REPEAT BLOODS AS HAEMO-LYSED FOR LFTS/U+E	

Clinical Notes continue on next page

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
	INCREASE DOSE OF PBL	
	Morphine 10 mg S.C. c/o nausea IV cyclizine. c/o pain oramorph for pain.	
19/11/15	PBH - ABX (oral trimethoprim) - laxatives - PO dose PPI - regular bloods. (urea and lytes) (80)	
	Nausea MSSUD	
	flu and DIET as ABX	
	Oramorph for pain	
19/11/15	Ward round. Home today with Trimethoprim and Analgesia. Doctors will arrange follow up appointment — C Williamson	
19/11/15 12 15	Patient independant with all personal care and hygeine. Passing Urine. Observations	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Date & Time		Signature, Print Name & Designation
18/11/16 12.5	cont.: - Stable as charted News - 0. Medications administered as per Kardex. Fentanyl patch not given Patient states Rot due until 9pm tonight. Home today awaits discharge scpt — U	L. Williamson. L Williamson SN
19/11/16 13.05	Patients venflon and S/C line removed. Awaiting discharge — U	L Williamson SN
16.00	Patient discharged home To follow up as OPD clinic home on oral Trimethoprim	

193443

Glasg
0712726128
SULLIVAN
Deborah
F
07/12/1972

NHS
Greater Glasgow and Clyde

Nam
Unit No.:

Date:		18/11	18/11	19/11									
Time of Result:		12:10	19:21	07:06									
WCC	4-11	7.2		6.0									
Hb	M - 13-18 F - 11.5-16.5	128		115									
Plat	150-400	308		275									
Amylase	<100	NA	81	83									
CRP	<10	3		2									
Na+	135-145	140	140	140									
K+	3-5-50	4.2	4.2	4.0									
Cl-	98-108	111	111	(109)									
Bic	21-28												
Urea	2.5-7.5	5.6	4.6	4.3									
Creat.	57-113	58	57	62									
Glucose	3.5-5.5												
Bilirubin	3-22	5	6	8									
AST	<40	18	17	18									
ALT	<50	21	18	19									
G-GT	<55												
Alk. Phos.	40 -150	60	59	59									
Protein	60-80												
Albumin	32-45	30	36	35									
Globulin	22-33												
Ca	2.1-2.6			(2.19)									
Adj Ca	2.1-2.6			2.25									
PO4	0.7-1.4												
PT	9-12	12/1.0		13/1.0									
APTT	25-37	29/0.9		33/1.0									
TCT	11-15	12/0.9		13/1.0									
H+	35-45												
PO2	12-15												
PCO2	4.4-5.6 MM GFR			083									
HCO2	20-28			760									

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
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
CHI No. Glasgow, Lanarkshire
DoB G69 7EP

	Date	Ward
Admitted	16/11/16	
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

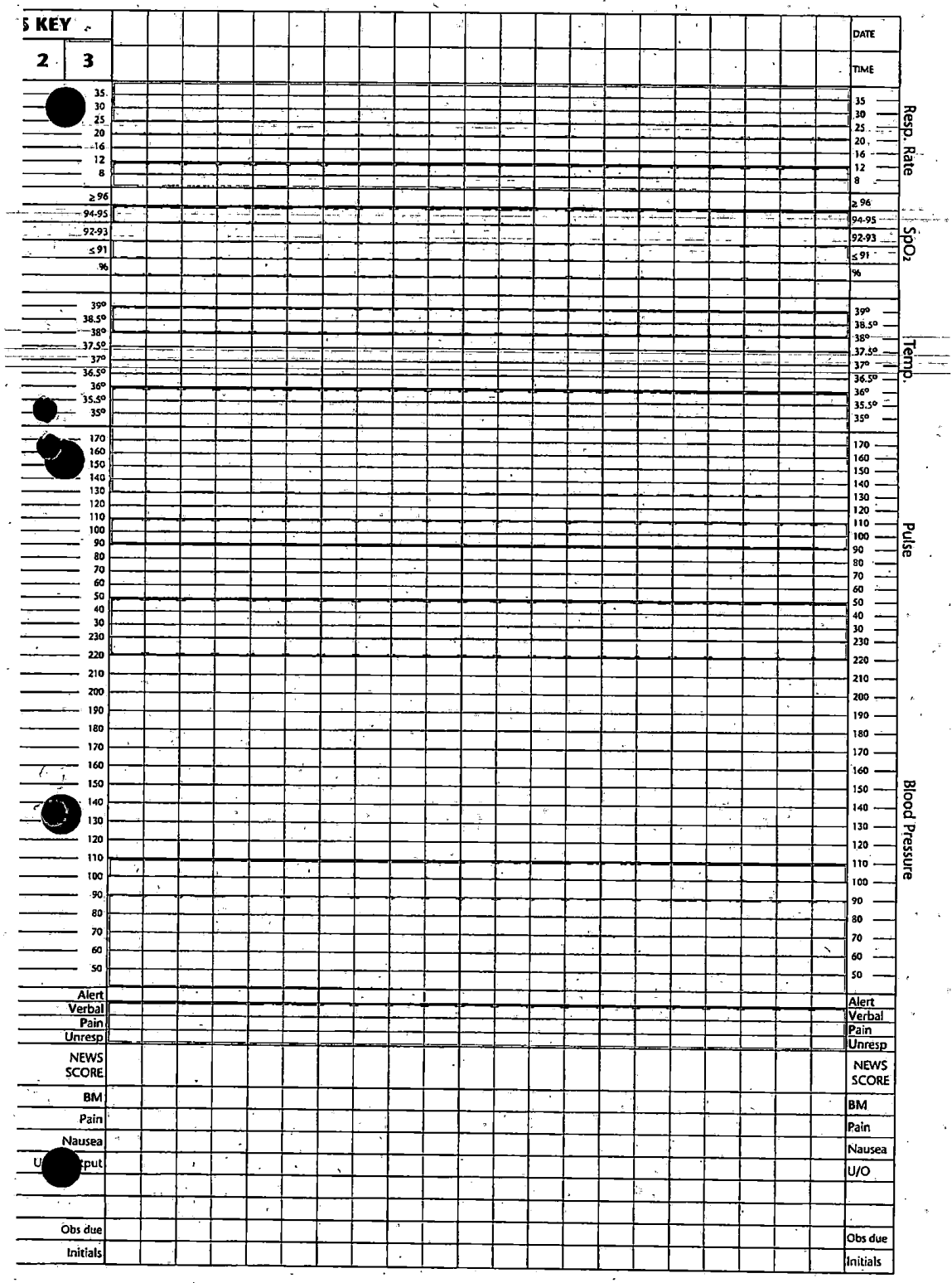
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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

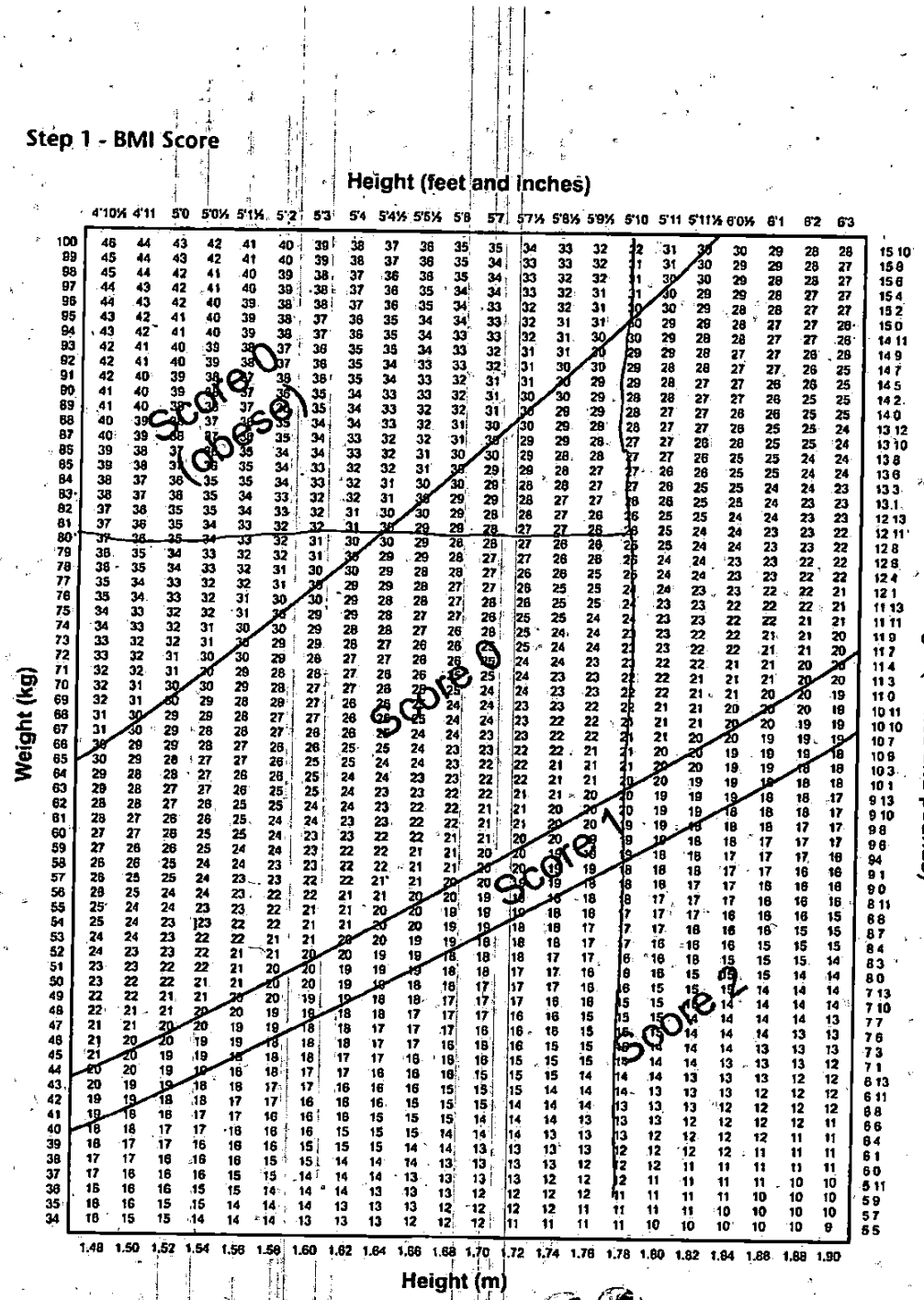
| | | |


S 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

Neurological Observations

| | | |

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3 kg	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Medical Illustration Services • 235261
STORES ORDER CODE 41850

Falls Assessment Care Plan

Please tick all applicable nursing interventions

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

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

Cl 0712726128 SULLIVAN Deborah F 07/12/1972 nt) Moving and Handling Risk Assessment Form

Patient's name:		Named Nurse:		If Patient is totally independent, tick here and go to date box		Risk: Low / Medium / High	

BODY BUILD			
Obese		Tall	
Above average		Medium	
Average	✓	Short	
Below average			

RISK OF FALLS			
High		Low	

Problems with comprehension, behaviour, co-operation (specify):

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

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)		ASSISTANCE		SUPERVISION		INDEPENDENT	
Model:		People: 1	2 3	Additional Information:			
Sling type:		Walking aid (specify)					
Sling size:							

Toileting

HOIST/STANDAID		ASSISTANCE		SUPERVISION		INDEPENDENT	
		People: 1	2 3	Additional Information:			

Move on / off bed pan

HOIST		MANEOUVRE		ASSISTANCE		SUPERVISION		N / A	
		Roll patient		People 1		Additional Information:			
		Monkey pole		People 2					
		Patient bridges		People 3					

Move up / down bed

HOIST		HANDLING AIDS		ASSISTANCE		SUPERVISION		INDEPENDENT	
		Sliding sheet		People 1		Additional Information:			
		Monkey pole		People 2					
		Rope ladder		People 3					

Transfer to / from trolley (or bed etc.)

HOIST		HANDLING AIDS		ASSISTANCE		SUPERVISION		INDEPENDENT	
		Patslide		People 1		Additional Information:			
		Other		People 2					
		Fabric sliding aid		People 3					

Sit up over side of bed

BED REST		ASSISTANCE		SUPERVISION		INDEPENDENT	
		People: 1	2 3	Additional Information (e.g. equipment to be used – swivel cushion):			

Into Bath or Shower

WHICH BATH		HANDLING AID		ASSISTANCE		SUPERVISION		INDEPENDENT	
Shower		Shower chair		People 1		Additional Information:			
Variable height bath		Bathing Hoist e.g. Alenti		People 2					
Bed bath		Sling lifting Hoist		People 3					

Walking

NO WALKING		WALKING AID (specify)		ASSISTANCE		SUPERVISION		INDEPENDENT	
				People 1		Distanced walked / Additional Information:			
				People 2					
				People 3					

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:	18/11/15		
Assessor's signature:			
Proposed Review date:			

05236

Continuation Sheet

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N / A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

Care Plan

0712726128
SULLIVAN
Deborah
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP
F
07/12/1972

NHS Greater Glasgow and Clyde

Commenced and Signature	[illegible] and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
18/11	4X DAILY TPR+BP+O2 SAT		18/11	TOILETS DAILY	
	2, 3. Communication and senses			8. Mobility	
18/11	FINGERTIP		18/11	TOILET MAN.	
	4. Cognitive status			9. Maintaining a safe environment	
18/11	ALERT		18/11	BOOKLET	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
18/11/15	REGULAR AMOUNTS TO DRINK				
	6. Elimination			Negotiated care - Care discussed with patient / family Yes / No Patient able to participate Yes / No	
18/11/11	MUSCULAR DECAY				

223591

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

Acute Services Division

Nursing Admission & Assessment

1. Admission

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Hospital: GRI	Ward: G7
Date of admission: 2/9/15	Time: 1500
Admitting Consultant: Craig	Admitting Nurse: [illegible]
Expected date of discharge: / /	

1. Patient Details

Preferred name:	Next of Kin (NoK): Kathleen Sullivan
Age: 42	Relationship: Mother
Religion:	NoK Address: SH
Telephone:	
GP: Dr. JJ Langan, Mcglone Practice, Baillieston Health Centre, 20 Muirside Road baillieston, Glasgow, G69 7AD	NoK Telephone: 771 3743
	NoK Aware of admission: ☐ Yes ☐ No
	Consent for information to be given to relatives: ☐ Yes ☐ No
	Nominated family contact:
	Telephone - Day:
	Telephone - Evening:

Is the patient a carer? ☐ Yes ☒ No If 'Yes' refer to Duty Social Worker if required: ☐ Referred ☐ Not required

Does the patient have an appointed Welfare Guardian / Power of Attorney? ☐ Yes ☐ No ☐ N/A

a. If 'Yes' please provide – Name: ..... Relationship: .....

Contact telephone number: .....

b. If 'Yes' does the patient have an 'Adult with Incapacity Section 47' certificate in place? ☐ Yes ☐ No ☐

If 'No' to 'b' please inform medical staff. Name of doctor informed: .....

2. Presenting Complaint / Diagnosis

Loose abdo pain & back pain?

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

SOB - abd distention

3. Allergies (including food allergies)

No known allergies: ☐ 3/9 090 - gastric motility disorder - ?gastroperisis

4. Observations

Cannard	Waterlow	MUST	Pulse	BP	Resp	SaO_2	Temp
4	3	0	88	148/110	18	99	37°
Urinalysis: NAD		AMT4 Score	BM	NEWS Score	Weight Estimated / 12½ Actual	Height Estimated / 5'10 Actual	BMI
				0	77	178	23

5. Current Medication

Duloxetine, Esomeprazole, Amitriptyline, Morphine, Cyclizine, Diazepam, Senna

Medicines reconciled on admission? ☐ Yes ☐ No

6. Relevant Past Medical History

Anxiety, Depression, Constipation, + Frusemide? Fundiplication previously

7. Risk Assessment

MUST

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

   Score .....
2. Has the patient had unplanned weight loss in the past 3-6 months?
   - < 5% ..... Score 0
   - 5-10% ..... Score 1
   - >10% ..... Score 2

   Score .....
3. If the patient is acutely unwell and there has been or is likely to be no food intake for > 5 days:
   - Score = 2

   Not applicable: Score = 0

   Score .....

MUST Score:

If score 1 or more, complete full Nutrition Profile

Name: .....

Address: .....

.....

DoB: .....

CHI number: .....

Affix patient data label

8. Cognitive Impairment

For all patients ≥ 65 years, ask the following 4 AMT questions:

1. How old are you? ..... years
2. What is your date of birth? / /
3. What is this place? .....
4. What year is it? .....

If the patient does not answer all questions correctly then refer to medical staff.

AMT Score: ..... out of 4

Name of Doctor informed (if required)

..... Grade.....

9. MRSA Screening / CJD / Healthcare outside Scotland

Will the patient be an inpatient >23 hours? ☑ Yes ☐ No If 'Yes' complete the following section.

1. Has the patient ever had a previous positive MRSA result? ☐ Yes ☑ No ☐ Not known
2. Has the patient been admitted from a Care Home/ institutional setting or another hospital? ☐ Yes ☑ No ☐ Not known
3. Does the patient have a wound / ulcer or invasive device which was present prior to this admission? ☐ Yes ☑ No ☐ Not known

If **'Yes'** to any of the above questions **OR** if the patient is admitted to a 'high impact speciality' e.g. **Orthopaedics, Vascular, Renal Unit, Critical Care – then obtain MRSA Swabs:**

☐ **Nasal** ☐ **Perineum** ☐ **Other - Specify:** ☐ **Patient refused**

CJD: **Has the patient ever been contacted by Public Health and told that they are possibly at risk of CJD:**

☐ Yes ☐ No If 'Yes' contact Infection Control Team. Infection Control Team contacted: ☐

Healthcare outside Scotland

Has the patient been transferred from, or received health care in, a hospital outside of Scotland in the last 12 months:

☐ Yes ☑ No If 'Yes obtain rectal swab and send to microbiologty for CPE screen.

Rectal swab taken ☐ Patient refused ☐

10. Lifestyle

Smoking:

Does the patient smoke? ☐ Yes ☑ No

If 'Yes' how many per day:

Does the patient use nicotine replacement therapy? ☐ Yes ☐ No

Does the patient wish referral to Smoking Cessation Service?

☐ Yes ☐ No If 'Yes', date of referral: / /

Drugs: Does the patient use recreational drugs? ☐ Yes ☑ No If 'Yes' specify:

Alcohol (Men): How often do you have **8** or more drinks on one occasion:

☐ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

Alcohol (Women): How often do you have **6** or more drinks on one occasion:

☑ Never ☐ Less than monthly

☐ Monthly ☐ Weekly ☐ Daily or almost daily

If 'Monthly' or more then complete FAST Tool.

11. Admission Documentation Completed By

Name (Please PRINT):	Signature:
Designation:	Date: 29/11

Acute Services Division

Nursing Admission & Assessment

2. Assessment

Hospital: [illegible]	Ward: [illegible]
Date of Assessment: 2/9/15	Time: 1500

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

1. Breathing and Circulation

Breathing:

- ☑ No symptoms or history of respiratory problems
- ☐ Dyspnoeic at rest
- ☐ Dyspnoeic on minimal exertion
- ☐ Dyspnoeic on maximum exertion
- ☐ Productive / non-productive cough evident
- ☐ Normally receives oxygen therapy

If 'Yes' provide details:

Circulation:

- ☑ No symptoms
- ☐ Known cardiac or circulatory problems

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

	Initial

2. Communication

Assessment of ability to communicate:

What language does the patient speak?:

[illegible]

Interpreter: Required ☐ Not required ☐

If required, provide details and arrangement made:

.....

.....

Does the patient have:

a. Speech difficulties? ☐ Yes ☐ No

b. A learning disability e.g. Down's Syndrome?
☐ Yes ☐ No

If 'Yes' please specify:

.....

If 'Yes' contact Liaison Learning Disability Team.

Liaison Learning Disability Team contacted:
☐ Yes ☐ No

c. A learning difficulty e.g. dyslexia, dyspraxia?
☐ Yes ☐ No

If 'Yes' please specify:

.....

3. Senses

Senses:

Eyesight

- ☐ Normal vision
- ☑ Glasses – ☐ Distance ☑ Reading
- ☐ Prosthesis – ☐ Left ☐ Right
- ☐ Contact lenses
- ☐ Registered blind

Hearing

- ☑ Normal
- ☐ Hearing impaired
- ☐ Hearing aid – ☐ Left ☐ Right

4. Mental Status

Mental Status:

- ☑ Orientated
- ☐ Confused
- ☐ Distressed
- ☐ Aggressive /Abusive
- ☐ Unconcious

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

	Initial

Hydration and Nutrition

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

MUST Score: 0 **If score is 1 or more, complete a Nutrition Profile.**

Nutition Profile completed ☐ Yes ☐ No
If 'Yes' do not complete sections 5a to 5d.

- **If score is 0, reassess / screen patient in 7 days.**
- **Complete sections 5a to 5d.**

Date of reassessment: / /

5a 1. Food likes / dislikes:

No issues

5a 2. Fluid likes / dislikes:

5b. Cultural or religious diet needed (e.g. vegetarian, vegan, halal, kosher etc):
☐ Yes ☒ No
If 'Yes' specify diet needed:

5c. Help needed with eating and drinking:
☐ Yes ☒ No
If 'Yes' provide details:

5d. Texture Modified Diet needed?
☐ Yes ☒ No
If 'Yes' specify texture: A ☐ B ☐ C ☐ D ☐ E ☐
Thickened Fluids required? ☐ Yes ☐ No
If 'Yes' specify stage required: 1 ☐ 2 ☐ 3 ☐

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

	Initial

6. Elimination

Continent:	Incontinent:	NHS GGC Stool Chart commenced:
☒ Bladder	☐ Bladder	☐ Required ☒ Not required
☒ Bowel	☐ Bowel	

Long-term urinary catheter in situ? ☐ Yes ☒ No If 'Yes' – Size: .....fg Make: .....
Date catheter last changed: / /

Continence assessment commenced:
☐ Yes ☐ No ☒ Not applicable

Containment products in use? Please specify:

☐ Bowels regular
☒ Constipated
☐ Diarrhoea / loose stools

Stoma: ☐ Yes ☒ No
If 'Yes' please specify and list appliances used:

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

	Initial

7. Personal Hygiene, Oral Health and Skin Assessment

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Personal hygiene:

☑ Self-caring and independent
☐ Requires assistance

Specify assistance if required:

Oral health:

Self-caring and independent ☑ Yes ☐ No
Does the the patient have a sore mouth ☐ Yes ☑ No
Does the patient have a non healing mouth ulcer ☐ Yes ☑ No

If the patient has a sore mouth or non healing mouth ulcer, refer to dentist (See StaffNet for dentist referral pathway) and implement Oral Care Bundle.

Oral Hygiene Care Bundle:

☐ Required ☐ Not required

Dentures:

☐ Not worn ☐ Full set
☐ Upper set ☐ Dentures with patient on admission
☐ Lower set

Skin assessment:

☑ Skin healthy with no evidence of damage
☐ Skin broken ☐ Skin oedematous ☐ Skin discoloured ☐ Skin clammy

If 'Yes' to any of the above, describe skin condition:

Wound Assessment Chart completed: ☐ Yes ☐ No ☑ Not applicable

Pressure ulcer evident: ☐ Yes ☐ No

If 'Yes' please identify Grade and record on Pressure Ulcer record sheet – Grade: .....

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

	Initial

8. Mobility

Patient fully mobile / independent? ☑ Yes ☐ No If 'No' complete Moving and Handling Assessment.

☐ Limited mobility

☐ Mobile with aid – Specify:

☐ Prosthesis – Specify:

Moving and Handling Plan commenced:

☐ Yes ☐ No

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

	Initial

9. Maintaining a Safe Environment

Pain status:

Does the patient have pain? ☑ Yes ☐ No
If 'Yes' record Pain Score on NEWS chart.

What makes their pain better? Please provide brief details:

9/10

Bed rail assessment completed: ☐ Yes ☑ No

Bed rails required:

☐ Required ☑ Not required

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

	Initial

10. Sleep and Rest

Sleep habits:

☐ Less than 8 hours ☐ Afternoon nap
☐ Morning nap

Sleep difficulties:

☐ None ☒ Disturbed
☐ Early wakening e.g. nocturia, insomnia

Medication required: ☒ Yes ☐ No

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

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

	Initial
[illegible]	

Social Circumstances

☐ Employed ☒ Unemployed ☐ Retired
☐ Lives alone
☒ Lives with Family
☐ Friend
☐ Dependants
☐ Other: ☐ Nursing Home ☐ Residential

Current Care / Support arrangements:

☐ Social Services ☐ Unpaid carer e.g. family, friends
☐ Private Carers ☐ None

If support services in place, please provide details:

[illegible]

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

	Initial

12. Privacy, Dignity and Sexuality

Does the patient have issues related to privacy, dignity and/or sexuality that are relevant to admission? ☐ Yes ☐ No	If 'Yes' please provide brief details:

13. Spiritual Care

Is there anything with regard to faith or culture that we can support the patient with during their stay in hospital (e.g. prayer, meditation)? ☐ Yes ☐ No	If 'Yes' please provide brief details:
Is there anything causing the patient a lot of anxiety at the time of admission that staff should be aware of? ☐ Yes ☐ No	If 'Yes' please provide brief details:
Ask the patient: "Would you like the ward staff to arrange for a Hospital Chaplain to visit you while in hospital?" ☐ Yes ☐ No ☐ Not at this time	If 'Yes' please specify faith group:

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

14. Anticipatory Care

(This section is for patients thought to be in the last year of life, where appropriate and relevant)

Appropriate ☐ Not appropriate ☐

Is the **patient** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Is the **patient's family** aware of their:
Diagnosis? ☐ Yes ☐ No
Prognosis? ☐ Yes ☐ No

Preferred place of care:
Home: ☐ Hospital ☐ Hospice ☐

Preferred place of death:
Home: ☐ Hospital ☐ Hospice ☐

Current treatment – please identify (e.g. chemotherapy/ radiotherapy):

Other agencies involved in patient's care – please identify (e.g.) Marie Curie, MacMillan Nurses):

DNACPR order in place: ☑ Yes ☐ No
If 'Yes' are the patient's family and next of kin aware? ☐ Yes ☐ No

15. Admission Assessment Completed By

Name (Please PRINT):
Signature:
Designation:
Date: 2/9/15

Clinical Notes

Date and Time	Notes	Name, Signature and Designation
2/9/15	CA with lower abdo & back pain. Has passed urine + BC, is fully mobile, requires regular pads & retrieval bilateral SJ's only orally & resists SJ's orally. Wt 2nd daily. Monitor I/O. Fluids overnight reviewed in am - 2L/24hrs.	
3/9/15 0400	Settled at present	
	Slept for long periods.	
	Obs stable. Apyrexial.	

Clinical Notes continue on next page

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Clinical Notes (continued)

Date and Time	Notes	Name, Signature and Designation
3/9/15 04:00	Remains NBM.	
	NG insitu - resited overnight as dislodged.	
	250mls emptied at 2am.	
	IV Fluids continue 4°.	
	Passing good volumes of urine.	
	S/c morphine given for pain.	
	?For CT Scan today.	Stipel Rreg.
am W/R	Sips today.	
	(1) Self caring	
	(2) Fast.	
	(3) Passing urine	
	(5) Obs stable as charted afebrile	
	(6) IV cont. S/c morphine as per kardex. NG fell out.	
	(8) Attended OAD.	
pm W/R	For oral maxilax, cont PPI. Allow FTD. Allow settle.	BF/RReg
3/9/15 0500	Transfered from ward 05. overnight Self caring.	
	independents for discharge.	

NHS GREATER GLASGOW & CLYDE

CLINICAL NOTES - NURSING

0712726128
SULLIVAN
Deborah F
6 MUIRHEAD COURT 07/12/197
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Date & Time		Signature, Print Name & Designation
0500 4/9/15	later today	
4/9/15	wlk - for home today	
10am	? follow up	
	All care given as per	
	Care plan	
	Husband pending transport	
	will return for IVI +	
	meds	CROSTER
	Venflon + s/c line removed	

193443

NEWS – National Early Warning Score

NHS
Greater Glasgow and Clyde

Name
Address
0712726128
SULLIVAN
Deborah F
07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP
CHI No.
DoB

	Date	Ward
Admitted	2/9/15	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

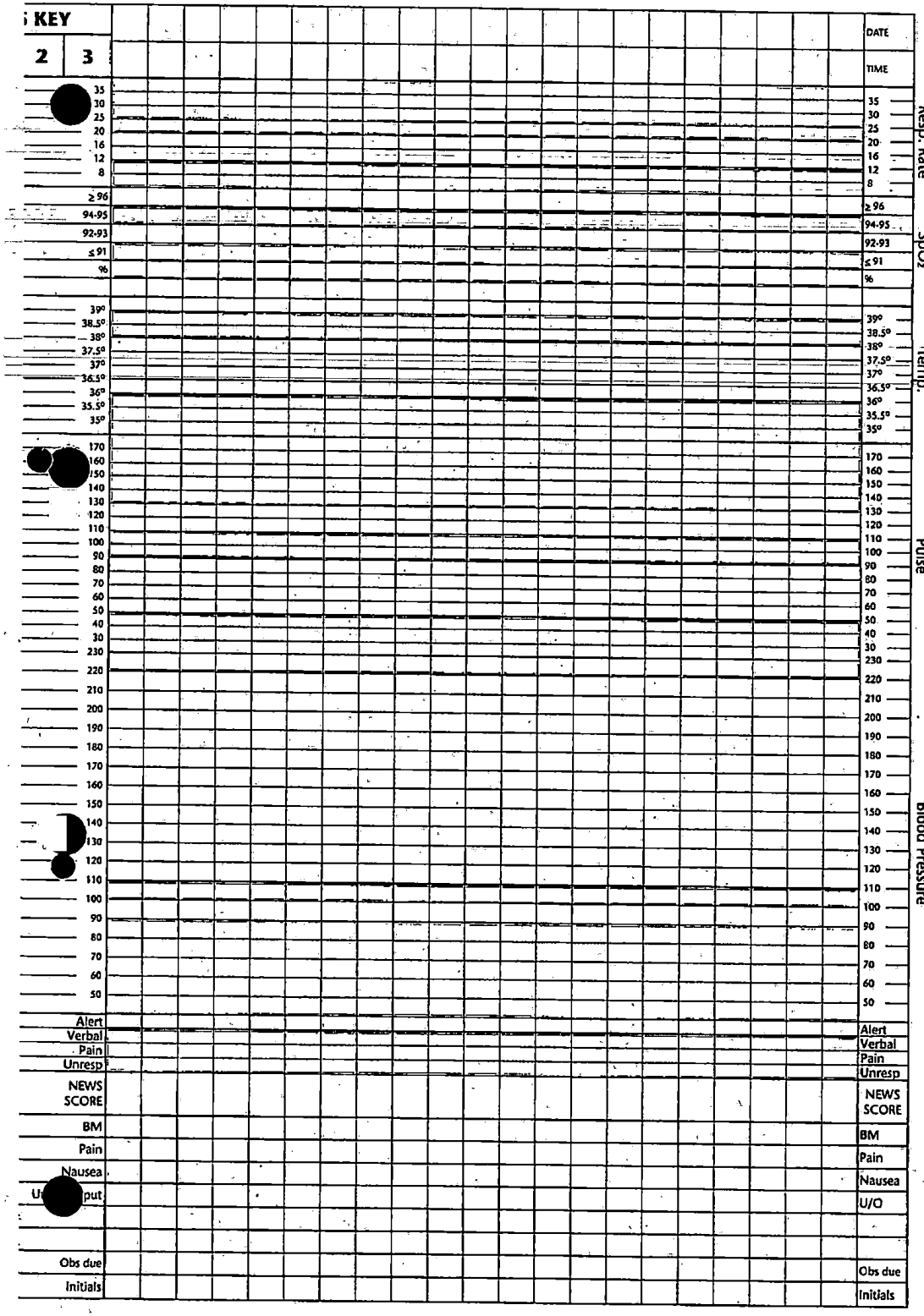
NEWS should not replace sound clinical judgement. Any concerns regarding the patient's condition should be appropriately escalated and documented in the Nursing Notes.

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.

① Deborah Sullivan.

	DATE:	2/9																				DATE	NEWS
	TIME:	1105	1330	1530	1600	1630	1100	1400	1745	1850												TIME	0 1
Resp. Rate Mark: •	35 30 25 20 16 12 8																						
SpO_2 (Enter Value)	≥96 94-95 92-93 ≤91	97	99	99	98	97	96	98	98	99	98												
Any Sup'l O_2 Room air	%	A	A	A	A	A	A	A	A	A	A												
Temp. Mark: X	39° 38.5° 38° 37.5° 37° 36.5° 36° 35.5° 35°																						
Pulse Mark: •	170 160 150 140 130 120 110 100 90 80 70 60 50 40 30				46	55				76													
Blood Pressure Mark: ^	230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50				131	138	136		142														
NEWS SCORE using Systolic BP					83	89	90		91	106	81												
Conscious Level Mark: •	Alert Verbal Pain Unresp	A		A	A	✓	✓	○	○	○	✓												
Total NEWS (with all obs)		3		1	0	0	0	0	0	6	1											NEWS SCORE	
BM					/	/	/	—		—	/											BM	
Pain					9	5	6	6	0	0	0											Pain	
Nausea					0	0	0	0	0	0	0											Nausea	
Urine output					✓	✓	✓	✓	✓	✓	✓											U/O	
Obs due					4'	4'	4'	4'	4'	4'	4'											Obs due	
Initials		DS		DS	DS	DS	DS	DS	DS	DS	DS											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

Neurological Observations

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

Glasgow Coma Scale

Pupil size (mm)

1
2
3
4
5
6
7
8

Pain Score

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

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

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

Management Plan and Patient Exclusions

Date and Time	Notes	Signed

Redesigned by Medical Illustration Services • 231261

Glasgow Royal I

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

NHS
Greater Glasgow and Clyde

Name: Unit No.:

Date:		2/4	3/9										
Time of Result:		11:14											
WCC	4-11	8.7	7.6										
Hb	M - 13-18 F - 11.5-16.5	126	115										
Plat	150-400	356	286										
Amylase	<100	85	61										
CRP	<10	3	X										
Na+	135-145	142	144										
K+	3-5-50	4.1	3.9										
Cl-	98-108	111	108										
Bic	~~21-28~~ eGFR		60										
Urea	2.5-7.5	4.8	3.7										
Creat.	57-113	58	57										
Glucose	3.5-5.5												
Bilirubin	3-22	5	7										
AST	<40	24	20										
ALT	<50	33	27										
G-GT	<55												
Alk. Phos.	40 -150	67	65										
Protein	60-80												
Albumin	32-45	36	(32)										
Globulin	22-33												
Ca	2.1-2.6		2.22										
Adj.Ca	2.1-2.6		2.33										
PO4	0.7-1.4	0.94	(1.52)										
PT	9-12	12	12/1.1										
APTT	25-37	34	35/1.1										
TCT	11-15		12/0.9										
H+	35-45												
PO2	12-15												
PCO2	4.4-5.6												
HCO2	20-28												

Mg2+ 0.78

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

Name: Deborah Sullivan
DoB: .....
Chi number: .....
Affix patient data label

Hospital: GRI
Ward: 65
Date: 2/9/15

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

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

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					INF	500			500	500							
02:00										500	750					1250	ST
03:00										200						2000	
04:00										200						2200	
05:00										100	500					2400	
06:00																3000	SL
07:00																	
08:00																	
09:00											NG tube DUB						
10:00					INF	500			1000								
11:00																	
12:00																	
13:00																	
14:00																	
15:00																	
16:00																	
17:00			~~~~	~~~~	~~~~	~~~~	~~~~	~~~~									
18:00			D/S														
19:00																	
20:00																	
21:00																	
22:00																	
23:00																	
								*Total Intake							*Total Output		

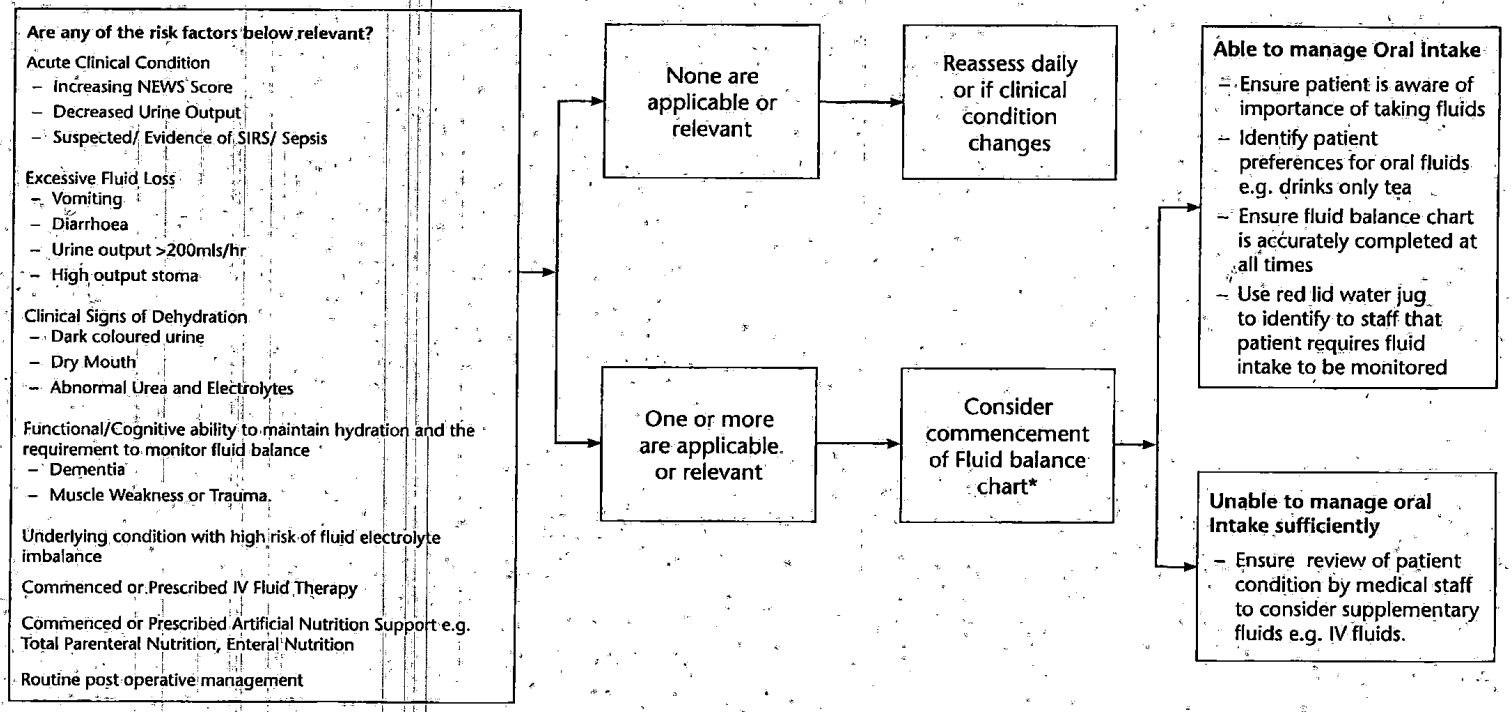
*24 hr Fluid Balance +/-

*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.



