MEDICAL CASENOTES

Allergies:

1703751191

Dr Rajendra Raman
Victoria Hospital
Kirkcaldy
KY2 5AH
Tel: 01592 643355
NHS
Fife

Patient surname: Gratton	Date of arrival: 30/08/2025	Management type: Resus ☑ Majors ☐ Minors ☐
Patient forename: Leon	Time of arrival: 08:57	
Patient address: 3 Makgill Row Cupar KY15 5SA	Date & time of incident: 30/08/2025 08:45	
DOB: 17/03/1975 Age: 50 Yrs	Incident location: Home	Discharge/Ward destination & Time: AU1 6/1
Patient email:	Incident type: Non-injurious cause	
Landline: 01334 769473 Mobile: 07368479150	Activity when injured:	Breach reason:
Ethnicity: BB Other British	Specific location:	
Special requirements:	Temporary alerts:	GP Address: Bank Street Medical Group, The Health Centre, Bank Street, Cupar, KY15 4JN Tel No: 01334 651201
Accompanied:		
1st Contact name:	Source of attendance: 999 Emergency Services	School/Nursery address:
1st Contact address:	Arrival mode: Ambulance (road)	
	Attendance category: New - unplanned	Tel No:
L: M:	Annual A&E attendance No: 1	Named person/HV:

Presenting complaint
Sepsis

STANDBY

Triage notes

Triage category.....

Observations

Temp	Pulse	BP	SpO2	RR	FEWS Score
	BM	Cap refill	Sup. O2	Weight/Kg	Pain score

1703751191

Follow up clinic (please √)			
C	[ ]	Knee	[ ]
ysiotherapy	[ ]	IAT	[ ]
hthalmology	[ ]	ENT	[ ]
ner (specify)	[ ]	OMFS	[ ]
		ECAS/DVT	[ ]

PVC Bundle audit.	
Reason for insertion:	Aseptic technique Yes [ ]
Colour Gauge:	Dressing date & timed Yes [ ]
	Skin cleansed Yes [ ]
Site/number:	Inserted by:
Hand hygiene Yes [ ]	

Allergies:

1703751191

Dr Rajendra Raman
Victoria Hospital
Kirkcaldy
KY2 5AH
Tel: 01592 643355

Leon Gratton

Once only prescription/treatments

Date	Time	Medicine/Treatment	Dose	Route	Prescribers signature	Treatment time	Administ by
3/8	11:21	Salbutamol	5mg	neb		1145	CD
~~3/8~~	11:21	Doxycycline	200mg	PO		1145	CD
3/8	11:21	~~Amoxicillin~~ Co-amoxiclav	~~1g~~ 1.2g	IV		1150	CD
3/8	15:30	Paracetamol	1g	oral		1550	LG

Take home medications

Date	Medicine	Dose	Route	Prescriber signature	Dispenser signature
	AUGMENTIN				

Date	Fluid	Vol/ml	Duration of administration	Clinician signature	Time started	Completion time	Adminis by
	Additional Medicine	Dose			(00:00 hrs)		Added

GRATTON LEON 17-03-1975
1703751191

Date & Time	MULTIDISCIPLINARY NOTES NAME MUST BE PRINTED AGAINST EACH ENTRY
	Meds: Olanzapine Fluoxetine Simvastatin Omeprazole Metformin Aripiprazole? Mefloxacin.
30/8/25 1330	Raman (EI Cons) Seen on arrival at 0857hrs and at intervals since. Please see summary of initial assessment documented by med student overleaf — thanks Laura. 3/7 headaches, fevers and progressive shortness of breath Looks + feels much better now after nebuliser, oxygen + antibiotics compared to on arrival Bilateral consolidation on CXR, good going inflammatory response → Treat for community-acquired pneumonia / early chest sepsis

GRATTON 17-03-1975
LEON
1703751191

Date & Time	MULTIDISCIPLINARY NOTES NAME MUST BE PRINTED AGAINST EACH ENTRY
	LAURA LAU SCOT GEM STUDENT
	P/C - SOB + Fever (query sepsis?)
	A - open & patent, on 6L of oxygen.
	B - 24 RR 93% O2 sats, equal bilateral airway
	entry, left basal crackles, Dry cough,
	no haemoptysis. Asthmatic. worsening SOB.
	C - 116 HR regular HS I + II + 0. No chest pain, no
	palpitations, CRT<2, warmly perfused peripheries.
	D - GCS 15, no confusion, neck stiffness
	Headache, no photophobia
	E - Apollo SNT, no calf swelling, no vomiting,
	nausea, eczema widespread on body - Arms, hands,
	legs.
	Thursday 28/08 had foot pain from eczema & fevers
	resolved by Friday morning then Friday night
	had fevers + headaches + worsening SOB.
	PMHx: Schizophrenia, diabetes, ↑ cholesterol, asthma
	eczema
	Medication: Metformin, [illegible], omeprazole
	Simvastatin, Aripiprazole, [illegible]
	Methotrexate, Clozapine, epaderm.
	Salbutamol, Symbicort, vitamin, dermol 500.
	Aveeno. NKDA
	SHx: NON Alcohol, will smoking, will recreational drugs

GRATTON
LEON

17-03-1975 **CORE**

1703751191

ton

er KY15 5SE

WD.

CONS.

FEWS KEY

0	1	2	3

FEWS ≥ 3 FOLLOW FEWS FLOWCHART

DATE	30-8-25
FREQUENCY	
TIME	0800 / 0951 / 1340 / 1530 / 1551 / 1612 / 1809 / 1909
TEMP. (40°, 39°, 38°, 37°, 36°, 35°)	36.9; 36.2
BLOOD PRESSURE / FEWS SCORE uses Systolic BP (210–50)	139
HEART RATE (170–20)	138; 113; 113
Sp02 (95+, 90-94, 85-89, <85)	94; 94; 92; 94
Fi02	5; 4L; 4; 4; 4
RESP. RATE (40, 36, 32, 28, 24, 20, 16, 12, <8)	28; 22
NEURO. (Awake, Verbal/Confu, Pain, Unresp)	✓
FEWS SCORE:	7; (5); 4; 3; 3
BM:	
Signature/initials	

MS1377

ECK LIST Version 1.2

Review: April 2024

EMERGENCY DEPARTMENT, VHK Care Rounds Check List

Date: 30/8/2025

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 L McGregor Name L McGregor Designation S/N

Signed [illegible] Name [illegible] Designation SN

Signed Name Designation

USE FOLLOWING CODES:

Y=YES N=NO NA=NOT APPLICABLE NT=NO THANKS S=SLEEPING O=OVERCAPACITY I=INDEPENDENT

	Times		1150									
1.	**THINK DELRIUM** Is the patient more confused or drowsy than normal? If YES inform nurse in charge of area	N	N									
2.	**PAIN: ASSESS AND ADDRESS** Is the patient distressed or in pain? If YES arrange analgesia as required	Y	N									
3.	**SKIN INSPECTION** -INDEPENDENT(I) patient reported as intact Pressure areas checked: Red (R) Discolored (D) Pressure Ulcer (PU) Intact (INT) Moisture (M)	NT	INT									
4.	**KEEP MOVING** - INDEPENDENT(I) Has the patient moved or walked? Position change (PC) Stick or Zimmer	Ind	I									
5.	**ELIMINATION** Does the patient need the toilet INDEPENDENT(I) Assistance (A) Incontinent of urine or faeces (IC)	Ind	I									
6.	**FOOD, FLUIDS AND NUTRITION** Is the patient nil by mouth (NBM) **SWALLOW ASSESSMENT FORM COMPLETED** if clinically needed Drink taken? Food, snack or supplement taken? IVI fluid balance chart where required	✓ ✓	NO + NF									
7.	**PATIENT SAFETY CHECK** Name band applied / Allergy band FEWs and Neuro Observations completed Elevated FEWS (>3) escalated as per protocol **FALLS RISK** identified Y/N Detail actions taken on documentation variance section	✓	4									
8.	**CHECK DRUG PRESCRIPTION** Routine medication prescribed eg: PARKINSONS, DIABETES, EPILEPSY	✓	4									
9.	**COMMUICATION** with patient, NOK other services eg, GP, Care home, Police	✓	A									
	Care provider intials/ role	[illegible]	[illegible]									

Care Rounds Nursing Variance Documentation Sheet

GRATTON LEON 17-03-1975

1703751191

Codes: Record of any interventions, treatments or communication, variances and any escalations required, noting any out comes as appropriate.

1.Think Delirium 2.Pain 3.Skin Inspection 4.Keep moving 5. Elimination

6.Food,Fluids,Nutrition 7.Patient safety/Falls risks check 8.Check drug prescription 9.Communication

DATE	TIME/24 HR	CODE	ACTION/INTERVENTION	SIGN & PRINT NAME
30/3	0840	1-9	obs completed ECG requested ☐ Gown	dM Gregor dM
30/3/25	1150	1-9	FEWS = 4 NEB(salbutamol given). IV Abx given. oral Abx given	[illegible] RGN [illegible] RGN
30/3/25	13:09	1-9	Obs taken FEWS (5) on O2 4L via NConnula.	A Jackman S/W

SCOTTISH AMBULANCE SERVICE - PATIENT REPORT FORM

CCS INCIDENT No. G K U N R B 8 1 4 8 6 N N N

Last Name GRATTON

First Name LEON

Location 3 MAGGIE ROW

SPRINGFIELD

KY15 5SA

Age 50

Sex M F

D of B 07/03/75

Date 30/08/25

Time of Call 02:27

Time at Patient 07:45

Time Left 08:16

AMPDS Code

AMPDS Revised

Airway Clear Y Suction

Breathing Y Rate F S

Pulse Y Rate F N S

N/OPA BVM CPR

ET IV/IO

LMA Ventilation Fluids

Successful ? Y

Successful ? Y

Successful ? Y

C-spine Injury Y

Paralysis Y Fitting Y

ECG SINUS

Despite the above unable to

Clear airway Detect breathing Detect pulse

A V P U

Injury Site Wound # Pain Splint Dressed

Head

Neck

Chest

Abdomen

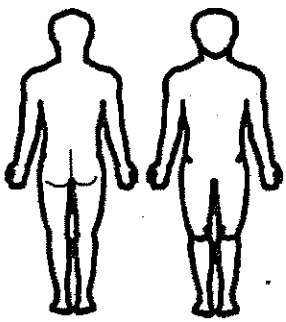
Back

R/Arm

R/Leg

L/Arm

L/Leg



RTA

Trapped

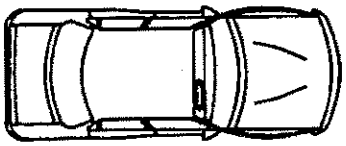
Ejected

M / cyclist

Cyclist

Pedestrian

>20 min. Extricate



Temp. °C

PEFR %

B. Sugar mmol

Allergies 1 2 3 4 5 6 7 8 9

Medication

Assisted by and Name -

Doctor Y Nurse Y Other Y

Time	Pulse	Resp	BP	C / Refill	SpO2 %	GCS	Lpupil	Rpupil
0800	155	28	123	FSN	90	E V M	S R	S R
0805	148	28	126	FSN	93	E V M	S R	S R
			SYS	FSN		E V M	S R	S R
			SYS	FSN		E V M	S R	S R

Time	Fluid/Drug/Gas	Dose	Unit	Route	Effect	Rhythm	No. Joules	Repeat	Result Rhythm
0810	PARA	1	GM	OR	+				
0810	O2	6	LT	NM	+				
					+ 0				
					+ 0				

Condition at hospital Pulse Y Breathing Y Conscious Y Time at Hospital 0820

History and Additional Information

999 FOR 50YOM - HEADACHE/DIZZINESS, OA - PT IN 1500 - TEMP 34.8 UNWELL FOR 2+ DAYS. NAUSEA/DIZZY ON STANDING - OFF FOOD. OWN PARACETAMOL @ 2100 (29/8/25). CREW C/ SEPSIS. - PMH ASTHMA SCHIZOPHRENIA + ECZEMA. NEWS 11 - GIVEN PARACETAMOL @ 0810 CONVEYED TO VHK - PRE ALERT.

Working assessment SEPSIS

Diagnosis Code

Crew Name 1 G. GREEN Grade L P Y C

Crew Name 2 A FINLAYSON Grade L N T C

RADIOMETER ABL90 SERIES

ABL90 ED Resus I393-092R0328N0001 10:44 30/08/2025
PATIENT REPORT Syringe - S 65uL short probe Sample # 3960

Identifications

Patient ID	1703751191
Operator	Rachael Bradley
Patient last name	Gratton
Patient first name	Leon
Date of birth	17/03/1975
Sample type	Venous
T	37.0 °C
$FO_2(I)$	21.0 %
Note	

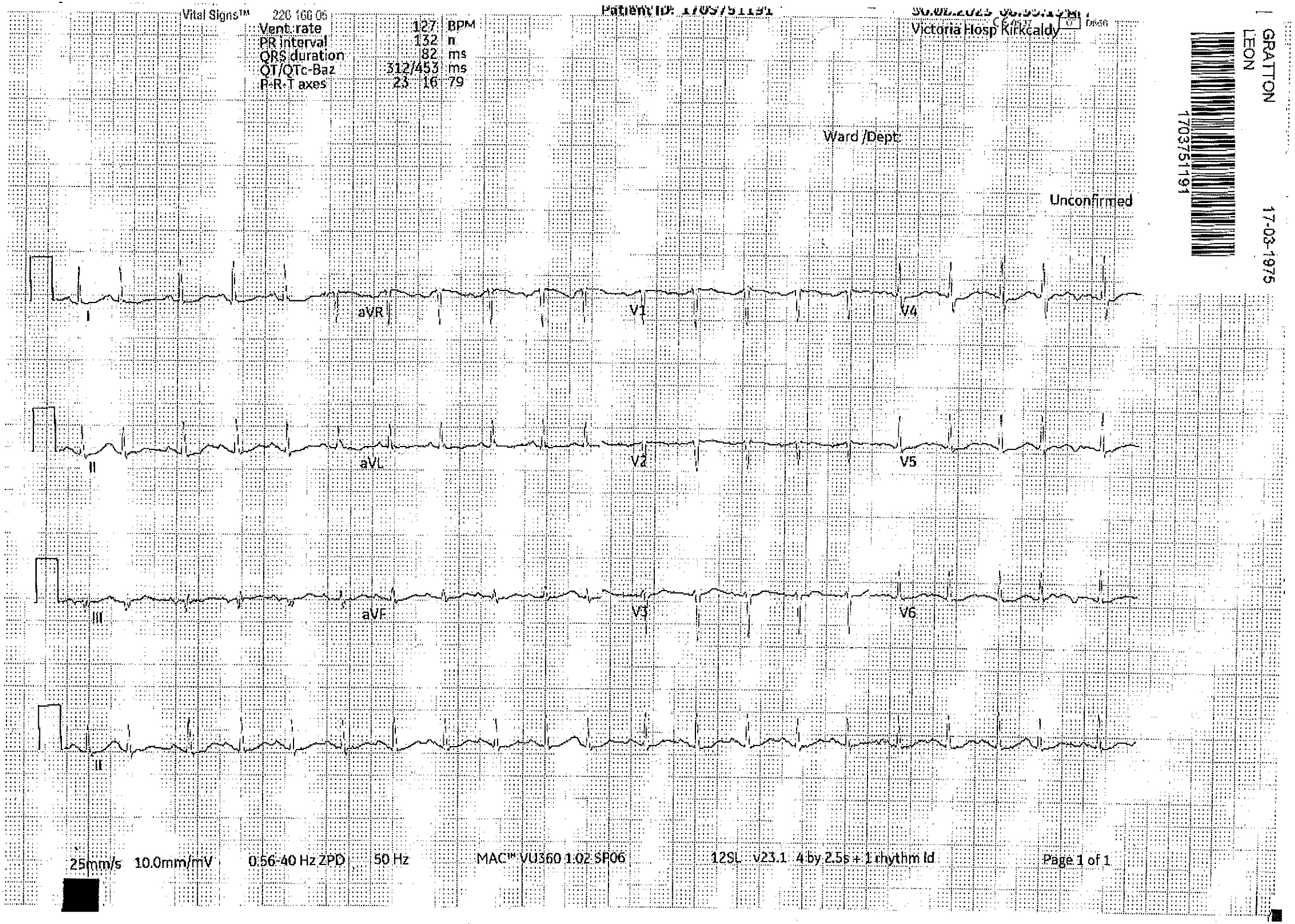
Blood gas values

↑	pH	7.469		[7.350 - 7.450]
↓	cH^+c	33.9	nmol/L	[35.0 - 45.0]
?	pCO_2		kPa	[-]
↓	pO_2	6.79	kPa	[10.0 - 14.0]
↓	sO_2	89.3	%	[95.0 - 98.0]
↑	cLac	2.1	mmol/L	[1.0 - 2.1]
	cCa^{2+}	1.17	mmol/L	[1.15 - 1.35]
↓	cK^+	3.3	mmol/L	[3.5 - 5.3]
	cNa^+	142	mmol/L	[133 - 146]
	ctHb	153	g/L	[120 - 175]
↑	FO_2Hb	88.1	%	[0.9 - 1.0]
	FCOHb	0.8	%	[0.5 - 1.5]
	FMetHb	0.5	%	[0.1 - 1.5]
↑	FHHb	10.6	%	[1.0 - 5.0]

Notes

↑	Value(s) above reference range
↓	Value(s) below reference range
c	Calculated value(s)
pCO_2	0210: Calibration error(s) present
pCO_2	0211: Quality control error(s) present

Solution pack lot: RE-02 Sensor cassette run #:
Printed 10:45:15 30/08/2025 2562-217


Vital Signs™ 220 160 06
Vent. rate 127 BPM
PR interval 132 n
QRS duration 82 ms
QT/QTc-Baz 312/453 ms
P-R-T axes 23 16 79
Victoria Hosp Kirkcaldy
Ward /Dept:
Unconfirmed
GRATTON
LEON
17-03-1975
1703751191
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II
25mm/s 10.0mm/mV 0.56-40 Hz ZPD 50 Hz
MAC™ VU360 1.02 SP06
12SL v23.1 4 by 2.5s + 1 rhythm ld
Page 1 of 1

Acute Services Division

NHS Fife

V Emergency Department

KJ MacLaren
20413/1
Bank Street Medical Group
The Health Centre
Bank Street
Cupar
Cupar
KY15 4JN

Victoria Hospital
Hayfield Road
Kirkcaldy
KY2 5AH

Dear Doctor

Mr Leon Gratton
3 Makgill Row
Springfield
Cupar
KY15 5SA

CHI: 1703751191
ED Consultant:Dr Rajendra Raman

The above patient attended the V Emergency Department on 30/08/2025 at 08:57. I outline below some information regarding this attendance.

Present Complaint: Sepsis

Diagnosis:			
Description	Body Site	Laterality	Comments
ED diagnosis - Respiratory - Lobar pneumonia			

Investigation(s)/Treatment(s):

Medication(s):

Additional Notes (for GP):
Your patient has been admitted to hospital for further investigations/treatment. A final discharge letter will be issued from the admitting specialty team.

Senior Review:
Senior Review Comments:

Yours sincerely

Christopher Braid SN

NHS Fife

GRATTON, Leon J
BORN 17-Mar-1975 (50y) GENDER Male
CHI 1703751191

Immediate Discharge Letter

Last updated by Nicola CURRAN on 05-Sep-2025 17:51 (v. 22)

Patient Address	3 MAKGILL ROW SPRINGFIELD CUPAR FIFE KY15 5SA	GP Name GP Practice Address	KATHRYN MACLAREN Bank Street Medical Group The Health Centre Bank Street Cupar — KY15 4JN

Encounter Details

Encounter Id	I0000791968	Hospital	Victoria Hospital
Type	Inpatient	Ward	V Ward 53
Specialty	Respiratory Medicine	Consultant	Iain MURRAY
Discharge Date	—		

Admission Details

Date of Admission
31-Aug-2025 17:45

Discharge To
Home - Living Alone

Discharge Date
05-Sep-2025 13:00

Clinical and Management Information

Primary reason for admission

Pneumonia
DIAGNOSIS

Secondary / Other Diagnoses

No problems selected

Presenting complaint
SOB + Cough

Operation / Procedures

Date of Operation/ Procedure
—

Operation Type
—

Operation/ Procedure detail

—

Responsible Consultant

—

Clinical summary

Dear Doctor,

Leon Gratton was admitted to VHK with 3/52 generally well with SOB + cough.

PMH: T2DM, Asthma, Schizophrenia, Anxiety, Eczema, Psoriaisis, Obesity, Ex-smoker

Investigations: CXR - Rt basal consolidation

Issues: 1. Sepsis secondary to Pneumonia - started on IV Co-amox + Doxycycline. Pt completed 5/7 Doxy and was IVOSTed to oral Co-amox to complete 10/7 course total
Resp Specialist nurse saw patient, gave inhaler advice and completed spirometry testing. Pt is for repeat spirometry when chest settles to determine true results.
Methotrexate and Metformin were withheld on admission. They have now been resumed on discharge.

Medication changes: D/C to complete oral Co-amoxiclav

Follow-up: CXR in 6/52 to assess resolution
PFTs in 3/52

Many thanks for your ongoing care,
VHK Ward 53

Notes/ Follow Up for GP

—

Awaiting results

—

Explanation given to patient and/or their representative

—

Med 3 Fitness to Work Certificate

—

Care arrangements made

—

Allergies

Allergies

ADVERSE REACTION Filter Applied

NO KNOWN
Megan TEMPLE confirmed there are no known adverse reactions 04-Sep-2025 12:32

Medications

Medication History 16 VERIFIED
Last updated by Megan TEMPLE on
04-Sep-2025 12:31

Discharge 17 VERIFIED
Last updated by Daniel WATKINS on
05-Sep-2025 14:03

Encounter	I0000791968 (TrakCare)
Sources Used	Community Pharmacy, Emergency Care Summary, Patient
Details	Medication history completed by A. Akoh (Trainee Pharmacist) but updated by M. Temple (Pharmacist)
Verification	Verified by Megan TEMPLE, 04-Sep-2025 12:31.

Aripiprazole 10mg tablets
ORAL 2 tablets once daily, via compliance aid

Betamethasone valerate 0.1% ointment
TOPICAL 1 application once daily for 1-2 weeks, then reduce to alternate days for 1-2 weeks, then reduce to twice weekly for 1-2 weeks, then stop (patient reports still applying once daily)

Clozapine 100mg tablets
ORAL 3 tablets once daily at night, via compliance aid (dispensed at QMH & collects from Weston Day Hospital)

Dermol 500 lotion (Dermal Laboratories Ltd) BRAND RESTRICTED
TOPICAL 1 application when required as a soap substitute PRN

Fluoxetine 20mg capsules
ORAL 3 capsules once daily, via compliance aid

Encounter	I0000791968 (TrakCare)
Verification	Verified by Erin SINCLAIR, 05-Sep-2025 14:34.

Aripiprazole 10mg tablets RX
ORAL 2 tablets once daily, via compliance aid

Supply	14
Script Details	M

Betamethasone valerate 0.1% ointment SUPPLY
TOPICAL 1 application once daily for 1-2 weeks, then reduce to alternate days for 1-2 weeks, then reduce to twice weekly for 1-2 weeks, then stop (patient reports still applying once daily)

Supply	Own at home

Clozapine 100mg tablets SUPPLY
ORAL 3 tablets once daily at night, via compliance aid (dispensed at QMH & collects from Weston Day Hospital)

Supply	Own at home, receives 4 weekly nomads separately to community nomad for clozapine from day hospital QMH.

Co-amoxiclav 500mg/125mg tablets ▶ ADDED
ORAL 1 tablet three times daily RX

Duration	Fixed Period for 5 Day(s), starting on 03-Sep-2025 ending on 08-Sep-2025
Supply	7
Script Details	started lunchtime 3/9, last dose to be given 8/9/25 AM dose as per kardex

Reconciliation History

05-Sep-2025	Added - Daniel WATKINS

Dermol 500 lotion (Dermal Laboratories Ltd) SUPPLY BRAND RESTRICTED
TOPICAL 1 application when required as a soap substitute PRN

Supply	Own at home

Fluoxetine 20mg capsules RX
ORAL 3 capsules once daily, via compliance aid

Supply	21
Script Details	M

Folic acid 5mg tablets
ORAL 1 tablet once daily except day of methotrexate (Tuesdays), outwith compliance aid

Folic acid 5mg tablets SUPPLY
ORAL 1 tablet once daily except day of methotrexate (Tuesdays), outwith compliance aid
Supply Own at home

Generic Aveeno cream
TOPICAL 1 application when required for dry skin PRN

Generic Aveeno cream SUPPLY
TOPICAL 1 application when required for dry skin PRN
Supply Own at home

Generic Epaderm cream DEVICE
TOPICAL 1 application twice daily

Generic Epaderm cream DEVICE SUPPLY
TOPICAL 1 application twice daily
Supply Own at home

Liquid paraffin light 63.4% bath additive
DEVICE
TOPICAL 1 application twice weekly

Liquid paraffin light 63.4% bath additive DEVICE SUPPLY
TOPICAL 1 application twice weekly
Supply Own at home

Metformin 500mg tablets
ORAL 1 tablet once daily, via compliance aid

Metformin 500mg tablets RX
ORAL 1 tablet once daily, via compliance aid
Supply 7
Script Details M

Methotrexate 2.5mg tablets
ORAL 4 tablets once a week on a Tuesday, outw ith compliance aid

Methotrexate 2.5mg tablets SUPPLY
ORAL 4 tablets once a week on a Tuesday, outw ith compliance aid
Supply Own at home

Omeprazole 20mg gastro-resistant capsules
ORAL 1 capsule once daily, via compliance aid

Omeprazole 20mg gastro-resistant capsules RX
ORAL 1 capsule once daily, via compliance aid
Supply 7
Script Details M

Paracetamol 500 mg Caplets
ORAL 1 - 2 tablets four times daily PRN, acute Rx 01/07/25
Max 8 tablets per 24 hour(s)

Paracetamol 500 mg Caplets SUPPLY
ORAL 1 - 2 tablets four times daily PRN, acute Rx 01/07/25
Max 8 tablets per 24 hour(s)
Supply Patient Pack / TTO

Salbutamol 100micrograms/dose inhaler CFC free
INHALATION 2 puffs four times daily PRN, Max 8 puffs per 24 hour(s)

Salbutamol 100micrograms/dose inhaler CFC free SUPPLY
INHALATION 2 puffs four times daily PRN, Max 8 puffs per 24 hour(s)
Supply Patient Pack / TTO

Simvastatin 40mg tablets
ORAL 1 tablet once daily at night, via compliance aid

Simvastatin 40mg tablets RX
ORAL 1 tablet once daily at night, via compliance aid
Supply 7
Script Details N

Soprobec 100micrograms/dose inhaler (Glenmark Pharmaceuticals Europe Ltd)
BRAND RESTRICTED
INHALATION 2 puffs twice daily

Soprobec 100micrograms/dose inhaler (Glenmark Pharmaceuticals Europe Ltd) SUPPLY
BRAND RESTRICTED
INHALATION 2 puffs twice daily
Supply Patient's Own Supply

Authorising Clinician
Daniel Watkins 05 Sep 2025 14:04

Prescriber Contact Number
29539

Pharmacy Verification Required
Yes

Patient's Length /Height —

Patient's Weight —

BMI —

Date —

Community Pharmacy

Community Pharmacy Name
Rowlands Pharmacy - Cupar

Contact Number
01334 654755

Medicines Supply
Compliance Aid

Details
Note also receives separate NOMAD from QMH (collects from Weston Day Hospital) containing clozapine. unable to contact pharmacy on discharge, new nomad supplied from VHK disp 5/9/25 no reg med changes but unable to contact pharmacy for redelivery of community nomad for pt going home. L. Mcluckie ext. 26952

Mental Health template required
No

Nursing Information Required
No

Ward Discharge

Ward Comments
—

Pharmacy Comments
Professionally checked in VHK dispensary without access to medical notes or kardex. Patient supplied ONE WEEK NOMAD on discharge (E.Sinclair 05/09/2025 @14:35)

I confirm that medications issued for this patient discharge have been checked in accordance with the local policy and medication issued for discharge has been discussed with the patient and/or their representative.

I Confirm
Yes

Registered Healthcare Practitioner (e.g. Nurse)
Sarah Miller 05 Sep 2025 17:48

Secondary Registered Healthcare Practitioner
Nicola Curran 05 Sep 2025 17:51

Victoria Hospital
Hayfield Road
Kirkcaldy
Fife
KY2 5AH

Department of Respiratory
Tel: 01592 643355 21755
http://www.nhsfife.scot.nhs.uk

NHS
Fife

Dr KJ MacLaren
Bank Street Medical Group
The Health Centre
Bank Street
Cupar
KY15 4JN

1703751191

CHI: 1703751191

Letter ID: 200203135

Date Typed: 06 November 2025

Dear Dr MacLaren

Leon Gratton, 3 Makgill Row, Springfield, Cupar, Fife, KY15 5SA

Date of Birth: 17/03/1975

Date of Admission: 31/08/2025 Date of Discharge: 05/09/2025

Diagnosis:	Pneumonia
Medication:	As per discharge letter
Follow up:	Repeat chest x-ray

Please take the immediate discharge summary as an accurate representation of this gentleman's recent admission to the Victoria. I will be in touch with his chest x-ray results in due course.

18/11/25

His CXR shows resolution of his right lower zone consolidation: I will write to let him know.

Yours sincerely

Dr Iain Murray
Consultant in Respiratory Medicine

Authorised on 18/11/2025 12:31:42 by Iain Murray.

20588.

PATIENT CARE ASSESSMENT AND ADMISSION RECORD

NHS Fife

PATIENT DATA: Patient label or write

PATIENT NAME: GRATTON P LEON
17-03-1975
D.: 1703751191 (50)

ADDRESS:

PHONE NUMBER:

GP PRACTICE: Bank Street Medical Group

DATE OF ARRIVAL: 30/8/25

TIME OF ARRIVAL: 2050

SOURCE OF REFERRAL: GP (ED) OTHER

ESTIMATED DISCHARGE DATE:

NAME OF ADMITTING CONSULTANT:

WARD CONSULTANT:

SPECIALTY:

NEXT OF KIN
NAME: George Martin
RELATIONSHIP: step-dad
ADDRESS:

TEL: 01316239928
Patient consent to inform of admission: ☐ YES ☐ NO
Next of kin informed: ☐ YES ☐ NO

ALTERNATIVE CONTACT
NAME: Graeme Lumsden
RELATIONSHIP: Richmond Fellowship key worker
ADDRESS:

TEL: 07586310838
Patient consent to inform of admission: ☐ YES ☐ NO
Contact person informed: ☐ YES ☐ NO

FEWS on ADMISSION: (3)
If FEWS ≥3, complete the 'SCOTTISH STRUCTURED RESPONSE'

Nurse in charge informed: ☐ YES ☐ NO
ePCS/eKIS reviewed (*acute admissions wards only*): ☐ YES ☐ NO ☐ N/A
Please provide an explanation in the Continuation Notes for points 1 to 7, utilising the 'SSR Sticker'

1. Screened for Sepsis
2. Appropriate care givers have met and discussed plan
3. Documentation of active problems, working diagnosis, management plan and review time
4. Patientrack observation profiles / flags reviewed
5. Escalation ceiling recorded
6. Early referral to higher level of care considered and documented
7. DNACPR considered and completed if appropriate

ETHNIC STATUS: _____ ***(see ETHNIC STATUS KEY information, held at nurses' station)***
FIRST LANGUAGE ☑ English ☐ Other: (specify) _____
Does this person require an interpreter? ☐ YES ☑ NO If yes, specify: _____

ACUTE DIVISION

BED BUREAU MUST BE PHONED WITHIN 15 MINUTES OF PATIENT'S ADMISSION
BED BUREAU TEL: x29964
Tick when completed: ☑ CONFIRM PATIENT DETAILS ☑ BED BUREAU INFORMED ☑ PATIENT NAME / FEWS

Transfer Checklist

Ob's checked within last hour?	Y	N	Dentures?	Y	N
Medications packed?	Y	N	Glasses?	Y	N
Infection control issue?	Y	N	Hearing aid?	Y	N
Skin integrity assessed?	Y	N	Mobile/Charger?	Y	N
Falls risk?	Y	N	Clothing?	Y	N
Toilet bag?	Y	N	Footwear?	Y	N

SIGNED:

SIGNATURES

This record is a LEGAL DOCUMENT. Your signature indicates that you have reviewed and updated the record, and it is a true reflection of the treatment and care given by you or delegated by you.

Whenever anyone writes in this record for the first time, they should fill in their details below:

NAME *(please print)*	SIGNATURE	JOB TITLE
KIM GILES	[signature]	SN
M GRANGER	[signature]	SN
Aimee Scott	A Scott	SN

ASSESSMENT

PRACTITIONERS NAME: Karthik Ajith	DATE: 30/08/25
	TIME COMMENCED: 21:42
JOB TITLE: FY2	LOCATION: AU 1

PRESENTING COMPLAINT

Shortness of Breath.
Cough.
Generally unwell

HISTORY OF PRESENTING COMPLAINT

50 yr old gentleman presenting with feeling generally unwell for 2-3 weeks with progressive shortness of breath and cough. For the past few days, he has also been feeling warm, having chills and sweating. He called the ambulance today and they found that he was pyrexic.

⇒ No expectoration with cough.
→ Mild chest pain present., Headache present
→ No burning pain on micturition, no abdominal pain, no diarrhoea
→ No painful swollen feet.

He was seen in A and E, and started on antibiotics for probable sepsis.

CHECKLIST

CVS	Chest Pain
	SOB
	PND/Orthopnoea
	Palpitations
	Ankle Swelling
	Claudication
RS	Cough
	Sputum
	Wheeze
	Haemoptysis
GI	Anorexia/Weight loss
	Abdominal Pain
	Nausea/Vomiting
	Dysphagia
	Heartburn
	Diarrhoea
	Constipation
	PR Bleeding
GUS	Dysuria
	Nocturia
	Frequency/Urgency
	Haematuria
	Incontinence
	Last menstrual period
	Cervical smear
	Contraception
CNS	Headache
	Dizziness
	Fits/Blackouts
	Memory Problems
	Visual Problems
	Hearing Problems
	Weakness
	Paraesthesia
MS	Joint pains
	Joint stiffness

PAST MEDICAL, SURGICAL, OBSTETRIC and ANAESTHETIC HISTORY

(tick box and give dates and details)

Cardiac Disease / Pacemaker		
Hypertension		
Diabetes		DM - II
Asthma / COPD		Asthma
Epilepsy		
Stroke Disease		
Thromboembolic Disease (DVT / PE)		
Cognitive Impairment		
Liver Disease		
Other (e.g. Mental Health)		Schizophrenia, Anxiety disorder, Eczema, Psoriasis
Malignancy / Chemotherapy		Cancer diagnosis: Previous treatment (date last treatment):

Surgical / Anaesthetic History:	Past Obstetric History:

Relevant Family History:

SOCIAL HISTORY

Smoking:	☐ Never	Ex-smoker since: 2020	Current:_____ /per day	Pack years:
Alcohol:	Units / week: 0		History of previous excess:	
Driving:	☐ Yes ☐ No			
Occupation:	Write		Retired: ☐ Yes	☑ No

Usual level of activity (please circle):

Bedbound	Dependent for personal care	Requires minimal assistance with ADLs	Slowed: assistance with heavier household tasks	"Slowed-up" but not requiring assistance	No exercise beyond walking	Occasional exercise	Regular exercise

MEDICINES RECONCILIATION

(You must complete below **AND** print ECS checklist)

Source of information
Must be at least 2 of the following:

Patient Consent for ECS ☐ YES ☐ NO

GP letter / Print out	☐ YES ☐ NO	Patient's Own Drugs / Compliance Aid	☑ YES ☐ NO
ECS	☑ YES ☐ NO	Nursing Home Chart	☐ YES ☐ NO
Patient / Carer / Relative	☑ YES ☐ NO	Repeat Prescription	☐ YES ☐ NO

Allergies: Drugs

NKDA.