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

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Hospital: GRI
Ward: C7
Date: 2/9/15

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

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

NHS Greater Glasgow and Clyde

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input								Running Total	Output						Running Total	Initials
	Oral Fluids		Enteral		IV / Other					Urine	Gastric / Vomit	Bowel	Type	Type	Type		
	Type	Volume	Type	Volume	Type	Volume	Type	Volume	INPUT							OUTPUT	
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
11:00																	
12:00																	
13:00										50							
14:00																1/4/15 10:40	
15:00																	
16:00					IV	1000											
17:00					IV	500				300							
18:00																	
19:00																	
20:00																	
21:00																	
22:00																	
23:00									1500								
								*Total Intake	[redacted]						*Total Output	300+[redacted]	

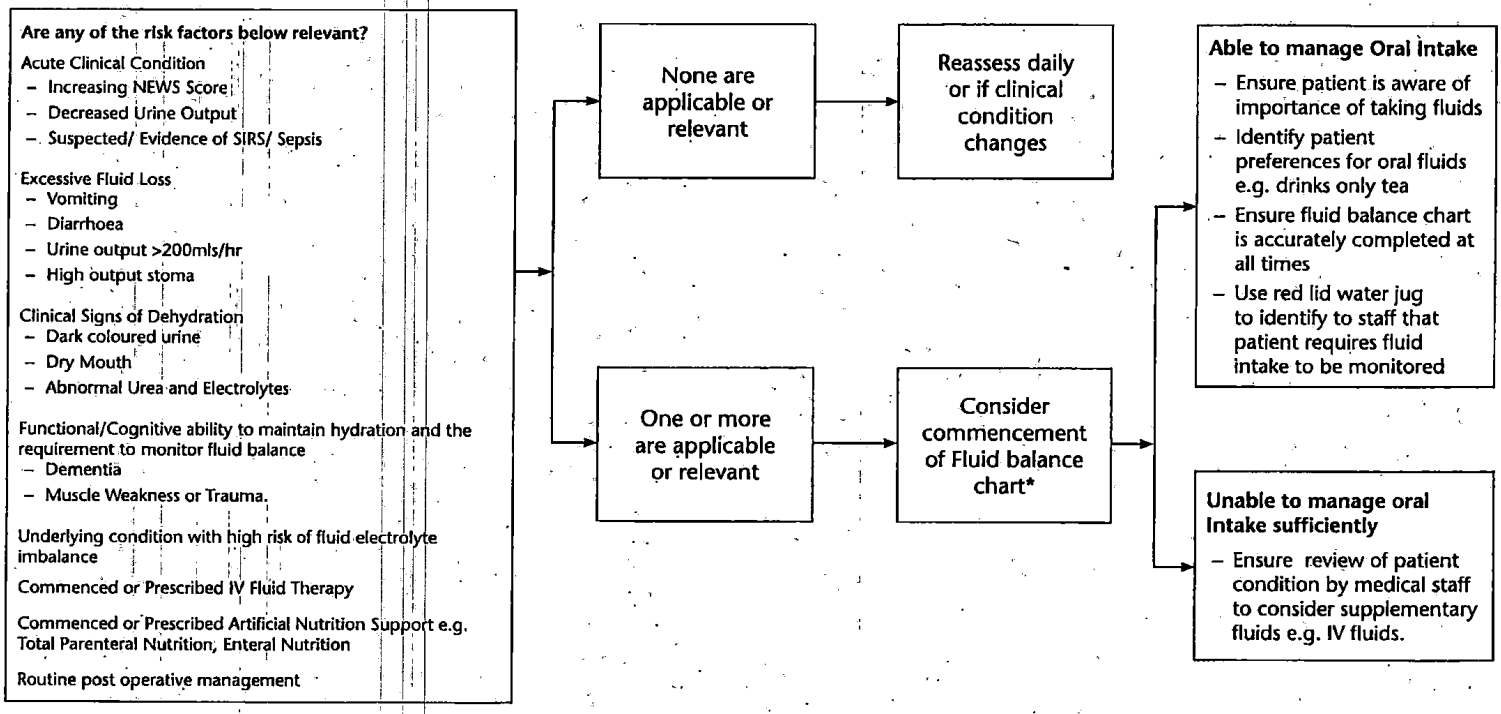
*24 hr Fluid Balance +/-

*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

0712726128
SULLIVAN F
Deborah 07/12/197

Peripheral Vascular Cannula(PVC) Insertion & Maintenance

NHS Greater Glasgow and Clyde

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

Insertion – Complete all sections

PVC inserted	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *[only if inserted in ward]*
ED Theatre Ward_____	2/9/15	L/Hand	Pink	

Clinical Indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:

Insertion Criteria (If no: please explain in comments below)	Clean field used	Hand hygiene	Skin asepsis	Dressing affixed	Non touch technique (do not re- contaminate cleaned skin)
	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 1	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/__	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

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

Date & time	PVC no.	Comments	Signature

MIS 269426
81117

CHI:	Modified V.I.P (Visual Infl [illegible] 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
	As above including: palpable venous cord	4 Phlebitis/Thrombophlebitis Remove & resite cannula Seek further advice
	As above including :pyrexia	5

Insertion – Complete all sections

PVC Inserted ED Theatre Ward_____	Date inserted	Insertion site	Colour of PVC	Inserted by: Name & Designation *(only if inserted in ward)*
Clinical Indication	IV Fluids/IV Medication ☐	Urgent access ☐	Interventional procedures ☐	Other Please state:
Insertion Criteria (If no: please explain in comments below)	Clean field used Yes ☐ No ☐ Unknown ☐	Hand hygiene Yes ☐ No ☐ Unknown ☐	Skin asepsis Yes ☐ No ☐ Unknown ☐	Dressing affixed Yes ☐ No ☐ Unknown ☐	Non touch technique (do not re- contaminate cleaned skin) Yes ☐ No ☐ Unknown ☐

Maintenance – To be completed daily

PVC 2	Has the PVC been used in the past 24 hours?	Absence of inflammation and or extravasation Record VIP score	The PVC dressing is intact	The PVC has been inserted less than 72 hours	Hand hygiene before & after all procedures	If answer is no to any of the criteria or if VIP 2 or more and PVC left in situ: document rationale for decision in comments	Initial
Day 1 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 2 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 3 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
After day 3 consider removal, if there is still a clinical reason justify rationale for PVC to remain in situ.							
Day 4 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	
Day 5 __/__/____	Yes ☐ No ☐	V.I.P:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Left in situ ☐ Removed ☐	

Date & time	PVC no.	Comments	Signature

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

NHS Greater Glasgow and Clyde
Active Care Checklist

Date: 2/9/10

Attach Addresso

0712726128
SULLIVAN F
Deborah 07/12/197
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

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) 6r

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

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

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

		Times	3/9	20/50	01[10]	06[30]	11[30]	15[00]												
	1.	**Pain: assess and address** If in pain inform registered nurse Y / N or N/A	Y	Y	S	Y	Y													
S	2.	**SKIN INSPECTION** Pressure areas checked: Y / N / I (Independent)	I	I	I	I	I	I												
		Redness (R) / Discolouration (D) / Pressure Ulcer (PU) / Intact (INT)		/	/	/	INT	INT												
K	3.	**KEEP MOVING:** Have you moved or walked Y / N / I (independent)	I	I	I	I	I	I												
		Bed Right side (30° tilt) – R Left Side (30° tilt) – L Back– B		/	/	/	—	R												
		Chair Assist to walk, stand or tilt (W /ST/ T)		/	/	/	—	/												
I	4.	**ELIMINATION:** Do you need the toilet? I = Independent A = Assistance given IC = patient incontinent of urine or faeces	I	I	I	I	I	I												
N	5.	**FOOD, FLUIDS AND NUTRITION:** Is the patient nil by mouth? Y / N (consider mouth care)	Y	Y	Y	Y	Y	Y												
		Encourage the patient to drink? Y / N / N/A	NA	2	S	2	2	W												
		Food, snack or supplement taken? Y / N / N/A	NA	2	S	2	2	W												
	6.	**ENVIRONMENT: Check:** Is the patient's call buzzer to hand? Is the area clutter free, clean and safe? Does the patient have everything they require in safe reach? Is the bed in lowest position? Y/N/O/S	Y	Y	Y	Y	Y	Y												
	7.	**INFORMATION:** Ask: Is there anything else I can help you with? Inform patient of the time of return. Y/N/O/S	Y	N	S	N	N	N												
	8.	**ESCALATION:** Escalate any issues to the Registered Nurse Y / N/A	NA	NA	S	NA	NA	NA												
		Nurse Initials		JT	JT	JT	PC	CT												

Attach Addressograph label Ward:

NHS
Greater Glasgow and Clyde

Specialist Pressure Redistributing equipment ordered and in place:

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

Active Care variant sheet - Care Number

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

Date	Time	Number	Variation	Signed

MIS 258902

Nutrition Profile

NHS Greater Glasgow and Clyde

Name: 0712726128 SULLIVAN F Deborah 07/12/197 6 MUIRHEAD COURT BAILLIESTON Glasgow, Lanarkshire G69 7EP CHI number: *Affix patient data label*	Date of admission: 2/9/15 Time: 1500 HOSPITAL: GRI Ward: 67

To be recorded within 24 hours of admission*

Height: 1.78 metres Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Weight: 77 kg Actual ☐ Patient/ carer reported ☐ Alternative measurement ☐

Recent unplanned weight loss: Yes ☐ No ☐

If 'Yes' how much?: kg Over what period of time?: weeks/months

Is there evidence of recent weight loss?

No ☐ Loose clothing ☐ History of reduced food intake/appetite ☐ Swallowing problem ☐

Dietary requirements (e.g. vegetarian; texture modified diet and fluids; halal; kosher) Yes ☐ No ☐

Please state:

Food Allergies: Yes ☐ No ☐ If 'Yes' please state:

Eating likes and dislikes (including appetite):	Drinking likes and dislikes:	Patient NBM Yes ☐ No ☐ If 'Yes' why?:
No issues		

Are there any contributing factors that may affect food intake such as **physical** (e.g. swallowing difficulties, loose teeth), **physiological** (e.g. nausea), **psychological** (e.g. dementia), **social or environmental?** Yes ☐ No ☐

Please specify all factors:

Is the patient on oral nutritional supplements? Yes ☐ No ☐

If 'Yes' please state:

Is the patient experiencing oropharyngeal swallowing problems (excluding oesophageal issues e.g. GORD, Stricture)? Yes ☐ No ☐

If 'Yes' please complete Screening Tool for Oropharyngeal Swallow Symptoms (STOPSS). If oesophageal problem present please discuss with medical staff.

Is there a need for equipment and/or assistance with eating and drinking? Yes ☐ No ☐

If 'Yes' please state:

Has this patient received written information about inpatient food (e.g. "Food in Hospitals" leaflet)?

Yes ☐ No ☐ Not applicable (received on previous admission) ☐

Profile completed by: Name (PRINT): [redacted] Signature: [redacted] Date: 2/9/15

NOTE: This is ADMISSION DATA - please refer to changes in Care Plan.

* Quality Improvement Scotland (2003). Food, Fluids and Nutritional Care in Hospitals Edinburgh QIS

Is your patient on the Liverpool Care Pathway (LCP)? Yes ☐ No ☐

If 'Yes' please follow LCP advice as screening for malnutrition may not be appropriate.

Malnutrition Universal Screening Tool ('MUST')

Date	2/9											
Initials												
Height (see page 1) ____ Weight												
Oedema or ascites present Y/N	N											
BMI (refer to chart on page 4)	23											

'MUST'

Step 1: BMI Score (refer to chart on page 4) >20 (>30 = Obese) .....0 18.5 - 20 .....1 <18.5.....2	0											
Step 2: Weight Loss Score Unplanned weight loss in past 3-6 months: <5% ..... 0 5-10% ..... 1 >10% 2	0											
Step 3: Acute Disease Effect Score If patient is acutely ill and there has been or is likely to be no, or virtually no, food intake for > 5 days.....Score 2 Not applicable.....Score 0	0											
Step 4: Overall Risk of Malnutrition Total:	0											

Step 5: Management Guidelines

Score of Overall Risk of Malnutrition	Action Required
0	**LOW RISK – *Routine Clinical Care*** • Repeat screening. Hospital Acute .....Weekly Hospital Rehabilitation .....Monthly
1	**MEDIUM RISK – *Observe*** • Document dietary intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Repeat screening weekly.
2 or more	**HIGH RISK – *Treat**** • Refer to Dietitian and document food intake for 3 days on a Food Record Chart. • Encourage oral intake. • Assist patient to choose high-energy meals/snacks and offer full cream milk to drink with and between meals. • Monitor and review Care Plan weekly. * Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.

Management Plan

FOR ALL PATIENTS

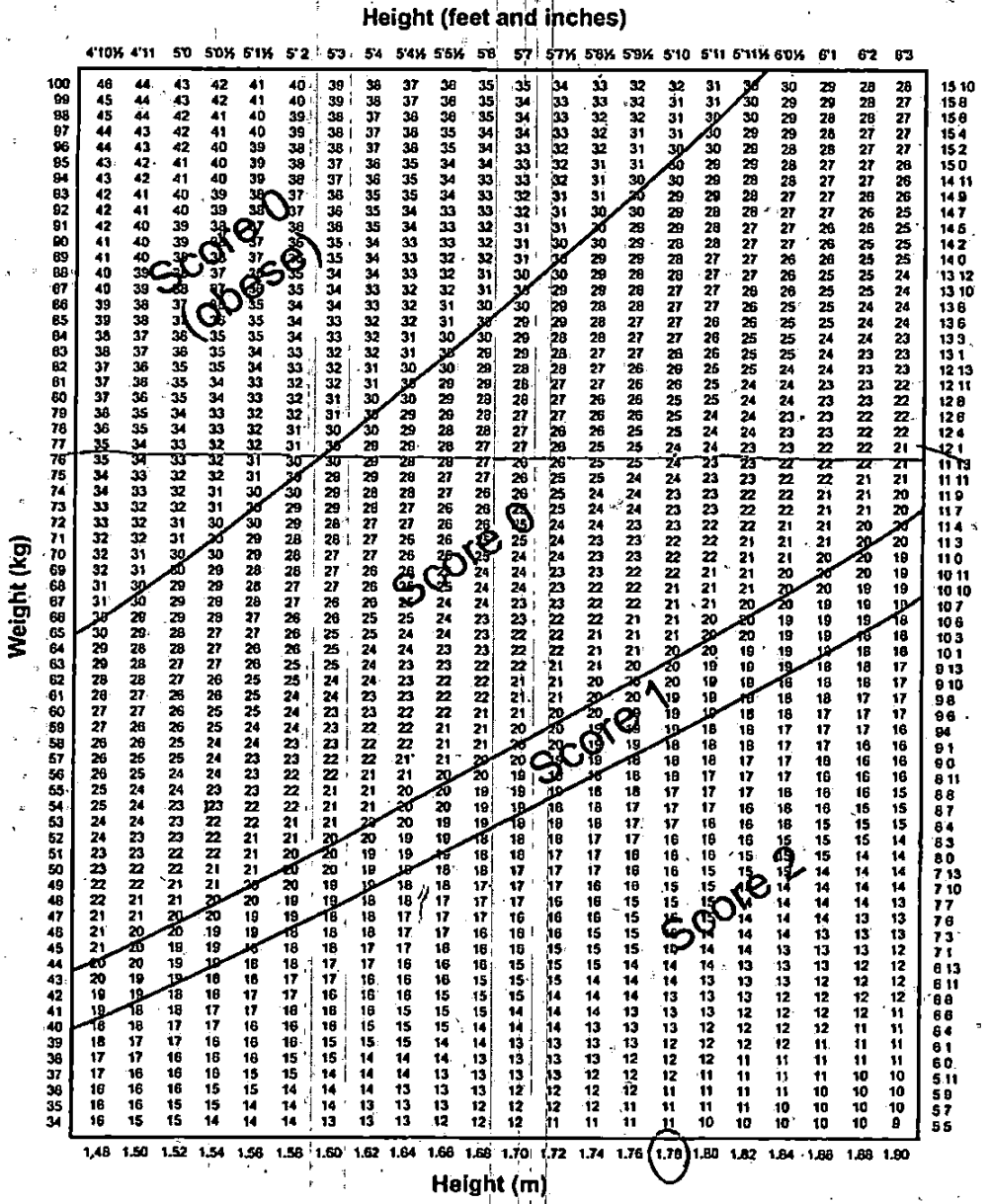
- Provide help and advice on food choices and eating and drinking when necessary.
- Treat underlying conditions and initiate appropriate treatment to relieve symptoms that affect nutritional intake e.g. nausea, vomiting, constipation, diarrhoea and/or pain.
- Refer to dietitian if any specialist advice is required.
- Use a recognised system to identify when equipment or asssistance is required at mealtimes (e.g. red mats, coloured napkins).
- REMEMBER TO CONSIDER YOUR PATIENT'S HYDRATION REQUIREMENTS.
- Ensure Discharge Plan includes most recent 'MUST' Score and any necessary follow-up requirements.

Referral Services		Referred by	Method of referral	Reason for referral
Nutritional Support Team	Date Referred / /			
Dietitian	Date Referred: / /			
Speech and Language Therapy	Date Referred: / /			
Occupational Therapy	Date Referred / /			
Dental Service	Date Referred / /			

Multidisciplinary Nutrition Care Plan

Date	Overall Risk	Action	Action discussed with patient / carer	Review date	Name (PRINT) Signature/ Designation
2/9		No Issues			

Step 1 - BMI Score



Step 2 - Weight Loss Score

Weight before weight loss (kg)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
34 kg	<1.7 kg	1.7-3.4 kg	>3.4 kg
36 kg	<1.8 kg	1.8-3.6 kg	>3.6 kg
38 kg	<1.9 kg	1.9-3.8 kg	>3.8 kg
40 kg	<2 kg	2-4 kg	>4 kg
42 kg	<2.1 kg	2.1-4.2 kg	>4.2 kg
44 kg	<2.2 kg	2.2-4.4 kg	>4.4 kg
46 kg	<2.3 kg	2.3-4.6 kg	>4.6 kg
48 kg	<2.4 kg	2.4-4.8 kg	>4.8 kg
50 kg	<2.5 kg	2.5-5 kg	>5 kg
52 kg	<2.6 kg	2.6-5.2 kg	>5.2 kg
54 kg	<2.7 kg	2.7-5.4 kg	>5.4 kg
56 kg	<2.8 kg	2.8-5.6 kg	>5.6 kg
58 kg	<2.9 kg	2.9-5.8 kg	>5.8 kg
60 kg	<3 kg	3-6 kg	>6 kg
62 kg	<3.1 kg	3.1-6.2 kg	>6.2 kg
64 kg	<3.2 kg	3.2-6.4 kg	>6.4 kg
66 kg	<3.3 kg	3.3-6.6 kg	>6.6 kg
68 kg	<3.4 kg	3.4-6.8 kg	>6.8 kg
70 kg	<3.5 kg	3.5-7 kg	>7 kg
72 kg	<3.6 kg	3.6-7.2 kg	>7.2 kg
74 kg	<3.7 kg	3.7-7.4 kg	>7.4 kg
76 kg	<3.8 kg	3.8-7.6 kg	>7.6 kg
78 kg	<3.9 kg	3.9-7.8 kg	>7.8 kg
80 kg	<4 kg	4-8 kg	>8 kg
82 kg	<4.1 kg	4.1-8.2 kg	>8.2 kg
84 kg	<4.2 kg	4.2-8.4 kg	>8.4 kg
86 kg	<4.3 kg	4.3-8.6 kg	>8.6 kg
88 kg	<4.4 kg	4.4-8.8 kg	>8.8 kg
90 kg	<4.5 kg	4.5-9 kg	>9 kg
92 kg	<4.6 kg	4.6-9.2 kg	>9.2 kg
94 kg	<4.7 kg	4.7-9.4 kg	>9.4 kg
96 kg	<4.8 kg	4.8-9.6 kg	>9.6 kg
98 kg	<4.9 kg	4.9-9.8 kg	>9.8 kg
100 kg	<5 kg	5-10 kg	>10 kg
102 kg	<5.1 kg	5.1-10.2 kg	>10.2 kg
104 kg	<5.2 kg	5.2-10.4 kg	>10.4 kg
106 kg	<5.3 kg	5.3-10.6 kg	>10.6 kg
108 kg	<5.4 kg	5.4-10.8 kg	>10.8 kg
110 kg	<5.5 kg	5.5-11 kg	>11 kg
112 kg	<5.6 kg	5.6-11.2 kg	>11.2 kg
114 kg	<5.7 kg	5.7-11.4 kg	>11.4 kg
116 kg	<5.8 kg	5.8-11.6 kg	>11.6 kg
118 kg	<5.9 kg	5.9-11.8 kg	>11.8 kg
120 kg	<6 kg	6-12 kg	>12 kg
122 kg	<6.1 kg	6.1-12.2 kg	>12.2 kg
124 kg	<6.2 kg	6.2-12.4 kg	>12.4 kg
126 kg	<6.3	6.3-12.6 kg	>12.6 kg

Weight before weight loss (st/lb)	Score 0 Wt loss <5%	Score 1 Wt loss 5-10%	Score 2 Wt loss >10%
5st 4lb	<4lb	4lb-7lb	>7lb
5st 7lb	<4lb	4lb-8lb	>8lb
5st 11lb	<4lb	4lb-8lb	>8lb
6st	<4lb	4lb-8lb	>8lb
6st 4lb	<4lb	4lb-9lb	>9lb
6st 7lb	<5lb	5lb-9lb	>9lb
6st 11lb	<5lb	5lb-10lb	>10lb
7st	<5lb	5lb-10lb	>10lb
7st 4lb	<5lb	5lb-10lb	>10lb
7st 7lb	<5lb	5lb-11lb	>11lb
7st 11lb	<5lb	5lb-11lb	>11lb
8st	<6lb	6lb-11lb	>11lb
8st 4lb	<6lb	6lb-12lb	>12lb
8st 7lb	<6lb	6lb-12lb	>12lb
8st 11lb	<6lb	6lb-12lb	>12lb
9st	<6lb	6lb-13lb	>13lb
9st 4lb	<7lb	7lb-13lb	>13lb
9st 7lb	<7lb	7lb-13lb	>13lb
9st 11lb	<7lb	7lb-1st	>1st
10st	<7lb	7lb-1st	>1st
10st 4lb	<7lb	7lb-1st	>1st
10st 7lb	<7lb	7lb-1st 1lb	>1st 1lb
10st 11lb	<8lb	8lb-1st 1lb	>1st 1lb
11st	<8lb	8lb-1st 1lb	>1st 1lb
11st 4lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 7lb	<8lb	8lb-1st 2lb	>1st 2lb
11st 11lb	<8lb	8lb-1st 3lb	>1st 3lb
12st	<8lb	8lb-1st 3lb	>1st 3lb
12st 4lb	<9lb	9lb-1st 3lb	>1st 3lb
12st 7lb	<9lb	9lb-1st 4lb	>1st 4lb
12st 11lb	<9lb	9lb-1st 4lb	>1st 4lb
13st	<9lb	9lb-1st 4lb	>1st 4lb
13st 4lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 7lb	<9lb	9lb-1st 5lb	>1st 5lb
13st 11lb	<10lb	10lb-1st 5lb	>1st 5lb
14st	<10lb	10lb-1st 6lb	>1st 6lb
14st 4lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 7lb	<10lb	10lb-1st 6lb	>1st 6lb
14st 11lb	<10lb	10lb-1st 7lb	>1st 7lb
15st	<11lb	11lb-1st 7lb	>1st 7lb
15st 4lb	<11lb	11lb-1st 7lb	>1st 7lb
15st 7lb	<11lb	11lb-1st 8lb	>1st 8lb
15st 11lb	<11lb	11lb-1st 8lb	>1st 8lb
16st	<11lb	11lb-1st 8lb	>1st 8lb
16st 4lb	<11lb	11lb-1st 9lb	>1st 9lb
16st 7lb	<12lb	12lb-1st 9lb	>1st 9lb
16st 11lb	<12lb	12lb-1st 9lb	>1st 9lb

Medical Illustration Services • 235261
STORES ORDER CODE 41850

Acute Services Division

Hospital / Department 421

NHS Greater Glasgow and Clyde

Cannard Falls Risk Assessment Pack

0712726128
SULLIVAN F
Deborah 07/12/197
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire Unit/Hospital number
G69 7EP

Contents

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

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

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

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

Referral Criteria for Hospital Falls Prevention Co-ordinator

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

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

General Safety Precautions

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

Cannard Falls Risk Assessment

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

SCORE ALL OPTIONS THAT APPLY IN EACH SECTION						Date: 2/9 Ward: 5	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:	Date: Ward:
History of falls in the last 6 months	At home 1	In ward / unit 2	None 0			0						
Sex	Male 1	Female 2				2						
Age	13-59 0	60-70 1	71-80 2	81+ 1		0						
Sensory deficit	Sight* 2	Hearing* 1	Balance* 2	None 0		0						
Medication type **	Drugs for mental illness 1	Blood pressure / water tablets 1	Sleeping tablets 1	None of these 0		0						
Medical history	Diabetes 1	Confusion 1	Fits 1	Incontinent 1	Inability to cooperate* 1	0						
Mobility	Fully mobile 1	Uses aids 2	Restricted* 3	Bed / chair-bound/ wheel-chair 1		1						
Gait	Steady 1	Hesitant in initiating movement* 1	Poor transfer* 3	Unsteady 3		1						
				TOTAL SCORE		4						
				ACTION(S) TAKEN Enter action code(s) from Care Plan below		1						
SCORE 13+ = HIGH RISK If patient unconscious score as N/A until patient status improves.				NURSE SIGNATURE								

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

Falls Assessment Care Plan

Please tick all applicable nursing interventions

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

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

Cannard Falls Risk Assessment

Glossary of terms used in risk assessment

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

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

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

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

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

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

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

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

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

HESITANT IN INITIATING MOVEMENT means difficulty in starting to walk.

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

0712726128
SULLIVAN
Deborah F 07/12/197
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

npatient) Moving and Handling Risk Assessment Form

Named Nurse:		If Patient is totally independent, tick here and go to date box		Risk: Low / Medium / High	

BODY BUILD			
Obese		Tall	
Above average		Medium	
Average		Short	
Below average			
RISK OF FALLS			
High		Low	

Problems with comprehension, behaviour, co-operation (specify):

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

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:	2/9/15		
Assessor's signature:			
Proposed Review date:	weekly		

05236

Continuation Sheet

Transfers (Including To/From: Bed; Wheelchair; Commode; Toilet)

HOIST/STANDAID (Specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
Model:	People: 1 2 3	Additional Information:	
Sling type:	Walking aid (specify)		
Sling size:			

Toileting

HOIST/STANDAID	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information:	

Move on / off bed pan

HOIST	MANEOUVRE	ASSISTANCE	SUPERVISION	N/A
	Roll patient	People 1	Additional Information:	
	Monkey pole	People 2		
	Patient bridges	People 3		

Move up / down bed

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Sliding sheet	People 1	Additional Information:	
	Monkey pole	People 2		
	Rope ladder	People 3		

Transfer to / from trolley (or bed etc.)

HOIST	HANDLING AIDS	ASSISTANCE	SUPERVISION	INDEPENDENT
	Patslide	People 1	Additional Information:	
	Other	People 2		
	Fabric sliding aid	People 3		

Sit up over side of bed

BED REST	ASSISTANCE	SUPERVISION	INDEPENDENT
	People: 1 2 3	Additional Information (e.g. equipment to be used – swivel cushion):	

Into Bath or Shower

WHICH BATH	HANDLING AID	ASSISTANCE	SUPERVISION	INDEPENDENT
Shower	Shower chair	People 1	Additional Information:	
Variable height bath	Bathing Hoist e.g. Alenti	People 2		
Bed bath	Sling lifting Hoist	People 3		

Walking

NO WALKING	WALKING AID (specify)	ASSISTANCE	SUPERVISION	INDEPENDENT
		People 1	Distanced walked / Additional Information:	
		People 2		
		People 3		

Other Instructions

Recording Symbol:	/	X	*
Date Assessed:			
Assessor's signature:			
Proposed Review date:			

NHS
Greater Glasgow and Clyde

NATVNS
SCOTLAND

0712726128 EL
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

ADAPTED WATERLOW PRESSURE AREA RISK ASSESSMENT CHART

More than one score/category can be used: **10+= 'At Risk': 15+= 'High Risk': 20+= 'Very High Risk'**

Complete assessment on admission/1st visit, if there is a change in individuals condition and repeat regularly according to local protocol

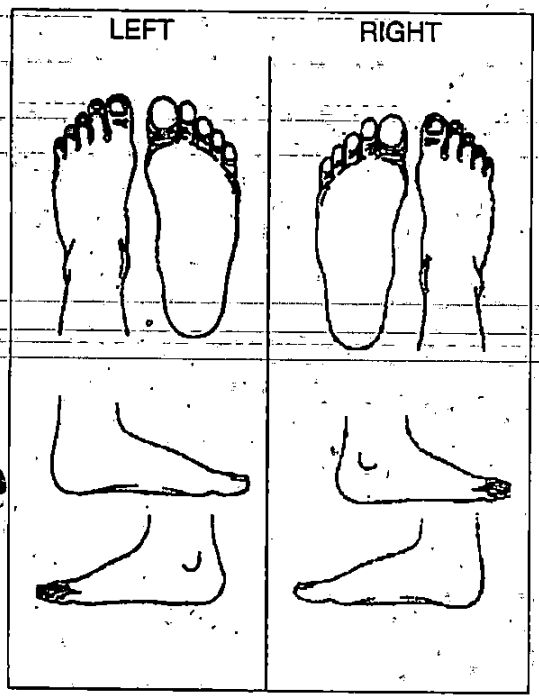
Sex										
Male	1									
Female	2	2								
Age										
14 -49	1									
50.-64	2	1								
65 - 74	3									
75 - 80	4									
81+	5									
Build/Weight for Height (BMI=weight in Kg/height in m²)										
Average - BMI 20-24.9	0	0								
Above average - BMI 25-29.9	1									
Obese - BMI > 30	2									
Below average - BMI < 20	3									
Continence										
Complete/catheterised	0									
Incontinent urine	1	0								
Incontinent faeces	2									
Doubly incontinent (urine & faeces)	3									
Skin Type - Visual Risks Area										
Healthy	0									
Tissue paper (thin/fragile)	1	0								
Dry (appears flaky)	1									
Oedematous (puffy)	1									
Clammy (moist to touch)/pyrexia	1									
Discoloured (bruising/mottled)	2									
Broken (established ulcer)	3									
Mobility										
Fully mobile	0									
Restless/fidgety	1									
Apathetic (sedated/depressed/reluctant to move)	2	0								
Restricted (restricted by sever pain or disease)	3									
Bedbound (unconscious/unable to change position/traction)	4									
Chairbound (unable to leave chair without assistance)	5									
Nutritional Element										
Unplanned weight loss in past 3-6 months										
<5% Score **0**, 5-10% Score 1, >10% Score **2**	0-2	0								
BMI > 20 Score **0**, BMI 18.5-20 Score 1, BMI < 18.5 Score **2**	0-2									
Patient acutely ill or no nutritional intake > 5 days	2									
Special Risks - Tissue Malnutrition										
Multiple organ failure/terminal cachexia	8									
Single organ failure e.g. cardiac, renal, respiratory	5									
Peripheral vascular disease	5	0								
Anaemia = Hb < 8	2									
Smoking	1									
Special Risks - Neurological Deficit		0								
Diabetes/MS/CVA/motor/sensory/paraplegia *Max 6*	4-6									
Special Risks - Surgery/Trauma										
On table > 6 hours	8									
Orthopaedic/below waist/spinal (up to 48 hours post op)	5	0								
On table > 2 hours (up to 48 hours post op)	5									
Special Risks - Medication										
Cytotoxic, anti-inflammatory, long term/high dose steroid *Max 4*	4	0								
Total Score		3								
Date		21/9								
Initials		EJ								
Time		1500								

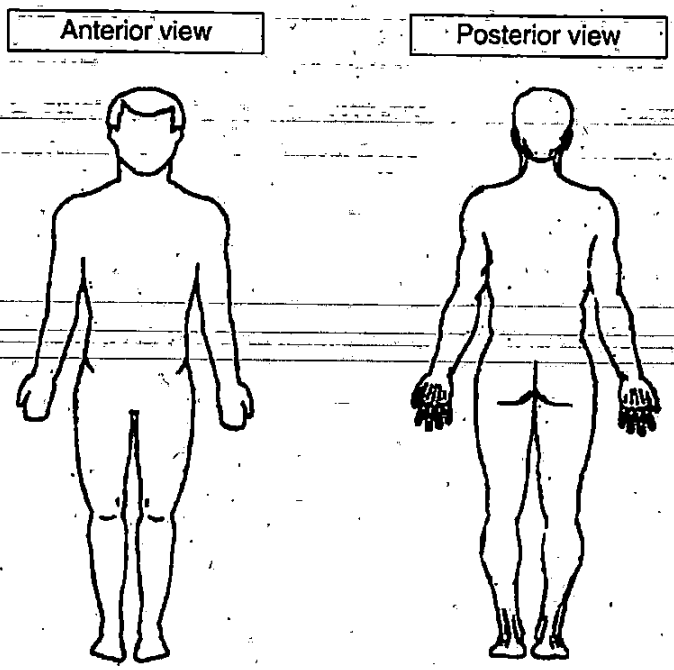
83826

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

PRESSURE ULCER RECORD

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





SCOTTISH ADAPTED EPUAP PRESSURE ULCER GRADING TOOL

GRADE 1 Non-blanchable erythema of intact skin. Discolouration of the skin, warmth, oedema, induration or hardness may also be used as indicators, particularly on individuals with darker skin.