Allergies: Other

C: Continue
W: Withhold
A: Amend
St : Stop
(Tick appropriate box)

Compliance Aid ☑ YES ☐ NO
Community Pharmacy *(please specify which Pharmacy)*:

Medicine Form and Strength	Dose	Route	Freq	C	W	A	St	Comments
Betamethasone Valerate 0.1%	ointment	local	alternate days	✓				
Paracetamol	500mg	PO	PRN (4 tablets)	✓		✓		500mg PRN - since he is pyrexial
Folic acid	5mg	PO	OD (except on MTX day)	✓				
Methotrexate	2.5mg	PO	4 tablets once a week		✓		✓	Currently in sepsis - usually Tuesdays
Metformin	500mg	PO	OD		✓			Currently high lactate.
Omeprazole	20mg	PO	OD	✓				
Simvastatin	40mg	PO	NOCTE	✓				
Aripiprazole	10mg	PO	OD	✓				
~~Fluoxetine~~	~~60mg~~	PO	~~OD~~	✓				
Aveeno Cream		local	PRN	✓				
Soprobec 100micrograms/puff		INH	2 puffs BD	✓				see EIDL on clinical portal for medication history.
Salbutamol 100micrograms/puff		INH	2 puffs PRN	✓				
Clozapine	300mg	PO	OD (NOCTE)	✓				
Epaderm Crea.	Large	local	BD.	✓				
Oilatum.		local	twice a week	✓				
Dermol 500 Lotion	use as soap substitute.			✓				
Fluoxetine	60mg	PO	OD	✓				

Over the counter / Illicit substances / Herbal remedies / Homeopathic drugs

Medicine reconciliation completed by: Karen Rafik
Date: 30/04/25 Sign: Karen Designation: FY2

Pharmacy Review
Comments:
FBC ☑ ↑WCC Alb ↓ Ferr ↑Neut U+ES ☑ Cr 77 eGFR 760 LFTs ☑ Pharmacist ↑CRP. ODs ☑
Date: 4/9/25 Sign: [signature] #28038 Designation: pharmacist 4/9/25

FOR ORTHOPAEDICS: SEE MEDICATION GUIDANCE, PAGE 8
INFORMATION ON 'PATIENTS ON ANTICOAGULATION': SEE PAGE 8

102
124
56
kg
176
78
cm

EXAMINATION

General Appearance:	Hydration Status:	Is this patient SEPTIC?
unwell	euvolemic	☑ YES ☐ NO

T °C:	S_pO_2:	F_iO_2:	BP:	HR:	RR:	BM:	FEWS SCORE:
36.0	93	4L NC	121/56	101	18	-	2

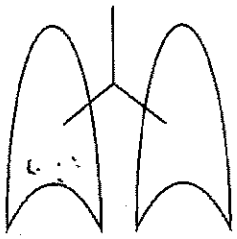
CARDIOVASCULAR

Pulse

JVP

Oedema no pedal edema.

RESPIRATORY



Rt basal and middle lung fields have crepts.

ABDOMEN

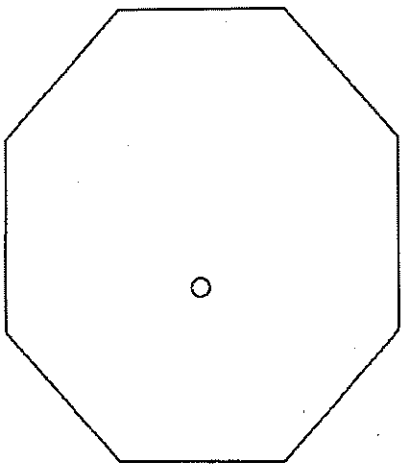
Mouth

Herniae

Genitalia

- Speculum Exam
- VE

PR / Anal Tone



soft non tender

CIRCULATION

Capillary Refill 1 second

Pedal pulses palpable

MUSCULOSKELETAL / SKIN

Describe (use diagrams where appropriate), joint examination

Multiple scabs over arms and legs. legs appear red, but not swollen & warm to touch.

BREASTS

PERIPHERAL LYMPH NODES

INVASIVE DEVICES (eg Hickman line, catheter, pacemaker)

EXAMINATION

NEUROLOGY: Full neurological assessment is not required on all patients. However, general assessment of Tone, Reflexes, Power and Sensation should be documented to exclude acute neurology and as a baseline to assess any subsequent neurological decline. Full assessment is required in all patients admitted with spinal trauma or back pain.

GCS

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
Spontaneous =4	Orientated =5	Obeys =6
To command =3	Confused =4	Localises pain =5
To pain =2	Random =3	Withdraws =4
None=1	Incomprehensible sounds = 2	Flexes to pain =3
	None =1	Extends to pain=2
		None =1

TOTAL____/15

CRANIAL NERVES

II

III, IV, VI

V

VII

VIII

IX, X

XI

XII

TONE

tick	*normal*	*flaccid*	*spasticity*	*clonus*
Right UL				
Left UL				
Right LL				
Left LL				

REFLEXES

Mark:
- - = absent
- = reduced
+ = normal
++ = brisk

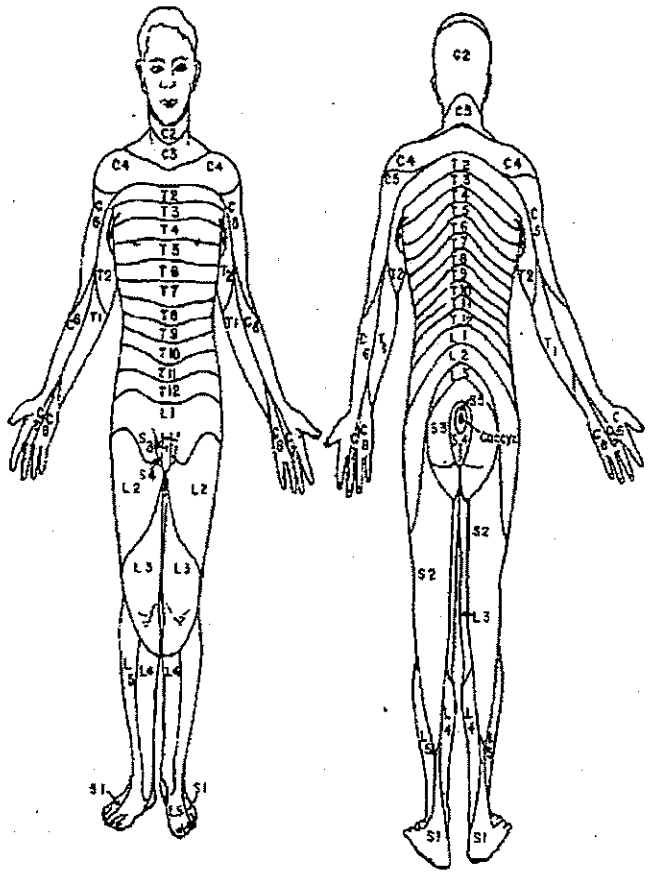
Please tick		*right*	*left*
Biceps	C6		
Triceps	C7		
Knee	L3,L4		
Ankle	S1, S2		
Plantar response			

POWER

Please tick		*right*	*left*
Shoulder abduct	C5		
Elbow flex	C5, 6		
Wrist ext	C6, 7		
Elbow ext	C7, 8		
Grip	C7, 8		
Finger abduction	T1		

Please tick		*right*	*left*
Hip flexion	L2, 3		
Knee ext	L3, 4		
Foot dorsal	L4, 5		
EHL	L5		
Knee flex	L5, S1		
Foot plant flex	S1, S2		

SENSATION mark areas reduced and absent sensation



ABBREVIATED NEUROLOGICAL ASSESSMENT
(comment on PTRS in all limbs)

Normal tone and power in all 4 limbs.

VENOUS THROMBOEMBOLISM (VTE) RISK ASSESSMENT

Medical patient expected to be mobilising as normal within 2 days		Proceed to **VTE risk actions**
Medical patient with reduced mobility for ≥2 days OR Surgical patient	✓	Assess **thrombosis and bleeding risk factors**

Thrombosis risk factors.
ANY thrombosis risk factor(s) should prompt VTE prophylaxis measures unless contraindicated → Assess bleeding risk.

- ☐ Mobility reduced for >2 days
- ☐ Age >60
- ☐ Dehydration
- ☑ Obesity BMI>30 kg/ m^2
- ☑ Significant medical comorbidity (e.g. cardiac, respiratory, endocrine, inflammatory, infectious conditions)
- ☐ Active cancer or cancer treatment
- ☐ Thrombophilia
- ☐ Personal history or first degree relative with history of VTE
- ☐ Use of hormone replacement therapy or oestrogen containing contraceptive
- ☐ Pregnancy or <6/52 post-partum
- ☐ Acute surgical admission with inflammatory or intra-abdominal condition
- ☐ Surgery with significant reduction in mobility
- ☐ Critical care admission
- ☐ Knee or hip replacement
- ☐ Hip facture
- ☐ Total anaesthetic+ surgical time >90mins
- ☐ Pelvic or lower-limb surgery with anaesthetic+ surgical time >60mins
- ☐ Varicose veins with phlebitis

Bleeding risk factors.
Consider whether sufficient to preclude pharmacological prophylaxis

- ☐ Active bleeding
- ☐ Acquired bleeding disorder (e.g. acute liver failure)
- ☐ Current use of therapeutic anticoagulation (e.g. warfarin, rivaroxaban, dabigatran)
- ☐ Acute stroke
- ☐ Thrombocytopenia (<75x10^9/L)
- ☐ Uncontrolled hypertension (>230/120mmHg)
- ☐ Untreated inherited bleeding disorder
- ☐ Neurosurgery, spinal surgery or eye surgery
- ☐ Other procedure with high bleeding risk
- ☐ Lumbar puncture, epidural or spinal anaesthesia expected within the next 12 hours
- ☐ Lumbar puncture, epidural or spinal anaesthesia within the previous 4 hours

VTE risk actions

INFORMATION PROVIDED TO PATIENT
Provide if admission is anticipated
☑ YES ☐ NO

LMWH
☐ YES ☐ NO ☐ **Contraindicated**
If NO Bleeding Risk, prescribe Dalteparin 5000 units daily (2500 units if <46kg. No dose change in renal failure).
☑ **Dalteparin prescribed**

ANTIEMBOLISM STOCKINGS
Consider if thrombosis risk factors present and bleeding risk factors preclude LMWH. Contraindicated in peripheral neuropathy, PVD, ulceration, cellulitis, gross oedema
☐ YES ☑ NO ☐ **Contraindicated**

Name: [illegible] **Sign** [illegible] **Date:** ~~0-0-0~~ 31/01 **Time:** 00:00

MEDICATION GUIDANCE: PATIENTS ON ANTICOAGULATION

INR is only necessary in patients on Warfarin or those with known or suspected liver disease. If INR >1.5 check with surgeon if they wish to proceed with surgery. For a spinal anaesthetic, the INR must be less than 1.5.

Warfarin must be reversed immediately to prevent delay to surgery.

Refer to guidance on intranet:

- Management of anticoagulation during surgery
- Emergency reversal of warfarin
- NOAC – advice on emergency situations (or discuss with haematology on call)

MEDICATION GUIDANCE: ORTHOPAEDICS

Omit **ACE-INHIBITORS** (perindopril, lisinopril, losartan, candesartan, telmisartan, olmesartan) and omit **DIURETICS** (furosemide, bumetanide, bendroflumethiazide) if patient is:

- Dehydrated, Low BP, Septic
- pre-op, and 24 hours post op in hip fracture

NSAIDs:

- Do not prescribe, D/W senior if indicated

ANALGESIA PROTOCOL: ORTHOPAEDICS (for patients aged ≥70 who have sustained a fragility fracture)

WARD PRESCRIBING: All patients should be prescribed the following:

- Regular **Paracetamol** 1g four times daily orally
  - Reduce the dose to 500mg four times daily if patient weighs <50kg
- **Oxycodone** Immediate Release liquid 2mg three times daily orally OR 1mg subcutaneously if unable to take orally
- **Oxycodone** Immediate Release liquid 2mg orally OR 1mg subcutaneously, hourly as required (PRN)
- **Cyclizine** 50mg orally or intramuscularly six to eight hourly PRN (maximum 150mg in 24 hours)

NSAIDs, Nefopam, Tramadol, Codeine and Dihydrocodeine should NOT be started as NEW prescriptions.

- IF A PATIENT HAS KNOWN **SENSITIVITIES** TO ANY OF THE ABOVE MEDICATIONS OR HAS A MEDICAL CONTRA-INDICATION, **DO NOT PRESCRIBE** IT AND PLEASE SEEK SENIOR ADVICE ON ANALGESIC CHOICE.

DIFFERENTIAL DIAGNOSIS AND PROBLEM LIST

- Sepsis
- Pneumonia

MANAGEMENT PLAN (REMEMBER: FEWS of 3 or more = Scottish Structured Response

- Sepsis 6 protocol.
1. Antibiotics ⇒ IV Co-amoxiclav + PO Doxycycline
2. IV fluids → Plasmalyte.
3. O_2 ⇒ via nasal cannula
4. Blood cultures – sent
5. Lactate → elevated
6. Urine output ⇒ monitor

FLUIDS / FASTING Allow clear fluids until 2 hrs pre op. Allow normal diet until 6 hrs pre op.

Anticipated op time: _____am / _____pm

Fast for theatre: ☐ YES ☐ NO

Clear fluids until: _____

Fasting from: _____

Clerking Practitioner Sign off	Tick Box
Completed: VTE risk assessment	✓
Prescribed Dalteparin if indicated	✓
Completed: medicines reconciliation and kardex written	✓
Clerking complete	✓

Name:	Signature:	Job Title:	Date:	Time:
Kerrhuk Ajith		FY2	30/08	23:22

RESULTS

XR	CT	MRI	USS	ECG	~~ABG~~ VBG
Rt basal consolidation.				Sinus tachycardia	Fi02 pH 7.47 BE HC03 pCO2 p02

Blood Results (previous results in shaded area

Date	30/08			Date	30/08			Date	30/08		
WCC	24.5			Na	140			Alb	38		
Neut	22.03			K	3.6			Protein			
Lymph	0.75			Urea	4.5			Alk Phos	87		
Hb	147			Creat	81			GGT			
MCV				eGFR	760			ALT	18		
PLT	226			HCO_3	15			Bilirubin	14		
Ddimer				Cor Ca^{2+}				Amylase			
PT				Phos				CRP	37.9		
APTT				Mg				Serum HCG			
INR				TSH				Adm Trop			
B12				Glucose				12h Trop			
Folate				Lactate	2.1			CK			

CONSULTANT (REGISTRAR) WARD ROUND	**Consultant Name:** DELICATA

50 ♂ Schizophrenia, anxiety disorder, T2DM, eczema, obesity

Adm SOB + cough.

Drug, exacerbation, obesity

SOB + cough (green phlegm) for about a week. Also felt hot (fevers)

o/e Alert, not distressed

S1+2

chest ↓ air entry DL2

NEWS 2
HR 103
BP 99/56

Hgb 147
WCC 24.5
Plt 226
U+E (N)
CRP 37.9
Glucose 7.1
LFTs (N)
CXR - DL2 consolidation

IMPRESSION (to be completed by Consultant / Registrar only)

Atelectasis also
HR/... DVT
ECG - sinus tachy

① Pneumonia w sepsis - for IV ABx

CONSULTANT SIGN OFF (to be completed by Consultant only)

PLAN:

① IV ABx
② IV fluids
③ BCs. D
④ Sputum culture D
⑤ Lactate D
⑥ ABG, please for sats target (no pCO_2 result on initial ABG). D (Rechecked)

Analgesia considered	☐YES	☐NO	Med rec complete	☐YES	
CXR seen	☐YES	☐NO	Remove unwanted PVCs	☐YES	
ECG seen	☐YES	☐NO	AWI required	☐YES	☐N/A
Bloods seen	☐YES	☐NO	Oxygen prescribed	☐YES	☐N/A
VTE Risk assessment	☐YES		Target saturations / Other	>94%	88% - 92%
Dalteparin prescribed	☐YES	☐N/A	IV fluid prescription considered	Yes	☐N/A

Resuscitation and Escalation status	Discussed with patient / family / POA: ☐Family phoned, but not contactable ☐Yes ☐To be discussed (state time of discussion:________) ☐No

☑For CPR	☐Not for CPR	DNACPR form completed ☐YES ☐NO	**<48 hour stay**	**Specialty**
☑ICU	☐MHDU	☐Ward level care		RETI / GEN MED
Escalation Plan: Full				
Consultant Name: DELICATA		**Sign:** [signature]	**Date:** 31/08/2025	**Time:** 9:35am

FRAILTY SCREENING TOOL

Would this person benefit from Comprehensive Geriatric Assessment? If answered "Yes" to any of the following questions please refer to the Integrated Assessment Team

Practitioner Signature..... Date: 3018 Time: 2110

1. Has the patient been admitted from a nursing or residential home?	☐ YES ☐ NO
2. Does the patient have **NEW functional** decline?	☐ YES ☐ NO
3. Dementia diagnosis or are there any concerns about memory/cognition?	☐ YES ☐ NO
4. Is the patient acutely confused, more confused than usual or more sleepy/drowsy than usual?	☐ YES ☐ NO
5. Has the patient fallen in the past 3 months or is a fall the reason for admission?	☐ YES ☐ NO
6. Does the patient attempt to walk alone although unsteady or unsafe?	☐ YES ☐ NO
7. Does the patient or their relatives have fear or anxiety re falling?	☐ YES ☐ NO
If YES to Question 3, 4 or 5: Complete 4AT below. THINK DELIRIUM **Initiate FALLS PATHWAY if FALLS and COGNITIVE questions positive** **FALLS PATHWAY initiated**	☐ YES ☑ NO

	4AT	**SCORE**
1	**Alertness:** This includes patients who may be markedly drowsy (eg difficult to rouse &/ or obviously sleepy during assessment) or agitated/hyperactive. Observe the patient. If asleep attempt to wake with speech or gentle touch on shoulder. **Ask patient to state their name and address to assist rating** • Normal (fully alert, but not agitated throughout assessment • Mild sleepiness for 10 secs after waking, then normal • Clearly abnormal	 0 0 4
2	**AMT 4:** **Age, DOB, place name and current year** **AMT score= /4** • No mistakes • 1 mistake • 2 or more mistakes/untestable	 0 1 2
3	**Attention:** Ask the patient: "Please tell me the months of the year backwards starting at December" You can assist with 1 prompt of "What is the month before Dec?" • Achieves 7 or more • Starts but score <7 months/refuses to start • Untestable (cannot start because unwell, drowsy, inattentive)	 0 1 2
4	**Acute change or fluctuating course:** Evidence of significant change or fluctuation in: alertness, cognition, other mental function (eg paranoia, hallucinations arising over last 2 weeks and evident in last 24 hours • No • Yes	 0 4
	4AT score **4 or above:** possible delirium+/- cognitive impairment: **THINK DELIRIUM - initiate TIME BUNDLE** **1-3:** possible cognitive impairment **0:** delirium or severe cognitive impairment unlikely (but delirium still possible if question 4 Information incomplete)	**Total score:**

NURSING ASSESSMENT – INITIAL ASSESSMENT ON ADMISSION

Belongings *(tick)*	With patient		✓ With family		In safe		Bagged		Labelled	
Own medication	☐ YES		☑ NO							
Name band	☑ YES		☐ NO							
Patient fasted	☐ YES		☑ NO		Food time:		Fluid time:		See also page 9	
Relatives with patient	☐ YES		☑ NO		☐ Informed					

Home circumstances:	☑ Lives alone	Lives with:		
Living Arrangements:	☐ Own Home	☐ Sheltered	☐ Care Home	☐ Homeless
Care Package:	☐ Yes	☑ No	Frequency:	
Family Support:	Details: Richmond Fellowship - Company.			

CAPACITY AND CONSENT

Mental State	Orientated ☑ YES ☐ NO	Confused ☐ YES ☑ NO	Distressed ☐ YES ☑ NO	Unconscious ☐ YES (GCS ≤ 9)

Consider if the patient has capacity to consent. If the patient's ability to consent is in doubt refer to medical staff to assess and then complete the following:

Is there a concern that the patient is at risk?

1. Are they unable to safeguard their own wellbeing, property rights or other interests?	☐ YES ☑ NO
2. Are they at risk of harm?	☐ YES ☑ NO
3. Are they affected by disability, mental disorder, illness, physical or mental infirmity which makes them more vulnerable to harm than adults not affected in this way	☐ YES ☑ NO

If the patient meets all 3 points, follow NHS Fife Adult Protection and Support process

Does patient require supervision / special observation?	☐ YES	☑ NO	Refer to Supervision Policy

Consider need for Violence and Aggression Risk Assessment

Adults With Incapacity (AWI) form completed	☐ YES	☐ NO	☐ N/A	Date:
Discussed with and signed by family / carer	☐ YES	☐ NO	☐ N/A	Date:
Date treatment plan in place?			☐ N/A	Date:
Is Welfare Power of Attorney held?	☐ YES	☐ NO	☐ N/A	Date:
Has copy been requested?	☐ YES	☐ NO	☐ N/A	Date:

Does the patient consent to us sharing information with:

Other Health Professionals ☐ YES ☐ NO	Family ☐ YES ☐ NO	Carers ☐ YES ☐ NO

Specify:

SPIRITUAL CARE & PSYCHOLOGICAL SUPPORT

Does the patient want you to contact their spiritual or religious leader?	☐ YES ☐ NO	Name: ☎: Date:
Does the family / carer want support from Spiritual Care Team (Chaplain)?		☐ YES ☐ NO
Reason for referral (please circle): Patient support / Family Support	Religious care *(faith group?)*	
Refer to Spiritual Care Team:	☐ YES ☐ NO	Date: Time:

NURSING ASSESSMENT – INITIAL ASSESSMENT ON ADMISSION

PAIN ASSESSMENT ON A SCALE OF 0 – 10 WHERE '0' = NO PAIN & '10' = WORST IMAGINABLE OR FACE LEGS ACTIVITY CRYING AND CONSOLABILITY (F.L.A.C.C. SCORE 0 - 10)		
Does the patient have pain?	☐ YES ☑ NO	**If ' Yes' initiate pain assessment chart**

SWALLOWING		
Does patient have any risk factors that would affect their ability to swallow? (e.g. previous or suspected stroke)	☐ YES ☑ NO	**Follow 'Compromised Swallow Assessment Flow chart' or 'Stroke Swallow Assessment' if stroke suspected**
Swallow Screen Checklist completed?	☐ YES ☑ NO	**If Nil By Mouth ensure essential medicines and hydration are prescribed via an appropriate route**

ORAL HEALTH (IF YES TO ANY OF THE FOLLOWING IMPLEMENT THE ORAL HYGIENE TOOL)					
Does the patient have dentures?	Full	Partial	No	Tongue coated?	☐ YES ☑ NO
Are there any issues with oral health?	☐ YES ☑ NO			Lips dry and cracked?	☐ YES ☑ NO

PRESSURE ULCER RISK ASSESSMENT (PURA)

Mobility: Patient is fully mobile without equipment/ assistance (Y/N)

Continence: Person is fully continent (Y/N)

Nutrition: Person appears well nourished and able to eat and drink (Y/N)

Record answer in grid below Y=Yes N=No

If the answer is **NO** to any assessments, commence SSKIN bundle

Remember
- People who are overweight may not be well nourished
- Please sign after each check

DATE	TIME	MOBILITY	CONTINENCE	NUTRITION	SKIN INSPECTED	SSKIN BUNDLE COMMENCED	SIGNATURE/ PRINT
30/8/25	2110	Y	Y	Y	N	N	KG

Name: ICU CNUT1 Signature: [signature] Date: 30/8 Time complete: 2110

FALLS *(see 'Falls History' Page 12)*

Please score through any part of the following that is not used

URINALYSIS

Glucose	Bilirubin	Ketones	SG	Blood	PH	Protein	Urobilin-ogen	Nitrates	Leuco-cytes	Date	Initials

MSU – Culture and Sensitivity			
Chlamydia (P.C.R.)			
What was the date of the patient's Last Menstrual Period?			
Ask the patient if there is any possibility that they may be pregnant			
Pregnancy Status on Admission (Female patients over 12 years) – please tick box			
Pregnant	Not Pregnant	Don't know	Not applicable
A pregnancy test must be carried out if the patient is uncertain/states that they are pregnant. **Ask the patient for verbal consent for a urine pregnancy test**			
Pregnancy test results	Negative	Positive	

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

Admission Record ☐ Nursing Assessment ☐

Bloods ☐

ECG ☐

Swabs - POC ☐ LFT ☐

Track Online Assessments Frailty ☐ +/- 4AT ☐ CPE ☐ & MRSA screening ☐

Nutrition profile ☐ MUST ☐ PVC ☐

30/8/25	2110	(S) 50 year old man admitted via A+E due to ?sepsis
		(B) PMH noted lives alone No POC - Richmond fellowship for company
		(A) FEWS (3) Alert and orientated Independant with ADL's. Normal diet and fluids BM = 7.1 Reports skin fully intact - not seen.
		(R) Awaiting medical review. —— [signature]

A: FEWS ≥ 3 RECOGNITION/ESCALATION (1 sticker per episode per 24 hours)

ESCALATE NOW IF CLINICAL CONCERN

Date: 30/8/25 Time 2110 FEWS (3)

Nurse in charge informed

Patientrack observation profiles/flags reviewed 61

PRINT NAME/SIGNATURE: [signature]

B: FEWS ≥ 4 (or 3 for more than 1 hour) RESPONSE/INTERVENTION

ESCALATE NOW (SEE FEWS ESCALATION CHART)

1. Responsible nurse and clinician to review patient & complete sticker (within 1hr) ☐
2. Possibly due to infection? Y ☐ (Complete Sepsis 6 form) N ☐
3. Appropriate escalation if ongoing deterioration – tick one only
   a) For ICU b) For HDU c) For ward based care ☐☐☐
4. Resuscitation status: for CPR ☐ DNACPR ☐ (Complete DNACPR Form)
5. DOCUMENT MANAGEMENT PLAN IN NOTES BELOW STICKER

PRINT NAME/SIGNATURE:

- IF NO IMPROVEMENT, OR FEWS 7 OR ABOVE - CALL FOR HELP
- IF FEWS 7 OR ABOVE AND NO IMPROVEMENT AFTER 1 HOUR WITH NO DECISION MADE TO LIMIT ESCALATION - MANDATORY CONSULTANT CONTACT NOW
- IF FEWS ≥ 5 OVERNIGHT – inform team consultant in morning

Discuss all plans with patient and family as soon as able & document ☐

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.		
31/8/25	0610	Settled throughout the night. FEWS now stable. BM stable. O2 via NC ongoing. IV fluids continue. IV co-amox given as prescribed. Clozapine given through the night from emergency drug cupboard. Datix submitted as per protocol. Remains independant. Not keen on catheter - using bottles to pass urine - fluid balance. No complaints of pain. ——— [signature]
31/8/25	1130	pt, has been settled. Remains on O2 - Canula Tissued throwing Re-Cannulated, IV fluids Re started, Blood culture taken e R-Bloods, Washed with a Basin. Didnt want to wash pelvis area. Skin very dry. Deland cream - on skin, ob's stable. Drinking more fluids (Juice) - AMC.
31/8/25	1420	Dr Delicata had requested ABG. Went to do it - pt refused investigation. A. BANHOWYMA, FY1 [signature]
31/8/25	1450	pt handed over to WD 53. - AMC

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

PRESSURE ULCER RISK ASSESSMENT STICKER
FILE IN NURSING NOTES

Date: 31/8/25 Time: 1700

Skin inspection within 6 hours of admission to Respiratory	YES/NO
Pura completed within 6 hours of admission to Respiratory	YES/NO
SSKIN bundle initiated	YES/NO/N/A
Frequency of skin bundle	2° 3° 4° (N/A)
Pressure damage present	YES/NO/N/A
Pressure Ulcer identified on admission: **GRADE**	
Appropriate pressure relieving equipment	YES/NO/N/A
Datix completed	YES/NO/N/A
WEB Number	
Referral to Tissue Viability/ Podiatry	YES/NO/N/A
Known to community district nurses/podiatry	YES/NO/N/A

		(S) & (B) as per chart.
		(A) FOWS (1), alert and orientated at time of assessment. Not on respiratory distress on 4L O2 via NC. ePVC insitu IV fluids resumed at 100ml/hr. DO/NF. Continent- uses bottle. Skin dry and scaley. NIL pressure sore noted. (Hx Eczema/Psoriasis). A+I with AOLS and with O2 cylinder at the moment; independent with mobility (needs encouragement)
		(R) Encourage ↑ fluid intake; encourage self care. monitor ePVC. Cont. with IV Abx; wean O2 as able. — #SN
31/8/25	2050	Leon's Key worker Graeme Lumsden called for an update on him. He has kindly left his mobile number if medical staff need any further information Graeme Lumsden Richmond Fellowship Key worker 07586310888 — SN

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

01/09/25 09:10 WR MURRAY

(50)♂ Admitted 30/08/25

Issues

1. Pneumonia with sepsis
   - on oral doxycycline + IV co-amoxiclav since 30/08 evening

CXR - (R) lower zone consolidation

BG: T2DM, asthma, schizophrenia, anxiety

NEWS = 2

T: 35.6 HR: 85 BP: 120/72 RR: 18 Sat: 91% NC

Blood cultures - awaiting results

Bloods (30/08) -

WCC: 24.5 Neut: 22 CRP: 37.9 UEE - (N)

ABG: 7.47 ↑ pCO_2 N pO_2 6.8 ↓ Lactate 2.1 ↑

LDH (31/08) - Haemolysed

BM: 14.4 - yesterday eve

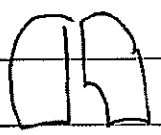
Pt lying on bed. Alert & chatty.

Cough - prod green sputum.

Sharp CP when deep breath - improving.

Gets SOB on walking, wheezy + inhalers help.

Stopped smoking 10 yr ago, smoked 20/day.



↓ Air entry

No wheeze

No crackles

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

DATE	TIME	NOTES
01/09/25	09:10	Plan 1. Bloods for inflammatory markers └ If improved IV → oral switch 2. ABG └ ? chronic CO_2 retainer & ↓ O_2 3. CXR 6/52 after discharge 4. Will need Spiro +/- Further PFTs in due course - RNS Spiro pre D/c Please 5. RNS RN pre D/c / Inhaler Tech [signature] CONS 21684 MURRAY
1/9/25	11:22	Pharmacy Review Med Hx Completed as per ECS. As per Case clinic letter from 25.2.25, Pt takes Methotrexate on a Tuesday. Phoned Chams who confirmed current Clozapine dose as 300mg ON FTY Pharmacist [signature]
01/09/25	14:00	Bloods Review Hb: 127 ↓(147) WCC 20.2 (24.5) Na 139 MCV: 97 Neut 16.9↑(22) K 4.0 RBC: 4.05 ↓ CRP 158↑(37.9) Cl 79 HCT: 0.39 ↓ eGFR > 60 Plt: 195 Bicarb 25.9 (Na, K, Cl, eGFR bracketed: (N))

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
		Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.
01/09/25		Due to ↓ Hb 147 → 127 Reg Sabih advised for repeat FBC tonight - will request for 9pm and handover for night team to chase. No bleeding - ø haematemesis ø haematuria ø melena ø PR bleed ø haemoptysis.
		WCC still ↑ at 20 and increasing CRP - keep on IV abx today and will request repeat bloods for tomorrow.
		ABG: LDrawbridge (FYI)
		ABG LABEL
		Normal pH
		Hypoxia - 9.78 (mild)
		Co_2 5.93 - not increased but higher end of normal range
		LDrawbridge (FYI)

PROGRESS / CONTINUATION EVALUATION OF CARE

DATE TIME

Patient name: LEON GRATTON

CHI: 1703751191

or attach addressograph

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

2/9/25 02[10] Repeat FBC taken @ 21[00] – Hb ↑ from 127 to 131. WBC ↓ from 20 to 17·7, for day team review. ? r/t bloods. Pt getting increasingly anxious about repeated venepuncture due to needle phobia. Settled night, bedtime meds including clozapine taken. IV abx given. Pt sleeping good spells. O2 weaned to 3L. Pt requesting drink and snacks and shower a/m – agreed to take this in morning – SN

02/09/25 09:40 Daily Review Dr Onifade + L Drawbridge

(50♂) Admitted 30/08/25

Issues

① Pneumonia with sepsis

L on oral doxy + IV co-Amox since 30/08 eve

Awaiting cultures

Bloods 01/09 eve ____ Todays bloods not yet back

Hb 131 (127) Normal

WCC 17·7 (20) FEWS = 2

Neut 13·7 (16·9) T: 36·6 HR: 83 BP: 90/56

RR: 19 Sat: 93% NC

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
		Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.
02/09/25	09:40	Review continued
		O/E - patient sleeping. Sounds like sleep apnoea.
		Plan
		1. Cont abx
		2. Chase blood today - switch to oral abx if CRP trend ↓
		3. Wean O2 as appropriate maintaining sats > 92%
		4. Refer to derm for skin
		5. Start discharge planning
		6. Call resp nurses for PFTs + spiro before discharge
		LDrawbridge (FY1)
3/9/25	00[00]	Pt has only 2 x clozapine 100mg Tablets left in box. Insufficient for tomm 12[00] dose. More ordered - unable to find Clozapine reporting option on datix - can this be clarified by pharmacy please - Dr SN
	02[45]	Settled night. Pt slept good spells, ate full supper, indep to toilet - removing n/c and indep w skin care for dry/irritated limbs w new creams. Obs stable. Apyrexial. Slight wet cough noted @ times

PROGRESS / CONTINUATION EVALUATION OF CARE

GRATTON PLEON 17-03-1975
1703751191
or attach addressograph

DATE TIME

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

		but able to expectorate. Will try to further wean O2 to below 1L in morning - JN.
3/9/25	0830	Respiratory Nurse - LEAMINGTONS (X 24237/200990) for Spirometry + inhaler review/technique at request of Dr Murray - PMH - Asthma - exacerbated 2020. (N) on Beclamethasone 100mcg 2pfs BD + Salbutamol PRN 2pfs. RNS will come back later + perform spirometry + then review inhalers Spo2s 93% on RA - (C) to wean off O2 - target Spo2s >94% PFTs will need to be organised with respiratory function lab and would need to be carried out post d/c once chest settled. (LEAMINGTONS (RNS)
03/09/25	12:00	Daily Review Dr Chilala + L. Drawbridge (SO) Admitted 30/08/25 Issues ① Pneumonia with sepsis └ on PO Doxy + IV Co-Amox since 30/08 eve Derm - nurse app team report pt has OP appt Resp nurses - RNS later will do spirometry + review inhalers Plan to wean O2 aim > 94% sats

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
		Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.
03/09/25		
		Bloods 02/09
		WCC - 14.8 (17.7) Inflamm markers still raised
		Neut - 11.01 (13.7) but improving + down-trending
		CRP 91 (158)
		FEWS = 1
		T: 36.0 HR: 83 BP: 114/78 RR: 18 Sats: 90% on NC
		Pt sat in chair. Appears better + brighter.
		Breathless (less) improving, mobilising to toilet independantly.
		Still bringing up some sputum. No concerns.
		Some minor (R) sided chest pain.
		Plan
		① IV → oral Co-Amox due to blood results
		② Stop Doxycycline - 5/7 complete
		③ Bloods tomorrow - FBC, CRP, UEEs
		④ Continue to wean O2 - on 1L currently.
		LDrawbridge (FY1)

PROGRESS / CONTINUATION EVALUATION OF CARE

DATE TIME

GRATTON LEON 17-03-1975

1703751191

or attach addressograph.