GRADE 2 Partial thickness skin loss involving epidermis, dermis or both. The ulcer is superficial and presents clinically as an abrasion or blister.

GRADE 3 Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia.

GRADE 4 Extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures with or without full thickness skin loss.

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

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

0712726128
SULLIVAN F
Deborah 07/12/197
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Care Plan

NHS Greater Glasgow and Clyde

Date Commenced and Signature	1. Breathing and circulation	Date Discontinued and Signature	Date Commenced and Signature	7. Personal Hygiene, oral care and skin care	Date Discontinued and Signature
2/9	as per NAWS		2/9	independent	
	2, 3. Communication and senses			8. Mobility	
2/9	No issues		2/9	independent	
	4. Cognitive status			9. Maintaining a safe environment	
2/9	No issues		2/9	No issues	
	Getting to Know Me / What matters to me			10. Sleep and Rest	
	5. Hydration and Nutrition			12. Privacy, dignity and sexuality	
2/9	NAD N/G fitted				
	6. Elimination			Negotiated care - Care discussed with patient / family Yes / No Patient able to participate Yes / No	
2/9	continent			2/9/15	

223591

Care Plan Guidance

Below are some prompt questions to help you record the individualised care that your patient requires during their inpatient stay. You should record the care that the nurse / nursing staff require to provide. The 'Negotiated Care' component provides opportunity to record any care that the patients family or carers are participating in and care that patients are being taught to support changing self care. If the patient is independent in any of the activities of living and requires no nursing intervention then you should record this in the relevant section.

When care changes a note should be made in the nursing clinical notes / progress notes to confirm why this is required.

1. Breathing and circulation	7. Personal Hygiene, oral care and skin care
Record frequency of observations, TPR BP and SAO2. Record any other care that the patient requires for their breathing or their circulation e.g. seating position, apex beat with radial pulse, pedal pulse measurement, lying and standing Blood Pressure measurement etc.	Does the patient need assistance with personal hygiene? If so what needs to be done. Do they require assistance with oral care? If so what is this. Does the patient require any specifc pressure area care outwith the Active Care documentation. If totally independent record 'self caring'.
2, 3. Communication and senses	**8. Mobility**
What assistance does the patient need with communication? If they use spectacles or a hearing aid what assistance do they needs with these? Does the patient require an interpreter?	Does the patient require assistance when mobilising? Does the patient use mobility aids? Is the patient at risk of falling? Record key information from falls risk assessment, e.g. Cannard tool, to prevent falls
4. Cognitive status	**9. Maintaining a safe environment**
What care is required to minimise risk of harm due to behavioural disturbance? Think about capacity and adults with incapacity and what you need to do with the patient to alleviate distress.	How is the patients pain being assessed? Is a specific pain assessment tool used? What does the patient require to maintain their safety?
Getting to Know Me / What matters to me	**10. Sleep and Rest**
The 'Getting to know me' Document should be used for all patients with cognitive impairment. Once completed by the patients relatives / carer record the key information to plan care in the care plan. Ask the patent what matters to them during their hospital stay and record in this area.	What would help the patient achieve a good nights rest? Does the patients sleep pattern need to be monitored? if yes record what needs to be done.
5. Hydration and Nutrition	**12. Privacy, dignity and sexuality**
Does the patient require any assistance with eating and / or drinking? Does the patient require a special diet? Do they require fluid balance monitoring?	What do you need to do to maintain the patients modesty and dignity?
6. Elimination	**Negotiated care -** Care discussed with patient / family Yes / No Patient able to participate Yes / No
Does the patient require assistance to go to the toilet? Do they use continence aids? Does their urinary output require to be monitored? Are the patients stools / bowel activity being monitored?	Discuss patient care needs with them. If the patient is learning a new self care procedure record their process and progress of learning. If the patient has a learning disability or dementia use the information obtained in the Getting to Know Me document to identify the care that the family / carer could participate in.

Record of Communication with Relatives / Carers

NHS Greater Glasgow and Clyde

Nan
Add 0712726128
SULLIVAN F
Deborah 07/12/197
6 MUIRHEAD COURT
DoB BAILLIESTON
Chi Glasgow, Lanarkshire
G69 7EP

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: RAH Ward: 67

Please enter date of communication and topic (all entries must be signed and dated)

Date & Time	Full record of source; Topic of discussion; Name of relative/carer	Signed	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.

Date / Time	Full record of source; Topic of discussion; Name of relative/carer	Signed	Staff Code

BRONCHOSCOPY REPORT
NHS GREATER GLASGOW AND CLYDE

Record created: 13/12/2019 Last modified: 16/12/2019 Procedure date: 16/12/2019

Name:	Deborah SULLIVAN	Address:	Flat 0-1, 8 Boyndie Street
CHI No:	0712726128		Easterhouse
District:			Glasgow
Date of birth:	07/12/1972		Lanarkshire
Case note no.:	0712726128		G34 9JE
GP:	MCGINLEY, ANNE	Status:	Daypatient/NHS
Address:	Lochend Surgery	Hospital:	Glasgow Royal
	Easterhouse Health Centre	Ward:	Respiratory Dept.
	9 Auchinlea Road	Referring Cons:	Ms Martha Quinn
	Glasgow	Group:	Surgery
	G34 9HQ		

Clinical details: Haemoptysis, recent ex smoker

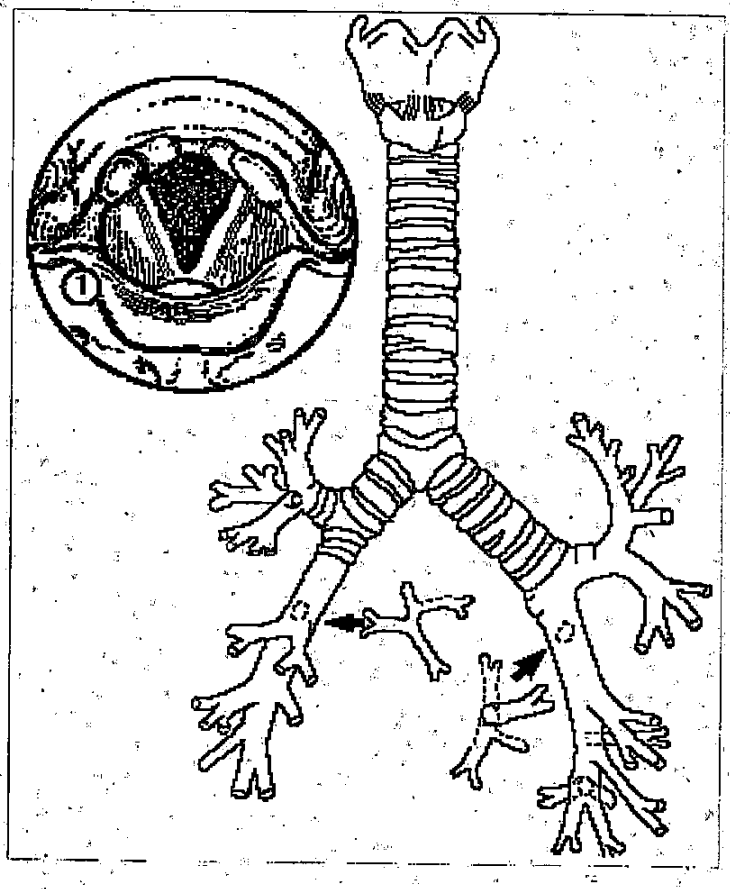
Drugs:

Midazolam (IV)	3 mgs	Lido\Lignocaine 1% to bronchial tree	16 r
Fentanyl (IV)	50 ugs	Nasal cannulae	2 L

Lido\Lignocaine spray was used
Lido\Lignocaine gel was used

Instrument and method of access:
GRI - Bronch 280 1114 via right nostril.

Findings:



Results:
Normal Bronchoscopy - No specimens

Notes:
Large nasal polyp visible right nostril, smaller nasal polyp left. no obvious bleeding nasopharynx/oropharynx.
Normal cords trachea and carina.
No endobronchial lesion seen.
Bronchial tree visualised to subsegmental areas with no lesion or bleeding seen.
Some superficial vessels visible but no bleeding point identified.

Site 1 Vallecula

Signature: _____
Operator: Dr Rosie Meharry
Consultant: Dr Hannah Bayes

BRONCHOSCOPY REPORT
NHS GREATER GLASGOW AND CLYDE

Record created: 13/12/2019 Last modified: 16/12/2019 Procedure date: 16/12/2019

Name:	Deborah SULLIVAN	Address:	Flat 0-1, 8 Boyndie Street
CHI No:	0712726128		Easterhouse
District:			Glasgow
Date of birth:	07/12/1972		Lanarkshire
Case note no.:	0712726128		G34 9JE
GP:	MCGINLEY, ANNE	Status:	Daypatient/NHS
Address:	Lochend Surgery	Hospital:	Glasgow Royal
	Easterhouse Health Centre	Ward:	Respiratory Dept.
	9 Auchinlea Road	Referring Cons:	Ms Martha Quinn
	Glasgow	Group:	Surgery
	G34 9HQ		

Clinical details: Haemoptysis, recent ex smoker

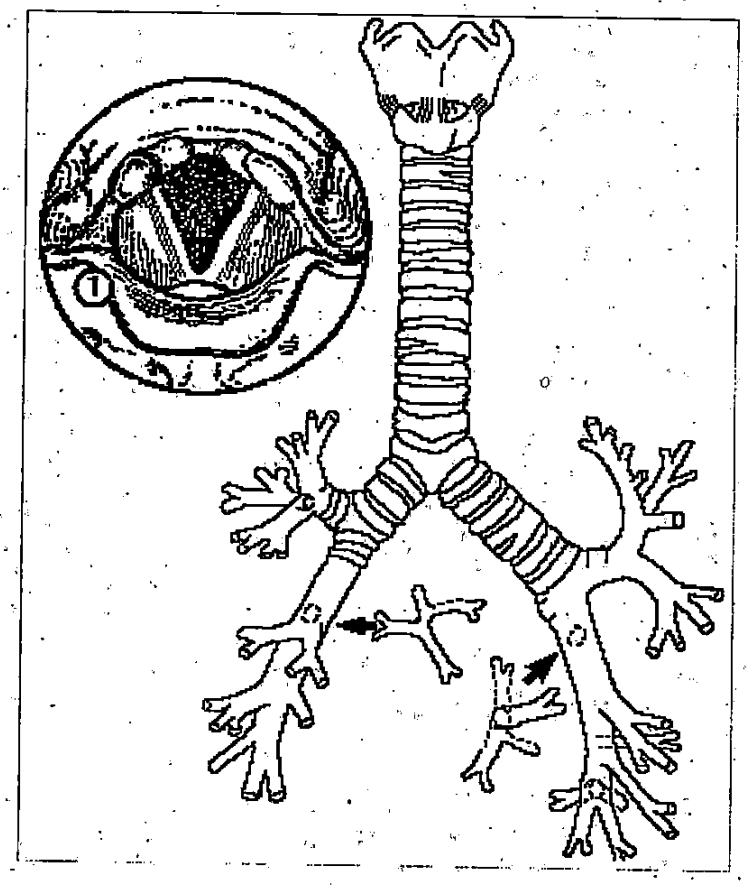
Drugs:

Midazolam (IV)	3 mgs	Lido\Lignocaine 1% to bronchial tree	16 ml
Fentanyl (IV)	50 ugs	Nasal cannulae	2 L

Lido\Lignocaine spray was used
Lido\Lignocaine gel was used

Instrument and method of access:
GRI - Bronch 280 1114 via right nostril

Findings:



Results:
Normal Bronchoscopy - No specimens
Notes:
Large nasal polyp visible right nostril, smaller nasal polyp left. no obvious bleeding nasopharynx/oropharynx.
Normal cords trachea and carina.
No endobronchial lesion seen.
Bronchial tree visualised to subsegmental areas with no lesion or bleeding seen.
Some superficial vessels visible but no bleeding point identified.

Site 1 Vallecula

Signature: _____
Operator: Dr Rosie Meharry
Consultant: Dr Hannah Bayes

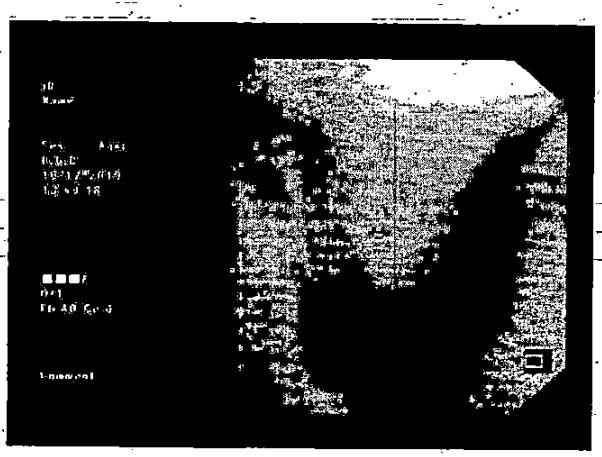
NHS Greater Glasgow And Clyde

Name: Deborah SULLIVAN
CHI no: 0712726128

Date of birth: 07/12/1972
Case note No: 0712726128

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

Procedure date: 16th December 2019



Site 0

Acute Services Division

NHS Greater Glasgow and Clyde

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

Perioperative Care Plan

Hospital: GRI.	Consultant: Miss Quinn
Ward: G6	Date: 23/2/23.

Theatre Staff - The following information can be found within the My Admission Record (MAR)

	Checked by: Reception Practitioner	Anaesthetic Practitioner
• Relevant Medical History - see MAR	Yes ☐ No ☐	Yes ☐ No ☐

THEATRE STAFF – For Baseline Observations refer to NEWS 2 chart.

Height: 175cm Weight: 96.35 kg

WARD Other information

Document any other relevant information e.g. needle phobia, preferred name, interpreter arranged.
Please provide e.g. theatre buddy, 'Getting to know me' document if available.

WARD Safety Checklist

Up-to-date Blood Results available on Clinical Portal	Yes ☑ No ☐	Comments if required:
Blood Cross Matched confirmed by labs	Yes ☐ No ☐ N/A ☑	
Blood Grouped and Saved confirmed by labs 1st sample ☐ 2nd Sample ☐	Yes ☐ No ☐ N/A ☑	
Antibodies +ve ☐ -ve ☐		

Date of Last Menstrual Period (LMP) N/A ☑	Date __/__/__	Comments
Is there any chance you are pregnant? N/A ☑	Yes ☐ No ☐	Comments
Pregnancy test carried out with the patient's consent	Yes ☐ Refused ☐	Comments
Pregnancy test result N/A ☑	Postive ☐ Negative ☐	
Tampon removed N/A ☑	Yes ☐	Comments
MRSA Positive ☐ Negative ☐ Results pending ☐ N/A ☑ CPE Positive ☐ Negative ☐ Results pending ☐ N/A ☑ Other Positive ☐ Negative ☐ Results pending ☐ N/A ☑		Comments
PUDRA Yes ☑ N/A ☐	Patient Refused ☐	Comments
PVC care plan in place Yes ☑	No ☐ N/A ☐	Comments

Topical Local Anaesthetic applied Specify site and time applied	Yes ☐ No ☐ N/A ☑ Site 1: Time: Site 2: Time:	

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

SAFETY Checklist – Ward Check completed immediately prior to the patient being given a Pre-Med

Preoperative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Practitioner
IDENTITY BAND CORRECT (Name, DoB, CHI number, gender, Ward)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Case Notes / Scanner Folder (circle)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
ECG	Yes ☐ No ☐ N/A ☑	Yes ☑ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑
MAR document	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
NEWS chart	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Falls risk assessment	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐
Prescription Chart	Yes ☐ No ☑ HERWA	Yes ☑ No ☐ HAND	Yes ☐ No ☑
Alert Sticker – specify:	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
Biometry	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
CONSENT FORM checks AWI ☐			
Correct patient information	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Procedure and laterality matches Theatre list	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Patient confirms proposed procedure	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Correct site marked	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
Signed by Surgeon and Patient	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
Dated			
ADULTS WITH INCAPACITY (AWI) N/A ☑			
Check;			
2 page Certificate of Incapacity for Single Procedure;	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Procedure and laterality matches Theatre list	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dated and Signed by operating surgeon	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Correct site marked	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4 page Capacity Documentation for Medical treatment present	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Certificate of Incapacity under section 47 completed and;	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dated and signed by medical practitioner	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
ALLERGIES/Sensitivities and Reactions (Please also include food allergies)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☑ No ☐
If 'Yes' specify:	PENICILLIN. - rash		PENICILLIN.
Fasted from – specify time (24 hr clock) N/A ☐	Food: 2200. Fluid: 0000.	Food: 2200 Fluid: 600 - WATER	Food: 12 M/N Fluid: 0600 HO
Blood Glucose Score – if relevant TYPE II	Time: 1130. Score: 6.7 N/A ☐	Time: Score: N/A ☐	Time: Score: N/A ☐
INTERNAL PROSTHESIS in situ e.g. metalwork, pacemaker, implant etc If 'Yes' state location and type	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
EXTERNAL PROSTHESIS N/A ☑ e.g. hairpiece, false eye etc. If 'Yes' state type where stored	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑

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

Pre-operative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Assistant
Dentures removed (N/A ☑)	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☑
If 'Yes' state where stored			
Loose teeth, caps and crowns and veneers State site and type	Yes ☐ No ☑	Yes ☐ No ☑	Yes ☐ No ☑
Hearing aid(s) N/A ☑	R ☐ L ☐ Insitu ☐ Removed ☐	R ☐ L ☐ Insitu ☐ Removed ☐	R ☐ L ☐ Insitu ☐ Removed ☐
If removed state where stored			
Spectacles/Contact lenses removed N/A ☐	Yes ☑ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
If 'Yes' state where stored	In pt locker	In ward	
Make-up/ Nail polish removed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
False nails in situ – Anaesthetist informed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
Jewellery/Body piercing removed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
If 'yes' state where stored If unable to remove,please tape and state location			
Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes? Please complete additional CJD question form for High Risk Ophthalmology Procedures	Yes ☐ No ☑ Not Known ☐ Yes ☐ N/A ☑	If yes, contact Infection Control Team and Theatres. Infection Control Team Informed on ___/___/___ Comments if required:	
Inhalers/ sprays with patient N/A ☑	Yes ☐ No ☐	Type:	
Anti-embolic Prophylaxis prescribed N/A ☐	Yes ☑ No ☐	Type: TEDs	
Paper pants in situ – If 'No' specify reason:	Yes ☑ No ☑ Cotton	State reason:	
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐	Comment if required:	
Pre-Medication given N/A ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Trolley/ Bed checked for head down tilt and O_2/ Accessories	Bed ☑ Trolley ☐ Operating chair ☐ Yes ☑ No ☐		Bed ☐ Trolley ☐ Operating chair ☐ Yes ☐ No ☐
PLEASE PRINT NAME AND SIGN ONCE CHECKLIST IS COMPLETE	Print: ABBIE GOLDIE Sign: Agolder Time: 1230	Print: A MURRAY Sign: AMurray Time: 1245	Print: SADAMSON Sign: SA Time:: 1305

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Surgical Brief

Surgical Brief carried out:	Yes ☑ No ☐	If 'No' specify reason:

Anaesthetics

Baseline Observations	Pulse: 89	BP: 124/71	Temp:	SpO₂: 94	Resps:

Stop Before You Block — This section NOT applicable ☑

Stop Before You Block carried out:	Yes ☐ No ☐

Anaesthetic Type – Please tick all that apply

General Anaesthetic ☐	Epidural ☐ Spinal ☐ Combined ☐	Regional Blocks ☐	Throat spray ☐ Time: _____
Local Anaesthetic ☐	Site: Drug:		mls
Sedation ☑	Drug: Midazolam 1mg/mL		4 mls

Skin Prepping used for Patient Monitoring / Blocks — This section NOT applicable ☐

ARTERIAL CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
CVP CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
SPINAL / EPIDURAL / COMBINED	Yes ☐ N/A ☐	Specify prep:		
REGIONAL BLOCK	Yes ☐ N/A ☐	Specify prep:		

Blood Glucose Monitoring — This section NOT applicable ☑

Time								
BM Score								

Prevention of Eye Injury — This section NOT applicable ☑

Eyes protected from injury during procedure	Yes ☐	Specify:

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Anaesthetics continued

Maintenance of Normothermia

This section NOT applicable ☑

Actions taken to maintain the patient's temperature	Yes ☐ No ☐	Warm air blanket device – specify: ✓	Yes ☐ No ☐ N/A ☐ ✓
		Warm Fluids ✓	Yes ☐ No ☐ N/A ☐
		Warming Mat	Yes ☐ No ☐ N/A ☐
		Thermal Hat	Yes ☐ No ☐ N/A ☐
		IV fluid warmer	Yes ☐ No ☐ N/A ☐
Temperature documented by Anaesthetist		Other – specify:	Yes ☐ No ☐ N/A ☐

Record of Anaesthetic Pump Infusion Device Numbers

This section NOT applicable ☐

Anaesthetic Practitioner Comments

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Theatre

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient	Yes ☑ / No ☐	Pat Slide ☐	Sliding sheet ☑	Roll board ☐	Hover Mattress ☐	Other: PT MOVES ON OWN.

Pressure Area Care (THIS MUST BE COMPLETED)

Pre-operative skin inspection scores (please circle)	Excoriation Level: 0	Pressure Ulcer Grade: No concerns identified ☐
	mild / moderate / severe	1 2 3 4 Ungradable Suspected Deep tissue

No areas of concern identified ☐ Patient refused ☐

Area of concern identified (include area of body)	Actions taken

Position	Positioning Devices		Pressure redistribution	Arm Position

Position 1
Time:

Supine ☐ Prone ☐
Left Lateral ☑ Right lateral ☐
Lloyd Davis ☐ Jack-knife ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐
Lower limb traction ☐ Deckchair ☐
Other ☐ Lithotomy ☐

Head ring ☐ Lateral supports ☑
Pillows ☑ Hydraulic leg supports ☐
Straps ☐ Limb traction ☐
Wedge ☐ Side supports ☐
Sandbag ☐ Bolster ☐
Oxford pillow ☐ Other ☐
Bean bag ☐
Head Pad ☐

Gel pads ☐
Heel gel pads ☐
Full gel mattress ☐
Gel wedge ☐
Pillows ☐

R Arm Position	L Arm Position
At side ☑	At side ☑
On boards ☐	On boards ☐
Across chest ☐	Across chest ☐
Hand table ☐	Hand table ☐
Hand traction ☐	Hand traction ☐
Secured with:	**Secured with:**
J-board ☐	J-board ☐
Straps ☐	Straps ☐
Pressure care:	**Pressure care:**
Gel/ Foam pads ☑	Gel/ Foam pads ☑

Position 2
Time: N/A

Supine ☐ Prone ☐
Left Lateral ☐ Right lateral ☐
Lloyd Davis ☐ Jack-knife ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐
Lower limb traction ☐ Deckchair ☐
Other ☐ Lithotomy ☐

Head ring ☐ Lateral supports ☐
Pillows ☐ Hydraulic leg supports ☐
Straps ☐ Limb traction ☐
Wedge ☐ Side supports ☐
Sandbag ☐ Bolster ☐
Oxford pillow ☐ Other ☐
Bean bag ☐
Head Pad ☐

Gel pads ☐
Heel gel pads ☐
Full gel mattress ☐
Gel wedge ☐
Pillows ☐

R Arm Position	L Arm Position
At side ☐	At side ☐
On boards ☐	On boards ☐
Across chest ☐	Across chest ☐
Hand table ☐	Hand table ☐
Hand traction ☐	Hand traction ☐
Secured with:	**Secured with:**
J-board ☐	J-board ☐
Straps ☐	Straps ☐
Pressure care:	**Pressure care:**
Gel/ Foam pads ☐	Gel/ Foam pads ☐

Position 3
Time: N/A

Supine ☐ Prone ☐
Left Lateral ☐ Right lateral ☐
Lloyd Davis ☐ Jack-knife ☐
Tren-delenburg ☐ Reverse Tren-delenburg ☐
Lower limb traction ☐ Deckchair ☐
Other ☐ Lithotomy ☐

Head ring ☐ Lateral supports ☐
Pillows ☐ Hydraulic leg supports ☐
Straps ☐ Limb traction ☐
Wedge ☐ Side supports ☐
Sandbag ☐ Bolster ☐
Oxford pillow ☐ Other ☐
Bean bag ☐
Head Pad ☐

Gel pads ☐
Heel gel pads ☐
Full gel mattress ☐
Gel wedge ☐
Pillows ☐

R Arm Position	L Arm Position
At side ☐	At side ☐
On boards ☐	On boards ☐
Across chest ☐	Across chest ☐
Hand table ☐	Hand table ☐
Hand traction ☐	Hand traction ☐
Secured with:	**Secured with:**
J-board ☐	J-board ☐
Straps ☐	Straps ☐
Pressure care:	**Pressure care:**
Gel/ Foam pads ☐	Gel/ Foam pads ☐

Pressure Area care Chart

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Insert KEY to identify pressure re-distribution:-
E – Elevation **U**- unable to access
R - Reposition

Prevention of Compartment Syndrome
Legs in Lloyd Davis or Lithotomy Position: This Section NOT Applicable ☐
Patient legs must be rested for 5 minutes every 3 hours. If this does not happen please document reason in comments section.

Time Legs Positioned	Position	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration

TIME (Hourly)	HEAD/FACE N/A ☐	ARMS N/A ☐ Left	ARMS Right	HEELS N/A ☐ Left	HEELS Right	LEGS N/A ☐ Left	LEGS Right	O2 SENSOR	OPERATING TABLE RE-POSITION N/A ☐	30° TILT With PILLOW N/A ☐	SIGNATURE
1345	PATIENT		POSITIONED					ON	TABLE		

Name:.....
Address:.....
.....
DoB:.....
CHI number:.....
Affix patient data label

Theatre continued

Electrosurgery

This section NOT applicable ☐

Monopolar: Yes ☐ N/A ☑		Bipolar: Yes ☐ N/A ☐
Site(s) of Monopolar Return Electrode:		
Skin site(s) assessed and meets safety criteria as per policy	Yes ☐ No ☐	If 'No' state reason:
Skin site(s) clipped	Yes ☐ N/A ☐	State site:
Return Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☐	If 'No' state reason and action:

Tourniquets

This section NOT applicable ☑

Tourniquet equipment applied	Yes ☐ No ☐ N/A ☐	
Padding under tourniquet	Yes ☐ No ☐ N/A ☐	
Cover over tourniquet	Yes ☐ No ☐ N/A ☐	
Post op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Site and side	Time inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time de-flated

Digit Tourniquet

This section NOT applicable ☑

Site and side applied	Time applied	Time removed

Prescribed DVT Prophylaxis

Contraindicated ☐ This section NOT applicable ☐

Intermittent Pneumatic Compression Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Foot Pump Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
TED Stockings	Yes ☑ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☑
Other – Specify:	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐

Fluids for Irrigation

This section NOT applicable ☑

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Theatre continued

Skin Preparation

This section NOT applicable ☑

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____
Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date: _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____
Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date: _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____
Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐ Batch no: _____ Expiry Date: _____	Chlorhexidine gluconate solution: ___% ☐ Chlorhexidine acetate solution: _____% ☐ Other – Specify: _____% ☐ Batch no: _____ Expiry Date: _____

Local Anaesthetic Infiltration to Wound

This section NOT applicable ☑

Site	Drug	Quantity

Drains

This section NOT applicable ☑

Drain	Site	Type	Size	Secured with	Dressing
1					
2					
3					
4					

Name: .....
Address:.....
.....
DoB: .....
CHI number:.....
Affix patient data label

Traceability Stickers

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Traceability Stickers

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Blood Tag Dispatch

This section NOT applicable ☑

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

Wound Closure and Dressings (including Packing)

This section NOT applicable ☑

Wound Closure used: Yes ☐ No ☐ N/A ☐ | Wound Dressings: Yes ☐ No ☐ N/A ☐

	Site	Skin Closure	Dressings	Packing and number of pieces
1		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
2		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
3		Type: Absorbable ☐ Non Absorbable ☐ Other.....		
4		Type: Absorbable ☐ Non Absorbable ☐ Other.....		

Electrosurgery

Electrosurgery return electrode site post-op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Operation / Procedure Performed

UPPER GI ENDOSCOPY & DUODENAL BIOPSIES & GASTRIC BIOPSIES

Pressure Area Care (MUST BE COMPLETED)

Post-operative skin inspection scores (please circle)	Excoriation Level: mild / moderate / severe	Pressure Ulcer Grade: No concerns identified ☑ 1 2 3 4 Ungradeable Suspected deep tissue

No areas of concern identified ☐ Patient refused ☐

Actions taken if required:

Notes / Comments

Note / Comment	Time	PRINT and Sign
LIDOCAINE THROAT SPRAY GIVEN	1355	

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Immediate Post-Operative Recovery

Surgical handover Instructions e.g. ' hand high elevation'

Verbal Handover from Theatre to Recovery

Verbal Handover given by: To:

Handover should include the following

Patient		**Other**
Patient's name		RSI
Theatre		Awake Fibre Optic Intubation
Procedure		
Allergies		

Recovery

This section NOT applicable ☐

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient: Yes ☐ No ☐	Pat Slide ☐ Sliding Sheet ☐ Roll Board ☐
If 'Yes' please specify (right)	Hover Mattress ☐ Other ☐ Specify:

Pressure Area Care (MUST BE COMPLETED)

Patient refused ☐

See post operative skin inspection score from theatre on previous page

Skin inspection required a minimum 2 hourly

Time	Patient Position	No Concerns Identified	Excoriation Level N/A ☑	Pressure Ulcer Grade N/A ☐
15:15	Supine	NA		

Area of concern identified (include area of body)	Actions taken (continue in events section on page 16)

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

14:45 – 1g IV Paracetamol Caitlin Hair.
15:01 – 3mg IV Morphine Caitlin Hair
15:11 – 3mg IV Morphine Caitlin Hair.

Post-operative Observations

Time			14:30	14:45	15:00	15:06	15:15												
210	97																		
200																			
190																			
180																			
170																			
160																			
150																			
140				139															
130	✓	✓	126	~	130		130												
120			~		~		~												
110																			
100																			
90																			
80	•	°	~	85	83		76												
70	^	^	72																
60																			
50																			
40																			
30																			
Airway type	1	1	1	1	1	1	1												
O_2 Therapy	2	2	A	A	A	2L	2L												
SpO_2	97	96	95	95	93	98	97												
Resp. Rate			17	16	15		12												
F. CG			SR	SR	SR		SR												
CVP			89	81	81		76												
Temp.			36.7	-	-		-												
Pain Score	1	1	9	9	9		7												
P.O.N.V.	0	0	0	0	0		0												
Sedation Score	1	1	0	0	0		0												
BM Score	0	0	-	-	-		-												
PV staining	0	0	-	-	-		-												
Hourly Urine Vol.	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
Total Urine Vol.			DNR	DNR	DNR		DNR												
Wound Score																			
Circulation +ve/-ve																			
Sensation +ve/-ve																			
Movement +ve/-ve																			
Pedal Pulse – R / L																			
Drain 1																			
Staff initials			CH	CH	CH	CH													

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Time							
210							
200							
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							
40							
30							
Airway type							
O_2 Therapy							
SpO_2							
Resp. Rate							
CVP							
Temp.							
Pain Score							
P.O.N.V.							
Sedation Score							
BM Score							
PV Staining							
Hourly Urine Vol. / Total Urine Vol.	/	/	/	/	/	/	/
Wound Score							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – R / L							
Drain 1							
Staff initials							

Key to Scoring / Abbreviations

Airway Type	
1	Own
2	Guedel
3	Naso-pharyngeal
4	L.M.A.
5	E.T.T.
6	Tracheostomy

Post Operative Nausea and Vomiting Assessment	
0	None
1	Mild – *Not distressed; No retching/vomiting*
2	Moderate – *Troublesome; Occasional retching/vomiting*
3	Severe – *Distressing; Frequent retching/vomiting*

Sedation Score	
0	Awake
S	Normal Sleep
1	Drowsy, easy to rouse – *Eyes open to speech or light shaking*
2	Sedated, difficult to rouse – *Eyes open only to vigorous shaking*
3	Unconscious, unrousable

Wound Score	
0	Dry and Intact
1	Slight Staining
2	Moderate Staining
3	Saturation / Pad required

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

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Events

Event	Action	Outcome

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Events

Event	Action	Outcome

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Discharge

NEWS 2 Score: 2 | Time: 15:15 | Local Discharge Criteria met: Yes ☑ No ☐

Discharge Comments 24/2/23 - 15:15.
SpO2 low (93-95%), 2L on nasal cannula applied - SpO2 increased to 97%. All other observations stable as charted. Patient complained of pain score 9/10, IV Paracetamol given as per Hepma and IV morphine given as per recovery protocol / Hepma. Nil by mouth for 2 hours post throat spray: Pain decreased to 5/10, patient visibly more comfortable.

Verbal Handover from Recovery to Ward

Verbal Handover given by: Caitlí Hais. To: Ward 66.

Handover should include the following

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic type	Drains	Skin Inspection results	
Theatre	CVP/Arterial Line	Wounds/Dressings	Surgical Instructions	
Procedure	Local anaesthetic Infiltration	Urinary catheter	NEWS 2 Score	
Allergies		Intra-operative events		
	IV Fluids			
	PVC			
	PVC Documentation			

Blood Tag Dispatch

This section NOT applicable ☑

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

Name: .....
Address: .....
.....
DoB: .....
CHI number: .....
Affix patient data label

Use this page to document further patient information if required.

Intraoperative Accountable Items Count Record

Date 24.02.23

ADDRESSOGRAPH LABEL

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

WARD

HOSPITAL GRI

THEATRE 6

COUNTS	Scrub/Registered Practitioner Print Name	Circulating Practitioner - Signature & Print name
PRE - OP SWAB COUNT		
PRE - OP INSTRUMENT COUNT		
FINAL SWAB COUNT		
FINAL INSTRUMENT COUNT		
FINAL DISPATCH COUNT		

SCRUB PRACTITIONER VERIFICATION

I have reviewed this count and can verify my count is correct

SCRUB PRACTITIONER 1 (Sign) - .....

SCRUB PRACTITIONER 2 (Sign) - ..... N/A ☑

OPERATION : OGD + Biopsies.

HANDOVER COUNT IN EVENT OF REPLACEMENT SCRUB PERSONEL DURING PROCEDURE
(This Section N/A) ☑

Temporary Change of Scrub Practitioner (Comments if required)	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner Signature/Print Name and Time	
	Outgoing Scrub (2) Print Name	Incoming Scrub (1) Print Name	Circulating Practitioner Signature/Print Name and Time	
Permanent Change of Scrub Practitioner and/or Circulating Practitioner	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner (1) Signature/Print Name and Time	
			Circulating Practitioner (2) Signature/Print Name and Time	

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)	0	Pledgelets	0	Caesarean Roll	0	ACCOUNTABLE ITEMS THAT ARE TO REMAIN IN SITU e.g. Abdo packs/Swabs, Quantity and Location
Swabs (10x10)	5	Tapes	0			
Abdominal packs	0	Sloops/Slings	0			
Sutures	6	Bulldogs	0			
Blades	6	Shods	0			
IV needles	0	Ports	0			
Syringes	6	Tibbs Cannula	0			
Discard-a-pad	0	Staple Gun Inserts	0			
Diathermy pencil	0	Spears	0			
Diathermy tips	0	Retrieval Bag (Bert)	0			
Scratch pad	0	Digital Tourniquets	0	Throat Pack IN	☐	
Reels	0	Pen & Ruler	0	Throat pack OUT	☐ ☐ ☐ ☐	
Patties	6	Bi-Polar	0	Total Number		

DISCREPANCY IN COUNT - THIS SECTION N/A ☑

DETAIL IN WHICH COUNT DISCREPANCY OCCURRED:-

Detail of the discrepancy:-

CTION TAKEN AND OUTCOME (e.g. search undertaken, wound explored, plain x-ray taken)

uty Practitioner Signature if count still incorrect

.....