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

DATE	TIME	
3/9/25	1150	Resp Nurse Specialist – Simmons (20090) (24237)
		Spirometry.
		fev 2.77 (62% Predicted)
		fvc 3.31 (58% Predicted)
		ratio 0.84
		PEFR 361 (56% Predicted)
		Discussed Dr Araujo – to disregard Spirometry results as patient currently in with a CAP therefore results may not be accurate – for PFTs once chest settles to determine true results.
		Education given re inhaler technique & given aerochamber.
		© to wean oxygen as Sp02's allow (RNS)
20:30		patient is suppose to be taken clozapine 300 mg at 22:00. But clozapine 200 mg left. Informed doctor on the ward. Dalix need to be done once the box get finished. As I am not aware about proper indication of dalix, informed charge nurse. Nicky staff nurse will be informing tomorrow to pharmacist for a dalix.

DATE	TIME	PROGRESS / CONTINUATION / EVALUATION OF CARE
		Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.
	22:30	S/N Maria has ordered Clozapam. Therefore, I have administered medication to the patient. DCN and charge nurse aware. dk 8tal/Pr
4/9/25		Sp^{02} 93% on RA pulse 95 on gang-ear a. Crews KNS 28562
04/09/25		Daily Review - Dr Chilala + L. Drawbridge (50♂) Admitted 30/08/25
		Issues ① Pneumonia with sepsis L completed PO Doxy course L IVOST 03/09 on PO Co-Amoxiclav L Weaning O2
		Bloods - requested for today, will chase
		FEWS = 1
		Sats: 92% on NC T: 36.1 HR: 90 BP: 132/83 RR: 18
		Nursing document 93% RA.
		° RNS r/v - Spirometry completed - for repeat when chest settles to determine true results
		° clozapine - DATIX

PROGRESS / CONTINUATION EVALUATION OF CARE

GRATTON LEON name: 17-03-1975

1703751191

or attach addressograph

DATE TIME

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

04/09/25 Daily review cont.

Bloods: HCO_3^- - 24.2 ⊜, CRP↓ 2·9·6 ∈ 91.5, ∈ 158., U+Es ⇒ ⊜

WBC↓ 12.8 (Neut 8.86) ⊂ 14.8 (Neut - 11.6↑)

Blood culture ⇒ negative

O/E Stable

Lying in bed on O2 - RC

Felt slightly breathless after taking shower.

Alert.

RR. SNS in distress.

Chest - ↓ BS in lower zones

Plan:

① Keep in

② Continue O2 weaning.

③ Discharge planning. Lumf

04/09/25 1210 Pharmacy

① No need to OATIx Clozapine - supply was on ward and given to patient

② Please review dalteparin & paracetamol doses. Patient 124 kg. ∴ ↑ dalteparin to 7500 units OD. Also stop to ↑ paracetamol if needed

③ metformin & MTX currently held whilst unwell

PROGRESS / CONTINUATION / EVALUATION OF CARE

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

DATE	TIME	
04/09/25	1210	Pharmacy cont.
	④	Oilatum Rx unsigned - please sign
	⑤	Please note risk of constipation c̄ clozapine - consider prescribing reg + prn laxatives. Especially as now on prn morphine.
		[illegible] Pharmacist #28038
5.9.25	0030	Independent with all ADLs
		Eating and drinking well
		Prescribed 1L O2 however not using this and sat 95%
		AScott
05/09/25	9:20h.	WR. Dr. Chulala [illegible]
		Reviewed.
		♂ 50 admitted for CAP c̄ B/G DM/Asthma/Schizophrenia/Anxiety.
		~ 5/7 of Abx now
		~ Inflammatory markers ↓
		~ CRP - ↓ feGB - 1-2
		~ Still on O2 on/off.
		S) oc. stable.
		E not currently needing O2 but says he feels breathless when he walking to shower/toilet.
		- But generally feeling much better
		Plan.
	①	Keep.
	②	Discharge planning
	③	Monitor saturations + weaning off O2.
	④	Continue Abx

PROGRESS / CONTINUATION
EVALUATION OF CARE

GRATTON LEON 17-03-1975
1703751191

DATE	TIME	

Please use 24 hour clock and sign each entry. Insert your details on 'Signature' sheet.

WR continued

Plan - continued

(5) Repeat bld

(6) On discharge follow up Renew + CXR (GP?)

[signature]

05/09/25 10:21 W. [illegible]

Sats 96% on [illegible]

Well, afebrile and keen to go home.

(P)

1) [illegible] 6/52
2) PFTs 3/12.
3) Total 5 days oral Abx
4) Restart MTX next week.
5) D/C today

[signature]

NURSING ASSESSMENT AND PATIENT CARE PLAN RECORD

NHS Fife

PATIENT DATA: Patient label or write

PATIENT NAME:

PATII GRATTON LEON 17-03-1975

DATI 1703751191

PREFERS TO BE CALLED: _____

ADMISSION / TRANSFER INFORMATION

Date of admission: 30/8/25

Time of admission: 2050

Ward admitted to: AAU

Consultant: _____

Ward transferred to: 53

Date of transfer: _____

Time of transfer: _____

Consultant: _____

Ward transferred to: _____

Date of transfer: _____

Time of transfer: _____

Consultant: _____

Ward transferred to: _____

Date of transfer: _____

Time of transfer: _____

Consultant: _____

Date of Actual Discharge: _____

COMPLETION OF ASSESSMENTS

PATIENT CARE ASSESSMENT AND ADMISSION RECORD:

- ☐ Frailty Screening and Assessment
- ☐ Infection Control
- ☐ Capacity and Consent

Initial assessments:

- ☐ Pain
- ☐ Swallowing
- ☐ Oral Health
- ☐ Pressure Ulcers
- ☐ Falls

NURSING ASSESSMENT AND PATIENT CARE PLAN RECORD:

- ☐ Pressure Ulcers *(within 6 hours of admission or transfer to ward)*
- ☐ Handling Risk Assessment (*within 6 hours of admission)*
- ☐ MUST (*within 24 hours of admission)*
- ☐ Nursing Assessment
- ☐ Daily Care Plans

The information within this document is CONFIDENTIAL and may only be viewed and shared with the permission of the named patient.

SIGNATURES

This record is a legal document. Your signature indicates that you have reviewed and updated it, and it is a true reflection of the care given by you or delegated by you.

Whenever anyone writes in this record for the first time, they should fill in their details below:

NAME *(please print)*	SIGNATURE	JOB TITLE
KIM GALES	[illegible]	SN
Ross Hume	[illegible]	AP
A [illegible]	[illegible]	AP
Chandralekha priyan	[illegible]	SN
A [illegible]	[illegible]	AP
Aimee Scott	A scott	SN
Nicky [illegible]	[illegible]	SN

PURA: PRESSURE ULCER RISK ASSESSMENT

On Patientrack: ☐ YES ☐ NO

USE WITHIN 6 HOURS OF ADMISSION TO CARE AREA

Use daily if the person is **not at risk**
Sign after each check
REMEMBER – PEOPLE CHANGE, RISKS CHANGE

MOBILITY:	Mobile without equipment / assistance OR able to mobilise with aid of Zimmer, or other walking aid
CONTINENCE:	Continent
NUTRITION:	Appears well nourished and able to eat and drink (people who are over-weight may not be well nourished
SKIN:	Skin condition good with no pressure damage or excoriation. **Record any identified skin integrity concerns on Pressure Ulcer Record (including diagram) on reverse of page**

Record your answer in the grid below Y = Yes or N = No

- If the answer is YES to all statements, use this chart daily
- If the answer is NO to any statement, implement SSKIN Care Bundle and continue to use this chart daily
- If the answer to at least one statement is NO, but you feel, within your clinical judgment, that the patient is not 'at risk', record the reasons for not commencing the SSKIN bundle at foot of page
- If you are unsure, default to SSKIN care bundle

Date	Time	Mobility	Continence	Nutrition	Skin intact	SSKIN Care Bundle Activated	Signature
30/8/25	11.15	Y	Y	Y	Y	N	[illegible]
53 31/8/25	22.15	Y	Y	Y	Y	N	AD
1/9/25	0020	Y	Y	Y	Y	N	ME
2/9/25	0925	Y	Y	Y	Y	N	RL
3/9/25	09.15	Y	Y	Y	Y	N	AD
4/9/25	08.15	Y	Y	Y	Y	N	AD
5/9/25	09.00	Y	Y	Y	Y	N	RL

Date	Time	Why SSKIN Care Bundle not implemented	Signature
1/9/25	0745	Independant	RL

CLIENT HANDLING RISK ASSESSMENT

On Patientrack: ☐ YES ☐ NO

A. CLIENT DETAILS AND ASSESSMENT

Date					Diagnosis:
Weight Kg					
Height Mt.					Operation:
BMI					Date of Surgery:

EQUIPMENT USED BY THE CLIENT PRIOR TO ADMISSION AND ASSISTANCE (0, 1, 2)

TYPE	✓ ( )	INITIAL	TYPE	✓ ( )	INITIAL	TYPE	✓ ( )	INITIAL
Zimmer			Crutches			Wheelchair		
Gutter Zimmer			Sticks			Hoist		
Rollator Zimmer			Gutter Crutch			Other:		

LEVEL OF MOBILTY FROM ADMISSION	✓	DATE	INITIAL	✓	DATE	INITIAL	✓	DATE	INITIAL	✓	DATE	INITIAL
Weight bearing	✓	3018	KB									
Non weight bearing												
Partial weight bearing												
Variable weight bearing												
Not to be mobilised				✓								
History of Falls	☐ YES		☑ NO									
Falls Risk Score												

ASSESSMENT STATE	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL	DATE	INITIAL
Comprehension: Sight, Hearing, Speech — No issues	3018	KB						
Behaviour: Unpredictable, Confused, Walking about Aggressive, Apprehensive, Delirium	↓	↓						
Ability: Balance, Movement, Weakness, Sensation — Indep								
Pain: Location — Nil								
Skin lesions or Sores: Location — Nil								
Attachments: Infusion, Catheter, PEG, Drains, Monitors — Nil								
Other: Medication — BS charted								
Culture or Religion (specify):								

OUTCOME / AIMS for PATIENT:

Date: _____ Aim: Maintenance

Date: _____

Action Plan discussed with client and carer	☐ YES ☐ NO	Date: 3018	Signature: KB

B. HANDLING ACTION PLAN

TASK No. 1 Toileting		Task No. 2 Bathing	
Number of staff required:		Number of staff required:	
Mechanical Hoist	Type:	Mechanical Hoist	Type:
Sling Type	Sling size:	Sling Type	Sling size:
Other Equipment Indep		Other Equipment Indep.	
Handling Instructions		Handling Instructions	
Signature:	Date: 3018	Signature:	Date: 3018

TASK No.		Task No.	
Number of staff required:		Number of staff required:	
Mechanical Hoist	Type:	Mechanical Hoist	Type:
Sling Type	Sling size:	Sling Type	Sling size:
Other Equipment		Other Equipment	
Handling Instructions		Handling Instructions	
Signature:	Date:	Signature:	Date:

TASK No.		Task No.	
Number of staff required:		Number of staff required:	
Mechanical Hoist	Type:	Mechanical Hoist	Type:
Sling Type	Sling size:	Sling Type	Sling size:
Other Equipment		Other Equipment	
Handling Instructions		Handling Instructions	
Signature:	Date:	Signature:	Date:

NURSING ASSESSMENT

	ASSESSMENT
Communication	Do you have any loss of sight ☐ hearing loss ☐ Do you use glasses / contact lenses ☑ hearing aids ☐ leading Do you have any problems / difficulty in understanding conversation ☐ YES ☑ NO Are there ways we can help with communication? Is referral to SALT required? ☐ YES ☐ NO Referral made to SALT (date): ____/____/____ or No Issues / Risk ☐
Pain	Are you in any pain? ☐ YES ☑ NO Where is the pain? _____ Severity of pain: mild ☐ moderate ☐ severe ☐ New pain ☐ Long term pain ☐ How long: hours ☐ days ☐ weeks ☐ months ☐ Regular Analgesia ☐ YES ☐ NO Pain assessment tool utilised ☐ YES ☐ NO Pain score: _____ or No Issues / Risk ☐
Respiratory	Do you have any difficulty with your breathing? ☐ YES ☑ NO Do you use inhalers? ☑ YES ☑ NO Domiciliary Oxygen? ☐ YES ☑ NO Do you smoke? ☐ YES ☐ NO Would you like to stop smoking ☐ YES ☐ NO Patient appears dyspnoeic ☐ YES ☐ NO At risk of deterioration (increasing FEWS) ☐ YES ☐ NO Referral to respiratory physio required? ☐ YES ☐ NO Referral made to respiratory physio (date): ____/____/____ Referral to Smoking Cessation service (SCS) required? ☐ YES ☐ NO Referral made to SCS (date): ____/____/____ or No Issues / Risk ☑
Falls	Falls Pathway initiated (see Patient Care Assessment and Admission Record) ☐ YES ☑ NO
Swallowing	**Please note if stroke is suspected follow NHS Fife Stroke Swallow Screening Protocol** Have you had any difficulties with swallowing: food ☐; liquids ☐ Is patient coughing or choking on oral intake ☐ YES ☐ NO Is patient alert enough to manage oral intake? ☐ YES ☐ NO Utilise 'Flowchart/care plan for patients with compromised swallow ' ☐ YES ☐ NO or No Issues / Risk ☐
Hydration / Fluid Management	Do you require any assistance with drinking? ☐ YES ☑ NO Do you use any special equipment? ☐ YES ☑ NO Do you feel thirsty? ☑ YES ☐ NO Nil by mouth? ☐ YES ☐ NO Does patient require intravenous fluids? ☐ YES ☐ NO Fluid management chart in use? ☐ YES ☐ NO Peripheral cannula in situ? ☐ YES ☐ NO Peripheral vascular catheter (PVC) Insertion and Maintenance Care Plan required? ☐ YES ☑ NO or No Issues / Risk ☐
Oral Hygiene	Do you have a sore mouth? ☐ YES ☑ NO Do you have dentures? ☐ YES ☑ NO What do you usually use to clean your teeth? _____ Initiate oral hygiene care plan? ☐ YES ☑ NO or No Issues / Risk ☐

ASSESSMENT

Elimination

Are you having any problems with: urinary incontinence ☐ urgency ☐ bowel incontinence ☐
Does patient have a urinary catheter in situ? ☐ YES ☐ NO
Catheter Associated UTI (CAUTI) Insertion and Maintenance Care Plan required? ☐ YES ☐ NO
Do you require assistance to go to the toilet? ☐ YES ☐ NO
Do you have a stoma? ☐ YES ☐ NO
Do you suffer from constipation? ☐ YES ☐ NO new problem ☐ long standing problem ☐
When did you last have a bowel motion? _____
How do you usually manage your constipation?

or No Issues / Risk ☐

Personal Hygiene

Do you usually need help or use special equipment to:
Bathe ☐ YES ☐ NO
Shower ☐ YES ☐ NO
Dress ☐ YES ☐ NO
What help is given / equipment used:

When you are in hospital, would you prefer to have a bath ☐ shower ☐ neither ☐
Referral to OT required? ☐ YES ☐ NO
Referral made to OT (date): ____/____/____
or No Issues / Risk ☐

Wound Care

Do you currently have a wound / broken skin ☐ YES ☐ NO
Dressing in situ ? ☐ YES ☐ NO
Wound post surgery? ☐ YES ☐ NO
Admitted with Pressure Ulcer? ☐ YES ☐ NO
Referral to Specialist Service required? ☐ YES ☐ NO
Referral made to Specialist Service (specify: _____) (date): ____/____/____
or No Issues / Risk ☐

Emotional well-being

Do you feel emotionally well? ☐ YES ☐ NO
Is there anything that we can offer to help support you? ☐ YES ☐ NO

Patient appears distressed / agitated / depressed ☐ YES ☐ NO or No Issues / Risk ☐

Sleep and rest

Do you usually have trouble sleeping? ☐ YES ☐ NO
Do you use any particular techniques to help you sleep? ☐ YES ☐ NO
How do you like to relax? reading ☐ listening to music ☐ TV ☐ other: _____
On medication? ☐ YES ☐ NO
or No Issues / Risk ☐

End of Life Care

Is this relevant to patient? ☐ YES ☐ NO
Referral to palliative care required? ☐ YES ☐ NO

Referral made to palliative care (date): ____/____/____

Patient Specific Area Specific

Signature:

Time:

DAILY CARE PLAN

Date: 31 / 8 / 25

Discussed with patient / carer on: ___ / ___ / ___

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion		on going Care
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):		Communicates well Call bell to hand
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures		Settled
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage Involvement of relatives and carers		alert
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check		as per track daily BMS
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):		as per Kardex
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention		NC

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian		DD/NF
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above –Datix		daily pura
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT		Incl
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care		Incl using bottles
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails		falls partway in place
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry		skin is a mess due to eczema
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required		Incl
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward		Standard APE
Sleep / Rest	☐ Medication ☐ Specify interventions:		
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management		as per Kardex
	Signature: **Time:**		

DAILY CARE PLAN

Date: 1/9/25

Discussed with patient / carer on: ___/___/___

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion	awaiting ward round.	Wean O2 as abl.
Communication	☑ ☐ Ensure environment conducive to communication ☑ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Nursed unbay Callbell bhand Can make needs known	call bell to hand. Can communicate need, well.
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures	No Signs of distress or Stress noted at this time	No issues.
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	Patient appears alert.	Alert + orentated
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	4 hourly Observations Pews (2) temperature 35.9 SpO_2 93% 4 litres O_2	Obs stable.
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):	Aspar Kardex	As charted.
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention	On 4 litres O_2 therapy Via nasal Cannula > 94%	Aim > 94% On 3L N/C