Datix is Completed ☐

Datix Incident Number.....

EONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS .....

SE INSERT TRACEABILITY LABELS ON BACK OF BLUE COPY- TO REMAIN IN THEATRE.

0712726128

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

Theatre: C

Date: 24/2/25

Patient Safety Checklists
North Sector Theatre Suite

NHS Greater Glasgow and Clyde

Anaesthetic Pause (Sign in)
Before any form of sedation or anaesthesia

Patient, Anaesthetist, Assistant/ODP to participate in the anaesthetic pause and cease their tasks:

Silence for pause.

Ask the patient their name and DoB. Check this matches name band and CHI is correct? Y/N

Does the patient have any Allergies? Y/N
Or metalwork? Y/N

Ask the patient what operation they are having?
Is there a signed consent form for the expected procedure? Y/N

Laterality – has the patient been marked? Y/ N/ NA
If lateral block planned attach
STOP BEFORE YOU BLOCK sticker. Y/N
If neuraxial block, check last dose LMWH >12h Y/N

Pregnancy: confirm that the pregnancy status question has been asked. Y/ N/ NA
(n/a in males, females >55, previous hysterectomy/BSO, post menopausal, surgery for ERPOC)

Anaesthetic equipment available and checked ready to use? Y/N/ NA

Name/Signed [signature]

Surgical Pause - Pre Skin Incision
Before start of surgical intervention

All the theatre team to participate in the surgical pause and cease their tasks:

Silent theatre for pause.

Scrub Team to Confirm:
Patient Name, DoB, CHI on Name Band and Consent Form? Y/N

Operation and Laterality on Consent Form (and check mark if laterality)? Y/N

Anaesthetic Team to Confirm:
Patient Allergies? Y/N
Antibiotics given in correct dose? Y/ N/ NA
A.S.A. 1E
Warming required ? Y/N
Any concerns ? Y/N

Anaesthetic Assistant to Confirm:
Position of any metalwork/ pacemaker? Y/N

Surgeon to Confirm:
Does imaging need to be displayed? Y/N
Any concerns? Y/N
Intra-op DVT prophylaxis? Y/N
If yes circle TED's/Flowtrons/LMWH Y/N

Circulating Team to Transfer Information above to the Theatre Whiteboard? YES

Emergency cases: CEPOD category agreed? Y/N
ELLSA data completed ? Y/ N/ NA

Name/Signed [signature]

Sign Out
Towards the end of procedure

All the theatre team to participate in the surgical sign out and cease their tasks:

Silent theatre for sign out.

Lead surgeon at table (start of skin closure) Y/N

Has the correct procedure been recorded? Y/N
Is the swab, needle and instrument count correct? Y/N

Is there a specimen? Y/N
Confirm - labelled and recorded correctly? Y/N

Are there any packs or drains in the patient? Y/N
What are the post-op instructions for these?

What is the estimated blood loss (EBL)? Min. ml

Are more antibiotics required? Y/N
Has post-op VTE prophylaxis been prescribed? Y/NA

Can the patient eat and drink immediately post-op? Y/N

Any concerns for the recovery and management of this patient? Y/N

Is the post-op destination still appropriate? Y/N

Name/Signed [signature]

Review Date: June 2024

Operation note: OGD and Biopsy

NHS
Greater Glasgow and Clyde
Glasgow Royal Infirmary
Alexandra Parade
Glasgow
G31 2ER
Main Switchboard: 0141 211 4000
Department: General Surgery
Contact Tel:
Enquiries to:
Letter Date: 24/02/2023
Reference: DA
Dictated Date: 24/02/2023
Transcribed Date: 24/02/2023

D Anderson ST6

Glasgow Royal Infirmary
Department: General Surgery

Sedation procedure - 4mg midazolam

OGD and biopsy

OGD and Biopsy with CLO test

Indication: Emergency Admission. Previous gallstone pancreatitis with subsequent cholecystectomy. Previous fundoplication. Admitted with N+V, epigastric pain and reflux Sx. Amylase Normal. CT Normal. Blood panel unremarkable. Note normal Ph and Manometry studies 2022. EUS 2020 unconvincing for Chronic Pancreatitis.

Findings: Large volume of food residue in stomach in keeping with delayed emptying. Significant volume of bile reflux associated with this.

Oesophagus - Normal.

Stomach - Food residue; bile ++; changes in keeping with gastritis. The fundus was not completely visualised despite wash and persistence due to food residue here; no obvious abnormalities seen otherwise

Duodenum - duodenitis; bile in duodenum refluxing through pylorus. No other findings

Pre-Operatively: Explanation and consent, review of notes and previous imaging/investigations, supine, WHO Checklist and surgical pause, Midazolam sedation 4mg, TEDs, Mouth guard placed.

Procedure: OGD performed to D2. Findings as described above. D2 Biopsies taken and sent for histopathology. Gastric Biopsies taken and sent for histopathology. CLO test taken. J-manoeuvre performed.

Bile reflux and large food residue with gastro-duodenitis in keeping with possible biliary dyspepsia and delayed emptying. She has been extensively investigated before but don't see gastric emptying studies. Would suggest dietary advice, a trial of Sucralfate for bile reflux and consider emptying studies of symptoms not settling.

Post-Operative Instructions

-To recovery and then ward level care

-Routine observations

-E+D as tolerated

-Trial of sucralfate for bile reflux

-Could consider emptying studies of ongoing symptoms of concern; not perfect views due to food residue so post Rx endoscopy in a few months could also be considered

-Let me know if any concern

NHS Greater Glasgow and Clyde

GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1, 8 Boyndie Street**
Date of birth:	**07/12/1972**		**Easterhouse**
CHI No:	**0712726128**		**Glasgow**
Case note no.:	**0712726128**		**Lanarkshire**
			G34 9JE

GP:	**MCGINLEY, ANNE**	Procedure date:	**10th December 2019 (08:50)**
	Lochend Surgery	Priority:	**Urgent**
	Easterhouse Health Centre	Status:	**Inpatient/NHS**
	9 Auchinlea Road	Hospital:	**GRI**
	Glasgow	Ward:	**(none)**
	G34 9HQ	Referring Cons:	**Mr Nigel Jamieson (General Surgery)**

Indications
Haematemesis.
Clinically important comments: Possible haematemesis.
Background noted, gut dysmotility, delayed gastric emptying, previous fundoplication, Endoscopy October 19.
Hb and urea unchanged.

Report
The procedure was completed successfully to D2.
The whole upper gastro-intestinal tract was normal.

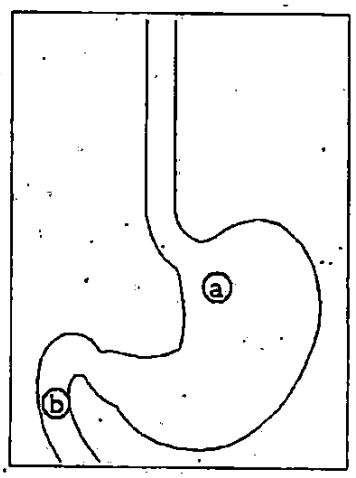
Advice/comments
No fresh or altered blood in the upper GI tract. Small food residue in keeping with delayed gastric emptying.
Reassuring line taken.

Follow up
Return to the ward.

Consultant/Endoscopist
List consultant: Dr Neil Lachlan
Endoscopist No1: Dr J Palmer
Endoscopist No2: Dr Neil Lachlan

Instrument
SCANTRACK

Premedication
Midazolam (IV) 3 mg
Xylocaine (Spray) 100 mg



a: *Upper body (photographed)*
b: *Second part (photographed)*

Dr J Palmer
ST3

Acute Services Division

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah
F
07/12/1972

Perioperative Care Plan

Hospital: GRI	Consultant: MISS QUINN
Ward: 64	Date:

Theatre Staff - The following information can be found within the My Admission Record (MAR)

	Checked by: Reception Practitioner	Anaesthetic Practitioner
• Relevant Medical History - see MAR	Yes ☐ No ☐	Yes ☐ No ☐
	Yes ☐ No ☐	Yes ☐ No ☐

THEATRE STAFF – For Baseline Observations refer to NEWS chart.

WARD Other information

Document any other relevant information e.g. needle phobia, request for female practitioner, preferred name, interpreter arranged.

Please provide e.g. theatre buddy, 'Getting to know me' document if available.

PMH: CHRONIC PANCREATITIS, CHOLECYSTECTOMY · REDO NISSANS FUNDOPLICATION GASTRIC DYSMOTILITY / OESOPHAGEAL SPASM · DELAED GASTRIC EMPTYING HAEMATEMESIS: N100M P100, APPENDECTOMY RECD MYALOMA.

WARD Safety Checklist

Up-to-date Blood Results available on Clinical Portal	Yes ☑ No ☐	Comments if required:
Blood Cross Matched confirmed by labs	Yes ☐ No ☐ N/A ☑	
Blood Grouped and Saved confirmed by labs	Yes ☐ No ☐ N/A ☑	
Antibodies +ve ☐ -ve ☐		
Date of Last Menstrual Period (LMP) N/A ☐	Date 27/10/19	
Is there any chance you are pregnant? N/A ☐	Yes ☐ No ☑	
Pregnancy test carried out with the patient's consent	Yes ☐ Refused ☐	
Pregnancy test result	Postive ☐ Negative ☐	
Tampon removed N/A ☐	Yes ☐	
MRSA Positive ☐ Negative ☐ Results pending ☐ N/A ☑		
CPE Positive ☐ Negative ☐ Results pending ☐ N/A ☑		
Topical Local Anaesthetic applied	Yes ☐ No ☐ N/A ☑	
Specify site and time applied	Site 1:	
	Time:	
	Site 2:	
	Time:	

N.
Ac 0712726128 F
SULLIVAN 07/12/1972
Deborah
Do
CH

SAFETY Checklist – Ward Check completed immediately prior to the patient being given a Pre-Med

Preoperative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Practitioner
IDENTITY BAND CORRECT (Name, DoB, CHI number, gender, Ward)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Case Notes / Scanner Folder (circle)	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
ECG	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐
MAR document	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
NEWS chart	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Falls risk assessment	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐
X-Ray and Scans – Hardcopy	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐
Prescription Chart	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
PUDRA	Yes ☐ N/A ☐	Yes ☐ N/A ☑	Yes ☐ N/A ☐
Alert Sticker – specify:	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
PVC Care Plan in place	Yes ☐ No ☐ N/A ☐	Yes ☑ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
CONSENT FORM checks AWI ☐			
Correct patient information	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Procedure matches theatre list	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Patient confirms proposed procedure	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Correct site marked	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐
Signed by Surgeon and Patient	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
Dated	Yes ☐ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
ADULTS WITH INCAPACITY (AWI) N/A ☐ Check;			
2 page Certificate of Incapacity for Single Procedure;	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
Matches Theatre list	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dated and Signed by operating surgeon	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Correct site marked	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
4 page Capacity Documentation for Medical treatment present	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Certificate of Incapacity under section 47 completed and;	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Dated and signed by medical practitioner	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
ALLERGIES/Sensitivities and Reactions (Please also include food allergies)	Yes ☑ No ☐	Yes ☑ No ☐	Yes ☐ No ☐
If 'Yes' specify:	PENICILLIN ;		
Fasted from – specify time (24 hr clock) N/A ☐ 0600	Food: ✓	Food: 1900 9/12/19	Food:
	Fluid: ✓	Fluid: 1900 9/12/19	Fluid:
Blood Glucose Score – if relevant	Time: Score: N/A ☐	Time: 0840 Score: 10.9 N/A ☐	Time: Score: N/A ☐
INTERNAL PROSTHESIS in situ e.g. metalwork, pacemaker, implant etc If 'Yes' state location and type	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
EXTERNAL PROSTHESIS N/A ☐ e.g. hairpiece, false eye etc. If 'Yes' state type where stored	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
C.. number.....
Affix patient data label

Pre-operative checks	Ward Check	Reception Check N/A ☐	Anaesthetic Assistant
Dentures removed N/A ☑ If 'Yes' state where stored	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☑	Yes ☐ No ☐ N/A ☐
Loose teeth, caps and crowns and veneers State site and type	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
Hearing aid(s) N/A ☑ If removed state where stored	R ☐ L ☐ Insitu ☐ Removed ☐	R ☐ L ☐ N/A Insitu ☐ Removed ☐	R ☐ L ☐ Insitu ☐ Removed ☐
Spectacles/Contact lenses removed N/A ☑ If 'Yes' state where stored	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
Make-up/ Nail polish removed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
False nails in situ – Anaesthetist informed N/A ☑	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Jewellery/Body piercing removed N/A ☑ If 'yes' state where stored If unable to remove, please tape and state location	Yes ☐ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
Have you ever been notified that you are at increased risk of CJD or vCJD for public health purposes?	Yes ☐ No ☑ Not Known ☐	If yes, contact Infection Control Team and Theatres. Infection Control Team Informed on ___/___/___ Comments if required:	
Inhalers/ sprays with patient N/A ☑	Yes ☐ No ☑	Type:	
Anti-embolic Prophylaxis – N/A ☐	Yes ☑ No ☐ TED's to leave	Type:	
Paper pants in situ – If 'No' specify reason:	Yes ☐ No ☑	State reason:	
Voided urine/ Catheter in situ/ Urostomy (circle)	Yes ☑ No ☐	Comment if required:	
Pre-Medication given N/A ☐	Yes ☑ No ☐	Yes ☐ No ☑	Yes ☐ No ☐
Trolley/ Bed checked for head down tilt and O_2/ Accessories	Bed ☐ Trolley ☐ Operating chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☑ Operating chair ☐ Yes ☐ No ☐	Bed ☐ Trolley ☐ Operating chair ☐ Yes ☐ No ☐
PLEASE PRINT NAME AND SIGN ONCE CHECKLIST IS COMPLETE	Print: R Docherty Sign: R Docherty Time:	Print: R Reid Sign: R Reid Time: 0835	Print: Sign: Time::

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

[illegible] & Surgical Pause

Surgical Brief carried out:	Yes ☐ No ☐	If 'No' specify reason:
Surgical Pause carried out:	Yes ☐ No ☐	If 'No' specify reason:

Anaesthetics

Baseline Observations	Pulse:	BP:	Temp:	SpO_2:	Resps:

Anaesthetic practitioner has confirmed with Anaesthetist that cross matched blood is:	Required: Yes ☐ N/A ☐	Available: Yes ☐ No ☐	Or patient has been Grouped and Saved: Yes ☐ No ☐

Stop Before You Block — This section NOT applicable ☐

Stop Before You Block carried out:	Yes ☐ No ☐

Anaesthetic Type – Please tick all that apply

General Anaesthetic ☐	Epidural ☐ Spinal ☐ Combined ☐	Regional Blocks ☐	Throat spray ☐ Time: _____
Local Anaesthetic ☐	Site: Drug:		mls
Sedation ☐	Drug:		mls

PVC site _____ Skin Prep specify: Batch no. _____
time inserted _____ Expiry date _____

Skin Prepping used for Patient Monitoring / Blocks — This section NOT applicable ☐

ARTERIAL CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
CVP CATHETER	Yes ☐ N/A ☐	Chlorhexidine 2%/70% alcohol ☐ Chlor-a-prep solution ☐	Yes ☐ Yes ☐	Other ☐ Specify prep:
SPINAL / EPIDURAL / COMBINED	Yes ☐ N/A ☐	Specify prep:	Skin prep Batch no. _____ Expiry Date _____	
REGIONAL BLOCK	Yes ☐ N/A ☐	Specify prep:	Skin prep Batch no. _____ Expiry Date _____	

Blood Glucose Monitoring — This section NOT applicable ☐

Time								
BM Score								

Prevention of Eye Injury — This section NOT applicable ☐

Eyes protected from injury during procedure	Yes ☐	Specify:

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

Anaesthetics continued

Maintenance of Normothermia — This section NOT applicable ☐

Actions taken to maintain the patient's temperature	Yes ☐ No ☐	Warm air blanket device – specify:	Yes ☐ No ☐ N/A ☐
		Warm Fluids	Yes ☐ No ☐ N/A ☐
		Warming Mat	Yes ☐ No ☐ N/A ☐
		Thermal Hat	Yes ☐ No ☐ N/A ☐
		IV fluid warmer	Yes ☐ No ☐ N/A ☐
		Other – specify:	Yes ☐ No ☐ N/A ☐
Temperature documented by Anaesthetist	Yes ☐ No ☐		

Record of Anaesthetic Pump Infusion Device Numbers — This section NOT applicable ☐

Anaesthetic Comments

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

Theatre

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient	Yes ☐ No ☐	Pat Slide ☐	Sliding sheet ☐	Roll board ☐
		Hover Mattress ☐	Other:	

Pressure Area Care (THIS MUST BE COMPLETED)

Pre-operative skin inspection scores (please circle)	Excoriation Level:	Pressure Ulcer Grade:
	mild / moderate / severe	1 2 3 4 Ungradable Suspected Deep tissue

Area of concern identified (include area of body)	Actions taken

Position	Positioning Devices		Pressure redistribution	Arm Position
Position 1 **Time:** Supine ☐ Prone ☐ Left Lateral ☐ Right lateral ☐ Lloyd Davis ☐ Jack-knife ☐ Tren-delenburg ☐ Reverse Tren-delenburg ☐ Lower limb traction ☐ Deckchair ☐ Other ☐ Lithotomy ☐	Head ring ☐ Pillows ☐ Straps ☐ Wedge ☐ Sandbag ☐ Oxford pillow ☐ Bean bag ☐ Head Pad ☐	Lateral supports ☐ Hydraulic leg supports ☐ Limb traction ☐ Side supports ☐ Bolster ☐ Other ☐	Gel pads ☐ Heel gel pads ☐ Full gel mattress ☐ Gel wedge ☐ Pillows ☐	**R Arm Position** At side ☐ On boards ☐ Across chest ☐ Hand table ☐ Hand traction ☐ **Secured with:** J-board ☐ Straps ☐ **Pressure care:** Gel/ Foam pads ☐ **L Arm Position** At side ☐ On boards ☐ Across chest ☐ Hand table ☐ Hand traction ☐ **Secured with:** J-board ☐ Straps ☐ **Pressure care:** Gel/ Foam pads ☐
Position 2 **Time:** Supine ☐ Prone ☐ Left Lateral ☐ Right lateral ☐ Lloyd Davis ☐ Jack-knife ☐ Tren-delenburg ☐ Reverse Tren-delenburg ☐ Lower limb traction ☐ Deckchair ☐ Other ☐ Lithotomy ☐	Head ring ☐ Pillows ☐ Straps ☐ Wedge ☐ Sandbag ☐ Oxford pillow ☐ Bean bag ☐ Head Pad ☐	Lateral supports ☐ Hydraulic leg supports ☐ Limb traction ☐ Side supports ☐ Bolster ☐ Other ☐	Gel pads ☐ Heel gel pads ☐ Full gel mattress ☐ Gel wedge ☐ Pillows ☐	**R Arm Position** At side ☐ On boards ☐ Across chest ☐ Hand table ☐ Hand traction ☐ **Secured with:** J-board ☐ Straps ☐ **Pressure care:** Gel/ Foam pads ☐ **L Arm Position** At side ☐ On boards ☐ Across chest ☐ Hand table ☐ Hand traction ☐ **Secured with:** J-board ☐ Straps ☐ **Pressure care:** Gel/ Foam pads ☐
Position 3 **Time:** Supine ☐ Prone ☐ Left Lateral ☐ Right lateral ☐ Lloyd Davis ☐ Jack-knife ☐ Tren-delenburg ☐ Reverse Tren-delenburg ☐ Lower limb traction ☐ Deckchair ☐ Other ☐ Lithotomy ☐	Head ring ☐ Pillows ☐ Straps ☐ Wedge ☐ Sandbag ☐ Oxford pillow ☐ Bean bag ☐ Head Pad ☐	Lateral supports ☐ Hydraulic leg supports ☐ Limb traction ☐ Side supports ☐ Bolster ☐ Other ☐	Gel pads ☐ Heel gel pads ☐ Full gel mattress ☐ Gel wedge ☐ Pillows ☐	**R Arm Position** At side ☐ On boards ☐ Across chest ☐ Hand table ☐ Hand traction ☐ **Secured with:** J-board ☐ Straps ☐ **Pressure care:** Gel/ Foam pads ☐ **L Arm Position** At side ☐ On boards ☐ Across chest ☐ Hand table ☐ Hand traction ☐ **Secured with:** J-board ☐ Straps ☐ **Pressure care:** Gel/ Foam pads ☐

Pressure Area care Chart

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

Insert KEY to identify pressure re-distribution:-
E – Elevation
R - Reposition
U- unable to access

TIME (Hourly)	HEAD/FACE N/A ☐	ARMS N/A ☐ Left	ARMS Right	HEELS N/A ☐ Left	HEELS Right	LEGS N/A ☐ Left	LEGS Right	O2 SENSOR	OPERATING TABLE RE-POSITION N/A ☐	30° TILT With PILLOW N/A ☐	SIGNATURE

Prevention of Compartment Syndrome
Legs in Lloyd Davis or Lithotomy Position:

This Section NOT Applicable ☐
Patient legs must be rested for 5 minutes every 3 hours. If this does not happen please document reason in comments section.

Time Legs Positioned	Position	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration	Time legs lowered and duration

Nam
Addr 0712726128
SULLIVAN F
Deborah 07/12/1972
DoB: Flat 0-1, 8 Boyndie Street
CHI r Easterhouse
Glasgow, Lanarkshire
G34 9JE

Theatre continued

Electrosurgery — This section NOT applicable ☐

Monopolar: Yes ☐ N/A ☐		Bipolar: Yes ☐ N/A ☐
Site(s) of Monopolar Return Electrode:		
Skin site(s) assessed and meets safety criteria as per policy	Yes ☐ No ☐	If 'No' state reason:
Skin site(s) clipped	Yes ☐ N/A ☐	State site:
Return Electrode site(s) checked after patient repositioned and is satisfactory	Yes ☐ No ☐ N/A ☐	If 'No' state reason and action:
Post-op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Tourniquets — This section NOT applicable ☐

Tourniquet equipment applied	Yes ☐ No ☐ N/A ☐	
Padding under tourniquet	Yes ☐ No ☐ N/A ☐	
Cover over tourniquet	Yes ☐ No ☐ N/A ☐	
Post op skin check(s) is satisfactory	Yes ☐ No ☐	If 'No' state reason and action:

Site and side	Time inflated	Pressure	Time deflated	Time re-inflated	Pressure	Time deflated

Digit Tourniquet — This section NOT applicable ☐

Site and side applied	Time applied	Time removed

DVT Prophylaxis — This section NOT applicable ☐

Intermittent Pneumatic Compression Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Foot Pump Devices: _____ mmHg	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
TED Stockings	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐
Other – Specify:	Yes ☐ No ☐ N/A ☐	Left ☐ Right ☐ Bilateral ☐

Fluids for Irrigation — Batch no./Expiry Date — This section NOT applicable ☐

0712726128
SULLIVAN
Deborah
F
07/12/1972

patient data label

Theatre continued

Skin Preparation

This section NOT applicable ☐

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐	Chlorhexidine gluconate solution: ___ % ☐ Chlorhexidine acetate solution: ___ % ☐ Other – Specify: ___ % ☐ Batch no: ___ Expiry date: ___

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐	Chlorhexidine gluconate solution: ___ % ☐ Chlorhexidine acetate solution: ___ % ☐ Other – Specify: ___ % ☐ Batch no: ___ Expiry date: ___

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐	Chlorhexidine gluconate solution: ___ % ☐ Chlorhexidine acetate solution: ___ % ☐ Other – Specify: ___ % ☐ Batch no: ___ Expiry date: ___

Site – specify: N/A ☐	Clipped	Preparation solution used	
	Yes ☐ No ☐ N/A ☐	Aqueous iodine based solution ☐ Alcohol iodine based solution ☐ Aqueous iodine and sodium chloride 50/50 ☐	Chlorhexidine gluconate solution: ___ % ☐ Chlorhexidine acetate solution: ___ % ☐ Other – Specify: ___ % ☐ Batch no: ___ Expiry date: ___

Local Anaesthetic Infiltration to Wound

This section NOT applicable ☐

Site	Drug	Quantity

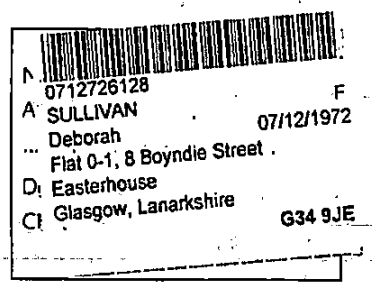
Drains

This section NOT applicable ☐

Drain	Site	Type	Size	Secured with	Dressing
1					
2					
3					
4					

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

Traceability Stickers



Traceability Stickers

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

Blood Tag Dispatch

This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐

Wound Closure and Dressings (including Packing)

This section NOT applicable ☐

Wound Closure used: Yes ☐ No ☐ N/A ☐

Wound Dressings: Yes ☐ No ☐ N/A ☐

	Site	Wound Closure	Dressings	Packing
1				
2				
3				
4				

Operation / Procedure Performed

Pressure Area Care (MUST BE COMPLETED)

Post-operative skin inspection scores (please circle)	Excoriation Level: mild / moderate / severe	Pressure Ulcer Grade: 1 2 3 4 Ungradeable Suspected deep tissue

Actions taken if required:

Notes / Comments

Note / Comment	Time	PRINT and Sign

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

Immediate Post-Operative Recovery

Surgical Instructions

Verbal Handover from Theatre to Recovery

Verbal Handover given by: To:

Handover should include the following

Patient	Anaesthetic	Theatre	Other
Patient's name	Anaesthetic type	Drains	RSI
Theatre	CVP/Arterial Line	Wounds/Dressings	Awake Fibre Optic Intubation
Procedure	Local anaesthetic Infiltration	Urinary catheter	
Allergies		Skin inspection results	
	IV Fluids	Intra-operative events	
	PVC	Surgical Instructions	
	PVC Documentation		
	Airway type		

Recovery

This section NOT applicable ■

Safe Positioning

This section NOT applicable ☐

Moving aids used to move patient: Yes ☐ No ☐
If 'Yes' please specify (right)

Pat Slide ☐ Sliding Sheet ☐ Roll Board ☐
Hover Mattress ☐ Other ☐ Specify:

Pressure Area Care (MUST BE COMPLETED)

See post operative skin inspection score from theatre on previous page

Skin inspection required a minimum 2 hourly

Time	Position	Excoriation Level	Pressure Ulcer Grade (if applicable)	Evaluation	Action

Area of concern identified (include area of body)	Actions taken

Nan
Adi
.... 07/12/1972 F
D
(

0712726128
SULLIVAN
Deborah

Post-operative Observations

Time																		
210																		
200																		
190																		
180																		
170																		
160																		
150																		
140																		
130																		
120																		
110																		
100																		
90																		
80																		
70																		
60																		
50																		
40																		
30																		
Airway type																		
O_2 Therapy																		
SpO_2																		
Resp. Rate																		
CVP																		
Temp.																		
Pain Score																		
P.O.N.V.																		
Sedation Score																		
BM Score																		
PV staining																		
Hourly Urine Vol.																		
Total Urine Vol.																		
Wound Score																		
Circulation +ve/-ve																		
Sensation +ve/-ve																		
Movement +ve/-ve																		
Pedal Pulse – R / L																		
Drain 1																		
Staff initials																		

0712726128
F SULLIVAN
07/12/1972 Deborah

Time							
210							
200							
190							
180							
170							
160							
150							
140							
130							
120							
110							
100							
90							
80							
70							
60							
50							
40							
30							
Airway type							
O_2 Therapy							
SpO_2							
Resp. Rate							
CVP							
Temp.							
Pain Score							
P.O.N.V.							
Sedation Score							
BM Score							
PV Staining							
Hourly Urine Vol. / Total Urine Vol.							
Wound Score							
Circulation +ve/-ve							
Sensation +ve/-ve							
Movement +ve/-ve							
Pedal Pulse – R / L							
Drain 1							
Staff initials							

Key to Scoring / Abbreviations

Airway Type

1	Own
2	Guedel
3	Naso-pharyngeal
4	L.M.A.
5	E.T.T.
6	Tracheostomy

Post Operative Nausea and Vomiting Assessment

0	None
1	Mild – *Not distressed; No retching/vomiting*
2	Moderate – *Troublesome; Occasional retching/vomiting*
3	Severe – *Distressing; Frequent retching/vomiting*

Sedation Score

0	Awake
S	Normal Sleep
1	Drowsy, easy to rouse – *Eyes open to speech or light shaking*
2	Sedated, difficult to rouse – *Eyes open only to vigorous shaking*
3	Unconscious, unrousable

Wound Score

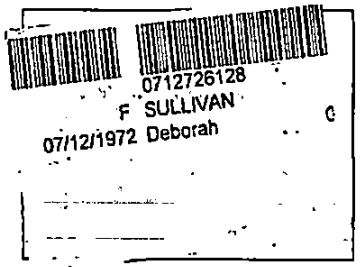
0	Dry and Intact
1	Slight Staining
2	Moderate Staining
3	Saturation / Pad required

Pain Score

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

Events

Event	Action	Outcome



Events		
Event	Action	Outcome

0712726128
SULLIVAN
Deborah
F
07/12/1972

Discharge

NEWS Score:	Time:	Local Discharge Criteria met: Yes ☐ No ☐

Discharge Comments

Verbal Handover from Recovery to Ward

Verbal Handover given by: To:

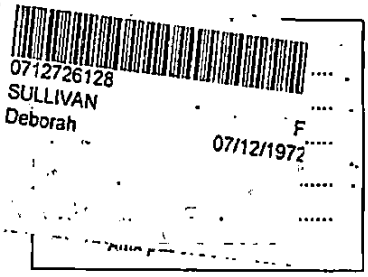
Handover should include the following

Patient	Anaesthetic	Theatre	Recovery	Other
Patient's name	Anaesthetic type	Drains	Skin Inspection results	
Theatre	CVP/Arterial Line	Wounds/Dressings	Surgical Instructions	
Procedure	Local anaesthetic Infiltration	Urinary catheter	NEWS Score	
Allergies		Intra-operative events		
	IV Fluids			
	PVC			
	PVC Documentation			

Blood Tag Dispatch

This section NOT applicable ☐

Blood Tags checked and dispatched appropriately: Yes ☐ No ☐



Use this page to document further patient information if required.

NHS Intraoperative Accountable Items Count Record

Date 29.9.19

ADDRESSOGRAPH

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

WARD

HOSPITAL GRI

THEATRE A

COUNTS	Scrub/Registered Practitioner Print Name	Circulating Practitioner(s) - Signature & Print name
PRE - OP SWAB COUNT	N/A	R Lewsley RN
PRE - OP INSTRUMENT COUNT	N/A	N/A
FINAL COUNT	N/A	R Lewsley RN
FINAL INSTRUMENT COUNT	N/A	N/A
FINAL DISPATCH COUNT	N/A	R Lewsley RN

SCRUB PRACTITIONER VERIFICATION

I have reviewed this count and can verify my count is correct
SCRUB PRACTITIONER 1- SIGNATURE:

SCRUB PRACTITIONER 2 - SIGNATURE :
To be signed by replacement scrub practitioner if applicable N/A ☐

OPERATION : upper GI endoscopy

HANDOVER COUNT IN EVENT OF REPLACEMENT SCRUB PERSONEL DURING PROCEDURE
(This Section N/A) ☐

Temporary Change of Scrub Practitioner (Comments if required)	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner Signature/Print Name and Time
	Outgoing Scrub (2) Print Name	Incoming Scrub (1) Print Name	Circulating Practitioner Signature/Print Name and Time
Permanent Change of Scrub Practitioner and/or Circulating Practitioner	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner (1) Signature/Print Name and Time
			Circulating Practitioner (2) Signature/Print Name and Time

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)		Pledgelets		Caesarean Roll		ACCOUNTABLE ITEMS THAT ARE TO REMAIN IN SITU e.g. Abdo packs/Swabs, Quantity and Location
Swabs (10x10)	5	Tapes				
Abdominal packs		Sloops/Slings				
Sutures		Bulldogs				
Blades		Shods				
IV needles		Ports				
Syringes		Tibbs Cannula				
Discard-a-pad		Staple Gun Inserts				
Diathermy pencil		Spears				
Diathermy tips		Retrieval Bag (Bert)				
Scratch pad		Digital Tourniquets		Throat Pack IN		
Reels		Pen & Ruler		Throat pack OUT		
Patties		Bi-Polar		Total Number		

DISCREPANCY IN COUNT - THIS SECTION N/A ☐

DETAIL WHICH COUNT DISCREPANCY OCCURRED

Detail of the discrepancy:-

ACTION TAKEN AND OUTCOME (e.g. search undertaken, wound explored, plain x-ray taken)

Scrub Practitioner Signature if count still incorrect	Ensure Datix is Completed ☐ Datix Incident Number.....

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS .....

PLEASE INSERT TRACEABILITY LABELS ON BACK OF BLUE COPY- TO REMAIN IN THEATRE.

Peri-Operative Care Plan

NHS Greater Glasgow and Clyde

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

Date: 29/9/19.
Ward: 65
Consultant: Mr. Durbury.
Proposed operation:

Baseline Observations

Water Low Score:	Pulse:	BP:	Temp:	SPO2:	Resp.	Height: Weight:	BMI:
	100	123/89	36°C	97%	14.		

These checks must be made immediately prior to administration of pre-med.