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Nutrition / hydration	☑ MUST rescreen due ☑ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian	Weight done 124.56Kg Diabetic diet Normal fluids	DD/NF
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above –Datix	Daily Pura	Daily PURA.
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT	Independant	Ind
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Independant Bottles	Ind
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails	4 Comfort Clock	4° comfort rounds
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	Psoriasis Pressure areas intact	Na
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required	Basin and Shower offered	Ind
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward	Standard PPE	SICPS.
Sleep / Rest	☐ Medication ☐ Specify interventions:	Settled	settled
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management	Oral	Meds as charted
	Signature: Time:	Rhe 0945	Mcvayden 00:20

DAILY CARE PLAN

Date: 2/9/25

Discussed with patient / carer on: ___/___/___

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion	Continence Care	Wean O2 as able -
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Nursed on bay Call bell to hand Can make needs known	call bell to hand. can communicate needs well.
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures	No Sign of Stress/distress noted	No issues
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	alert + orientated	Alert + orientated
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	4 hourly	Obs stable -
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):	as per Kardex	As charted.
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention	on 2 Litres O2 therapy	Aim >92%. on 1L NC

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Nutrition / hydration	☐ ☐ MUST rescreen due ☐ ☐ MUST care plan ☐ ☐ NBM / special diet ☐ ☐ Food / fluid chart ☐ ☐ Fluid restriction ☐ ☐ Parenteral / enteral feeds ☐ ☐ Oral supplements ☐ ☐ Enteral tube management ☐ ☐ Complete patient board ☐ ☐ Refer to dietitian	weekly weight diabet diet Normal fluids	DD/NF.
Pressure Area Care	☐ ☐ Reassess daily as per PURA ☐ ☐ Use SSKIN Bundle ☐ ☐ Document type of pressure relieving equipment ☐ ☐ Record any pressure ulcer on reverse of 'PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above –Datix	Daily Pura	Daily PURA.
Mobility	☐ ☐ Complete Client Handling Risk Assessment Form ☐ ☐ Ensure required equipment is available ☐ ☐ Refer to physiotherapy / OT	Independant	Ind
Elimination	☐ ☐ Assistance / supervision ☐ ☐ Provide equipment ☐ ☐ Bristol stool chart ☐ ☐ Utilise CAUTI bundle if catheter in situ ☐ ☐ Stoma care	Independant	Ind.
Falls Risk	☐ ☐ Falls Bundle implemented ☐ ☐ Minimum of 2 hourly care rounding initiated ☐ ☐ Falls equipment obtained as appropriate ☐ ☐ Update safety brief ☐ ☐ Assess need for bed rails	4°	4o comfort round.
Wound care	☐ ☐ Complete wound assessment chart ☐ ☐ Refer to Wound Formulary ☐ ☐ Drain care Refer to Specialist Service: ☐ ☐ Tissue Viability ☐ ☐ Plastic surgery ☐ ☐ Vascular ☐ ☐ Dermatology ☐ ☐ Podiatry	Pressure areas intact ? Dermatology	NA.
Personal hygiene	☐ ☐ Self-care ☐ ☐ Basin / shower / bed bath as preferred by patient ☐ ☐ Assistance with 1 / 2 nurse ☐ ☐ Oral Hygiene assistance / care plan ☐ ☐ All care required	Refused	Ind with ADL's.
Infection Control	☐ ☐ Ensure all invasive devices are documented and managed as per care plans ☐ ☐ Ensure appropriate patient placement in ward	Standard PPE	SICPS.
Sleep / Rest	☐ ☐ Medication Specify interventions:	Settled	settled.
IV Fluids / Meds	☐ ☐ Fluids / meds ☐ ☐ PVC insertion and maintenance bundle ☐ ☐ CVC insertion and maintenance bundle ☐ ☐ S/C management	oral	Meds as charted
	Signature:	[signature]	M. Graham
	Time:	1030	00:20

DAILY CARE PLAN

Date: 3 / 9 / 25

Discussed with patient / carer on: ___ / ___ / ___

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion	on going care	Ongoing medical Care
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Communicates well Call bell to hand	Can communicate the needs. CB within reach
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures	Settled at this time	Not Bothered/ Distressed.
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	Alert Orientated	A+O
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	Check BMS as per Kardex	As per patient Grade
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):	as per Kardex	As per Kardex
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention	1 LTR NC	On 1L NC 94%

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Nutrition / hydration	☐ ☐ MUST rescreen due ☐ ☐ MUST care plan ☐ ☐ N8M / special diet ☐ ☐ Food / fluid chart ☐ ☐ Fluid restriction ☐ ☐ Parenteral / enteral feeds ☐ ☐ Oral supplements ☐ ☐ Enteral tube management ☐ ☐ Complete patient board ☐ ☐ Refer to dietitian	DD INF weekly must	DD/NF
Pressure Area Care	☐ ☐ Reassess daily as per PURA ☐ ☐ Use SSKIN Bundle ☐ ☐ Document type of pressure relieving equipment ☐ ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above –Datix	daily pura	Daily PURA
Mobility	☐ ☐ Complete Client Handling Risk Assessment Form ☐ ☐ Ensure required equipment is available ☐ ☐ Refer to physiotherapy / OT	Incl	Incl
Elimination	☐ ☐ Assistance / supervision ☐ ☐ Provide equipment ☐ ☐ Bristol stool chart ☐ ☐ Utilise CAUTI bundle if catheter in situ ☐ ☐ Stoma care	Incl	Incl
Falls Risk	☐ ☐ Falls Bundle implemented ☐ ☐ Minimum of 2 hourly care rounding initiated ☐ ☐ Falls equipment obtained as appropriate ☐ ☐ Update safety brief ☐ ☐ Assess need for bed rails	↓ Risk	↓ risk.
Wound care	☐ ☐ Complete wound assessment chart ☐ ☐ Refer to Wound Formulary ☐ ☐ Drain care ☐ ☐ Refer to Specialist Service: ☐ ☐ Tissue Viability ☐ ☐ Plastic surgery ☐ ☐ Vascular ☐ ☐ Dermatology ☐ ☐ Podiatry	psoriasis all over body	Psoriasis all over body
Personal hygiene	☐ ☐ Self-care ☐ ☐ Basin / shower / bed bath as preferred by patient ☐ ☐ Assistance with 1 / 2 nurse ☐ ☐ Oral Hygiene assistance / care plan ☐ ☐ All care required	Incl	Incl
Infection Control	☐ ☐ Ensure all invasive devices are documented and managed as per care plans ☐ ☐ Ensure appropriate patient placement in ward	Standard PPE	SIPS
Sleep / Rest	☐ ☐ Medication ☐ ☐ Specify interventions:		—
IV Fluids / Meds	☐ ☐ Fluids / meds ☐ ☐ PVC insertion and maintenance bundle ☐ ☐ CVC insertion and maintenance bundle ☐ ☐ S/C management	as pe	oral meds
	Signature: Time:		ch

DAILY CARE PLAN

Date: 4 / 9 / 25

Discussed with patient / carer on: ___ / ___ / ___

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	**NIGHT**
Person-Centred Approach	☐ ☐ Patient's personal goals ☐ ☐ Carer / family discussion	on going care	Aim to sleep well
Communication	☐ ☐ Ensure environment conducive to communication ☐ ☐ Call buzzer ☐ ☐ Patient wears glasses ☐ ☐ Patient uses a hearing aid ☐ ☐ Refer to Speech and Language therapy ☐ ☐ Arrange Interpreter service ☐ ☐ Use written communication ☐ ☐ Use communication aid (specify):	Communicates well Call bell to hand	Communicates needs Utilizes call bell
Stressed or Distressed Behaviour	☐ ☐ Reduce stress / distress – specify: ☐ ☐ Consider need for Violence & Aggression Risk Assessment and complete same if applicable ☐ ☐ Implement safe working procedures	Settled	Settled
Cognitive Impairment /Delirium	☐ ☐ Inform medical staff of change ☐ ☐ Consider further frailty screen if previously negative ☐ ☐ If positive for frailty screening, ensure appropriate assessment undertaken ☐ ☐ Encourage involvement of relatives and carers	Alert oriented	A&O
Observations	☐ ☐ T,P,R,BP ☐ ☐ Fluid balance ☐ ☐ Weight ☐ ☐ Neuro obs ☐ ☐ Blood Glucose ☐ ☐ Circulation check	daily Bms as per trrcare	Bms TDS Less daily
Symptom Relief	☐ ☐ Pain relief ☐ ☐ Pain assessment tool ☐ ☐ Nausea relief ☐ ☐ Other (specify):	as per leader	as per kardex
Respiration / Airway	☐ ☐ Oxygen required ☐ ☐ Nebulisers / Inhalers ☐ ☐ Compromised swallow ☐ ☐ Tracheostomy ☐ ☐ Hospital Acquired Pneumonia intervention	ILTK NC	Room air currently

	MANAGEMENT / INTERVENTIONS *(Tick appropriate boxes)*	PERSON-CENTRED INTERVENTIONS	
		DAY	NIGHT
Nutrition / hydration	☐ MUST rescreen due ☐ MUST care plan ☐ NBM / special diet ☐ Food / fluid chart ☐ Fluid restriction ☐ Parenteral / enteral feeds ☐ Oral supplements ☐ Enteral tube management ☐ Complete patient board ☐ Refer to dietitian	DD, NF	NONF Weekly Must
Pressure Area Care	☐ Reassess daily as per PURA ☐ Use SSKIN Bundle ☐ Document type of pressure relieving equipment ☐ Record any pressure ulcer on reverse of PURA, Wound Chart, Safety Brief, Safety cross and, if grade 2 or above –Datix	daily pura	daily Pura
Mobility	☐ Complete Client Handling Risk Assessment Form ☐ Ensure required equipment is available ☐ Refer to physiotherapy / OT	Ind	independens
Elimination	☐ Assistance / supervision ☐ Provide equipment ☐ Bristol stool chart ☐ Utilise CAUTI bundle if catheter in situ ☐ Stoma care	Ind	independens
Falls Risk	☐ Falls Bundle implemented ☐ Minimum of 2 hourly care rounding initiated ☐ Falls equipment obtained as appropriate ☐ Update safety brief ☐ Assess need for bed rails	↓ Risic	Low risk
Wound care	☐ Complete wound assessment chart ☐ Refer to Wound Formulary ☐ Drain care ☐ Refer to Specialist Service: ☐ Tissue Viability ☐ Plastic surgery ☐ Vascular ☐ Dermatology ☐ Podiatry	psoras all ove body	psoriasis
Personal hygiene	☐ Self-care ☐ Basin / shower / bed bath as preferred by patient ☐ Assistance with 1 / 2 nurse ☐ Oral Hygiene assistance / care plan ☐ All care required	Ind	Independens
Infection Control	☐ Ensure all invasive devices are documented and managed as per care plans ☐ Ensure appropriate patient placement in ward	standard PPE	SICPS
Sleep / Rest	☐ Medication ☐ Specify interventions:		ao Kardex
IV Fluids / Meds	☐ Fluids / meds ☐ PVC insertion and maintenance bundle ☐ CVC insertion and maintenance bundle ☐ S/C management	as pe kardex	Oral
	Signature: Time:		Asoka 2200

Care and Comfort Clock

Date: 5/9/25

GRATTON LEON 17-03-1975

1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4 hourly

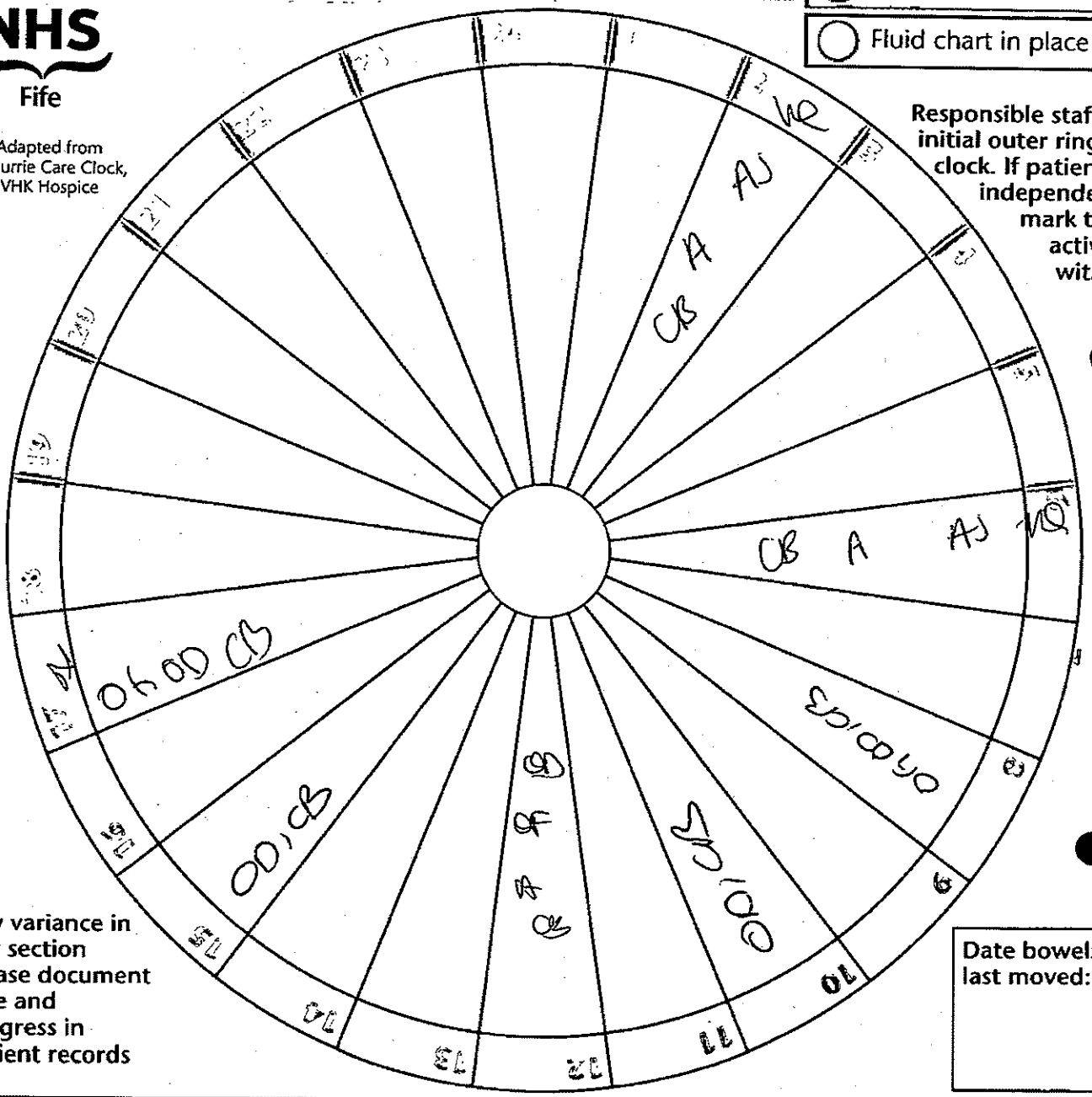
◯ Food chart in place

◯ Fluid chart in place

NHS Fife

Adapted from L Murrie Care Clock, VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 4/9/25

Gratton Ieon

Patient label here

170375191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:
- ○ 1
- ○ 2
- ○ 3
- ✓ 4 hourly

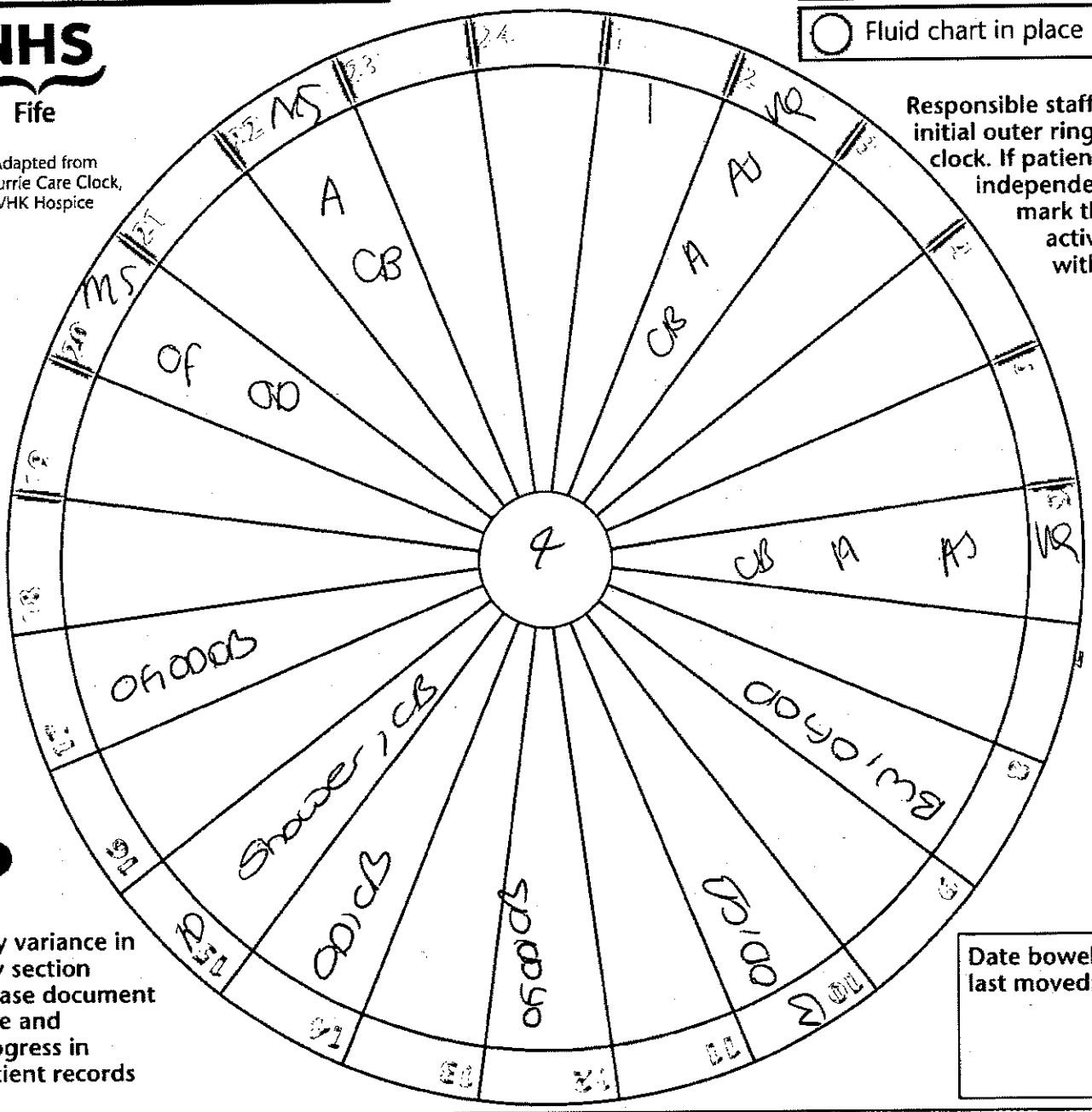
○ Food chart in place

○ Fluid chart in place

NHS Fife

Adapted from L Murrie Care Clock, VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 3/9/25

GRATTON LEON 17-03-1975

1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:
- ○ 1
- ○ 2
- ○ 3
- ✓ 4 hourly

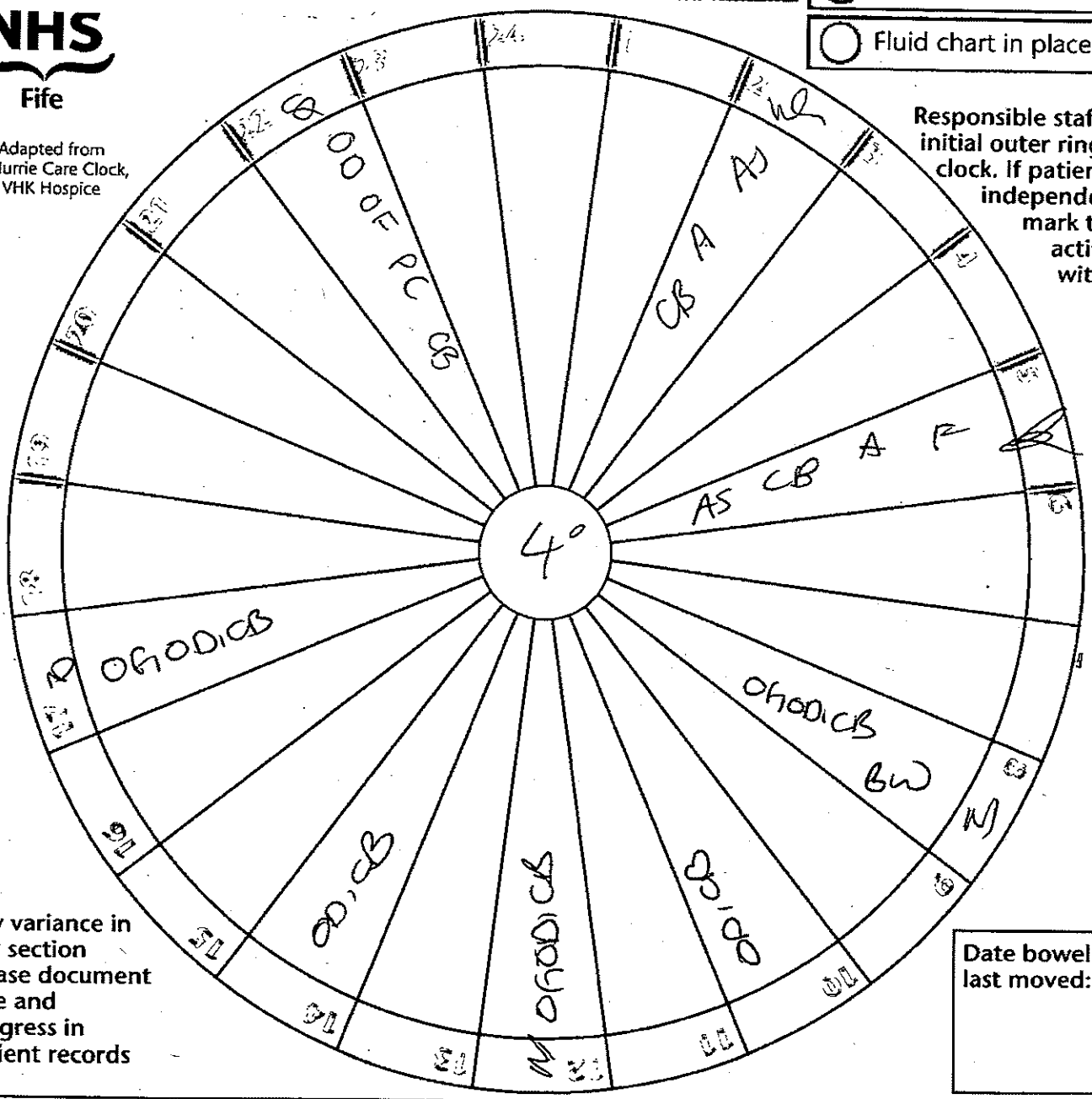
○ Food chart in place

○ Fluid chart in place

NHS Fife

Adapted from L Murrie Care Clock, VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 2/9/25

Leon Cwatton

Patient label here

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4 hourly

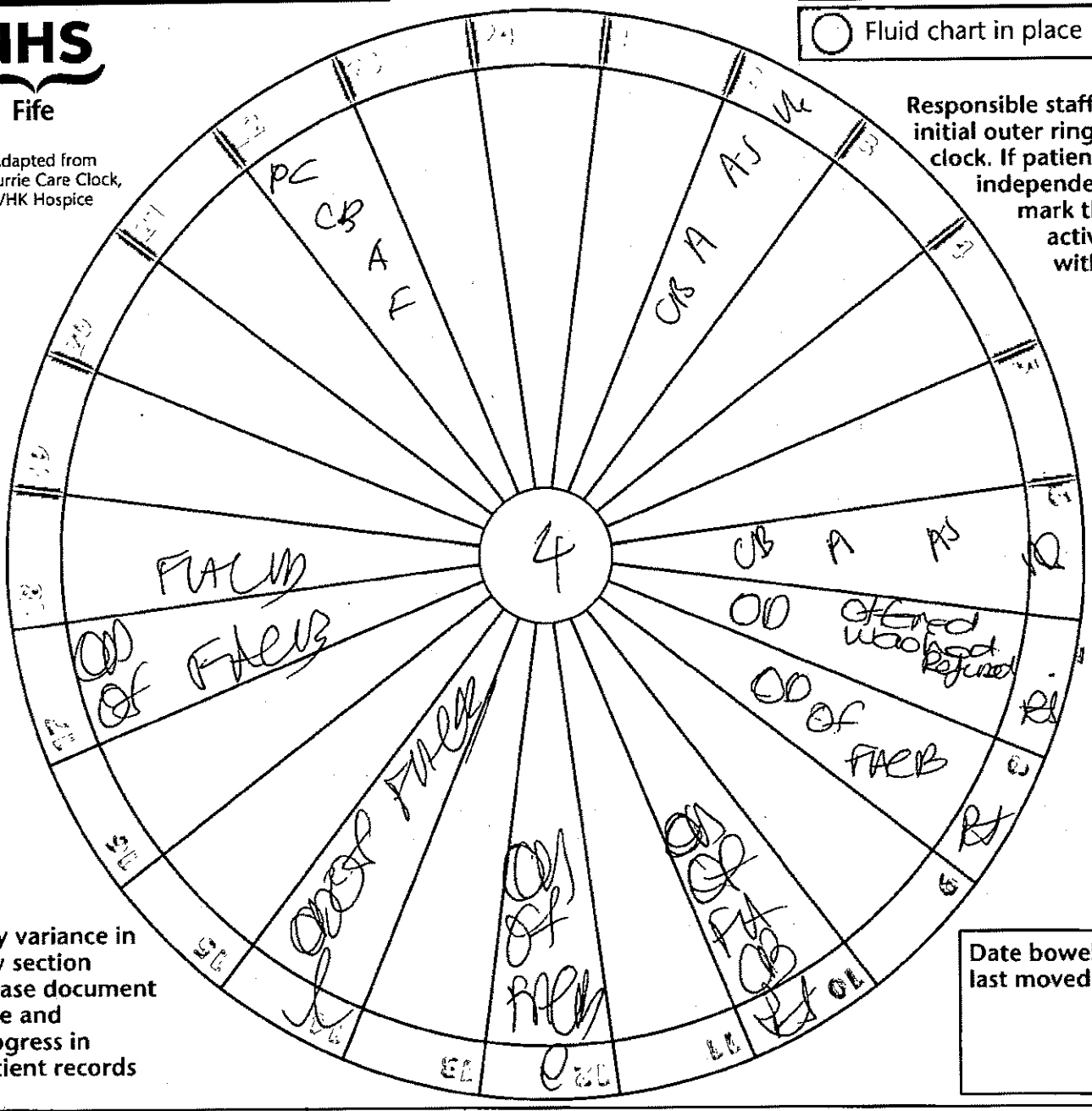
◯ Food chart in place

◯ Fluid chart in place

NHS Fife

Adapted from L Murrie Care Clock, VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



Any variance in any section please document care and progress in patient records

Date bowels last moved:

Food, Fluid and Nutrition Codes	Offered food (OF), Offered drink (OD)
Safety Codes	Walking aid available (W), Appropriate footwear available (F), Area de-cluttered (A), Call bell within reach (CB), Pain assessed† (PA)
Personal Care/ Elimination Codes	Passed urine (PU), Incontinence (I), Bowels moved (BO), Toilet no result (T), Catheter care (CC), Bed bath (BB), Shower (S), Bath (B), Basin wash (BW), Oral hygiene (OH)
Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

Care and Comfort Clock

Date: 1/9/25

Mean Gratton

Patient label here

1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:
- ○ 1
- ○ 2
- ○ 3
- ✓ 4 hourly

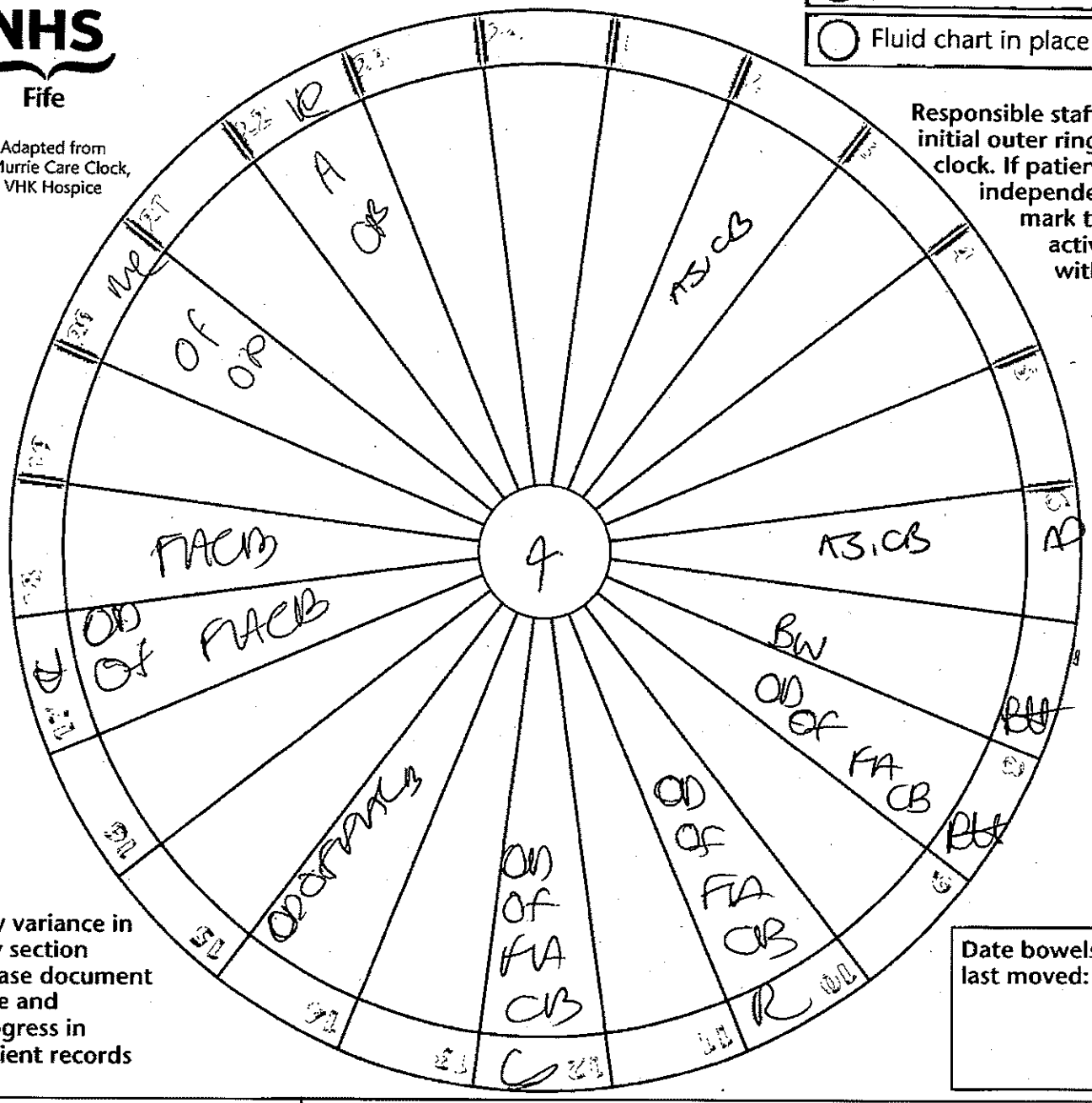
○ Food chart in place

○ Fluid chart in place

NHS Fife

Adapted from L Murrie Care Clock, VHK Hospice

Responsible staff to initial outer ring of clock. If patient is independent, mark that activity with *.



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MS2800

Care and Comfort Clock

Date: 31-8-25.

GRATTON
LEON
17-03-1975
1703751191

Registered Nurse to plan minimum comfort round frequency based on risk assessment, clinical condition and essential care needs.

Minimum frequency:
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4 hourly

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NHS Fife

Adapted from L Murrie Care Clock, VHK Hospice

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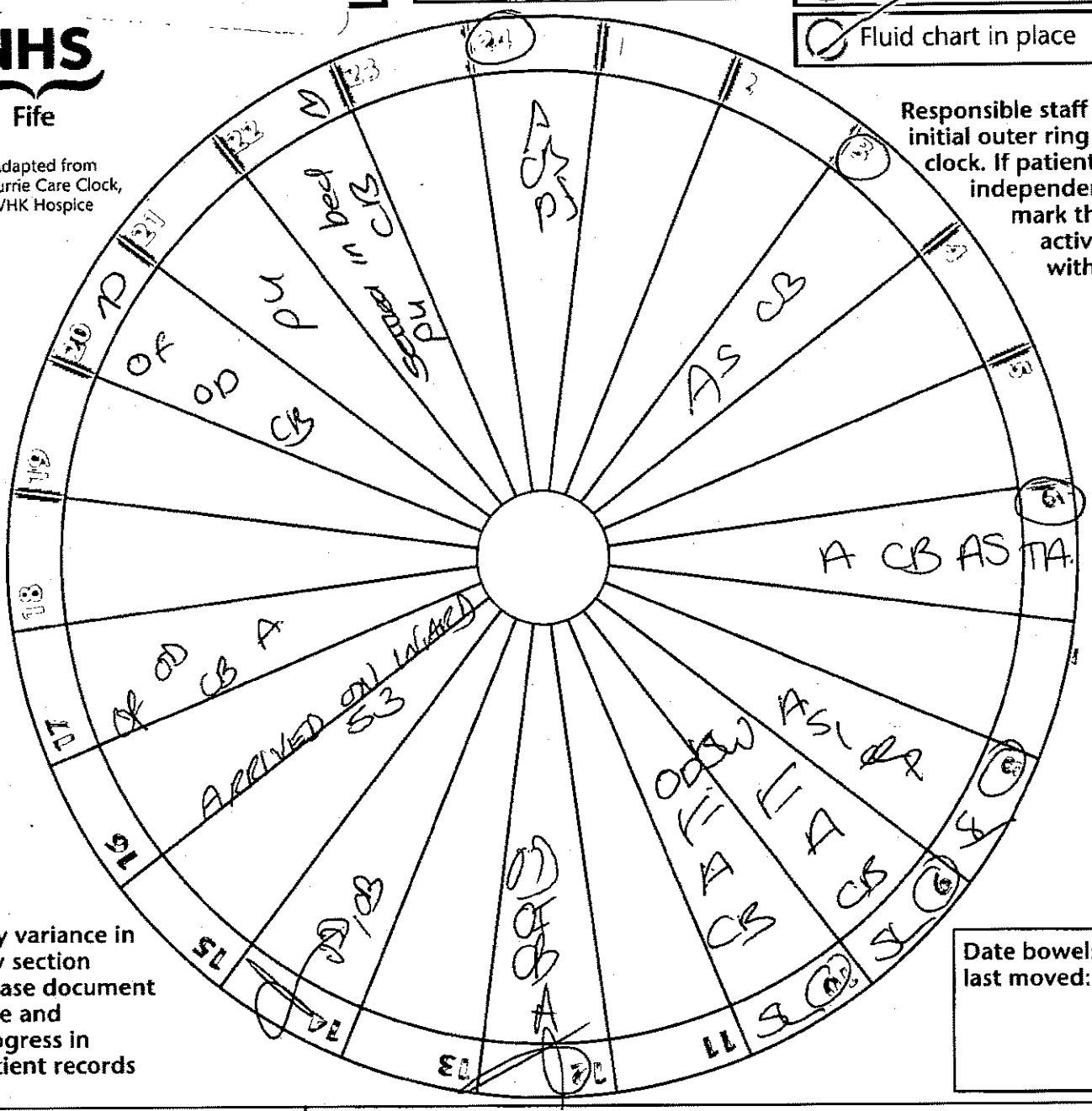

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Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
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Care and Comfort Clock

Date: 30-8-25.