Pre-operative checks comments:	Ward comments:	Reception
Identify band correct (name, date of birth, hospital number, ward	✓	Correct
Consent signed and dated	✓	Consented
Fasted from:	Food: 10pm 28/9 05:30 Fluid?	Fasted
Correct site surgery marked and prepared		
Allergies/sensitivities and reaction	Penicillin →	rash
Medical conditions, i.e. other relevant information:	fundo x2. T2DM BM 11.3 @ 06:30	
Inhalers/Sprays	N/A	NIL
Blood Glucose (if relevant)	11.3 mmol @ 06:30	BM 9.1 @ 07:0
Antiembolitic Treatment e.g. TEDs	✓	TEDS in SIN ✓
Implants insitu e.g. pacemaker, joint replacements	N/A	NIL
Dentures / loose teeth, Caps, Crowns	own teeth.	OWN TEETH - SECURE
Hearing Aid, Spectacles and Hair pieces remaining in situ (contact lenses to be removed) - please state		
Are you or could you be pregnant? Yes / No If "Yes", pregnancy test should be performed with patient's consent Pregnancy test results +ve / -ve SD7 Yes / No		
Group and Save Yes / No Date Antibodies +ve / -ve		
Make up/nail polish removed	✓	NIL
Jewellery/body piercing taped/removed	✓	NIL
Underwear removed/disposable pants	✓	NIL
Voided urine/catheter insitu	✓	P.V.
Documentation (case notes, nursing notes, prescription charts, ECG, X-ray, Blood results)		
Premedication given:		

Please sign once check completed:

Ward Nurse:	Reception Practitioner:	Anaesthetic assistant/Theatre Practitioner

Time into Reception: _____

Operational Data	Time into Anaesthetic Room [ ][ ][ ][ ] Time into Theatre [1][0][2][0] Time out of Theatre [ ][ ][ ][ ]	Scrub Practitioner _____ Circulating Practitioner C. McWilliams, C Dougall, L Cassidy Anaesthetic Assistant A. Smith

ANAESTHETIC ROOM

Blood Availability check	Anaesthetic Practitioner has confirmed with Anaesthetic that X matched blood is:- Required ☐ Available ☐ Grouped and Saved ☐ *(tick or cross as necessary)*	
Psychological care given to allay anxiety	Verbal & Non Verbal Communication given ☐ Explanation of expected events/routine given ☐ Communication adapted to meet needs of the patient ☐ Certificate of Incapacity ☐	
Safe Application, Preparation and Use of Equipment	SP02 ☑ Position Rotated Hourly ☐ Arterial Line ☐ CVP Line ☐ Temperature probe ☐	Infusion Device Numbers
	ECG ☑ Warming Device	
	NIBP ☐ Other	

THEATRE

Information given in Scrub Nurse and Senior Circulating Nurse by Anaesthetic Nurse	Scrub nurse must check patient ID band with consent ☐ Patient Allergies ☐ Prosthesis ☐ Other ☐ Name Scrub Practitioner n/a
Operation Site & procedure safety check	Scrub Nurse and Senior Circulating Nurse confirms with Surgeon the procedure to be performed ☐ Correct Site and Site of operation ☐
Safe positioning and prevention of injury to Skin, Joints and Nerves	Moving Aids - Pat Slide ☐ Roll Board ☐ Sliding Sheets ☐ Hover mattress ☐ Other ☐ _____ **DIATHERMY PAD MUST BE CHECKED WHEN RE-POSITONING PATIENT**

Position(s)	1- lateral	Torrence Score Key
Skin Integrity e.g. Intact, Red, Broken, Bruise — **Pre- operative Skin Check + Torrence Score**	appears intact	
Risk Assessment Toll - Name and Score — **Post operative Skin Check + Torrence Score**		
Positioning Devices e.g. Pillow, Wedge, Stirrups, Rolls etc. — Positioning Devices (type, position)	pillow	
Padding e.g. Heel, Pads, Headrest, Gel Pads etc. — Padding (type, position)		
Arm Position e.g. By side, Arm Boards, Over Abdomen. Secured By e.g. Ties, J Board — Arm Position and Security (type, position)	by side	

N.B ARM BOARDS MUST BE PLACED AT LESS THAN 90 DEGREES TO AVOID INJURY

Measures to reduce the risks of Compartment Syndrome

n/a

LEGS IN LITHOTOMY OR LLOYD DAVIS POSITION MUST BE LOWERED EVERY 3 HOURS FOR A MINIMUM OF 5 MINUTES Remove compression stockings pre operatively

Position	Time legs positioned	Time legs lowered and duration	Time legs lowered and duration	Removal of Comp. Stockings prior to surgery

DVT Prophylaxis

Elastic Compression Stockings ☑ Sequential Compression device _____ mmhg

Flowtron Boots ☐ _____ mmhg

Safe use and application of Intraoperative equipment to prevent injury

Diathermy - Monopolar Bi polar

Monopolar return eletrode - Site _____

Skin site assessed - meets safety criteria ☐ Skin prepared - N/A ☐ Clipped ☐ Dry Shaved ☐

Tourniquet - Checked ☐ Padding applied ☐

n/a

	Position	Time inflated	Pressure	Time deflated	Time inflated	Pressure	Time deflated
Site 1							
Site 2							

Skin Preparation to reduce the risk of infection

n/a

Correct site(s) to be checked with Surgeon ☐

Site	Skin	Prepping Solution
Site 1-	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ___ ☐ Chlorhexidine ___ ☐ Betadine Alcohol ☐ Other ☐
Site 2-	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ___ ☐ Chlorhexidine ___ ☐ Betadine Alcohol ☐ Other ☐

Aseptic Technique to reduce risk of infection

Drain(s) Inserted ☐

	Type	Site	Size	Secured with
Drain 1				
Drain 2				
Drain 3				

Urinary Catheter ☐

Type	Site	Size	Ballooned Inflated with	Pepping Solution
			mls	

Wound Closure/Dressings

	Site	Wound Closure	Dresssing	Other
1				
2				

Wound Bath - Sterile Saline 0.9% ☐ Other ☐ _____

Pack left in situ

Site	Type	Size	Number

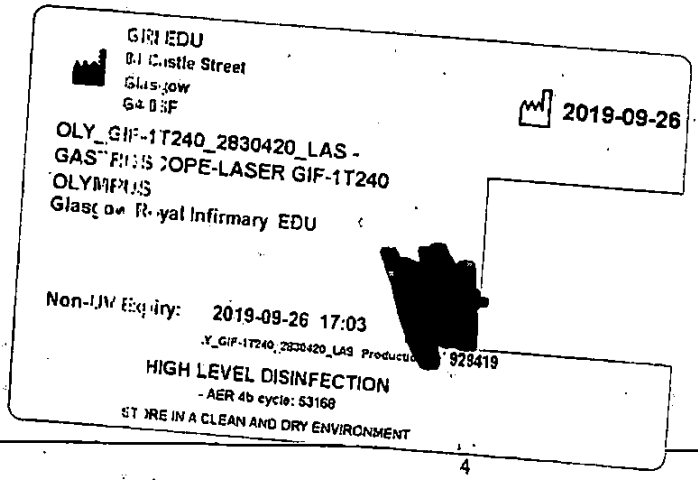
OPERATION PERFORMED

upper GI endoscopy

COMMENTS / NOTES

PROTHESIS STICKERS

TRACEABILITY STICKERS



Post Operative Instructions

Oxygen:

Fluids:

Other:

Anaesthetist's Signature:

Surgeons Notes

Signature of Surgeon:

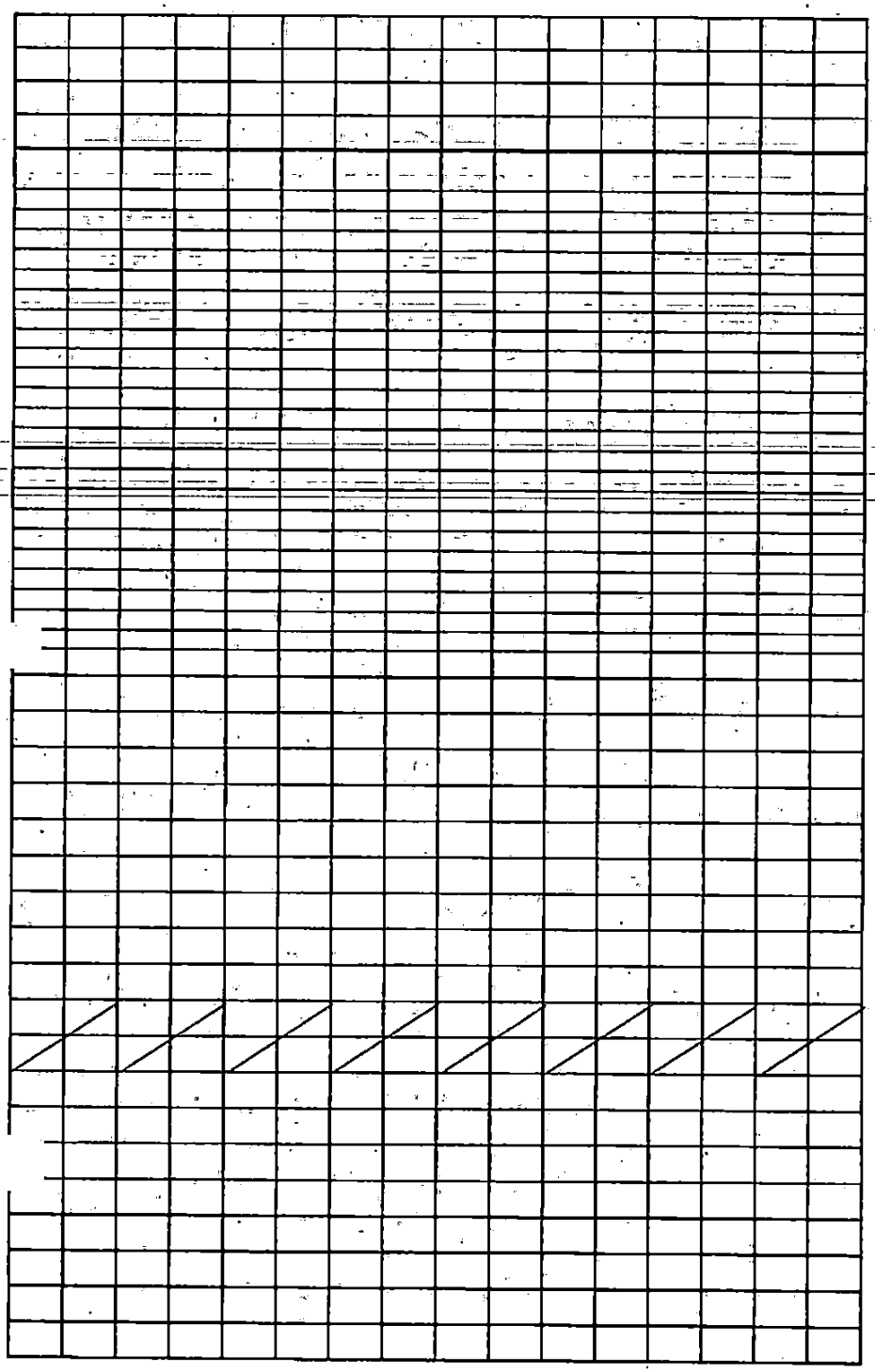
Nursing Notes

Drugs & Route	Time
Mcardam 7.5mg Throat Spray	1025 1040

Time	1025	1035	1040	1055
SPO_2 240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20	95	96	97	97
Airway Type	1	1	1	1
Resp. Rate			11	13
O_2 Therapy	RA	2L	3LM	3LM
Sedation score			S	S
E.C.G			SR	SR
Wound score			—	
Core Temp:			37.1	
Pain score			—	—
P.O.N.V.			—	—
½ Hrs Urine Volume				
Total Volume				

I.V. Fluids from Theatre

	Time	Type of Fluid	Volume	Batch No.	Signature
1					
2					
3					
4					
5					



KEYS

AIRWAY TYPE

1 Spontaneous
2 Guedel
3 NASO - pharangeal
4 L.M.A.
5 E.T.T.
6 Double lumen ET.T.
7 Tracheostomy

WOUND SCORE

0 Dry and intact
1 Slight staining
2 Moderate staining
3 Saturation/Pad req.

PAIN SCORE

0 No pain at rest, no pain on movement
1 No pain at rest, slight pain on movement
2 Intermittent pain at rest, moderate pain on movement
3 Continuous pain at rest, severe pain on movement

SEDATION SCORE

0 Awake
S Normal sleep
1 Drowsy, easy to rouse: eyes open to speech or light shake
2 Sedated, difficult to rouse: eyes open only to vigorous shaking
3 Unconscious, unrousable

PONV ASSESSMENT

0 None
1 Mild nausea
2 Moderate Nausea
3 Severe Nausea
4 Patient Vomiting

MEWS	
Pulse	
Resp. Rate	
Temp	
Avpu	
Urine Output	
Systolic BP	
$Sp0_2$%	
Total	

Waterlow Score
See Chart

Discharge Criteria Achieved Yes / No - see Nursing Notes

Recovery Practitioner Signature: _____

NHS Greater Glasgow and Clyde

GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1**
Date of birth:	**07/12/1972**		**8 Boyndie St**
CHI No:	**0712726128**		**Glasgow**
Case note no.:	**0712726128**		**Lanarkshire**
			G34 9JE

GP:	**MCGINLEY, ANNE**	Procedure date:	**29th September 2019 (10:23)**
	Lochend Surgery	Priority:	**Emergency (unspecified)**
	Easterhouse Health Centre	Status:	**Inpatient/NHS**
	9 Auchinlea Road	Hospital:	**GRI**
	Glasgow	Ward:	**(none)**
	G34 9HQ	Referring Cons:	**Mr Nigel Jamieson (General Surgery)**

Indications
Haematemesis and nausea and/or vomiting.

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Site a: An area extending from the upper body to the middle body
Lumen: a moderate amount of food residue found.

Diagnosis
OESOPHAGUS. Normal.
DUODENUM. Normal.

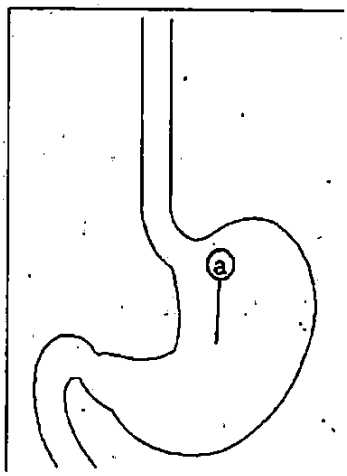
Advice/comments
Views obscured somewhat by gastric food residue (she has known delayed gastric emptying).
No blood or altered blood or culprit lesions seen. Blood tests do not suggest significant GI bleed

Follow up
Return to the ward.

Consultant/Endoscopist
Dr Jack Winter

Instrument
SCANTRACK

Premedication
Midazolam (IV) 2.5 mg
Xylocaine (Spray) 100 mg



a: *An area extending from the upper body to the middle body*

Dr Jack Winter
Consultant Gastroenterologist

NHS Greater Glasgow and Clyde

GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1**
Date of birth:	**07/12/1972**		**8 Boyndie St**
CHI No:	**0712726128**		**Glasgow**
Case note no.:	**0712726128**		**Lanarkshire**
			G34 9JE

GP:	**MCGINLEY, ANNE**	Procedure date:	**29th September 2019 (10:23)**
	Lochend Surgery	Priority:	**Emergency (unspecified)**
	Easterhouse Health Centre	Status:	**Inpatient/NHS**
	9 Auchinlea Road	Hospital:	**GRI**
	Glasgow	Ward:	**(none)**
	G34 9HQ	Referring Cons:	**Mr Nigel Jamieson (General Surgery)**

Indications
Haematemesis and nausea and/or vomiting.

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Site a: An area extending from the upper body to the middle body
Lumen: a moderate amount of food residue found.

Diagnosis
OESOPHAGUS. Normal.
DUODENUM. Normal.

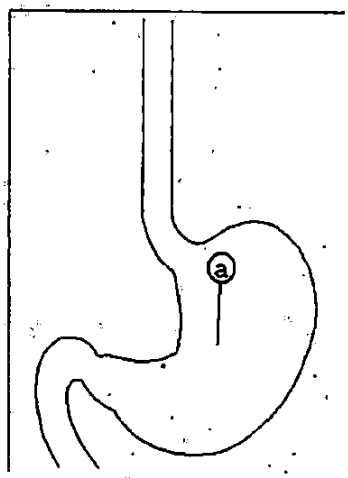
Advice/comments
Views obscured somewhat by gastric food residue (she has known delayed gastric emptying).
No blood or altered blood or culprit lesions seen. Blood tests do not suggest significant GI bleed

Follow up
Return to the ward.

Consultant/Endoscopist
Dr Jack Winter

Instrument
SCANTRACK

Premedication
Midazolam (IV) 2.5 mg
Xylocaine (Spray) 100 mg



a: *An area extending from the upper body to the middle body*

Dr Jack Winter
Consultant Gastroenterologist

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date 11/7/19

0712726128 F
SULLIVAN 07/12/1972
Deborah
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire G34 9JE

WARD 66

HOSPITAL GRI

THEATRE THA

COUNTS	Scrub/Registered Practitioner Print Name	Circulating Practitioner(s) - Signature & Print name
PRE - OP SWAB COUNT	N/A	Rowallan A Toner / Rowallan K. Toner
PRE - OP INSTRUMENT COUNT	N/A	Rowallan N/A Rowallan A Toner / Rowallan K. Toner
FINAL COUNT	N/A	Rowallan A Toner / Rowallan K. Toner
FINAL INSTRUMENT COUNT	N/A	Rowallan N/A Rowallan A Toner / Rowallan K. Toner
FINAL DISPATCH COUNT	N/A	Rowallan A Toner / Rowallan K. Toner

SCRUB PRACTITIONER VERIFICATION

I have reviewed this count and can verify my count is correct

SCRUB PRACTITIONER 1- SIGNATURE:

SCRUB PRACTITIONER 2 - SIGNATURE :
To be signed by replacement scrub practitioner if applicable N/A ☑

OPERATION : UPPER GI ENDOSCOPY

HANDOVER COUNT IN EVENT OF REPLACEMENT SCRUB PERSONEL DURING PROCEDURE
(This Section N/A) ☑

Temporary Change of Scrub Practitioner (Comments if required)	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner Signature/Print Name and Time
	Outgoing Scrub (2) Print Name	Incoming Scrub (1) Print Name	Circulating Practitioner Signature/Print Name and Time
Permanent Change of Scrub Practitioner and/or Circulating Practitioner	Outgoing Scrub (1) Print Name	Incoming Scrub (2) Print Name	Circulating Practitioner (1) Signature/Print Name and Time
			Circulating Practitioner (2) Signature/Print Name and Time

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)	0	Pledgelets	0	Caesarean Roll	6	ACCOUNTABLE ITEMS THAT ARE TO REMAIN IN SITU e.g. Abdo packs/Swabs, Quantity and Location
Swabs (10x10)	5	Tapes	0			
Abdominal packs	0	Sloops/Slings	0			
Sutures	0	Bulldogs	0			
Bl	0	Shods	0			
IV needles	0	Ports	0			
Syringes	0	Tibbs Cannula	0			
Discard-a-pad	0	Staple Gun Inserts	0			
Diathermy pencil	0	Spears	0			
Diathermy tips	0	Retrieval Bag (Bert)	0			
Scratch pad	0	Digital Tourniquets	0	Throat Pack IN		
Reels	0	Pen & Ruler	0	Throat pack OUT		
Patties	0	Bi-Polar	0	Total Number		

DISCREPANCY IN COUNT - THIS SECTION N/A ☑

DETAIL WHICH COUNT DISCREPANCY OCCURRED

Detail of the discrepancy:-

ACTION TAKEN AND OUTCOME (e.g. search undertaken, wound explored, plain x-ray taken)

Scrub Practitioner Signature if count still incorrect .....

Ensure Datix is Completed ☐
Datix Incident Number.....

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS .....

PLEASE INSERT TRACEABILITY LABELS ON BACK OF BLUE COPY- TO REMAIN IN THEATRE.

Peri-Operative Care Plan

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
FLAT 0-1
8 BOYNDIE ST
Glasgow, Lanarkshire
G34 9JE

Date: 11/09/19
Ward: ~~65/67~~ 66
Consultant: Mr. Jamieson
Proposed operation: OCD

Baseline Observations BM: 9.6

Water Low Score:	Pulse:	BP:	Temp:	SPO2:	Resp.	Height: / Weight:	BMI:
	82 bpm	118/60	36.2°c	96%	18	173 cm / 98.8 kg	33

These checks must be made immediately prior to administration of pre-med.

Pre-operative checks comments:	Ward comments:	Reception
Identify band correct (name, date of birth, hospital number, ward	☑	YES
Consent signed and dated	☑	YES
Fasted from: Midnight	Food: ~~NBM~~ Fluid: 6AM	EST 10/9/19 DRINK STILL WITHHELD
Correct site surgery marked and prepared	N/A	
Allergies/sensitivities and reaction	Penicillin	PENICILLIN — ROBIN.
Medical conditions, i.e. other relevant information: PREV CIAS NO KNOWN ISSUES. Cholecystitis, Gall stones ↑cholesterol.	Fybromyalgia, PTSD, Pancreatitis, Anxiety, Ovarian cysts, HTN, Appendicectomy, T2DM	TUBO NISSAN FUNDOPLICATIONS GALL BLADDER REMOVED APPENDICECTOMY TONSILS.
Inhalers/Sprays	Nil	NIL.
Blood Glucose (if relevant)	~~NBM~~ ☑ 9.1	7.9 immediately 10/09/19
Antiembolitic Treatment e.g. TEDs	☑	TEDS ELASTOPLAST LEGS.
Implants insitu e.g. pacemaker, joint replacements	Nil	INTERNAL STAPLES.
Dentures / loose teeth, Caps, Crowns	Nil	OWN SECURE.
Hearing Aid, Spectacles and Hair pieces remaining in situ (contact lenses to be removed) - please state	Nil	READING GLASSES NOT WITH PATIENT.
Others (please state) **Pregnancy Test** Pos / Neg **SD7** Yes / No	Neg →	
Make up/nail polish removed	☑	NIL
Jewellery/body piercing taped/removed	☑	NIL.
Underwear removed/disposable pants	☑	REMOVED
Voided urine/catheter insitu	☑	PU.
Documentation (case notes, nursing notes, prescription charts, ECG, X-ray, Blood results)	☑	NO PAPER ECG PATIENT STATES PAST CHECK PORTAL.
Premedication given:	YES ✓	SEE KARDEX

Please sign once check completed:

Ward Nurse:	Reception Practitioner	Anaesthetic assistant/Theatre Practitioner
SN	S. Graf.	

Time into Reception: _____

Operational Data	Time into Anaesthetic Room Time into Theatre 1020 Time out of Theatre 1645	Scrub Practitioner N/A Circulating Practitioner ATonerRuscliveJMachinon Anaesthetic Assistant EWilliamson

ANAESTHETIC ROOM

Blood Availability check	Anaesthetic Practitioner has confirmed with Anaesthetic that X matched blood is:- Required ☐ Available ☐ Grouped and Saved ☐ *(tick or cross as necessary)*	
Psychological care given to allay anxiety	Verbal & Non Verbal Communication given ☑ Explanation of expected events/routine given ☑ Communication adapted to meet needs of the patient ☐ Certificate of Incapacity ☐	
Safe Application, Preparation and Use of Equipment	SP02 ☑ Position Rotated Hourly ☐ Arterial Line ☐ CVP Line ☐ Temperature probe ☐	Infusion Device Numbers
	ECG ☑ Warming Device	
	NIBP ☑ Other	

THEATRE

Information given in Scrub Nurse and Senior Circulating Nurse by Anaesthetic Nurse	Scrub nurse must check patient ID band with consent ☑ Patient Allergies ☑ Prosthesis ☐ Other ☐ Name Scrub Practitioner N/A
Operation Site & procedure safety check	Scrub Nurse and Senior Circulating Nurse confirms with Surgeon the procedure to be performed ☐ Correct Site and Site of operation ☐
Safe positioning and prevention of injury to Skin, Joints and Nerves	Moving Aids - Pat Slide ☐ Roll Board ☐ Sliding Sheets ☐ Hover mattress ☐ Other ☐ _____

DIATHERMY PAD MUST BE CHECKED WHEN RE-POSITONING PATIENT

Position(s)	1- Left Lateral	Torrence Score Key
Skin Integrity e.g. Intact, Red, Broken, Bruise Pre- operative Skin Check + Torrence Score		
Risk Assessment Toll - Name and Score Post operative Skin Check + Torrence Score		
Positioning Devices e.g. Pillow, Wedge, Stirrups, Rolls etc. Positioning Devices (type, position)	Pillow	
Padding e.g. Heel, Pads, Headrest, Gel Pads etc. Padding (type, position)	Padding @ back	
Arm Position e.g. By side, Arm Boards, Over Abdomen. Secured By e.g. Ties, J Board Arm Position and Security (type, position)		

N.B ARM BOARDS MUST BE PLACED AT LESS THAN 90 DEGREES TO AVOID INJURY

Measures to reduce the risks of Compartment Syndrome

N/A

LEGS IN LITHOTOMY OR LLOYD DAVIS POSITION MUST BE LOWERED EVERY 3 HOURS FOR A MINIMUM OF 5 MINUTES. Remove compression stockings pre operatively

Position	Time legs positioned	Time legs lowered and duration	Time legs lowered and duration	Removal of Comp. Stockings prior to surgery

DVT Prophylaxis

Elastic Compression Stockings ☑ Sequential Compression device _____ mmhg

Flowtron Boots ☐ _____ mmhg

Safe use and application of Intraoperative equipment to prevent injury

Diathermy - Monopolar Bi polar

Monopolar return eletrode - Site _____

Skin site assessed - meets safety criteria ☐ Skin prepared - N/A ☐ Clipped ☐ Dry Shaved ☐

Tourniquet - Checked ☐ Padding applied ☐

N/A

	Position	Time inflated	Pressure	Time deflated	Time inflated	Pressure	Time deflated
Site 1							
Site 2							

Skin Preparation to reduce the risk of infection

N/A

Correct site(s) to be checked with Surgeon ☐

Site	Skin	Prepping Solution
Site 1-	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ___ ☐ Chlorhexidine ___ ☐ Betadine Alcohol ☐ Other ☐
Site 2-	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ___ ☐ Chlorhexidine ___ ☐ Betadine Alcohol ☐ Other ☐

Aseptic Technique to reduce risk of infection

N/A

Drain(s) Inserted ☐

	Type	Site	Size	Secured with
Drain 1				
Drain 2				
Drain 3				

Urinary Catheter ☐

Type	Site	Size	Ballooned Inflated with	Pepping Solution
			mls	

Wound Closure/Dressings

	Site	Wound Closure	Dresssing	Other
1				
2				

Wound Bath - Sterile Saline 0.9% ☐ Other ☐ _____

Pack left in situ

Site	Type	Size	Number

OPERATION PERFORMED

UPPER GI ENDOSCOPY

COMMENTS / NOTES

PROTHESIS STICKERS

TRACEABILITY STICKERS

GRI EDU
[illegible] Castle Street
Glasgow
G4 0SF

2019-07-11

OLY_GIF-1T240_2830414_LAS -
GASTROSCOPE-LASER GIF-1T240
OLYMPUS
Glasgow Royal Infirmary EDU

Non-UW Expiry: 2019-07-11 12:38

Y_GIF-1T240_2830414_LAS Production ID: 906663

HIGH LEVEL DISINFECTION

STORE IN A CLEAN AND DRY ENVIRONMENT

Post Operative Instructions

Oxygen:

Fluids:

Other:

Anaesthetist's Signature:

Surgeons Notes

Signature of Surgeon:

Nursing Notes

12 lead ECG carried out in Recovery → Dr Mackay wished it done in ward prior to prescribing metoclopramide → to be reviewed on ward by Dr Mackay on ward round (in 12 hours ECG) - procedure smooth

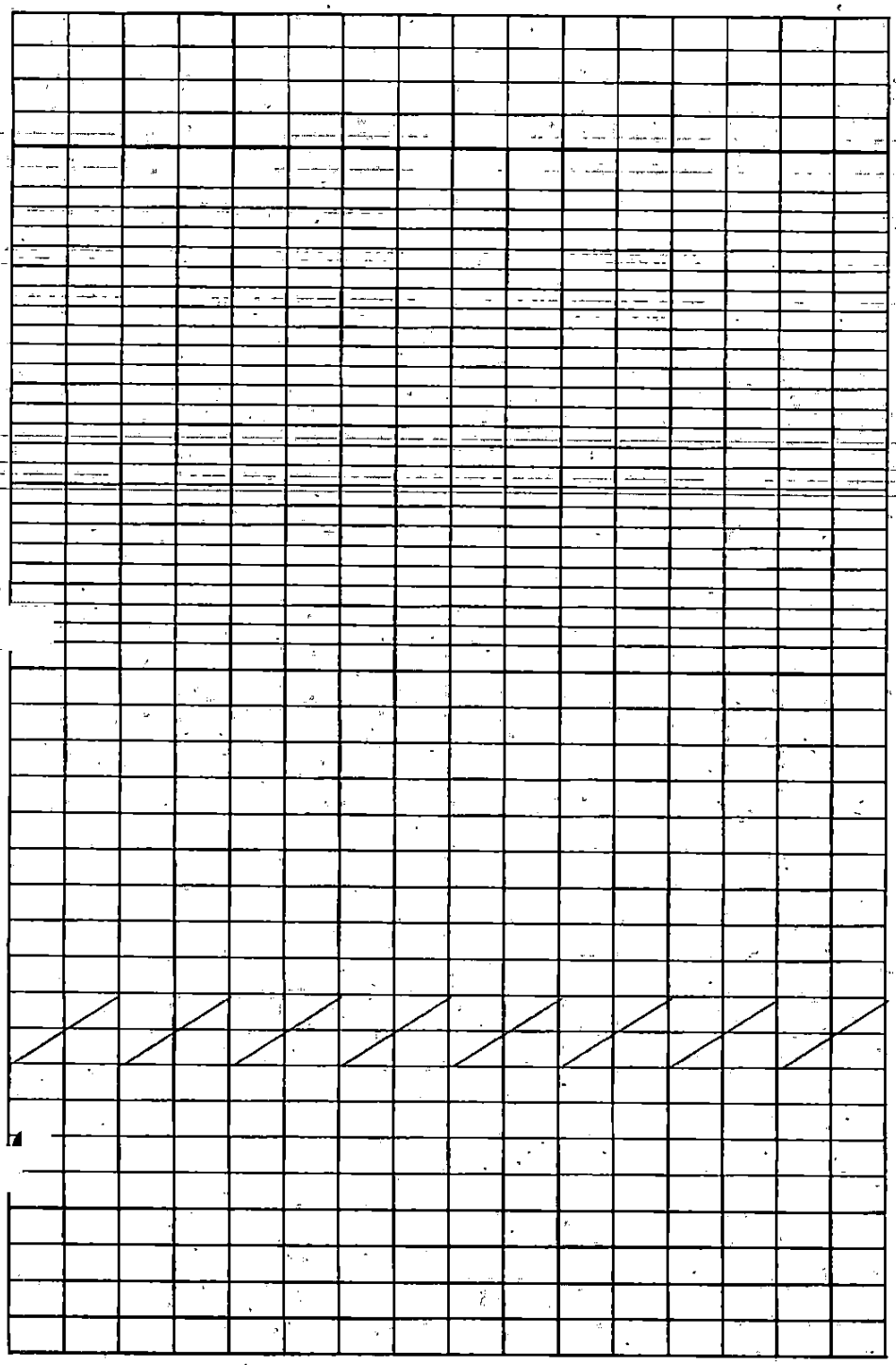
Drugs & Route	Time																				
	1020				1100	1110															
Midazolam	3mg																				
THROAT SPRAY																					
Morphine IV					2mg	2mg															

Time	1020	1025	1030	1035	10[40]	10[50]	11[0]	11[10]													
SPO_2 240	95%	94%	93%		94%	on air	called														
230																					
220																					
210																					
200																					
190																					
180																					
170																					
160																					
150		127	127																		
140																					
130	117																				
120		^	^																		
110	^				^	^	^	^													
100																					
90																					
80	v	v	v		o	o															
70																					
60	78	81	87		✓	✓	U	U													
50																					
40																					
30																					
20																					

Airway Type	Nasal	→	→		1	1	1	1													
Resp. Rate					11	11	12	12													
O_2 Therapy	3L	3L	→		3L	3L	3L	3L													
Sedation score					S/S	S/S	S/S	S/S													
E.C.G	SR	→	→		SR	SR	SR	SR													
Wound score																					
Core Temp:																					
Pain score					0	0	4	4													
P.O.N.V.					→	U	U	U													
½ Hrs Urine Volume																					
Total Volume																					
Bm					7.2																

I.V. Fluids from Theatre N/L

	Time	Type of Fluid	Volume	Batch No.	Signature
1					
2					
3					
4					
5					



KEYS

AIRWAY TYPE

1 Spontaneous
2 Guedel
3 NASO - pharangeal
4 L.M.A.
5 E.T.T.
6 Double lumen ET.T.
7 Tracheostomy

WOUND SCORE

0 Dry and intact
1 Slight staining
2 Moderate staining
3 Saturation/Pad req.

PAIN SCORE

0 No pain at rest, no pain on movement
1 No pain at rest, slight pain on movement
2 Intermittent pain at rest, moderate pain on movement
3 Continuous pain at rest, severe pain on movement

SEDATION SCORE

0 Awake
S Normal sleep
1 Drowsy, easy to rouse: eyes open to speech or light shake
2 Sedated, difficult to rouse: eyes open only to vigorous shaking
3 Unconscious, unrousable

PONV ASSESSMENT

0 None
1 Mild nausea
2 Moderate Nausea
3 Severe Nausea
4 Patient Vomiting

MEWS	
Pulse	
Resp. Rate	
Temp	
Avpu	
Urine Output	
Systolic BP	
$Sp0_2$%	
Total	

Waterlow Score
See Chart

Discharge Criteria Achieved Yes / No - see Nursing Notes

Recovery Practitioner Signature: _____

NHS Greater Glasgow and Clyde

GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1**
Date of birth:	**07/12/1972**		**8 Boyndie St**
CHI No:	**0712726128**		**Glasgow**
Case note no.:	**0712726128**		**Lanarkshire**
			G34 9JE

GP: **MCGINLEY, ANNE**
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Procedure date:	**11th July 2019 (10:40)**
Priority:	**Urgent**
Status:	**Inpatient/NHS**
Hospital:	**GRI**
Ward:	**(none)**
Referring Cons:	**Mr Nigel Jamieson (General Surgery)**

Indications
Abdominal pain.

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Post-surgical and previous fundoplication: intact. Bile and food residue.
DUODENUM. Food residue.

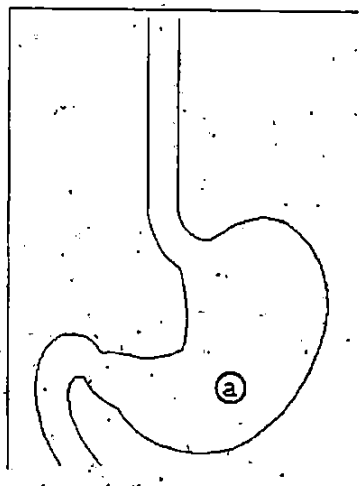
Medication
Continue medication.

Advice/comments
Asseen previously in 2015 there was bile and food residue (including yesterday evening's peas) in the stomach and some further food residue in duodenum obscuring views of mucosa. No abnormalities seen. No bile in oesophagus, normal oesophagus and wrap is intact. Suggests prokinetic and gastric emptying studies

Consultant/Endoscopist
List consultant: Mr John Anderson
Endoscopist No1: Mr Patrick MacGoey

Instrument
SCANTRACK

Premedication
Midazolam (IV) 3 mg
Xylocaine (Spray) 100 mg



a: *Lower body*

Mr Patrick MacGoey
ST8

Acute Services Division - Surgery & Anaesthetics Directorate
General Surgery

NHS Greater Glasgow and Clyde

Hospital:
Admission Date: **Operation Date:** 03/09/2015
Name: DEBORAH SULLIVAN (CHI:0712726128)
Date of Birth: 07/12/1972 **Age:** 42 yrs **Ward:**
Principal Surgeon: R Drummond
Anaesthetist:
Assistants: Ms C Craig
Diagnosis: Gastric motility disorder (K319)
Procedure: Fibreoptic endoscopy - OGD - diagnostic (G459)
Post Op Comments:
Routine post op
Continue PPI
5 days of metoclopramide
Operation Note:
Prev fundoplication and subsequent anterior wrap

Oesophageal spasm throughout
Stomach normal although small amount of food residue.

?degree of oeosophageal/gastric dysmotility

Trial of prokinetic.

Operation Note

Entered By: Carol Craig Date Entered: 03/09/2015

NHS Greater Glasgow and Clyde — Intraoperative Accountable Items Count Record

Date 3/9/15

ADDRESSOGRAPH

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

WARD 6S.

HOSP - GRI

THEATRE - A

COUNTS	Scrub Nurse(s) Print Name	Circulating Nurse(s) - Signature & Print name
PRE - OP SWAB COUNT CORRECT	N/A	K. SYMBORSKA / K. [illegible] R DAWSON
PRE - OP INSTRUMENT COUNT CORRECT		N/A
FINAL SWAB COUNT CORRECT	N/A	K. SYMBORSKA / K. [illegible] R DAWSON
FINAL INSTRUMENT COUNT CORRECT		N/A
FINAL SWAB DISPATCH COUNT CORRECT	N/A	K. SYMBORSKA / K. [illegible] R DAWSON

SCRUB NURSE VERIFICATION - PLEASE SIGN ON PAGE UNDERNEATH.

I have reviewed this count sheet and can verify my count(s) correct

SCRUB NURSE 1- SIGNATURE - N/A

SCRUB NURSE 2 SIGNATURE - N/A
To be signed by replacement scrub nurse if applicable

HANDOVER COUNT IN EVENT OF REPLACEMENT OF SCRUB NURSE DURING PROCEDURE

	Outgoing Scrub Nurse - Print Name	Incoming Scrub Nurse - Print Name	Circulating Nurse(s) - Signature & Print name
OUTGOING COUNT *To be completed for permanent and temporary replacement*			
INCOMING COUNT *To be completed for temporary replacement*			

OPERATION

UPPER GI SCOPE

TALLY OF EACH ITEM USED - ADD ANY ITEMS SPECIFIC TO YOUR SPECIALITY

Swabs (2x2)		Tapes				ITEMS REMAINING IN SITU (Type & Number)	
Swabs (10x10)	5	Sloops/Slings					
Abdominal packs		Bulldogs					
Sutures		Shods					
Blades		Tibbs Cannula					
IV needles		Ports					
Syringes		Staple Gun Inserts					
rd-a-pad		Spears					
Diathermy pencil		Throat packs - Anae					
Diathermy tips		Throat packs - Scrub					
Scratch pad		Retrieval Bag (Bert)					
Reels		Digital Tourniquets					
Patties							
Pledgelets						N/A	

DISCREPANCY IN COUNT - ACTIONS AND OUTCOME N/A

COUNT IN WHICH DISCREPANCY OCCURRED

DETAILS

ACTIONS TAKEN AND OUTCOME (I.E. SWABS ISOLATED, SEARCH UNDERTAKEN, WOUND EXPLORED, X - RAY TAKEN) -

SCRUB NURSES SIGNATURE IF COUNT STILL INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

SURGEONS SIGNATURE IF COUNT INCORRECT FOLLOWING ALL POSSIBLE ACTIONS

PLEASE INSERT TRACEABILITY STICKERS ON BACK OF COPY- TO STAY IN THEATRE.

Peri-Operative Care Plan

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN F
Deborah 07/12/1972
6 MUIRHEAD COURT
BAILLIESTON
Glasgow, Lanarkshire
G69 7EP

Date: 3/9/15
Ward: 65
Consultant: MISS CRAIG
Proposed operation: OUD.

Baseline Observations

Water Low Score:	Pulse:	BP:	Temp:	SPO2: (A)	Resp.	Height: / Weight:	BMI:
4.	80.	136/90.	36.5	98%.	16.	178 / 77	23

These checks must be made immediately prior to administration of pre-med.

Pre-operative checks comments:	Ward comments:	Reception
Identify band correct (name, date of birth, hospital number, ward	✓	✓
Consent signed and dated	✓	✓
Fasted from:	Food: 1/9. Fluid: SIPS · RPMN	
Correct site surgery marked and prepared	N/A	N/A
Allergies/sensitivities and reaction	*Penicillin* → RASH	
Medical conditions, i.e. other relevant information:	Pancreatitis Acute Pseudocyst.	
Inhalers/Sprays	N/A	No
Blood Glucose (if relevant)	N/A	No
Antiembolitic Treatment e.g. TEDs	✓	✓
Implants insitu e.g. pacemaker, joint replacements	N/A	STAPLES (GALLBLADDER TISSUE SEALANT)
Dentures / loose teeth, Caps, Crowns	N/A	
Hearing Aid, Spectacles and Hair pieces remaining in situ (contact lenses to be removed) - please state	Nil	No
Others (please state) **Pregnancy Test** Pos / Neg **SD7** Yes / No	NG fell out when in shower	
Make up/nail polish removed	removed	✓
Jewellery/body piercing taped/removed	taped	Removed
Underwear removed/disposable pants	✓	✓
Voided/urine/catheter insitu	✓	✓
Documentation (case notes, nursing notes, prescription charts, ECG, X-ray, Blood results)	✓	✓
Premedication given:	—	N/A

Please sign once check completed:

Ward Nurse:	Reception Practitioner:	Anaesthetic assistant/Theatre Practitioner
[signature]	[signature]	CATRINA DOWNEY RGN 1305

Time into Reception: _____

Operational Data	Time into Anaesthetic Room ☐☐☐☐ Time into Theatre 0515 Time out of Theatre 0820	Scrub Practitioner Nor. Circulating Practitioner Sn Sambale Anaesthetic Assistant Sn Bolay

ANAESTHETIC ROOM

Blood Availability check	Anaesthetic Practitioner has confirmed with Anaesthetic that X matched blood is:- Required ☐ Available ☐ Grouped and Saved ☑ *(tick or cross as necessary)*	
Psychological care given to allay anxiety	Verbal & Non Verbal Communication given ☐ Explanation of expected events/routine given ☐ Communication adapted to meet needs of the patient ☐ Certificate of Incapacity ☐	
Safe Application, Preparation and Use of Equipment	SP02 ☑ Position Rotated Hourly ☐ Arterial Line ☐ CVP Line ☐ Temperature probe ☐	Infusion Device Numbers
	ECG ☑ Warming Device	
	NIBP ☑ Other	

THEATRE

Information given in Scrub Nurse and Senior Circulating Nurse by Anaesthetic Nurse	Scrub nurse must check patient ID band with consent ☑ Patient Allergies ☑ Prosthesis ☐ Other ☐ Name Scrub Practitioner Nor
Operation Site & procedure safety check	Scrub Nurse and Senior Circulating Nurse confirms with Surgeon the procedure to be performed ☑ Correct Site and Site of operation ☑
Safe positioning and prevention of injury to Skin, Joints and Nerves	Moving Aids - Pat Slide ☐ Roll Board ☐ Sliding Sheets ☐ Hover mattress ☐ Other ☐ _____ **DIATHERMY PAD MUST BE CHECKED WHEN RE-POSITONING PATIENT**

Position(s)	1- Lft lateral	Torrence Score Key
Pre- operative Skin Check + Torrence Score	appears intact	
Post operative Skin Check + Torrence Score		
Positioning Devices (type, position)	pillow	
Padding (type, position)		
Arm Position and Security (type, position)	both arm across the chest	

N.B ARM BOARDS MUST BE PLACED AT LESS THAN 90 DEGREES TO AVOID INJURY

...in Integrity e.g. ...tact, Red, Broken, Bruise

Risk Assessment Toll - Name and Score

Positioning Devices e.g. Pillow, Wedge, Stirrups, Rolls etc.

Padding e.g. Heel, Pads, Headrest, Gel Pads etc.

Arm Position e.g. By side, Arm Boards, Over Abdomen. Secured By e.g. Ties, J Board

Measures to reduce the risks of Compartment Syndrome

LEGS IN LITHOTOMY OR LLOYD DAVIS POSITION MUST BE LOWERED EVERY 3 HOURS FOR A MINIMUM OF 5 MINUTES Remove compression stockings pre operatively

Position	Time legs positioned	Time legs lowered and duration	Time legs lowered and duration	Removal of Comp. Stockings prior to surgery
N/A				

DVT Prophylaxis

Elastic Compression Stockings ☑ Sequential Compression device N/A mmhg

Flowtron Boots ☐ N/A mmhg

Safe use and application of Intraoperative equipment to prevent injury

Diathermy - Monopolar Bi polar

Monopolar return eletrode - Site N/A

Skin site assessed - meets safety criteria ☐ Skin prepared - N/A ☐ Clipped ☐ Dry Shaved ☐

Tourniquet - Checked ☐ Padding applied ☐

	Position	Time inflated	Pressure	Time deflated	Time inflated	Pressure	Time deflated
Site 1	N/A						
Site 2							

Skin Preparation to reduce the risk of infection

Correct site(s) to be checked with Surgeon ☐

Site	Skin	Prepping Solution
Site 1- N/A	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ___ ☐ Chlorhexidine ___ ☐ Betadine Alcohol ☐ Other ☐
Site 2- N/A	None ☐ Clipped ☐ Wet Shave ☐ Dry Shave ☐	Betadine Antiseptic ☐ Chlorhexidine Acetate ___ ☐ Chlorhexidine ___ ☐ Betadine Alcohol ☐ Other ☐

Aseptic Technique to reduce risk of infection

Drain(s) Inserted ☐

	Type	Site	Size	Secured with
Drain 1				
Drain 2	N/A			
Drain 3				

Urinary Catheter ☐

Type	Site	Size	Ballooned Inflated with	Pepping Solution
N/A			mls	

Wound Closure/Dressings

	Site	Wound Closure	Dresssing	Other
1	N/A			
2				

Wound Bath - Sterile Saline 0.9% ☑ Other ☐ _____

Pack left in situ

Site	Type	Size	Number

OPERATION PERFORMED

Upper GI endoscopy

COMMENTS / NOTES

PROTHESIS STICKERS

TRACEABILITY STICKERS

Glasgow Royal Infirmary
84 Castle Street
Glasgow
G4 0SF

2015-09-03

OLY_GIF-1T240_2930457 -
Gastroscope-Laser Endoscopy GIF-1T240
OLYMPUS
GRI - Endoscopy

GRI - Endoscopy

Non-UV Expiry: 2015-09-03 15:27

OLY_GIF-1T240_2930457 Production ID: 498795

HIGH LEVEL DISINFECTION

STORE IN A CLEAN AND DRY ENVIRONMENT

Post Operative Instructions

Oxygen: _____

Fluids: _____

Other: _____

Anaesthetist's Signature: _____

Surgeons Notes

Signature of Surgeon:

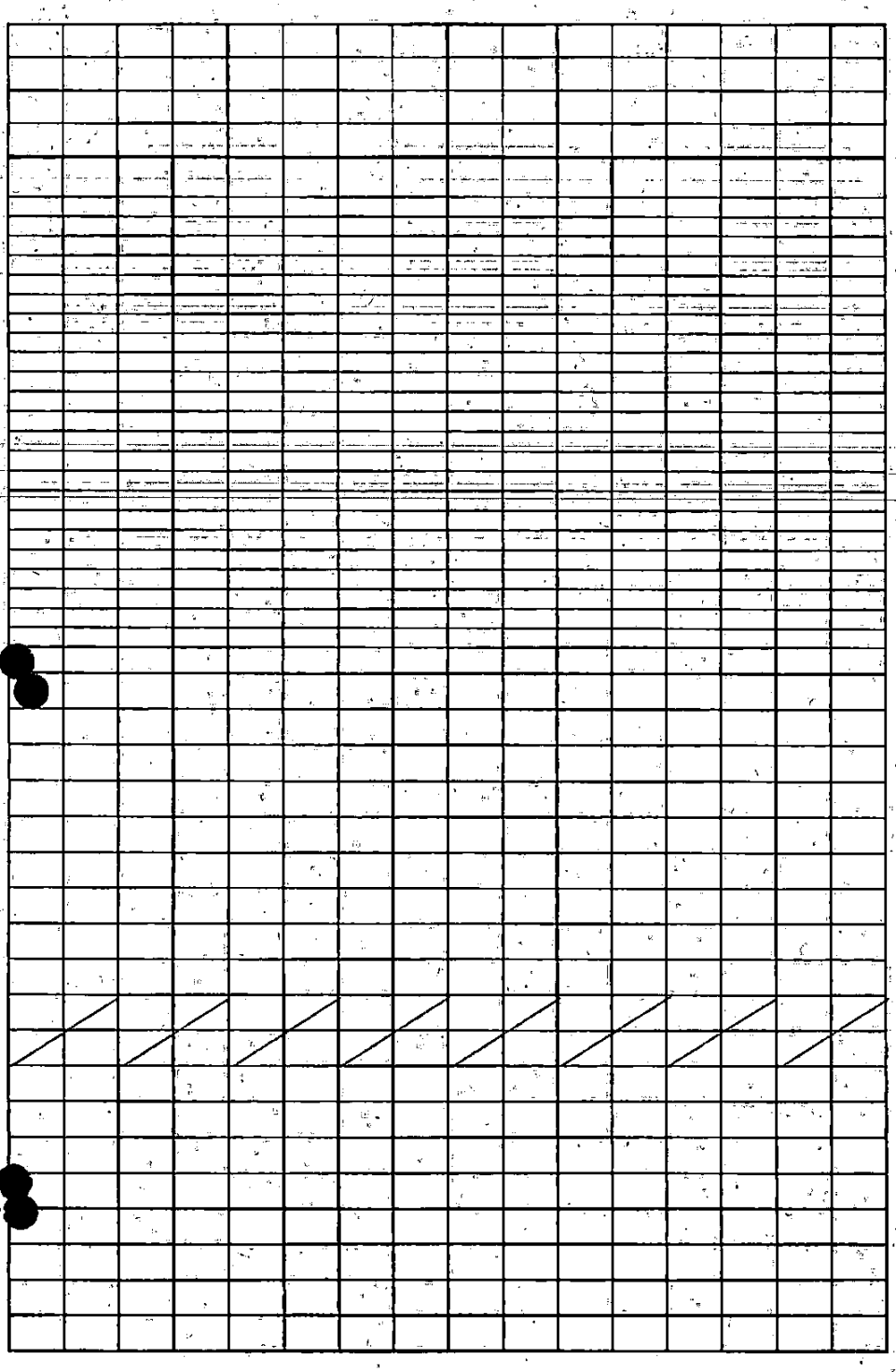
Nursing Notes

Drugs & Route	Time
THROAT SPRAY	13:16
MIDAZOLAM 5mg I.V.	

Time	13:17	13:25		13:30
SPO_2 240	97	98		98
230				
220				
210				
200				
190				
180				
170				
160				
150				
140				
130	^			^
120				
110	^		^	
100				
90				v
80				
70	v			—
60		v		
50				
40				
30				
20				
Airway Type	1			1
Resp. Rate	14			14
O_2 Therapy	2			2
Sedation score				5
E.C.G				SR
Wound score				0
Core Temp:				
Pain score				0
P.O.N.V.				0
½ Hrs Urine Volume				
Total Volume				

I.V. Fluids from Theatre

	Time	Type of Fluid	Volume	Batch No.	Signature
1					
2					
3					
4					
5					



KEYS

AIRWAY TYPE

1 Spontaneous
2 Guedel
3 NASO - pharangeal
4 L.M.A.
5 E.T.T.
6 Double lumen ET.T.
7 Tracheostomy

WOUND SCORE

0 Dry and intact
1 Slight staining
2 Moderate staining
3 Saturation/Pad req.

PAIN SCORE

0 No pain at rest, no pain on movement
1 No pain at rest, slight pain on movement
2 Intermittent pain at rest, moderate pain on movement
3 Continuous pain at rest, severe pain on movement

SEDATION SCORE

0 Awake
S Normal sleep
1 Drowsy, easy to rouse: eyes open to speech or light shake
2 Sedated, difficult to rouse: eyes open only to vigorous shaking
3 Unconscious, unrousable

PONV ASSESSMENT

0 None
1 Mild nausea
2 Moderate Nausea
3 Severe Nausea
4 Patient Vomiting

MEWS	
Pulse	
Resp. Rate	
Temp	
Avpu	
Urine Output	
Systolic BP	
$Sp0_2$%	
Total	

Waterlow Score
See Chart

Discharge Criteria Achieved Yes / No - see Nursing Notes

Recovery Practitioner Signature: _____

Gastroscopy report

Performed	13-Jan-2026 12:03	Received	13-Jan-2026 12:15
Reported	13-Jan-2026 12:15	Order Number	UNI400618-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name: **Deborah SULLIVAN (F)**
Date of birth: **07/12/1972**
NHS No: **0712726128**
Case Note No: **0712726128**

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

GP: **SHEPPARD, EMMA**
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Procedure date: **13th January 2026 (12:03)**
Priority: **Repeat/Scheduled**
Hospital: **GRI**
Ward: **(none)**
Referring Cons: **Miss Carol Craig (General S**

Indications
Clinically important comments: IM found on antral biopsies. For repeat scope with Sydney protocol biopsies.
Background of gut dysmotility, Nissen fundoplication, gallstone pancreatitis, lap chole.Chronic abdominal pain.

Consultant/Endo
List consultant: Mr Andrew DH M
Endoscopist No1: Mr Andrew DH M
Endoscopist No2: Mr David James

Inst
SC

Premed
Fentanyl (T
Midazolam
Xylocaine (Spra

Report
The procedure was completed successfully to D2.

Site a: Middle body
Specimens: 6x biopsy.
Site b: Upper body
Specimens: 6x biopsy.
Site c: Angulus
Specimens: 6x biopsy.
Site d: Antrum
Gastritis: mild atrophic with no bleeding.Specimens: 6x biopsy.
Site e: Antrum
Gastritis: mild atrophic with no bleeding.Specimens: 6x biopsy.

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

Advice/Comments
Awaiting biopsy results from Sydney protocol.

Follow up

Awaiting pathology results.

Mr Andrew DH Macdonald
Consultant

Produced by Unisoft's GI Reporting Tool Compiled on 13/01/202

Gastroscopy report

Performed	23-Sep-2025 10:38	Received	23-Sep-2025 10:50
Reported	23-Sep-2025 10:50	Order Number	UNI388120-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1, 8 Boyndie Street**
Date of birth:	**07/12/1972**		**Easterhouse**
NHS No:	**0712726128**		**Glasgow**
Case Note No:	**0712726128**		**Lanarkshire**
			G34 9JE

GP:	**SHEPPARD, EMMA**	Procedure date:	**23rd September 2025 (10:**
	Lochend Surgery	Priority:	**Elective**
	Easterhouse Health Centre	Hospital:	**GRI**
	9 Auchinlea Road	Ward:	**(none)**
	Glasgow	Referring Cons:	**Miss Carol Craig (General S**
	G34 9HQ		

Indications
Abdominal pain and nausea and/or vomiting.

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

Site a: Antrum
Specimens: 4x biopsy.

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Large food residue.
DUODENUM. Normal.

Advice/Comments
Large food residue in stomach - pylorus patent.
Likely delayed gastric emptying.

Follow up
Awaiting pathology results. No further follow up.

Fiona Beck
Nurse Endoscopist

Consultant/Endo
F

Inst
SC
Disposat

Premed
Midazolam
Xylonor (topic

Produced by Unisoft's GI Reporting Tool

Compiled on 23/09/202

EUS HPB report

Performed	05-Dec-2020 08:23	Received	05-Dec-2020 08:41
Reported	05-Dec-2020 08:41	Order Number	UNI181641-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
EUS HPB REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1, 8 Boyndie Street**
Date of birth:	**07/12/1972**		**Easterhouse**
NHS No:	**0712726128**		**Glasgow**
Case Note No:	**0712726128**		**Lanarkshire**
			G34 9JE

GP:	**MCGINLEY, ANNE**	Procedure date:	**5th December 2020 (08:23**
	Lochend Surgery	Priority:	**Elective**
	Easterhouse Health Centre	Hospital:	**GRI**
	9 Auchinlea Road	Ward:	**(none)**
	Glasgow	Referring Cons:	**Mr Nigel Jamieson (Genera**
	G34 9HQ		**Surgery)**

Indications
CT images were normal.

Report
The complete biliary and pancreatic systems were visualised. There were no peri-operative complications.

Diagnoses
BILIARY. Extrahepatic: post cholecystectomy.

Advice/Comments
Foodstuff in stomach in keeping with gastroparesis. pancreas exhibits some fibrotic parenchymal changes throughout but insufficient for diagnosis of CP. CBD not dilated and clear. Previous cholecystectomy. Liver echobright in keeping with fatty infiltration.

Follow up
Return to the referring Consultant.

Prof Colin J McKay
Consultant Upper GI Surgeon

Consultant/Endo
Prof Coli

Inst
SC

Premed
Fentanyl (T
Midazolam
Xylocaine (Spra

Produced by Unisoft's GI Reporting Tool

Compiled on 05/12/202

Gastroscopy report

Performed	10-Dec-2019 08:50	Received	10-Dec-2019 08:56
Reported	10-Dec-2019 08:56	Order Number	UNI154289-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name: **Deborah SULLIVAN (F)**
Date of birth: **07/12/1972**
NHS No: **0712726128**
Case Note No: **0712726128**

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

GP: **MCGINLEY, ANNE**
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Procedure date: **10th December 2019 (08:5**
Attachments: **Urgent**
Second part_1 **Inpatient/NHS**
Upper body_1 **GRI**
(none)
Priority: **Mr Nigel Jamieson (Genera**
Status: **Surgery)**
Hospital:
Ward:
Referring Cons:

Indications
Haematemesis.
Clinically important comments: Possible haematemesis.
Background noted, gut dysmotility, delayed gastric emptying, previous fundoplication, Endoscopy October 19.
Hb and urea unchanged.

Consultant/Endo
List consultant: Dr Ne
Endoscopist No1: D
Endoscopist No2: Dr Ne

Inst
SC

Report
The procedure was completed successfully to D2.
The whole upper gastro-intestinal tract was normal.

Premed
Midazolam
Xylocaine (Spra

Advice/Comments
No fresh or altered blood in the upper GI tract.
Small food residue in keeping with delayed gastric emptying.
Reassuring line taken.

Follow up
Return to the ward.

Dr J Palmer
ST3

Produced by Unisoft's GI Reporting Tool Compiled on 10/12/201!

Gastroscopy report

Performed	16-Oct-2019 15:44	Received	16-Oct-2019 15:50
Reported	16-Oct-2019 15:50	Order Number	UNI145934-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name: **Deborah SULLIVAN (F)**
Date of birth: **07/12/1972**
NHS No: **0712726128**
Case Note No: **0712726128**

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

GP: **MCGINLEY, ANNE**
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Procedure date: **16th October 2019 (15:44)**
Attachments: **Elective**
Upper body_1 **GRI**
First part_1 **(none)**
Upper body_2 **Mr Nigel Jamieson (Genera**
Upper body_3 **Surgery)**

Priority:
Hospital:
Ward:
Referring Cons:

Indications
Haematemesis and nausea and/or vomiting.
Clinically important comments: Known to have global gut motility issues
previous fundoplication
delayed gastric emptying.

Consultant/Endo
Miss C

Inst
SC

Premed
Midazolam
Xylocaine (Spra

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Post-surgical and wrap intact and intra abdominal , minimal residue today.
DUODENUM. Normal.

Advice/Comments
No upper gi bleeding source or signs of recent bleeding

given longstanding problems with gut motility there is little usrgical option for intervention and we should continue with conservative management

Follow up

Return to the referring GP.

Miss Carol Craig
Consultant

Produced by Unisoft's GI Reporting Tool Compiled on 16/10/201!

Gastroscopy report

Performed	29-Sep-2019 10:23	Received	29-Sep-2019 10:32
Reported	29-Sep-2019 10:32	Order Number	UNI143478-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name:	**Deborah SULLIVAN (F)**	Address:	**Flat 0-1**
Date of birth:	**07/12/1972**		**8 Boyndie St**
NHS No:	**0712726128**		**Glasgow**
Case Note No:	**0712726128**		**Lanarkshire**
			G34 9JE

GP:	**MCGINLEY, ANNE**	Procedure date:	**29th September 2019 (10:**
	Lochend Surgery	Priority:	**Emergency (unspecified)**
	Easterhouse Health Centre	Status:	**Inpatient/NHS**
	9 Auchinlea Road	Hospital:	**GRI**
	Glasgow	Ward:	**(none)**
	G34 9HQ	Referring Cons:	**Mr Nigel Jamieson (Genera Surgery)**

Indications
Haematemesis and nausea and/or vomiting.

Consultant/Endo
Dr Ja

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Site a: An area extending from the upper body to the middle body
Lumen: a moderate amount of food residue found.

Inst
SC

Premed
Midazolam (I
Xylocaine (Spra

Diagnoses
OESOPHAGUS. Normal.
DUODENUM. Normal.

Advice/Comments
Views obscured somewhat by gastric food residue (she has known delayed gastric emptying).
No blood or altered blood or culprit lesions seen.
Blood tests do not suggest significant GI bleed

Follow up
Return to the ward.

Dr Jack Winter
Consultant Gastroenterologist

Produced by Unisoft's GI Reporting Tool Compiled on 29/09/201

Gastroscopy report

Performed	11-Jul-2019 10:40	Received	11-Jul-2019 10:46
Reported	11-Jul-2019 10:46	Order Number	UNI131214-0712726128
Status	Final	Source System	MasterLab

UGI G1 Final

NHS Greater Glasgow and Clyde
GASTROSCOPY REPORT

Name: **Deborah SULLIVAN (F)**
Date of birth: **07/12/1972**
NHS No: **0712726128**
Case Note No: **0712726128**

Address: **Flat 0-1**
8 Boyndie St
Glasgow
Lanarkshire
G34 9JE

GP: **MCGINLEY, ANNE**
Lochend Surgery
Easterhouse Health Centre
9 Auchinlea Road
Glasgow
G34 9HQ

Procedure date: **11th July 2019 (10:40)**
Priority: **Urgent**
Status: **Inpatient/NHS**
Hospital: **GRI**
Ward: **(none)**
Referring Cons: **Mr Nigel Jamieson (Genera Surgery)**

Indications
Abdominal pain.

Consultant/Endo
List consultant: Mr John
Endoscopist No1: Mr Patrick

Report
The scope was retroflexed in the stomach.
The procedure was completed successfully to D2.

Inst
SC

Diagnoses
OESOPHAGUS. Normal.
STOMACH. Post-surgical and previous fundoplication: intact. Bile and food residue.
DUODENUM. Food residue.

Premed
Midazolam
Xylocaine (Spra

Medication
Continue medication.

Advice/Comments
Asseen previously in 2015 there was bile and food residue (including yesterday evening's peas) in the stomach and some further food residue in duodenum obscuring views of mucosa. No abnormalities seen. No bile in oesophagus, normal oesophagus and wrap is intact. Suggests prokinetic and gastric emptying studies

Mr Patrick MacGoey
ST8

Produced by Unisoft's GI Reporting Tool

Compiled on 11/07/201

Patient na: 0712726128
Date of bi: SULLIVAN F
Deborah 07/12/1972
CHI No:..... Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
5/12/26	17:24	0.9% Nacl	500ml	IV	4°			
5/12/26	22:24	0.9% Nacl	500ml	IV	4°			

Administration details

Date	Time	Given by	Checked by	Comments
23/5/26	23 15	SW		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient name:.....

Date of birth:..... 0712726128

CHI No:.....

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

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
10/2/16		HARTMANN'S	500	IV	6°		KTL		10/02	22 26	SM		
11/2/16		HARTMANN'S	500	IV	6°		KTL		10/	06			

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

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

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
6/2		Hartmann's	500	IV	2°			
6/2		Hartmann's	500	IV	4°			
		HARTMANN'S	500	IV	4°			
7/2		Hartmann's	500	IV	4°			
		Hartmann's	500	IV	4°			

Administration details

Date	Time	Given by	Checked by	Comments
6/2/26	1340	MC		
6/2	2020	EC		
7/2	0451	AM		
7/2/26	1010	M		
7/2/26	1413	M		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
12/26		(N) [illegible]	500ml	IV	6°		[illegible]	
		~~[illegible]~~						
8/2		HARTMANNS	500	IV	6°		[illegible]	
		HARTMANNS	500	IV	6°		[illegible]	
		HARTMANNS	500	IV	6°		[illegible]	
9/2		Hartmanns	500	IV	6°		[illegible]	
		Hartmanns	500	IV	6°		[illegible]	
		HARTMANNS	500	IV	6°		[illegible]	

Administration details - continued

Date	Time	Given by	Checked by	Comments
8/2/26	09 10	[illegible]		
8/2/26	1905.	[illegible]		
09/02	00 50	[illegible]		
09/02	06 50	[illegible]		
9/2/26	22 47	[illegible]		
10/2/26	04 45	[illegible]		
10/02	12 25	[illegible]		

*Prescriber should sign this box if the fluid/additive is no longer required.

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

0712726128
Name: SULLIVAN Deborah F
Address: Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire
DoB: 07/12/1972
Chi number: G34 9JE
Affix patient data label

Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☐

Self administering insulin: Yes ☐ No ☐

Usual diabetes medication and device:

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day:

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
11/02/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		7.9		Humulin I	15 units / units	[signature]				Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed		7.1			units / units					Y / N
12/2/26						units / units					Y / N
						units / units					Y / N
	Before Breakfast		7.8			units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
						units / units					Y / N
						units / units					Y / N
	Before Breakfast					units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/L
Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet Urgent medical review if unwell/deteriorating at any stage. • Mild and able to swallow: 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice • Severe: 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic) Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but do not omit insulin in type 1 diabetes.	Check urine or blood for ketones – need urgent medical review if ketones present or if unwell. Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion. Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes. If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

MEDICINE **PRESCRIPTION FORM** Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Number: 0712726128 Height:
DOB: SULLIVAN : F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Date of Admissior Easterhouse
Consultant Name: Glasgow, Lanarkshire
G34 9JE

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
5/12/16	Oramorph 10.	10mg	Po	21:21	[signature]	CR/RR	2243
5/2/16	Ondansetron 4	4mg	IV	21:21	[signature]	CR/RR	2243
6/12/16	Morphine	5mg	IV	0043	[signature]	NP/MR	0117

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

DATE

MONTH

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT?
RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time	Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
	S	DRUG														
	DOSE	ROUTE	DATE	STOPPED DATE:												
	PRESCRIBER (PRINT & SIGN)			INITIALS:												
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
	T	DRUG														
	DOSE	ROUTE	DATE	STOPPED DATE:												
	PRESCRIBER (PRINT & SIGN)			INITIALS:												
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
	V	DRUG														
	DOSE	ROUTE	DATE	STOPPED DATE:												
	PRESCRIBER (PRINT & SIGN)			INITIALS:												
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
BEFORE ADMISSION ☐ / NEW DOSE ☐ / NEW MEDICATION ☐					Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
	W	DRUG														
	DOSE	ROUTE	DATE	STOPPED DATE:												
	PRESCRIBER (PRINT & SIGN)			INITIALS:												
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															

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

Oral and Other Drugs: Regular Prescription

DATE / MONTH

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

CC

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

DD

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

EE

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

FF

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

All Routes: As Required Prescriptions

BEFORE ADMISSION ☐	NEW DOSE ☐	NEW MEDICATION ☐					STOPPED		DATE	TIME	DOSE	GIVEN BY	Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
			LL	DRUG			DATE:											
			DOSE	ROUTE	INDICATION		INITIALS:											
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:												
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
			MM	DRUG			DATE:											
			DOSE	ROUTE	INDICATION		INITIALS:											
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:												
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
			NN	DRUG			DATE:											
			DOSE	ROUTE	INDICATION		INITIALS:											
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:												
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															
			PP	DRUG			DATE:											
			DOSE	ROUTE	INDICATION		INITIALS:											
			PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DATE:												
			ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY															

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

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

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

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal must be written in full.

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4. 09/2010 GGC0029

Patient name: Deborah Sullivan

Date of birth: 7/12/72

CHI No: 0712726128

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
28/10/25	0700	HARTMANNS	1000	IV	85		Surgical Reg		28/10/25	08 IV			

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:	
500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE | **PRESCRIPTION FORM**

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____ | Sheet No ..... | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name DEBORAH SULLIVAN. Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Numbe: 0712726128
DOB: 07/12/1972
SULLIVAN F
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE
Date of Admiss
Consultant Nam

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
27/10	ONDANSETRON	4mg	IV	13:21	[signature]	[signature]	2336
27/10	DIAMORPH	5mg	O	13:21	[signature]	[signature]	2340
27/10	PARACETAMOL	1g	O	13:21	[signature]	[signature]	2350
28/10	Metoclopramide	10mg	PO	07⁰⁰	[signature]	[signature]	0848
28/10	Esomeprazole	40mg	IV	07⁰⁰	[signature]		
28/10	Humulin I	APC	1/mt	0900	[signature]	AVC	

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE

MONTH

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE: 28 | MONTH: 10

Other times | 0700-0859 | 1200-1400 | 1600-1800 | 2200-2400 | Other times

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

H — BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: Venlafaxine | DOSE: 75mg | ROUTE: O | DATE: 28/10 | STOPPED: DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): M Abbella

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

J — BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: Aripiprazole | DOSE: 15mg | ROUTE: O | DATE: 28/10 | STOPPED: DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): M Abbella

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

K — BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: Empagliflozin | DOSE: 10mg | ROUTE: O | DATE: 28/10 | STOPPED: DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): M Abbella

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

L — BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DRUG: Esomeprazole | DOSE: 40mg | ROUTE: O | DATE: | STOPPED: DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): M Abbella

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

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

Oral and Other Drugs: Regular Prescription

DATE → 28
MONTH → 10

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

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

M — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Simvastatin
DOSE: 20mg | ROUTE: O | DATE: 28/10 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): [signature]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

N — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Ramipril
DOSE: 2.5mg | ROUTE: O | DATE: | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): [signature]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

| 0700-0900 | 13 |

P — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: Prochlorperazine
DOSE: 2.5mg | ROUTE: O | DATE: 28/10 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): [signature]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

| 0700-0900 | 13 |
| 1600-1800 | 12 |

R — BEFORE ADMISSION ☑ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: METFORMIN (metformin).
DOSE: 1g | ROUTE: O | DATE: 28/10 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): [signature]
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

| 0700-0900 | 13 |

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

Oral and Other Drugs: Regular Prescription

DATE: 13 | MONTH: 10

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

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

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver. 4, 09/2010 GGC0029

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Name: ...	0712726128
Address:	SULLIVAN
.....	Deborah F
DoB:	07/12/1972
Chi num	Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire G34 9JE

Diabetes: Type 1 ☐ Type 2 ☑ Secondary ☐

Self administering insulin: Yes ☑ No ☐

Usual diabetes medication and device:

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
28/10/25						units					Y / N
						units					Y / N
	Before Breakfast		7.0		HUMULIN I	18 units	[signature]	✓	✓	0948	Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
				0		units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N

Date	Time	CBG Readings (mmol/L) <4	4.0-14.9	≥15	Insulin Preparation	Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L

Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet

gent medical review if unwell/deteriorating at any stage.

- Mild and able to swallow: 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice
- Severe: 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic)

Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but do not omit insulin in type 1 diabetes.

Hyperglycaemia: Glucose ≥ 15mmol/L

Check urine or blood for ketones – need urgent medical review if ketones present or if unwell.

Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion.

Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes.

If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

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

Diabetes: Type 1 ☐ Type 2 ☑ Secondary ☐

Self administering insulin: Yes ☐ No ☐

Usual diabetes medication and device:

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to **guidelines on reverse of form** when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
						units / units					Y / N
						units / units					Y / N
	Before Breakfast					units / units					Y / N
	08.35		13.2		Humulin	18 units / units	Self-administers				Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
						units / units					Y / N
						units / units					Y / N
	Before Breakfast					units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N
						units / units					Y / N
						units / units					Y / N
	Before Breakfast					units / units					Y / N
						units / units					Y / N
	Before Lunch					units / units					Y / N
						units / units					Y / N
	Before Dinner					units / units					Y / N
						units / units					Y / N
	Before Bed					units / units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L

Requires urgent treatment as per protocol: **www.diabetes.org.uk** or **StaffNet**

Jrgent medical review if unwell/deteriorating at any stage.

- **Mild and able to swallow:** 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice
- **Severe:** 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic)

Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**

Hyperglycaemia: Glucose ≥ 15mmol/L

Check urine or blood for ketones – need urgent medical review if ketones present or if unwell.

Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion.

Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes.

If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check Injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

Patie[illegible] 0712726128
Date SULLIVAN Deborah F 07/12/1972
CHI
patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
22/9		HARTMANN'S	500	IV	2°		STF	
22/9		HARTMANN'S	500	IV	4°		STF	
22/9		HARTMANN'S	500	IV	4°		STF	

Administration details

Date	Time	Given by	Checked by	Comments
22/9	07.00	[illegible]		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

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

NHS
Greater Glasgow and Clyde

Emergency Care Nursing Documentation

Initial Investigations

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

Signature:

Communication

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

Signature:

Risk Assessments and Screening Tools

	SEPSIS	Y	N	GMAWS	Y	N
	FAST	Y	N	Adult Support and Protection	Y	N
Time:	Swallow Testing	Y	N	Mental Health Triage Assessment	Y	N
	Falls Risk (clinical judgement)	Y	N	Child Protection Concerns	Y	N
	4AT Assessment	Y	N	Frailty Assessment	Y	N
				Public Protection (NOC)	Y	N

Signature:

Pause for Discharge or Transfer

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

Signature:

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

NHS
Greater Glasgow and Clyde

Care Rounds Checklist

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

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Signed _____ Name _____ Designation _____

Use the following Codes:
Y = Yes N = No NA = Not Applicable NT = No Thanks S = Sleeping O = Off the ward I - Independent

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

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

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

Hospital:

Ward:

Points to consider:

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

NHS Greater Glasgow and Clyde

PUDRA

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

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

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

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

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

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

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

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

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

NHS
Greater Glasgow and Clyde

Ongoing Care

	4 Hours	5 Hours	6 Hours	7 Hours	8 Hours	9 Hours	10 Hours	11 Hours	12 Hours
Time									
Nursing notes updated including (NEWS, MEWS,PEWS)									
FFN (provide details)									
IVI/IVABs									
Routine Medications prescribed and administered									
Falls risk assessment									
Skin assessed and supported (PURDRA)									
Analgesia assessment									
Nurse call system in place									
SBAR commenced									
Patient/ relatives updated									
Elimination needs met (does the patient know where toilet is)									
If patient not in cubicle space think about patients dignity requirements eg hearing aids, mobility aids, glasses, interpreter									
STOPPS completed									

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

NHS
Greater Glasgow and Clyde

Nursing notes

Date and Time	Name/Signature
Pt attends department with Abdo pain and vomiting. News 4	
18:35 analgesia given (2 cocodamol) slnt.	
2310 accepted tea + sandwich — tolerating now	
23.45 ondansetron & PO cyclizine given to pt — MPatterson	

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

NHS
Greater Glasgow and Clyde

Nursing notes cont.