GRATTON LEON 17-03-1975

1703751191

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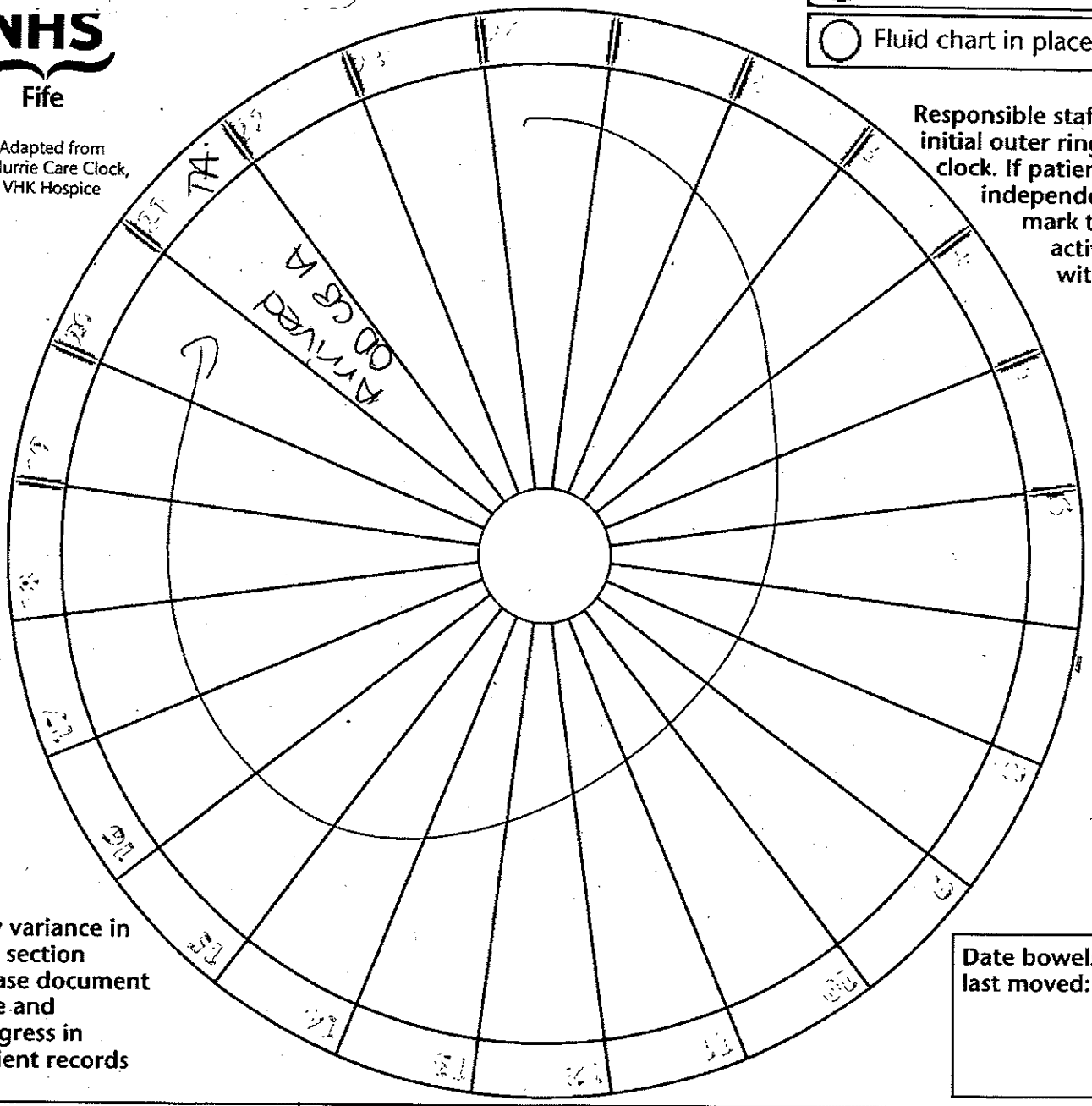

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Pressure Area Care Codes	Positional change (PC), Wound care (WC)

Exception codes: D (declined) OW (off ward) AS (asleep) TH (theatre)
†Use appropriate pain tool if pain is present

FALLS & BEDRAILS ASSESSMENT AND INTERVENTION CARE PLAN

NHS Fife

F has patient had a FALL since last review?
A is the patient AGITATED or confused today?
L is the patient LIKELY to forget instructions?
L is the patient LIKELY to mobilise without supervision?
S Ensure SAFE environment every time you leave patient/ call bell to hand/walking aid

GRATTON LEON
17-03-1975
1703751191

Admission / Transfer to Ward (MUST BE COMPLETED FOR EVERY TRANSFER)	Date	30/8/25			1/8/25					
	Ward	AU1								
		Yes	No	N/A	Yes	No	N/A	Yes	No	N/A
Provide FALLS leaflet to patient carer/family					✓					
Check E + S BPs completed on Patient Trak						✓				
Medical staff asked to complete falls assessment					✓					

Record you answer in the grid below with Y = Yes and N = No – If Yes to any of these, activate daily bundle overleaf

Date	Time	F	A	L	L	S	Signature

Date	Time	Why has the FALLS daily bundle not been implemented?	Signature
30/8/25	2115	Independant with ADLs	KS

Mental		Mobility		
		Patient is very immobile (bed fast or hoist – dependent)	Patient is neither independent nor immobile	Patient can mobilise without help from staff
	Patient is confused & disorientated	A - Use bed rails with care	B - Bed rails NOT recommended	C - Bed rails NOT recommended
	Patient is drowsy	D - Bed rails recommended	E - Use bedrails with care	F - Bed rails NOT recommended
	Patient is orientated and alert	G - Bed rails recommended	H - Bed rails recommended	I - Bed rails NOT recommended
	Patient is unconscious	J - Bed rails recommended	N/A	N/A

Bed Rails Assessment Matrix – The matrix and the codes must be used in conjunction with NHS Fife Bed Rail Policy as combination of clinical judgement and awareness. Patients with capacity can make their own decisions about bed rail use. Patients with visual impairment may be more vulnerable to falling from bed. Patients with involuntary movements (e.g. spasms) may be more vulnerable to falling from bed and if bed rails are used, may need padded covers. **Discuss with welfare POA/NOK if patient does not have capacity and document in notes.**

F has patient had a FALL since last review?
A is the patient AGITATED or confused today?
L is the patient LIKELY to forget instructions?
L is the patient LIKELY to mobilise without supervision?
S Ensure SAFE environment every time you leave patient/ call bell to hand/walking aid

Patient Label CHI

KEY - YES = Y; NO = N; NOT APPLICABLE = N/A

F	**Falls and Bedrail Care Planning Daily Bundle / Post Fall** Date	3018									
	Patient uses - glasses /hearing aid (circle as appropriate)	~~✓~~									
	Advise patient to take time when rising from sitting/lying to standing	~~✓~~									
	Ask medical staff to complete medical falls review										
A	Complete 4AT and start TIME bundle if new 4AT 4 or above										
	Consider placement in the ward and patients orientation to ward										
	Ask/encourage patient to sit-stand. Change position										
L	Call bell within reach										
	Care and comfort frequency (1/2/3/4 hourly) (add number to box)										
	Consider whether enhanced or 1:1 supervision or use of Chair/Bed alarm (circle appropriate)										
L	Follow mobility risk assessment/care plan. Consider referral to Physiotherapy and/or OT										
	If patient requires walking aid is it within easy reach?										
	Assess continence. Document support required in care plan.										
S	Area hazard free, personal belongings within easy reach										
	Select suitable seating										
	Bed at lowest level and brakes applied										
	Consider suitability and appropriateness of clothing / footwear /referral to podiatry										
	BEDRAIL ASSESSMENT										
	Bedrails Appropriate, as per Matrix (Yes/No)	N									
	Bedrails used (Yes/No) * document professional judgement on page 3	N									
	Bedrail Bumpers Appropriate (Yes/No) *document rationale on page 3	N									
	Discuss with Patients Next of Kin (Yes/No) *document outcome on page 3	N									
	Matrix Code	I									
	Signed	[illegible]									

RADIOMETER ABL90 SERIES

ABL90 Ward 43 I393-092R0352N0004 14:49 01/09/2025
PATIENT REPORT Syringe - S 65uL short probe Sample # 238

Identifications

Patient ID	8173321X
Operator	Suzanne Artley
Patient last name	
Patient first name	
Date of birth	
Sample type	Arterial
T	37.0 °C
$FO_2(I)$	21.0 %
Note	

Blood gas values

	pH	7.433		[7.350 - 7.450]
	cH^+_c	36.9	nmol/L	[35.0 - 45.0]
	pCO_2	5.93	kPa	[4.67 - 6.00]
↓	pO_2	9.78	kPa	[10.0 - 14.0]
	$cHCO_3^-(P,st)_c$	28.6	mmol/L	[22.0 - 32.0]
	$cBase(B)_c$	4.7	mmol/L	[-]
	sO_2	96.1	%	[95.0 - 98.0]
	cLac	1.0	mmol/L	[1.0 - 2.1]
	cCa^{2+}	1.16	mmol/L	[1.15 - 1.35]
	cK^+	3.7	mmol/L	[3.5 - 5.3]
	cNa^+	142	mmol/L	[133 - 146]
	ctHb	139	g/L	[120 - 175]
↑	FO_2Hb	94.9	%	[0.9 - 1.0]
	FCOHb	0.8	%	[0.5 - 1.5]
	FMetHb	0.4	%	[0.1 - 1.5]
	FHHb	3.9	%	[1.0 - 5.0]

Notes

↑	Value(s) above reference range
↓	Value(s) below reference range
c	Calculated value(s)

Solution pack lot: RE-02 Sensor cassette run #:
Printed 14:50:29 01/09/2025 1978-150

RADIOMETER ABL90 SERIES

ABL90 Ward 43 I393-092R0352N0004 14:49 01/09/2025
PATIENT REPORT Syringe - S 65uL short probe Sample # 238

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Operator	Suzanne Artley
Patient last name	
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Date of birth	
Sample type	Arterial
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FO_2(I)	21.0 %
Note	

4L O2 NC.

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Notes

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Solution pack lot: RE-02 Sensor cassette run #:
Printed 14:50:25 01/09/2025 1978-150

6.1

DRUG PRESCRIPTION AND ADMINISTRATION RECORD
SHORT STAY

NHS

17-03-1975

ALLERGIES: Yes or No *(Delete as appropriate)* If Yes, Please list	Consultant ..... GRATTON LEON Hospital ...VHK..... Ward ...S3..... Weight ..... Height	1703751191

INSTRUCTIONS FOR USE

- Use of this prescription must follow the Code of Practice Medicines.
- Use the Approved Drug name and print each entry **LEGIBLY IN CAPITAL LETTERS** in indelible ink.
- **NEVER alter existing instructions, write a new entry.**
- To stop a prescription, score a single line through both drug and administration sections, sign and date.
- When a dose is administered the person doing so must initial the appropriate box.
- When prescribing new medicines be mindful of administration times and if necessary prescribe a dose in the once only section to ensure patients do not miss doses.

Place Any Additional Stickers Here

Compliance MD

CHARTS IN THE BOOKLET	Additional Charts (Attached)	√	Date started	Date finished
Thromboprophylaxis	Warfarin			
Oxygen Prescriptions	Subcutaneous Insulin			
Regular Prescriptions	Intravenous Insulin			
As Required/ Symptomatic Relief	Intravenous Fluid			
	Syringe Driver			
	Others			

Codes for Drugs Not Administered

A - Patient refused
B - Patient Unavailable
C - Instructions not clear / legal
D - Medicine not available
E - Nil by mouth
F - Once only / pm given
G - Dose withheld – Prescriber's instructions
H - Self-administered by patient
I - Nausea / Vomiting
J - Unable to swallow
K - No intravenous access
L Other

ONCE ONLY PRESCRIPTIONS

Date	Time	Medicine	Dose	Route	Prescriber's Signature	Time Given	Given by

MS2791

THROMBOPROPHYLAXIS

THROMBOPROPHYLAXIS SHOULD BE REASSESSED EVERY 48 HOURS	Times to be given	Date ⇓ and Month ⇒
DRUG DALTEPARIN	Q24hr	
Dose 5000 units / **Route** S/C / **Start Date** 2018		
Reason for Change/Stopping:	1800	IP IP dM
Prescriber's signature Kath / Comments REVIEW CLOSED		

VTE RISK ASSESSMENT - STOP !!!!

		Date ⇓ and Month ⇒
1	Patient VTE Risk Assessment completed on admission (medical clerking)	yes
2	For Dalteparin	(YES) / NO
3	If YES give patient VTE information leaflet prior to 1st dose	
REASSESS IN 48hrs Date Reassessed:		
Continue with Dalteparin	YES / NO	

OXYGEN PRESCRIPTIONS

		Time / Date ⇓ and Month ⇒
DRUG OXYGEN	**Observation** 4 hourly ☐ 12 hourly ☐ Daily ☐ Other	
Titrate to achieve target oxygen saturation as indicated Not Indicated (see oxygen policy) ☐		
94% - 98% ☐ 88% - 92% ☐ Other _____ ☐		
Starting device/flow rate	Start Date	
As required ☐ Countinuous ☐ (Refer to oxygen policy)	Route: Inhaled	
Prescribers Signature		

		Time
DRUG OXYGEN	**Observation** 4 hourly ☐ 12 hourly ☐ Daily ☐ Other	
Titrate to achieve target oxygen saturation as indicated Not Indicated (see oxygen policy) ☐		
94% - 98% ☐ 88% - 92% ☐ Other _____ ☐		
Starting device/flow rate	Start Date	
As required ☐ Countinuous ☐ (Refer to oxygen policy)	Route: Inhaled	
Prescribers Signature		

PATIENT NAME ..... CHI ..... CONSULTANT .....

REGULAR PRESCRIPTIONS

Times to be given | Date ⇓ and Month ⇒ | 30/08 | 31/8 | 1/9 | 2/9 | 3/9 | 4/9 | 5/9

DRUG DOXYCYCLINE

Dose 100 mg | Route PO | Start Date 30/08/25

Reason for Change/Stopping

Indication CAP | Comments

Prescriber's Signature Kartik

0800 | X | JW | [illegible] | AP | AP

completed 5/7 course

DRUG CO-AMOXICLAV

Dose 1.2g | Route IV | Start Date 30/08/25

Reason for Change/Stopping

Indication CAP | Comments

Prescriber's Signature Kartik

0800 | X | [illegible]

1400 | X | [illegible]

2200 | [illegible]

ORAL SWITCH

DRUG CLOZAPINE

Dose 300 mg | Route PO | Start Date 30/08

Reason for Change/Stopping M319

Indication | Comments ~~Data report when box is finished~~ 2 DOSE

Prescriber's Signature Kartik

2200 | [illegible]

DRUG SOPROBEC 100 micrograms

Dose 2 puffs | Route INH. | Start Date 30/08

Reason for Change/Stopping

Indication Asthma | Comments M419 Dose

Prescriber's Signature Kartik

0800 | — | [illegible]

2200 | [illegible]

DRUG ARIPIPRAZOLE

Dose 20 mg | Route PO | Start Date 30/08

Reason for Change/Stopping

Indication | Comments Dose M419

Prescriber's Signature Kartik

0800 | — | D | D | AP | AP | SM | AP

DRUG FLUOXETINE

Dose 60 mg | Route PO | Start Date 30/8

Reason for Change/Stopping

Indication | Comments Dose M419

Prescriber's Signature Kartik

0800 | — | JW | [illegible] | AP | AP | JW | AP

PATIENT NAME .... CHI .... CONSULTANT ....

REGULAR PRESCRIPTIONS

Times to be given | Date ⇓ and Month ⇒ 3/8, 1/9, 2/9, 3, 4/9, 5/9

Drug details	Times to be given	3/8	1/9	2/9	3	4/9	5/9
DRUG OMEPRAZOLE; **Dose** 20 mg; **Route** PO; **Start Date** 30/08; Reason for Change/Stopping; **Indication**; **Comments** M419 DHE; Prescriber's Signature Karth	0800	[initials]	[initials]	[initials]	[initials]	SM	[initials]
DRUG SIMVASTATIN; **Dose** 40mg; **Route** PO; **Start Date** 30/08; Reason for Change/Stopping; **Indication**; **Comments** DHE M419; Prescriber's Signature Karth	2200	[initials]	[initials]	[initials]	[initials]	[initials]	
DRUG FOLIC ACID; **Dose** 5mg; **Route** PO; **Start Date** 30/08; Reason for Change/Stopping M419; **Indication** except Tuesdays; **Comments** DHE except the day of Methotrexate; Prescriber's Signature Karth	0800	[initials]	[initials]	[initials]	[initials]	SM/H	
DRUG Betamethasone Valerate; **Dose** 0.1% ointment; **Route** topical; **Start Date** 30/08; Reason for Change/Stopping; **Indication**; **Comments** alternate days DHE; Prescriber's Signature Karth	0800	ordered (D)	D	(H)	(H)	(H)	(H)
DRUG EPADERM CREAM; **Dose** 1 application; **Route** topical; **Start Date** 30/08; Reason for Change/Stopping; **Indication**; **Comments** M419 DHE; Prescriber's Signature Karth	0800	ordered (D)	D	(H)	(H)	(H)	(H)
	2200	(D)	D	H	(R)	(H)	
DRUG Oilatum; **Dose** 1 application; **Route** topical; **Start Date** 30/08; Reason for Change/Stopping; **Indication**; **Comments** twice a week DHE; Prescriber's Signature [illegible]							