Date and Time	Name/Signature

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	☐

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

Hospital: GRCI Ward: 64
Date of Admission: 22/8/25 Time: 00:00
Information obtained from: Name: Deborah sullivan
Patient ☑ Relative ☐ Other ☐ _____
Preferred Name:
Age: 52 Telephone Number:
Consultant: Craig.

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: Robert glass	Name:
Relationship: partner	Relationship:
Address: 19 Wheams gardens	Address:
Telephone: 07597 356283	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, 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 ☐ Penicilin

Relevant past medical history

Pancreatitis PTSD delayed gastric emptying
Fibromiyalga T1DM

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

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

Affix patient ID label

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): Leona Wilson Signature: LWilson

Designation: ~~Midwife~~ STN Date: 22/8/18

My Assessment Record

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
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: _____		✓	

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

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.

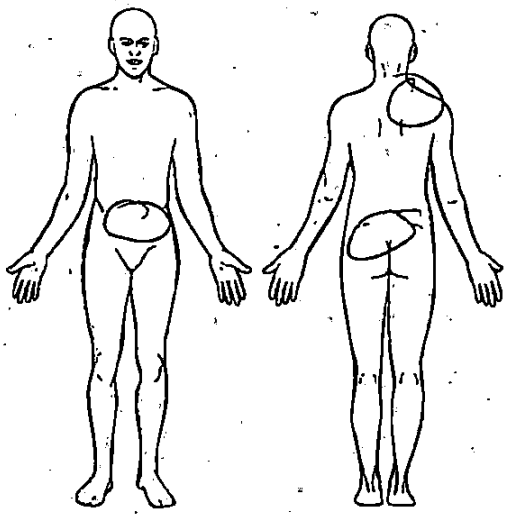
Can you describe any chronic pain that you have?

fibermyalgia

What makes the pain better?

✓

Mark current pain on body chart



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

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?

/

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		

0712726128
SULLIVAN F
Deborah 07/12/1972

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		

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

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? 21/8/25

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	✓	✓	
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?		✓	

0712726128
SULLIVAN F
Deborah 07/12/1972

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**		

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G84 9JE
Affix patient ID label

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?	✓		

0712726128
SULLIVAN F
Deborah 07/12/1972

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 ☐

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
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?

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 ☐

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

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 ___/___/___

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

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
22/8/25 0000	Pt admitted to ward 1B from ED with abdo pain and vomiting. NEWS2 1 for hypotension. Pt fully independent with all ADL's. AJW urine sample. AJW surgical review. On sips at present.	Leona Wilson RGN STN
03:30	WR: non-specific A.P	

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

Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation
	• IVF	
	• Not for CT at present	
	• symptom control	Pmayuran
11:20	Written introspective by	
	DR (T) (H) and K opond.	
	PVC out (A)	
	UL to be done	surgeon

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

Affix patient ID label

Clinical Notes (cont.)

Date and Time	Notes	Print Name, Signature and Designation

Care Rounds Checklist

Date: 22/08/25

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
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)

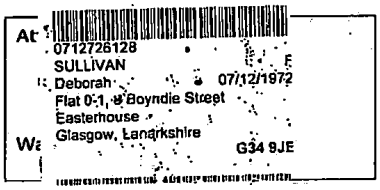
1. Signed [signature] Name Lauren Wilson Designation STN
2. Signed _____ Name _____ Designation _____
3. Signed _____ Name _____ Designation _____

'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	0000	0800	2000																		
	1	**THINK DELIRIUM** Is the patient more confused or drowsy than normal? If YES, inform registered nurse.	N	N	S																		
	2	**PAIN: assess and address** Is the patient distressed or in pain? If YES, inform registered nurse.	N	N	S																		
S	3	**SKIN INSPECTION** Pressure areas checked:	I	I	S																		
		Red (R) / Discoloured (D) / Pressure Ulcer (PU) / Intact (INT) / Moisture (M)	/	–																			
K	4	**KEEP MOVING** Has the patient moved or walked?	I	I	S																		
		Bed Right side (30° tilt) – R Left side (30° tilt) – L Back – B	I	I	B																		
		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	S																		
N	6	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth?	N	N	S																		
		Drink taken?	I	I	S																		
		Food, snack, or supplement taken?	I	I	S																		
		Has oral hygiene been carried out as per care plan?	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																		
	8	**INFORMATION** Is there anything else I can help you with? Inform patient of the time of return.	NT	NT	S																		
	9	**ESCALATION** Escalate any issues to the registered nurse and document overleaf.	NA	NA	S																		
		Care provider / role	[illegible]	[illegible]	[illegible]																		

Care Rounds Variance Sheet



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

Fluid Balance Chart

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

Hospital: GRI

Ward: 64

Date: 22/8/25

Reason for Fluid Balance Chart _____

Is patient fluid restricted? Yes ☐ No ☐

If yes how many mls in 24 hours? _____

Fluid balance from previous 24hrs
+/- _____

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

Is the patient on an oral supplement? Yes ☐ No ☐ If YES please indicate:

1. Type _____ circle how many daily 1 2 3

2. Type _____ circle how many daily 1 2 3

Signature: _____ Designation: _____

ONLY RECORD INTAKE CONSUMED NOT WHAT IS GIVEN TO PATIENT

Time	Input									Output							
	Oral Fluids		Enteral		IV / Other				Running Total INPUT	Urine	Gastric / Vomit	Bowel	Type	Type	Type	Running Total OUTPUT	Initials
	Type	Volume	Type	Volume	Type	Volume	Type	Volume									
00:00																	
01:00																	
02:00																	
03:00																	
04:00																	
05:00																	
06:00																	
07:00																	
08:00																	
09:00																	
10:00																	
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			

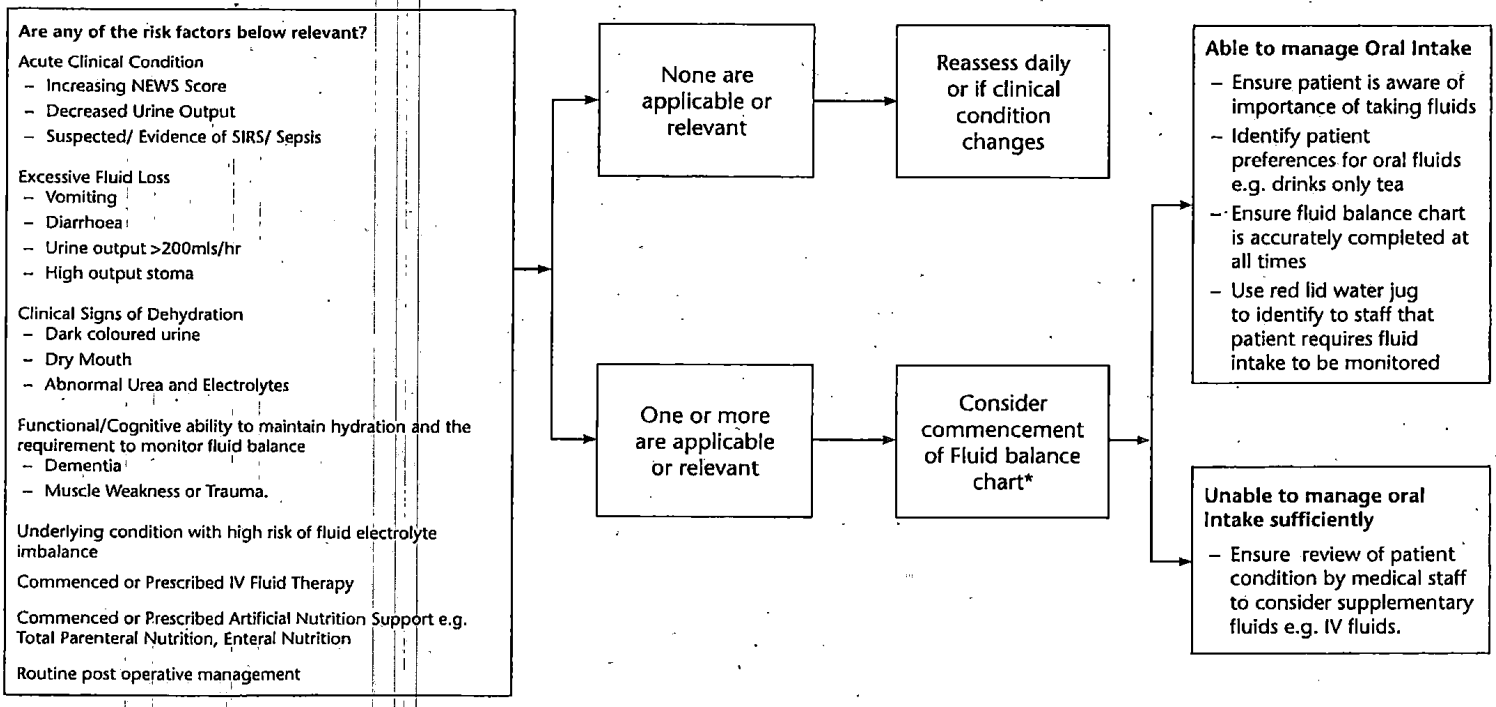
*24 hr Fluid Balance +/-

*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.



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

ssograph

Hospital: GRI

Ward: 64

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

Pressure damage	No RISK	At RISK	Grade 1 – non blanching skin Grade 2,3,4, suspected deep tissue injury (SDTI), ungradable pressure ulcer, Moisture Associate Skin Damage (MASD)	Device Related Pressure Damage i.e. nasogastric, catheters, oxygen tubing
YOU MUST CHECK SKIN at pressure points	Daily skin check	4 hourly positioning Complete SSKINS care plan (Overleaf)	2 hourly positioning with skin checks, Complete SSKINS care plan (overleaf)	All devices need a SSKINS care plan (overleaf)

1	PressureDamage	Does the person have Pressure damage; Grade 1, 2, 3, 4, SDTI, Ungradable?
2	Mobility	Does the person require assistance to mobilise or change position?
3	Continence	Does the person have moisture issues, or, continence issues with urine and/or faeces?
4	Nutrition	Does the person appear malnourished and/or unable to eat or drink?
5	Skin	Is skin compromised by any other source, e.g. medical devices; neurological deficit; surgery; medication; co-morbidities?
6	Judgement	In your clinical judgement, is this person at risk of developing pressure damage?

Date	Location of pressure damage	Grade of ulcer	Date	Location of pressure damage	Grade of ulcer
/ /			/ /		
/ /			/ /		
/ /			/ /		

If NO to all questions, continue Care Rounds Prescribed as assessed for individual need and re-assess daily.
If you have answered YES to any of the questions above, please complete the SSKINS care plan overleaf.

Date	Time	Pressure Damage	Mobility	Continence	Nutrition	Skin Compromised	Clinical Judgement	Check Skin	Signature
22/8/25	00:00	N	N	N	N	N	N	4 hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	
/ /	:							hrly	

Patient Centred SSKINS care plan

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

NB. Avoid patients lying on back/sitting for prolonged episodes, a total change of position is required, standing only is not sufficient

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

NHS Greater Glasgow and Clyde

	S SKIN INSPECTION	S SURFACE	K KEEP MOVING	I INCREASED MOISTURE AND CONTINENCE MANAGEMENT	N NUTRITION	S SELF MANAGEMENT / SHARED CARE	Sign / Comments
Date of plan:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:
Date Reviewed:	Check: • Pressure areas ____ hourly. • Skin under medical devices ____ hourly. • Specify medical devices used: Catheter ☐ Naso gastric ☐ Oxygen mask ☐ Nasal oxygen ☐ Vascular Access Device ☐ Off loading boot ☐ Other:	Specify: • Mattress: • Cushion: • Detail additional pressure redistributing equipment: Off loading boot: ☐ Protective product:	• Reposition ____ hourly in bed. • Reposition ____ hourly in chair. • Overnight patient / carer has agreed to repositioning ____ hourly • Specify any manual handling equipment used: Tilting device ☐ • Knee bend in place ☐ Record reason for no knee bend:	• Does patient have Moisture Associated Skin Damage Yes ☐ • Skin care to be carried out ____hourly. • Specify products required for increased moisture / continence management: Barrier Cream ☐ Pad / Pants ☐	• Optimise nutrition and hydration. • Refer to MUST	• Provide information in a format appropriate to patient / family/ carer needs : • Specify: Leaflet ☐ Verbal ☐ Not provided record reason:	Date discontinued:

0712726128
SULLIVAN
Deborah
F
07/12/1972

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: 64 Date: 22/8/25 Time: 20:00	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	[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

cific (Inpatient) Moving and Handling Assessment Form

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

	Named Nurse:		Person is totally independent (tick here and go to data box)

on

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 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

	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:	22/8/25		
Assessor's signature:	[signature]		
Proposed Review date:	29/8/25		

Continuation Sheet

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

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			
	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:			

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

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

NHS Greater Glasgow and Clyde

Date 22/8/25 Time 00:00 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	88 Kg	☑	☐	

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

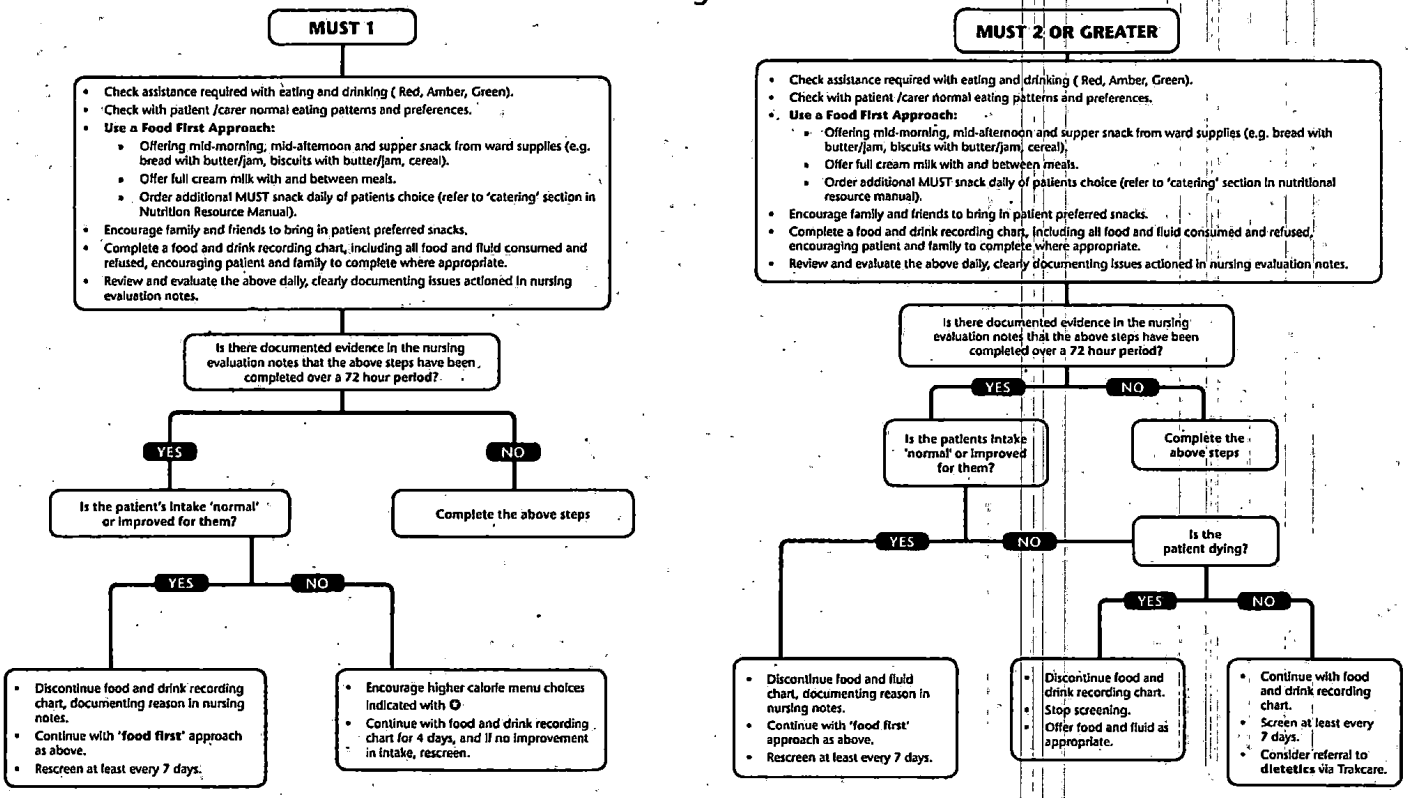
Patients reported normal weight _____ Unable to Recall ☑

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

Date	22/8/25							
Time	00:30							
Ward	64							
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)	88							
BMI	28.7							
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	30/8/25							
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/

fm • 285884 v3.0 • CGC0250

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

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
22/8/25 MM	No breathing or circulation problems.		22/8/25 MM	Getting better	
			22/8/25 MM	5. Hydration and Nutrition	
				On sips at present	
22/8/25 MM	2, 3. Communication and senses				
	~~Communicates fine~~ Communicates freely				
			22/8/25 MM	6. Elimination	
22/8/25 MM	4. Cognitive status			Passing urine	
	Alert and orientated				

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

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
22/8/25 [illegible]	Independent with all ADL's		22/8/25 [illegible]	Maintain	
			22/8/25 [illegible]	10. Sleep and Rest	
				Promote	
22/8/25 [illegible]	8. Mobility				
	Fully independent		22/8/25 [illegible]	12. Privacy, dignity and sexuality	
				Respect	
				Negotiated care - Please record any planned involvement of patient/family in delivery of care	

Write or affix label

N: 0712726128
A: SULLIVAN F
Cl: Deborah 07/12/1972
D: Flat 0-1, 8 Boyndie Street Easterhouse Glasgow, Lanarkshire
H: G34 9JE

Peripheral Venous Cannula (PVC) Insertion & maintenance

Please complete insertion details for each PVC inserted

Care & maintenance to be undertaken & documentation completed twice each day.

Modified Visual Infusion Phlebitis (VIP) Score		
PVC site appears healthy	0	No phlebitis: Continue care and maintenance
Either slight pain or redness near site	1	Possible first signs: Observe PVC site
Two or more: pain / redness / swelling	2	Early stage of phlebitis: Remove and resite PVC
All: pain / redness / hardening of surrounding area	3	Phlebitis/thrombophlebitis: Remove and resite PVC Seek further advice
As above and including: palpable venous cord	4	
As above and including: pyrexia	5	

NHS Greater Glasgow and Clyde

Insertion details:	Where inserted:	Insertion site:	Side:	Size of cannula:	Inserted by:
Date: 21/8/25 (Day 1) Time: ____:____	☑ ED ☐ Theatre ☐ ITU/HDU ☐ Ward ____ ☐ Unknown	☑ Hand ☐ Arm Other ____	☐ Left ☑ Right	☐ 26G Purple ☐ 24G Yellow ☐ 18G Green ☑ 23G Blue ☐ 16G Grey ☐ 20G Pink ☐ 14G Orange	Print: ____ Signature: ____ Designation: ____

Clinical indication:	☐ Diagnostics	☐ Resuscitation	☐ IV medications	☐ Fluids	☐ Transfusion

Insertion criteria:	Hand hygiene performed ☐ Yes ☐ No	Skin decontamination (2% chlorhexidine in 70% isopropyl alcohol) ☐ Yes ☐ No	Sterile transparent semi-permeable dressing affixed ☐ Yes ☐ No	PVC explained to patient/carer ☐ Yes ☐ No

DRIFT PVCs are associated with an increased risk of phlebitis, thrombosis, infection and S.aureus bacteraemia.

Justify the need for your patient to have a PVC using the DRIFT mnemonic.
- ✓ Diagnostics - Does the patient need the PVC for a diagnostic procedure e.g. CT scan
- ✓ Resuscitation - Is the patient at risk of cardiac or respiratory arrest?
- ✓ Intravenous (IV) - Does the patient require intravenous (IV) medication? Could these be switched to another route?
- ✓ Fluids - Does the patient require IV fluids? Could this be switched or oral fluids?
- ✓ Transfusion - Does the patient require a transfusion of blood products?

Signs of local or systemic infection

Local infection
- Erythema / inflammation
- Exudate
- Hot to touch
- Pain/tenderness

Systemic Infection
- Hypotension
- Tachycardia
- Pyrexia

Adult IVOST Guideline:

Always refer to full IV route to Oral route Switch Therapy (IVOST) guidelines

IV → Oral Antibiotic Switch Therapy (IVOST) Guideline

Review need for IV antibiotics daily

Can antibiotic therapy be stopped? (eg: alternative diagnosis)?

If ongoing antibiotics required - document patient progress/IVOST plan within 72 hours

↓

Switch to oral when:

a CLINICAL IMPROVEMENT in signs of infection eg: temperature ≤37.9°C, reduction in the NEWS score, improving SEPSIS

a ORAL ROUTE is available reliably (eating/drinking no concerns regarding absorption)

a UNCOMPLICATED INFECTION i.e. specialist advice not required prior to IVOST: Infection requiring specialist advice includes CNS infection, Cystic fibrosis, S. aureas bacteraemia (minimum 14 days IV), Endocarditis, Vascular graft or bone/joint infection, Undrainable deep abscess.

DO NOT use CRP in isolation to assess IVOST suitability as does not reflect severity of illness

Record the stop date on HEPMA

↓

If IVOST criteria met → Switch to oral

Review MICROBIOLOGY results and NARROW THE SPECTRUM based on cultures

IF not responsive MICROBIOLOGY switch to oral as outlined below

Paediatric IVOST Guideline:

0712726128
SULLIVAN F
Deborah 07/12/1972

PVCs should be removed as soon as no longer clinically indicated.

NHS Greater Glasgow and Clyde

Maintenance – to be completed twice daily (Observe for signs and symptoms of local or systemic infection)

Date	Need for PVC reviewed today?		Any sign of PVC site infection?		Is the dressing intact?		Before / after PVC procedures; hand hygiene performed?		PVC patent?		What has been done?		Sign: Leona Wilson Print: Leona Wilson Designation: SSTN
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Day 1 Insertion Date 02/12/25	☑ Yes ☐ No	☐ Yes ☐ No	VIP 0	VIP ____	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Yes ☐ No	☐ Yes ☐ No	☑ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night Leona Wilson
Day 2	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 3	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 4	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 5	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 6	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Left in situ ☐ Redressed ☐ Removed	Day Night
Day 7	☐ Yes ☐ No	☐ Yes ☐ No	VIP ____	VIP ____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Left in situ ☐ Redressed ☐ Removed	☐ Removed	Day Night

PVCs should be removed on day 7. Reassess ongoing needs and vessel health for most appropriate vascular access device. Date removed __/__/__

Reason for removal	☐ Site infection	☐ Infiltration	☐ Extravasation	☐ End of treatment	Other:

NHSGGC NEWS – National Early Warning Score

NHS Greater Glasgow and Clyde

0712726128
SULLIVAN
Deborah
F
07/12/1972
Flat 0-1, 8 Boyndie Street
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
	Low Clinical Risk	Medium Clinical Risk	High Clinical Risk
Min 12 Hourly Observations	Min 4 Hourly Observation	Min Hourly Observations	Continuous Monitoring
	Inform Registered Nurse	Urgent Assessment by Medical Team	Urgent Assessment by Senior Medical Team
	Agree Frequency of Observation Required	ACE Response in Medical Notes	ACE Response in Medical Notes
		Think Sepsis if Suspicion of Infection	Consider 2222

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

Discontinuation of NEWS

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

Signed.....

Medical:.....

Date:.....

Pupil Reaction and size

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

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

Glasgow Coma Scale

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

| | | |

(1) DEBORAH SULLIVAN

NEWS 2 Key | 1 | 2 | 3

| | | |

Patient name: Deborah Sullivan

Date of bir [redacted] F

CHI No: [redacted] 07/12/1972

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

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
19/3	2:15	Hartmans	500	IV	40		S. Ave C.F.	
19/3	2:15	Hartmans	500	IV	40		S. Ave C.F.	
19/3	2:15	Hartmans	500	IV	40		S. Ave C.F.	

Administration details

Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow = (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient n [barcode] .....
0712726128
Date of b SULLIVAN F ....
Deborah 07/12/1972
CHI No:... Flat 0-1, 8 Boyndie Street ....
Easterhouse
Glasgow, Lanarkshire
G34 9JE *label*

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
18/03		0.9% NaCl	500	IV	2°			
18/03		0.9% NaCl	500	IV	4°			
18/03		0.9% NaCl	500	IV	4°			

Administration details

Date	Time	Given by	Checked by	Comments
18/3/23	20 12	[illegible]		
19/3/23	00 00	AD		
19/3/23	02 00	AD.		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr)- Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
___/___/___ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

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

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

	DATE →																								
	MONTH →																								
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																								
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																									
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																									
SIGNATURE OF ASSESSOR																									
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																									

Parenteral Drugs : Regular Prescription

																									Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**A** DRUG DOSE / ROUTE / DATE / STOPPED DATE: PRESCRIBER (PRINT & SIGN) / INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																							For Use Y/N
		0700-0900																							Qty:
		1200-1400																							Date:
		1600-1800																							Assessed by:
		2200-2400																							Ordered from Pharm.
		Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**B** DRUG DOSE / ROUTE / DATE / STOPPED DATE: PRESCRIBER (PRINT & SIGN) / INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																							For Use Y/N
		0700-0900																							Qty:
		1200-1400																							Date:
		1600-1800																							Assessed by:
		2200-2400																							Ordered from Pharm.
		Other time																							
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**C** DRUG DOSE / ROUTE / DATE / STOPPED DATE: PRESCRIBER (PRINT & SIGN) / INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																							For Use Y/N
		0700-0900																							Qty:
		1200-1400																							Date:
		1600-1800																							Assessed by:
		2200-2400																							Ordered from Pharm.
		Other time																							

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

All Routes: As Required Prescriptions

| | | |

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= naso-jejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

0712726128
Pat: SULLIVAN F
2 Deborah 07/12/1972
Dat Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
CH: G34 9JE
Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
7 / 12		Hartmanns / NB	1000	N	84)		[signature] CONRAD		8/12/24	15.40	[signature]		
8/12		Hartmanns	500	IV	4°		[signature] MWALTERS FYI		9/12/24	02 40	[signature]		
9/12		HARTMANNS	500	IV	4°		[signature]		9/12/24	18 00	[signature]		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details continued									Administration details continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____ | Sheet No ..... | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: __/__/__	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
3/12	Morphine Sulf	4mg	IV	19:45	[illegible]	[illegible]	20:08

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

DATE: __/__/__ PRESCRIBER (PRINT & SIGN): _____

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE →

MONTH →

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

H

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG | DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's own Medicine

BEFORE ADMISSION ☐

X **DRUG**

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

NEW DOSE ☐

NEW MEDICATION ☐

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐

Y **DRUG**

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

NEW DOSE ☐

NEW MEDICATION ☐

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐

AA **DRUG**

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

NEW DOSE ☐

NEW MEDICATION ☐

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐

BB **DRUG**

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

NEW DOSE ☐

NEW MEDICATION ☐

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

CC

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

DD

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

EE

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

FF

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY
STOPPED DATE: INITIALS:

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Drug Allergies / Sensitivities None Known ☐ Yes ☐ (provide details below)

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40955 Ver 4, 09/2010 GSC0029

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Name: Deboran sullivan Address: DoB: Chi number: 0712726128 *Affix patient data label*	Diabetes: Type 1 ☐ Type 2 ☐ Secondary ☐ Self administering insulin: Yes ☐ No ☐ Usual diabetes medication and device: HUMULIN NUMID AM I If unwell, vomiting or septic, check for ketones and request urgent medical review.	• When prescribing insulin always write the word units in full (do not abbreviate to U or IU) • Always measure the dose and administer insulin using an insulin syringe • Rapid acting and premix insulin should be given with meals • Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	CBG Readings (mmol/L) 4.0-14.9	CBG Readings (mmol/L) ≥15	Insulin Preparation	Insulin Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
4/12/24						units					Y / N
						units					Y / N
	Before Breakfast		2*		HUMULIN I	12 units	ANNELLEN MURPHY	JP.	JL		Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner		12*			units					Y / N
						units					Y / N
	Before Bed		8.4			units					Y / N
5/12/24						units					Y / N
						units					Y / N
	Before Breakfast		7.8			units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
	Before Breakfast					units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L	Hyperglycaemia: Glucose ≥ 15mmol/L
Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet Urgent medical review if unwell/deteriorating at any stage. **Mild and able to swallow:** 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice • **Severe:** 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic) Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**	Check urine or blood for ketones – need urgent medical review if ketones present or if unwell. Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion. Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes. If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

Insulin Prescription and Administration Form

NHS Greater Glasgow and Clyde

Name: 0712726128 SULLIVAN F
Address: Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
DoB: G34 9JE
Chi nur
Affix patient data label

Diabetes: Type 1 ☐ Type 2 ☑ Secondary ☐

Self administering insulin: Yes ☐ No ☐

Usual diabetes medication and device:
HUMULIN I 8units am

If unwell, vomiting or septic, check for ketones and request urgent medical review.

- When prescribing insulin always write the word units in full (do not abbreviate to U or IU)
- Always measure the dose and administer insulin using an insulin syringe
- Rapid acting and premix insulin should be given with meals
- Long acting insulin should be given at the same time every day

****Ensure that the insulin type and adminstration times are also prescribed on the Kardex. Adminstration of all doses must be recorded on both chart and Kardex.****

Refer to guidelines on reverse of form when blood glucose falls into the shaded areas.

Frequency of capillary blood glucose (CBG) monitoring: _____ /day.

Date	Time	CBG Readings (mmol/L) <4	4.0-14.9	≥15	Insulin Preparation	Dose (units)	Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
						units					Y / N
						units					Y / N
12/9/24	Before Breakfast		19.6		HUMULIN I	8 units					Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
	20.00hrs		12.2			units					Y / N
	Before Bed					units					Y / N
13/9						units					Y / N
						units					Y / N
	Before Breakfast		9.0		HUMULIN I	8 units				0900	Y / N
						units					Y / N
	Before Lunch					units					Y / N
			10.1			units					Y / N
	Before Dinner					units					Y / N
			12.6			units					Y / N
	Before Bed					units					Y / N
						units					Y / N
						units					Y / N
14/9	Before Breakfast				HUMULIN I	8 units			AM	0845	Y / N
						units					Y / N
	Before Lunch					units					Y / N
						units					Y / N
	Before Dinner					units					Y / N
						units					Y / N
	Before Bed					units					Y / N

Date	Time	CBG Readings (mmol/L)			Insulin		Print prescriber's name and sign below	Given by	Checked by	Time given	Ketones present Y / N
		<4	4.0-14.9	≥15	Preparation	Dose (units)					
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N
						units units					Y / N
						units units					Y / N
	Before Breakfast					units units					Y / N
						units units					Y / N
	Before Lunch					units units					Y / N
						units units					Y / N
	Before Dinner					units units					Y / N
						units units					Y / N
	Before Bed					units units					Y / N

Guidelines for capillary blood glucose readings falling into the shaded area

Hypoglycaemia: Glucose < 4mmol/L

Requires urgent treatment as per protocol: www.diabetes.org.uk or StaffNet

Urgent medical review if unwell/deteriorating at any stage.

Mild and able to swallow: 15-20g carbohydrate such as 4-5 Glucotabs®, 60ml Glucojuice®, 100ml original Lucozade® or 150-200ml pure fruit juice

- Severe: 100mls IV 20% Glucose or 150-200mls IV 10% Glucose (or 1mg Glucagon IM if venous access problematic)

Check glucose after 10-15 minutes to ensure resolved – if glucose >4mmol/L give two biscuits / sandwich, if not then treat again as per protocol. Following treatment of hypoglycaemia, review insulin doses, but **do not omit insulin in type 1 diabetes.**

Hyperglycaemia: Glucose ≥ 15mmol/L

Check urine or blood for ketones – need urgent medical review if ketones present or if unwell.

Assess risk of DKA in patients with type 1 diabetes and monitor closely – consider increase in insulin doses; may need IV insulin infusion.

Assess risk of hyperglycaemic hyperosmolar syndrome in type 2 diabetes.

If hyperglycaemic at same time on two consecutive days (even if mild), ask medical team to review diabetes treatment.

Consider and address causes of hypoglycaemia or hyperglycaemia

- Assess oral intake: too little or too much carbohydrate
- Consider renal failure, liver failure, pancreatic disease, sepsis or steroid therapy
- Review medication: check correct insulin (or other medication), dose and time of administration
- Check injection sites in patients taking insulin

Contact Numbers

On-call medical page: _____ Hospital at night _____

Diabetes specialist nurse page: _____ Ext: _____

Name: .....

Address: .....

.....

DoB: .....

Chi number: .....

Affix patient data label

Approved by: NHSGGC Safer Use of Medicines Committee, Dec 2014. Date of review: Dec 2016

mi • 243189 Version 1_0 • GGC0123

Patient name:...0712726128
SULLIVAN F
Date of birth:... Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
CHI No:.....Glasgow, Lanarkshire
G34 9JE

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
12/9/22	07[45]	Hartmanns	500	IV	125ml/hr	✓	K Dunlop K. DUNLOP CST2		12/9	18[20]			
		Hartmanns	500	IV	125ml/hr	✓	K Dunlop K. DUNLOP CST2						

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

0712726128

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

x patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
12/9	0730	HARTMANNS	1L	IV	2hr								

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____ | Sheet No ..... | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital No: 0712726128

DOB: SULLIVAN F

Deborah 07/12/1972

Flat 0-1, 8 Boyndie Street

Easterhouse

Glasgow, Lanarkshire

G34 9JE

Date of Birth: __/__/__

Consultant:

Height:

Weight:

Surface area:

Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
12/9	DICLOFENAC	100mg	PR	0230	[signature]	[signature]	02:45

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

94–98%	88–92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE: 12/9/24 PRESCRIBER (PRINT & SIGN): [signature]

	DATE / MONTH
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N	
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N	
SIGNATURE OF ASSESSOR	
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N	

Parenteral Drugs : Regular Prescription

			Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time	Patient's Own Medicine	For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	A DRUG	DOSE / ROUTE / DATE / STOPPED DATE: / INITIALS: / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	B DRUG	DOSE / ROUTE / DATE / STOPPED DATE: / INITIALS: / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	C DRUG	DOSE / ROUTE / DATE / STOPPED DATE: / INITIALS: / PRESCRIBER (PRINT & SIGN) / ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

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

D

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

E

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

F

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

G

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

BEFORE ADMISSION	NEW DOSE	NEW MEDICATION					STOPPED DATE: / INITIALS:	DATE	TIME	DOSE	GIVEN BY	Patient's Own Medicine: For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
☐	☐	☐	LL	DRUG: PARACETAMOL												
				DOSE: 1g	ROUTE: PO	INDICATION: Pain										
				PRESCRIBER (PRINT & SIGN):		MAX.FREQ: QID	DATE: 12/9									
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												
☐	☐	☐	MM	DRUG: ONDANSETRON												
				DOSE: 4mg	ROUTE: IV	INDICATION: N/V										
				PRESCRIBER (PRINT & SIGN):		MAX.FREQ: TDS	DATE: 12/9									
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												
☐	☐	☐	NN	DRUG:												
				DOSE:	ROUTE:	INDICATION:										
				PRESCRIBER (PRINT & SIGN):		MAX.FREQ:	DATE:									
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												
☐	☐	☐	PP	DRUG:												
				DOSE:	ROUTE:	INDICATION:										
				PRESCRIBER (PRINT & SIGN):		MAX.FREQ:	DATE:									
				ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY												

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

BEFORE ADMISSION ☐	RR	DRUG			STOPPED DATE:	DATE																						Patient's Own Medicine For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION		INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																						Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																						Assessed by:
																												Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG			STOPPED DATE:	DATE																						For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION		INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																						Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																						Assessed by:
																												Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG			STOPPED DATE:	DATE																						For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION		INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																						Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																						Assessed by:
																												Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG			STOPPED DATE:	DATE																						For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION		INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.		DATE:	DOSE																						Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY					GIVEN BY																						Assessed by:
																												Ordered from Pharm.

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

Name _____

CHI No _____

Drug Allergies / Sensitivities **None Known** ☐ **Yes** ☐ **(provide details below)**

Opioids, Duloxetine

Penicillin

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1600.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal **must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

MEDICINE

PRESCRIPTION FORM

Hospital Name: GRI

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (If required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & _____

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

PATIENT DETAILS

Hospital No:	Height:
DOB:	Weight:
	Surface area:
Date of Admission: __/__/__	
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
22/2	Morphine	5mg	IV	1825	CS	MM/CO	1915

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

DATE

MONTH

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE / MONTH

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

All Routes: As Required Prescriptions

| | | |

BEFORE ADMISSION ☐	RR	DRUG	STOPPED DATE: INITIALS:	DATE																								Patient's Own Medicine For Use Y/N
	DOSE	ROUTE	INDICATION	TIME																								Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DOSE																								Date:
			DATE:	GIVEN BY																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																											Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG	STOPPED DATE: INITIALS:	DATE																								For Use Y/N
	DOSE	ROUTE	INDICATION	TIME																								Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DOSE																								Date:
			DATE:	GIVEN BY																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																											Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG	STOPPED DATE: INITIALS:	DATE																								For Use Y/N
	DOSE	ROUTE	INDICATION	TIME																								Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DOSE																								Date:
			DATE:	GIVEN BY																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY																											Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG	STOPPED DATE: INITIALS:	DATE																								For Use Y/N
	DOSE	ROUTE	INDICATION	TIME																								Qty:
NEW DOSE ☐	PRESCRIBER (PRINT & SIGN)		MAX.FREQ.	DOSE																								Date:
			DATE:	GIVEN BY																								Assessed by:
NEW MEDICATION ☐	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.																								Ordered from Pharm.

Name Deborah Sullivan

CHI No 0712726128

Drug Allergies / Sensitivities **None Known** ☐ **Yes** ☐ **(provide details below)**

Penicillin

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0500, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

Patie 0712726128 F .....
SULLIVAN 07/12/1972
Date Deborah .....
Flat 0-1, 8 Boyndie Street
Easterhouse
CHI N Glasgow, Lanarkshire G34 9JE .....
Patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
22/2		Hartmanns	1000	IV	1°			
		Hartmann's	500	IV	2°			
		Hartmann's	500	IV	~~4~~ 2°		PHL R.Vaish	
		HARTMANNS	500	IV	2°			
23/2/23	23:00	Nacl 0.9%	500	IV	4°		JWILLIS JWillis.	

Administration details

Date	Time	Given by	Checked by	Comments
22/2	19:00	MM		500 ☑ 500 ☑ @23:00
23/2	06:00	MM		
23/2	11:00			
23/2	15:00			
23/2/23	23:20			22-14T 4G 05/24

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)*
23/2/23 23.00		Nacl 0.9%	500	IV	4	—	JWILLIS JWillis.	JNP.
		—			—	Stopped.		—

Administration details - continued

Date	Time	Given by	Checked by	Comments
23/2/23	23.00	CJ		

*Prescriber should sign this box if the fluid/additive is no longer required.

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

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details									Administration details				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments
11/2/22	1425	0.9% NaCl	500	IV	START				11/02/22	15.28			
11/2/22	1425	0.9% NaCl	500	IV	2°				11/02/22	17.10			

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)

Administration details - continued

Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

Patient name: 0712726128 SULLIVAN Deborah F
Date of birth: 07/12/1972
Flat 0-1; 8 Boyndie Street Easterhouse Glasgow, Lanarkshire
CHI No: G34 9JE

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg): ..... Height (cm): .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
		NaCl 0·9%	500	IV	4°			
		NaCl 0·9%	500	IV	4°			

Administration details

Date	Time	Given by	Checked by	Comments
13/02	00 10	MS		

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional Instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE **PRESCRIPTION FORM**

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (If required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number: 0712726128 F

DOB: 07/12/1972 SULLIVAN Deborah

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

Weight:

Height:

Surface area:

Date of Admission:

Consultant Name:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
4/2	ONDANSETRON	4mg	IV	1425		AS	14:30 15:30
4/2	MORPHINE	5mg	IV	1425		AS	14:30 15:21
4/2	MORPHINE	5	IV			AS/AS	17.10.
4/2	BECLOMETH	2	INHALER			AS	17.10

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

DATE →

MONTH →

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT?
RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

H DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

J DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

K DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

L DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M | DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N | DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P | DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R | DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

CC DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

All Routes: As Required Prescriptions

																																Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	LL DRUG	DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE																							For Use Y/N
										TIME																							Qty:
										DOSE																							Date:
										GIVEN BY																							Assessed by:
																																	Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	MM DRUG	DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE																							For Use Y/N
										TIME																							Qty:
										DOSE																							Date:
										GIVEN BY																							Assessed by:
																																	Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	NN DRUG	DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE																							For Use Y/N
										TIME																							Qty:
										DOSE																							Date:
										GIVEN BY																							Assessed by:
																																	Ordered from Pharm.
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	PP DRUG	DOSE	ROUTE	INDICATION	STOPPED DATE: INITIALS:	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	DATE																							For Use Y/N
										TIME																							Qty:
										DOSE																							Date:
										GIVEN BY																							Assessed by:
																																	Ordered from Pharm.

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

BEFORE ADMISSION ☐	RR	DRUG	STOPPED DATE:	DATE																							Patient's Own Medicine For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION	INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE																							Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY																							Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION ☐	SS	DRUG	STOPPED DATE:	DATE																							For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION	INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE																							Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY																							Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION ☐	TT	DRUG	STOPPED DATE:	DATE																							For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION	INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE																							Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY																							Assessed by:
																											Ordered from Pharm.
BEFORE ADMISSION ☐	VV	DRUG	STOPPED DATE:	DATE																							For Use Y/N
NEW DOSE ☐	DOSE	ROUTE	INDICATION	INITIALS:	TIME																						Qty:
NEW MEDICATION ☐	PRESCRIBER (PRINT & SIGN)	MAX.FREQ.	DATE:	DOSE																							Date:
	ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY			GIVEN BY																							Assessed by:
																											Ordered from Pharm.

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

Name _____

CHI No _____

Drug Allergies / Sensitivities **None Known** ☐ **Yes** ☑ **(provide details below)**

Penicillin

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

0712728128

Patient SULLIVAN F .....
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Date of Easterhouse .....
Glasgow, Lanarkshire
CHI No G34 9JE .....

...ent label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
17/8		HARTMANS	1L	IV	8			
17/8		HARTMANS	1L	IV	8			

Administration details

Date	Time	Given by	Checked by	Comments
17/8/12	19			

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid Name of additive	Volume (ml) Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE | PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐

Date _____ Name (Print) _____

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared: ___/___/___ Time: _____ | Sheet No ..... | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details _____

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: ___/___/___	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
17/5	MORPHINE	10mg	IV	1947	WALLACE	[illegible]	1955

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

| | | |

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

| | | |

Oral and Other Drugs: Regular Prescription

DATE: 18 | MONTH: 8

H — DRUG: PARACETAMOL
DOSE: 1g QDS | ROUTE: PO | DATE: 18/8 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): RC
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: —
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

J — DRUG: DIHYDROCODEINE
DOSE: 30mg | ROUTE: PO | DATE: 18/8 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): R
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

K — DRUG: CYCLIZINE
DOSE: 50mg TDS | ROUTE: PO | DATE: 18/8 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN): RC
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

L — DRUG: CYC
DOSE: | ROUTE: | DATE: | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

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

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

M DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

N DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

P DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

R DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

S DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

T DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

V DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

W DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

X DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

Y DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

AA DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

BB DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

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

All Routes: As Required Prescriptions

Patient's Own Medicine

| | | |

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

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

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following –

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal must be written in full.

FOR NURSES

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

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

MEDICINE | PRESCRIPTION FORM

Hospital Name: GRI

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____ | Sheet No _____ | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (If required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name LLOYDS PHARMACY Tel No. 0141 773-2003
Address CASTLEHOUSE
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital No. [redacted] F
DOB 07/12/1972
SULLIVAN
Deborah
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire G34 9JE
Consu

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
28/6/21	MORPHINE	5mg	IV	22:00	RITCHIE	[redacted]	2004
29/6/21	ONDANSETRON	4mg	IV	22:00	RITCHIE	[redacted]	2017
28/6/21	MORPHINE	5mg	IV	22:50	RITCHIE	[redacted]	2255
29/6/21	Oxycodone	10mg	PO	03:21	[redacted]	[redacted]	0325
1/7/21	PARACETAMOL	1g	PR		[redacted]		

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

	DATE → 29 30	MONTH → 6 6
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y/N	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)	
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y/N		
SIGNATURE OF ASSESSOR		
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N		

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: ENOXAPARIN

DOSE: 40mg | ROUTE: SC | DATE: 29/6 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): TAYLOR FYI

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time		For Use Y/N
0700-0900		City:
1200-1400		Date:
1600-1800 (circled)	GJ VSM	Assessed by:
2200-2400		Ordered from Pharm.
Other time		

B — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time		For Use Y/N
0700-0900		City:
1200-1400		Date:
1600-1800		Assessed by:
2200-2400		Ordered from Pharm.
Other time		

C — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG:

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time		For Use Y/N
0700-0900		City:
1200-1400		Date:
1600-1800		Assessed by:
2200-2400		Ordered from Pharm.
Other time		

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

Oral and Other Drugs: Regular Prescription

| | | |

Oral and Other Drugs: Regular Prescription

Row 1
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
M | DRUG: GLICLAZIDE (M/R)
DOSE: 30 mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tq
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Row 2
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
N | DRUG: ARIPIPRAZOLE
DOSE: 25 mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tq
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Row 3
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
P | DRUG: METFORMIN
DOSE: 1g | ROUTE: Po | DATE: 29/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tq
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Row 4
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
R | DRUG: DIAZEPAM
DOSE: 5mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tq
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

	DATE	29	30	1
	MONTH	6	6	7
Other time				
0700-0900		9	9	15 MH
1200-1400		17 20		
1600-1800				
2200-2400				
Other time				
Other time				
0700-0900		13	13	13
1200-1400				
1600-1800				
2200-2400				
Other time				
Other time				
0700-0900		13	13	13
1200-1400				
1600-1800		13	13	
2200-2400				
Other time				
Other time				
0700-0900				
1200-1400				
1600-1800				
2200-2400		13	13	
Other time				

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

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

Oral and Other Drugs: Regular Prescription

DATE → 30 | 1
MONTH → 6 | 7

S — DRUG: DEPTAC
DOSE: 5 mls | ROUTE: PO | DATE: 29/6 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
Other time: 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

T — DRUG: PROCYCLIDINE HYDROCHLORIDE
DOSE: 5 mg | ROUTE: PO | DATE: 29/6 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
Other time: 0700-0900 (B) (B) (B) | 1200-1400 | 1600-1800 | 2200-2400 | Other time

V — DRUG: CREON (10,000 UNITS)
DOSE: 1 TAB | ROUTE: PO | DATE: 29/6 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
Other time: 0700-0900 (B) (B) (B) | 1200-1400 (B) (B) | 1600-1800 (B) (B) | 2200-2400 | Other time

W — DRUG: PARACETAMOL
DOSE: 1g | ROUTE: PO | DATE: 29/6 | STOPPED: DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
Other time: 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

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

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

Oral and Other Drugs: Regular Prescription

DATE: 29 30 1
MONTH: 6 6 7

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

BEFORE ADMISSION ☑ **NEW DOSE** ☐ **NEW MEDICATION** ☐

X DRUG: LACTULOSE
DOSE: 15mls | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	10 qu KM			14 22	

BEFORE ADMISSION ☑ **NEW DOSE** ☐ **NEW MEDICATION** ☐

Y DRUG: ESOMEPRAZOLE
DOSE: 40mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	13		13		

BEFORE ADMISSION ☑ **NEW DOSE** ☐ **NEW MEDICATION** ☐

AA DRUG: DULOXETINE
DOSE: 60mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	13		13	13	

BEFORE ADMISSION ☑ **NEW DOSE** ☐ **NEW MEDICATION** ☐

BB DRUG: PREGABALIN
DOSE: 300mg | ROUTE: PO | DATE: 29/6 | STOPPED DATE: | STOPPED INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

Other time	0700-0900	1200-1400	1600-1800	2200-2400	Other time
	13		13	13	

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

Oral and Other Drugs: Regular Prescription

DATE: 29 30 1
MONTH: 6 6 7

CC DRUG: SIMVASTATIN
BEFORE ADMISSION ☑ NEW DOSE ☐ NEW MEDICATION ☐
DOSE: 20 mg | ROUTE: PO | DATE: 2/16 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

DD DRUG: RAMIPRIL
BEFORE ADMISSION ☑ NEW DOSE ☐ NEW MEDICATION ☐
DOSE: 2.5 mg | ROUTE: PO | DATE: 2/16 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

EE DRUG: TEMAZEPAM
BEFORE ADMISSION ☑ NEW DOSE ☐ NEW MEDICATION ☐
DOSE: 10 mg | ROUTE: PO | DATE: 2/16 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

FF DRUG:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
DOSE: | ROUTE: | DATE: | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

	CC	DD	EE	FF
Other time				
0700-0900		13 13 13		
1200-1400				
1600-1800				
2200-2400	13 13		13 13	
Other time				

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

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

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

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

All Routes: As Required Prescriptions

Patient's Own Medicine

LL — DRUG: Cyclizine — STOPPED DATE: — STOPPED INITIALS:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 50mg | ROUTE: PO | INDICATION: Pain
PRESCRIBER (PRINT & SIGN): OMemid | MAX.FREQ.: 8O | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

																																For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
DATE	28/6	30/6	1/6																																	
TIME	15	04 30	14 35																																	
DOSE	50 mg	50 mg	50 mg																																	
GIVEN BY	KW	KW	KW																																	

MM — DRUG: Oramorph — STOPPED DATE: — STOPPED INITIALS:
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑
DOSE: 5-10mg | ROUTE: PO | INDICATION: Pain
PRESCRIBER (PRINT & SIGN): OMemid | MAX.FREQ.: 20 | DATE:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: Observe for Opioid toxicity

DATE	28/6	29/6	29/6	29/6	29/6	29/6	30/6	30/6	30/6	30/6	30/6	30/6																								
TIME	15	07 30	16 00	18 15	00 00	04 30	11 00	13 40	18 25	20 30																										
DOSE	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg																										
GIVEN BY	KW	KW	KW	KW	KW	KW	KW	KW	KW	KW																										

NN — DRUG: ONDANSETRON — STOPPED DATE: — STOPPED INITIALS:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 4mg | ROUTE: PO | INDICATION: N+V
PRESCRIBER (PRINT & SIGN): TG | MAX.FREQ.: TDS | DATE: 29/6
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE	28/6																																			
TIME	20 30																																			
DOSE	4mg																																			
GIVEN BY	KW																																			

PP — DRUG: LAXIDO — STOPPED DATE: — STOPPED INITIALS:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 1 SACH | ROUTE: PO | INDICATION: CONSTIP
PRESCRIBER (PRINT & SIGN): TG | MAX.FREQ.: BD | DATE: 29/6
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

DATE																																				
TIME																																				
DOSE																																				
GIVEN BY																																				

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

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

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

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - Intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

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

Cat. No. 40995 Ver 4, 09/2010 GGC0029

MEDICINE **PRESCRIPTION FORM** Hospital Name: GRI

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☐
Date _____ Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____ | Sheet No ..... | 2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (If required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____
Address _____
Compliance Aid Details _____
Patient consent to share discharge information Y/N
Print & Sign _____

PATIENT DETAILS

Hospital Number: 0712726128
DOB: F SULLIVAN
/2 Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street Area:
Date of Admission: Easterhouse
Consultant Name: E Glasgow, Lanarkshire G34 9JE

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
07/12	ONDANSATRON	4mg	PO	18.00	K4 Kwaku Ley	LG.	1800

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

On Home Oxygen? Yes / No _____ L/min

DATE: ____/____/____ PRESCRIBER (PRINT & SIGN): _____

	DATE → 7 8																										
	MONTH → 2 2																										
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																										
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N																											
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N																											
SIGNATURE OF ASSESSOR																											
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																											

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑

A DRUG: ENOXAPARIN

DOSE: 40 mg | ROUTE: SC | DATE: 8/2 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN): Ty K TAYLOR

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800	W					
2200-2400						
Other time						

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

B DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

C DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

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

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

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

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

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

E DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

F DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

G DRUG
DOSE | ROUTE | DATE
PRESCRIBER (PRINT & SIGN)
STOPPED DATE: INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

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

Oral and Other Drugs: Regular Prescription

DATE → 7 9
MONTH → 2 2

Patient's Own Medicine

H — DRUG: SIMVASTATIN
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 20 mg | ROUTE: ORAL | DATE: 6/2
PRESCRIBER (PRINT & SIGN): TAYLOR
STOPPED DATE: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG: TEMAZEPAM
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 10 mg | ROUTE: ORAL | DATE: 6/2
PRESCRIBER (PRINT & SIGN): TAYLOR
STOPPED DATE: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG: ESOMEPRAZOLE
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 40mg | ROUTE: ORAL | DATE: 6/2
PRESCRIBER (PRINT & SIGN):
STOPPED DATE: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG: GLICLAZIDE (MR)
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 30 mg | ROUTE: ORAL | DATE: 6/2
PRESCRIBER (PRINT & SIGN):
STOPPED DATE: | INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm. 8/2/24

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE → 7 8
MONTH → 2

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

M — METFORMIN

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 1g | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: 1 cp
2200-2400: 1

N — MIRTAZAPINE

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 30mg | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

P — PREGABALIN

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 300mg | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: 1 cp
2200-2400: 1

R — PROCYCLIDINE

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

DOSE: 5mg | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | STOPPED INITIALS:

PRESCRIBER (PRINT & SIGN): [signature]

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: 1 cp

Ordered from Pharm. ✓ 8/2/21

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE → 7 8.
MONTH → 2 2.

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

S — DRUG: RAMIPRIL
DOSE: 2.5mg | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tm
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: 1 op

T — DRUG: ALOGLIPTIN
DOSE: 25mg | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tm
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: ½ op

V — DRUG: ARIPIPRAZOLE
DOSE: 25mg | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tm
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: ½ op
Ordered from Pharm.: 6/2 TL

W — DRUG: CREON
DOSE: 10000 Units | ROUTE: ORAL | DATE: 6/2 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): Tm
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: 1 op
1200-1400: 1 op

Note: To discontinue a prescription, initial and date appropriate boxes; draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE → 7/12 8/12

MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

X DRUG: DIAZEPAM

DOSE: 5mg | ROUTE: ORAL | DATE: 6/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): T...

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

2200-2400: JD

BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐

Y DRUG: DULOXETINE

DOSE: 60mg | ROUTE: ORAL | DATE: 6/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): T...

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: JD 9p

2200-2400: JD

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑

AA DRUG: PARACETAMOL

DOSE: 1g | ROUTE: ORAL | DATE: 6/12 | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN): T...

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

0700-0900: JD 9p

1200-1400: JD 9p

1600-1800: 10

2200-2400: JD

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

BB DRUG:

DOSE: | ROUTE: | DATE: | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN):

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

CC DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

DD DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

EE DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

FF DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE →
MONTH →

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

Patient's Own Medicine

LL — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☐

DRUG: RIZATRIPTAN | DOSE: 10 mg | ROUTE: ORAL | INDICATION: MIGRAINE | PRESCRIBER (PRINT & SIGN): T | MAX.FREQ.: BD | DATE: 6/2 | STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

		For Use Y/N
DATE		Qty:
TIME		Date:
DOSE		Assessed by:
GIVEN BY		Ordered from Pharm.

MM — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: DIHYDROCODEINE | DOSE: 30mg | ROUTE: ORAL | INDICATION: PAIN | PRESCRIBER (PRINT & SIGN): T | MAX.FREQ.: QDS | DATE: 6/2 | STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

				For Use Y/N
DATE	06/2	7/2		Qty:
TIME	23[10]	21[00]		Date:
DOSE	30 mg	30 mg		Assessed by:
GIVEN BY	[illegible]	AK		Ordered from Pharm.

NN — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: ORAMORPH | DOSE: 5-10mg | ROUTE: ORAL | INDICATION: PAIN | PRESCRIBER (PRINT & SIGN): T | MAX.FREQ.: 1 | DATE: 6/2 | STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

				For Use Y/N
DATE	06/2	06/2	07/2	Qty:
TIME	23[10]	00[35]	21[20]	Date:
DOSE	10 mg	10 mg	10 mg	Assessed by:
GIVEN BY	CM	CM	MB	Ordered from Pharm.

PP — BEFORE ADMISSION ☐ — NEW DOSE ☐ — NEW MEDICATION ☑

DRUG: MORPHINE | DOSE: 5-10mg | ROUTE: S/C | INDICATION: PAIN | PRESCRIBER (PRINT & SIGN): O'CIMPEANU F4 | MAX.FREQ.: 1 | DATE: 07/02 | STOPPED DATE: | INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: while not tolerating oral Morphine

							For Use Y/N
DATE	07/02	07/02	7/2	7/2	7/2	7/2	Qty:
TIME	01:45	06[05]	09[10]	11[50]	14[50]	18[50]	Date:
DOSE	10 mg	10 mg	10 mg	10 mg	10 mg	10 mg	Assessed by:
GIVEN BY	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

| BEFORE ADMISSION | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg — Gram = g
Millilitre = ml — Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= naso-jejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - intrathecal must be written in full.

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused	(7) Patient asleep	(11) Unable to swallow	(14) Other - Record in nursing notes
(4) Drug not available	(8) Time varied on doctor's instructions	(12) No intravenous access	(15) Prescription clarification required
(5) Nil by mouth/fasting	(9) Dose withheld on doctor's instructions	(13) Patient Self-Administration of Medicine	
(6) Patient unavailable	(10) Nausea/vomiting		

Cat. No. 40995 Ver 4. 09/2010 GGC0029

Patient n: 0712726128
SULLIVAN
Deborah F
Date of b 07/12/1972
CHI No:
raine Mikle ...t label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Patient's weight and height

Weight (kg) ..... Height (cm) .....

Prescription details

Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)
6/2	1745	NaCl 0·9%.	500	IV	START		FORBES 7601376	
07/02	00:30	Dextrose 5%	500	IV	4°		O. Cimpeanu F4,	
		HARTMANN'S	500	IV	6°		O. Cimpeanu F4,	

Administration details

Date	Time	Given by	Checked by	Comments
6/2	1750			
07/02	0300	CM		
07/02	2000	CM	* NOT given * Venflon Dex. Sit.	Temperamental Running

*Prescriber should sign this box if the fluid/additive is no longer required.

Nursing staff guidance on using a drops/min flow rate (if administered by gravity flow)

Calculation:

Rate of flow (drops/min) = Volume of fluid (ml) x 20 / Duration of admin (min)

NB: 1ml = 20 drops (for a standard giving set)

Example:

500ml over 1 hour	167 drops/min
500ml over 4 hours	42 drops/min
500ml over 6 hours	28 drops/min
500ml over 8 hours	21 drops/min

Patient name:.....

Date of birth:.....

CHI No:.....

Affix patient label

ADULT FLUID AND ADDITIVE PRESCRIPTION AND ADMINISTRATION CHART

NHS Greater Glasgow and Clyde

Prescription details - continued									Administration details - continued				
Date	Time	Name of fluid / Name of additive	Volume (ml) / Dose	Route	Duration(hr) Or Flow rate (ml/hr)	Additional instructions	Prescriber's signature, PRINTED name and designation	*Discontinued by (initial, date and time)	Date	Time	Given by	Checked by	Comments

*Prescriber should sign this box if the fluid/additive is no longer required.

MEDICINE **PRESCRIPTION FORM** Hospital Name: GRI

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☑
Date 11/6/20 Name (Print) _____
Discharge Prescription Prepared & Reconciled YES ☐
Date _____ Name (Print) _____

Date and time this form prepared:	Sheet No	2nd Prescription in use
__/__/__ Time: _____	.....	YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

_____

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name Lloyds Tel No. 773 2003
Address _____
Compliance Aid Details PlusPak
Patient consent to share discharge information Y/N
Print & Sign SO 11/6/20

PATIENT DETAILS

Hospital I
DOB:
Date of A
Consultar

0712726128
SULLIVAN F
Deborah 07/12/1972
Flat 0-1, 8 Boyndie Street
Easterhouse
Glasgow, Lanarkshire
G34 9JE

Height:
Weight:
Surface area:
Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

94 – 98%	88 – 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

DATE → 11
MONTH → 6

RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)

IS DRUG THROMBOPROPHYLAXIS INDICATED? Y / N

ARE ANTIEMBOLISM STOCKINGS INDICATED? Y / N

SIGNATURE OF ASSESSOR

ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N

Parenteral Drugs : Regular Prescription

Patient's Own Medicine

A

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG: Enoxaparin

DOSE: 40mg | ROUTE: SIC | DATE: 11/6/20 | STOPPED DATE:

PRESCRIBER (PRINT & SIGN): T. AITKEN

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800	MC					
2200-2400						
Other time						

B

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN)

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

C

BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐

DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN)

STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

		For Use Y/N	Qty:	Date:	Assessed by:	Ordered from Pharm.
Other time						
0700-0900						
1200-1400						
1600-1800						
2200-2400						
Other time						

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE → 11
MONTH → 6

Patient's Own Medicine

H — DRUG: Agoliptin
DOSE: 25mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J. AITKEN (A)Aitken
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
0700-0900: MC 11/14 | 1200-1400: | 1600-1800: | 2200-2400:
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

J — DRUG: Aripiprazole
DOSE: 10mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J. AITKEN (A)Aitken
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
0700-0900: MC 11/14 | 1200-1400: | 1600-1800: | 2200-2400:
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

K — DRUG: Aripiprazole
DOSE: 15mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J. AITKEN (A)Aitken
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
0700-0900: MC 11/14 | 1200-1400: | 1600-1800: | 2200-2400:
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

L — DRUG: Creon 10000
DOSE: 1x tab | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J. AITKEN (A)Aitken
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
0700-0900: MC 11/14 | 1200-1400: MC 11/14 | 1600-1800: MC | 2200-2400:
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE → 11
MONTH → 6

| | | |

Oral and Other Drugs: Regular Prescription

DATE → 11
MONTH → 6

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

S — DRUG: Metformin
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 500mg | ROUTE: | DATE: | STOPPED DATE: 11/6/20
PRESCRIBER (PRINT & SIGN): | STOPPED INITIALS: JA
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
error

T — DRUG: Metformin
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 1g | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE:
PRESCRIBER (PRINT & SIGN): J. AITKEN | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: MC 11
1600-1800: MC

V — DRUG: Mirtazepine
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 30mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE:
PRESCRIBER (PRINT & SIGN): J. AITKEN | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
2200-2400: JA

W — DRUG: Pregabalin
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
DOSE: 300mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE:
PRESCRIBER (PRINT & SIGN): J. AITKEN | STOPPED INITIALS:
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CD
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
0700-0900: MC 11
2200-2400: JA

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE 11 | MONTH 6

X — DRUG: Procyclidine
DOSE: 5mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J A ITKEN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
0700-0900: MC

Y — DRUG: Ramipril
DOSE: 2.5mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J A ITKEN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
0700-0900: MC

AA — DRUG: Simvistatin
DOSE: 40mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J A ITKEN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
2200-2400: MM

BB — DRUG: Temazepam
DOSE: 10mg | ROUTE: oral | DATE: 11/06/20 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): J A ITKEN
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: CD
BEFORE ADMISSION ☑ | NEW DOSE ☐ | NEW MEDICATION ☐
2200-2400: MM

Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time

Patient's Own Medicine | For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

Oral and Other Drugs: Regular Prescription

DATE: 11 12
MONTH: 6 6

Patient's Own Medicine

CC DRUG: Nicotine Patch
DOSE: 14 mg | ROUTE: TOP | DATE: 11/06 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN): KB Byrne Bowe
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☑
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

DD DRUG: PARACETAMOL
DOSE: 1g | ROUTE: PO | DATE: 12/6 | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY: PRN@home
BEFORE ADMISSION ☑ NEW DOSE ☐ NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

EE DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

FF DRUG
DOSE | ROUTE | DATE | STOPPED DATE: | (INITIALS:
PRESCRIBER (PRINT & SIGN):
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐
Other time | 0700-0900 | 1200-1400 | 1600-1800 | 2200-2400 | Other time
For Use Y/N | Qty: | Date: | Assessed by: | Ordered from Pharm.

Note: To discontinue a prescription, initial and date appropriate boxes, draw a diagonal line through section & record reason

Oral and Other Drugs: Regular Prescription

DATE
MONTH

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

GG DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

HH DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

JJ DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

KK DRUG

DOSE | ROUTE | DATE | STOPPED DATE:

PRESCRIBER (PRINT & SIGN) | STOPPED INITIALS:

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.

All Routes: As Required Prescriptions

1
BEFORE ADMISSION ☐ | NEW DOSE ☐ | NEW MEDICATION ☑
DRUG: Oramorph | STOPPED DATE: | INITIALS:
DOSE: 5-10mg | ROUTE: oral | INDICATION: Pain
PRESCRIBER (PRINT & SIGN): J. AITKEN | MAX.FREQ.: 1° | DATE: 11/6/20
ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY:

| | | |

| | | |

Nurse/Midwife Administration by Symptomatic Relief Policy or other Protocol - Authorised Nurses/Midwives Only (Maximum number of doses as per protocol)

Warning: Check the As Required and Regular Prescription sections to ensure that the drug has not already been prescribed by a doctor.

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	NURSE (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)

Notes for Users

FOR PRESCRIBERS:

1. Prescribe drugs generically using the Approved Name (except in circumstances where bioavailability differences between brands of the same drug are so important as to warrant prescribing by brand name e.g. in the case of sustained release lithium or theophylline).

2. All prescription entries must be legible and made so as to be indelible (black ink is recommended).

3. Print & Sign your full name clearly against each prescription entry.

4. Time should be recorded in 24hr format e.g. 0600, 1800.

5. When drugs are discontinued, draw a diagonal line through the prescription box, initial and date the appropriate boxes and record reason.

6. If an existing prescription entry is to be modified, delete the existing prescription and re-write the new instructions as a new prescription entry.

7. The following metric unit abbreviations must be used –

Milligram = mg | Gram = g
Millilitre = ml | Millimoles = mmol
Microgram / Nanogram / Units – **Do not abbreviate, write in full**

Fractions of a milligram should be written in micrograms. The use of decimal points should be avoided, if possible. If decimal points must be used a zero must be written in front of the decimal point (e.g. 0.5ml **NOT** .5ml).

8. The route of administration can be abbreviated using the following -

O	= oral	ID	= intradermal
IM	= intramuscular	SL	= sublingual
SC	= subcutaneous	PR	= per rectum
NG	= nasogastric	PEG	= percutaneous endoscopic gastrostomy
PV	= per vagina	RIG	= radiologically inserted gastrostomy
NJ	= nasojejunostomy	PEJ	= percutaneous endoscopic jejunostomy
TOP	= topical	ETT	= endotracheal
NEB	= nebulised	INHAL	= inhaled
IV	= intravenous		

Please note - **intrathecal must be written in full.**

FOR NURSES

1. The 'Once only', 'Regular' and 'As required' sections should be checked at each administration round to ensure that inadvertent omission or double dosing are avoided.

2. Insert initials in the relevant date column and time row each time a drug is administered.

3. Check that all drugs prescribed at a certain time have been administered.

4. If a drug is not administered enter the reason code in the appropriate date column and time row and also document the full reason in the patient's notes.

Codes for Non-Administration of Drugs

(3) Patient refused
(4) Drug not available
(5) Nil by mouth/fasting
(6) Patient unavailable
(7) Patient asleep
(8) Time varied on doctor's instructions
(9) Dose withheld on doctor's instructions
(10) Nausea/vomiting
(11) Unable to swallow
(12) No intravenous access
(13) Patient Self-Administration of Medicine
(14) Other - Record in nursing notes
(15) Prescription clarification required

Cat. No. 40995 Ver 4, 09/2010 GGC0029

MEDICINE

PRESCRIPTION FORM

Hospital Name: .....

MEDICINES RECONCILIATION

Medicines Reconciled on Admission YES ☑

Date 21/04 Name (Print) Y CAPEL

Discharge Prescription Prepared & Reconciled YES ☐

Date _____ Name (Print) _____

Date and time this form prepared: __/__/__ Time: _____

Sheet No .....

2nd Prescription in use YES ☐ NO ☐

DOCTOR'S DECLARATION (if required by Local Protocol)

I authorise nurse/midwife administration of the medicines included in the symptomatic relief policy & local protocol:

with the following exceptions: _____

Print & Sign: _____ Date: _____

COMMUNITY PHARMACY INFORMATION

Name _____ Tel No. _____

Address _____

Compliance Aid Details Dalton

Patient consent to share discharge information Y/N

Print & Sign _____

PATIENT DETAILS

Hospital Number:	Height:
DOB:	Weight:
Date of Admission: __/__/__	Surface area:
Consultant Name:	Ward:

ONCE ONLY AND PREMEDICATION DRUGS

DATE	DRUG	DOSE	ROUTE	TIME (24hr)	PRESCRIBER (PRINT & SIGN)	GIVEN BY	TIME GIVEN (24hr)
31/3	MORPHINE	5mg	IV	2310		ND/d	2330
31/3	ONDANSETRON	4mg	IV	2314		ND/d	2320

TARGET OXYGEN SATURATIONS

Please CIRCLE a target saturation and prescribe oxygen on the Regular Prescription section.

On Home Oxygen? Yes / No _____ L/min

DATE: _____/_____/_____ PRESCRIBER (PRINT & SIGN): _____

94 – 98%	88– 92% (e.g. in hypercapnic respiratory failure)	Other (please specify)

	DATE → 1																									
	MONTH → 4																									
	RECORD OF THROMBOPROPHYLAXIS ASSESSMENT (IN EACH CASE RECORD WITH Y OR N - REASSESS NEED AT LEAST EVERY 48 HRS)																									
IS DRUG THROMBOPROPHYLAXIS INDICATED? Y/N																										
ARE ANTIEMBOLISM STOCKINGS INDICATED? Y/N																										
SIGNATURE OF ASSESSOR																										
ARE ANTIEMBOLIC STOCKINGS ON PATIENT? RECORD DAILY AT 1800 DRUG ROUND WITH Y OR N																										

Parenteral Drugs : Regular Prescription

																										Patient's Own Medicine
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**A** DRUG ENOXAPARIN + TEDS DOSE 40mg ROUTE SC DATE 01/04 STOPPED DATE: PRESCRIBER (PRINT & SIGN) Y CAPER INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																								For Use Y/N
		0700-0900																								Qty:
		1200-1400																								Date:
		1600-1800	M																							Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**B** DRUG DOSE ROUTE DATE STOPPED DATE: PRESCRIBER (PRINT & SIGN) INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																								For Use Y/N
		0700-0900																								Qty:
		1200-1400																								Date:
		1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								
BEFORE ADMISSION ☐ NEW DOSE ☐ NEW MEDICATION ☐	**C** DRUG DOSE ROUTE DATE STOPPED DATE: PRESCRIBER (PRINT & SIGN) INITIALS: ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY	Other time																								For Use Y/N
		0700-0900																								Qty:
		1200-1400																								Date:
		1600-1800																								Assessed by:
		2200-2400																								Ordered from Pharm.
		Other time																								

REVIEW THE NEED FOR IV ANTIBIOTIC DAILY. SWITCH TO ORAL THERAPY AS SOON AS POSSIBLE (SEE IVOST POLICY)

Parenteral Drugs: Regular Prescription

DATE →
MONTH →

Patient's Own Medicine

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

D DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

E DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

F DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

BEFORE ADMISSION ☐
NEW DOSE ☐
NEW MEDICATION ☐

G DRUG

DOSE | ROUTE | DATE | STOPPED DATE: | INITIALS:

PRESCRIBER (PRINT & SIGN)

ADDITIONAL INSTRUCTIONS / COMMENTS / PHARMACY

Other time
0700-0900
1200-1400
1600-1800
2200-2400
Other time

For Use Y/N
Qty:
Date:
Assessed by:
Ordered from Pharm.

The 'Regular' and 'as required' medicines sections should be checked at each administration round to ensure that inadvertent omission or double dosing is avoided.